Holsworthy 20 August 2015

Questions and concerns

Decision-making criteria

The distance to travel from Holsworthy to NDDH is so great, the public transport scarce and the taxi costs are enormously high – that is if you can find a taxi that will take you. It is nearly impossible for people with children to travel to Barnstaple out of school hours. How do you expect people to do this?
We recognise this is a real issue for many communities in Devon. We have listed access and transport as one of the important decision-making criteria and this will be taken into account when we make the final decision.

This is exactly why these meetings are so important. At the three meetings today we've heard that a taxi fare to Holsworthy can be up to £200 return and that you can't book one immediately. We would not have known this without you telling us so it is really important that you state this sort of example when completing the consultation response form.

If the population is increasing, why do we need fewer beds?
We can care for more people if we look after them at home. On average, it costs around £75,000 a month to staff a community hospital for nursing. In a month, a community hospital looks after about 21 people. For the same amount of money, we can deliver the same level of care to approx. 82 people in their own homes.

Why is the number of nursing homes in the region relevant to this consultation?
The decision-making criteria that we are using as part of this consultation was developed through feedback from the public during the CCG's Care Closer to Home consultation and is included because people thought this was an important criterion. Whilst the care offered by nursing homes is different to that provided by community hospitals, they provide care and particularly end of life care so form part of the wider health services.

Why is having a hospice viewed as a weakness?
Clearly, having a hospice is of great benefit to the community. However, it could be viewed that if a town has a hospice, there are more end of life services for people there, and so that community may be less reliant on a community hospital to offer these services.

We have corrected this in our consultation document as we appreciate this was not worded in a clear way.

There are pockets of deprivation across the ward and the area is generally underfunded. You have a social duty to promote equality – what will you do to ensure that people in this area do not lose out?

Again, this is an important factor to consider when the Board make their final decision.

Home-based care

We have concerns over the availability and quality of social care in our area.
We have heard people's concerns about access to social care in the local area. Whilst social care is the responsibility of Devon County Council, our services offer care either immediately before, after or instead of a hospital admission. It is really important that we make the distinction between the short-term NHS provision and longer-term social care, the latter is not impacted by this consultation.

Where we can avoid hospital admissions, we are finding that we are reducing reliance on social care because people with health needs get high-quality and safe care and support in their own homes, thus retaining their independence. People tell us they don't want to be in an institution if it can be avoided and we are tailoring our services to help people remain independent and well for as long as possible.

If, after that short time, someone needs ongoing care to recover fully, NDHT links up with the social care teams, the patient and their family to decide what support the patient needs to remain independent in their own home. This is called a care package and elements of it (social care) will be means-tested.

This consultation is only about how we meet the short term health need and potentially replacing a community hospital stay with the support needed in their own home.

We have heard people express concerns that the availability of social care is a problem in their community. Care homes offer different services and levels of care to community hospitals. If someone is very ill, they should be in hospital, but someone who is well enough to be at home, but who requires social care at home, should not be in a community hospital.

Can social services and NHS get together to prevent us coming back again and again into hospital?
Yes and already have a well-established joined-up approach to health and social care in Devon. Of course we can always get better and our teams work hard to continually develop that integrated service.

Our community teams are led by people who work jointly for the NHS and for Devon County Council. We do work together to provide integrated health and social care but you're absolutely right that we feel we can go further to make this better for patients.

For an example of how this works in reality: our social services carer might notice that there is a problem with a patient whom they think is at risk of a fall. They will speak to therapists in the community hospital who will go and

assess that person and perhaps refer them to the strength and balance class at the community hospital.

Through this joint working, we can pick up on issues before they become real problems and before the person falls in their own home or experiences a health crisis which results in a hospital stay.

Are community nurses given transport to visit their patients, or do they have to use their own cars?
Community nursing staff have an option of using their own cars for work purposes and are then reimbursed for mileage in accordance with the NHS's national terms and conditions. This allowance reduces after 3500 miles. Alternative they can choose to be part of the lease car system or use a pool car.

I live way out in the countryside, would a community nurse visit me in my home?
The community nursing service will visit anywhere if the patient needs our service. We have a great deal of experience of visiting people in very rural areas, including one patient currently where the track to their house is so bad, we cannot drive down it.

I nursed a family member at home and the equipment we needed was not available.
We do not know the details of what happened in this case, but this sounds like something you need to take up with Devon County Council as they are responsible for providing equipment to people in their own homes.

Community care is not cheaper – there isn't the staff, it is expensive and doesn't have back-up that a hospital has if something goes wrong.
We believe that we do have sufficient staff to deliver home-facing services and our resources go further because we can support far more people in their homes as we can in a community hospital.

We do not have the same problems recruiting nurses into community nursing roles as we do in our community hospitals.

We have done the financial modelling and we know that it is more cost-effective to look after people in their own homes as we can care for many more people for the same amount of money. From our experience where community beds have been closed (e.g. Torrington and Ilfracombe) we have good evidence that the level of care is as good as in hospital and the level of patient satisfaction is extremely high.

Whilst we always try to ensure that nothing goes wrong, both at home and in hospital, unfortunately there are times when things do go wrong and we know that if someone stays in hospital for over 11 days the chance of them getting a complication simply due to the fact that they are in hospital is high. We believe that, where clinically appropriate, the safest place for people is in their own home.

I have to travel a long way for an outpatient appointment at NDDH. Why can't we make more use of our community hospital for outpatients?
We agree that more outpatient clinics could be held at community hospitals and this is something we'd be happy to look at with the Holsworthy community.

Is Devon County Council ready and staffed to provide carers from this October?
We need to be really clear that we are not talking about replacing qualified nurses or therapists with domicilary care workers.

We are only talking about the services which are free at the point of need, and which replace the care in a community hospital bed with care at home in your own bed.

Long term care is provided through Devon County Council and delivered by care agencies.

Based on our past experiences in Ilfracombe and Torrington, we feel confident that we will have sufficient nurses, therapists and healthcare assistants to deliver the short-term, health-funded care that replaces a community hospital stay. We would not even consider removing community hospital beds unless we were sure that the alternative was safe and effective.

From a GP: the increase of community services provision hasn't happened. I can't get rapid response to deliver care to my patients in an emergency, there is no facility to spot purchase beds in nursing homes.
We do need to develop the rapid response service in all areas. In towns where there are no beds we have increased the community care provision, including more community nurses and therapists.

Option of community beds at NDDH

How would it work if there was a "community" ward in NDDH and the hospital was suffering a period of extra demand, for example in winter? Would the "community" beds be taken over by the acute patients?

This is something we are currently working through and we agree that the NDDH option would have to provide the opportunity to flex up our capacity to cope with winter pressures. There is a possibility that, at periods of surge, someone requiring acute treatment might have to be placed on the community ward temporarily. However, I am sure that you would agree that if there was someone urgently needing hospital admission, then using an empty bed in the community ward would be preferable to turning them away.

Do you get paid extra for people going into NDDH?
No, the community beds are on a block contract and we would not get paid any more, even if we admitted these people into a community ward at NDDH.

If a frail person is being nursed at home and suddenly needs to go to NDDH – they could die during transfer.
We understand your concerns over the distance to travel to Barnstaple. However, if a person is very ill then they would probably have to go to the acute hospital anyway, whether they are being nursed at home or in the community hospital.

There is an inference in the options that a bed at NDDH is the same as a bed in a local hospital. This is not true. People feel so much better coming back to their local town – it helps people get better.
We agree that the care people receive at their local community hospital is excellent. We also know that it is much easier for loved ones to visit when their hospital is local. We would also suggest that if someone is being looked after in their own home, then that would be even easier for family members to visit.

Consultation process

We are concerned that the CCG do not support your consultation. Why are you not working together with the CCG in this?
We are charged with delivering safe and effective care within the budget given to us each year by the Clinical Commissioning Group (NEW Devon CCG).

The Trust's consultation process is constrained by the budget for a financial year ending in March 2016.

This means we are proceeding at different paces to the CCG, which is charged with the long-term strategy for local health services. The CCG feels it is clearer for stakeholders and the public if we separate our two processes, and we respect this point of view and decision. We have ensured the CCG understands it can re-join our consultation at any point and are ensuring that any option for consultation is entirely aligned to the objectives of the CCG's Care Closer to Home strategy.

We have concern over the process of the stakeholder meeting.
Throughout this process, we have been working closely with our stakeholders, (which include town, district and county councillors, Leagues of Friends, GPs and other bodies such as Healthwatch and voluntary organisations) to ensure that their views are captured and considered.

On the 6th and 10th August, we held two stakeholder meetings. The purpose of these meetings were as follows:

- To review and shortlist the criteria being used to make decisions about bed locations across Northern Devon

- To weight the criteria according to how important and relevant it was to the decision of where beds should be located
- To score each of the proposed sites against each of the criteria
- To agree options for public consultation

We know that this was a really difficult thing for people to do. The evaluation of the criteria was always going to be a subjective process as we were asking people to confirm what they viewed as really important. However, that doesn't mean the efforts of this group should be discounted. The stakeholders made some excellent contributions to these meetings and the productive discussions provided some valuable insight.

When you have consulted with stakeholders, why have you not included GPs?
We have included GPs as part of our stakeholder engagement. We invited GPs to our stakeholder reference group meetings and are meeting with them on 25 August to discuss the consultation. We welcome the views of GPs as part of this consultation.

We feel that you have already made up your mind and that we have lost our hospital. Is this a done deal?
No, the decision has definitely not been made. All the options in the consultation would meet our requirements in terms of delivering safe and effective care within the budget. We need to consider all the feedback about the different options and then the Trust board will make a decision on the 6th October.

Why do you not have "Do nothing" as an option?
Doing nothing is not an option. The current situation is not sustainable, either financially or in terms of workforce. As well as having to find £5 million from our community services budget, we are not able to recruit sufficient staff for our community hospitals.

Why is a six-week consultation sufficient?
We need to ensure that we give people enough to put forward their views and opinions and believe that six weeks is sufficient for people to do this. Many people are complaining that this decision should have been made earlier in the year. In addition, we need to have made a decision and put in place robust plans before the winter.

The finances

Do savings have to be made by the community hospital bed closures? Could savings come from anywhere else? Can the options definitely deliver the savings?
In total, the Trust has to make £11M of savings this year to live within its budget. Out of this, £5M of savings have to come from the community services – North and East.

To put this in context, the NHS is required annually to make efficiency savings and this will continue for the foreseeable future.

The anticipated cost savings offered by closing one inpatient unit is in the region of £700K. The remaining savings will be made through other efficiencies.

More importantly, by moving to more home-based care, we can look after many more people for less money: a 16-bedded community hospital unit costs approx. £75K per month for nursing. In one month, a unit like this cares for around 21 people in a month. For the same amount of money, we can care for around 82 people per month in their own homes.

However, this is not just about the money. We truly believe that this is a better model of care. We would like to assure you that safety is our paramount concern and we will not just go for the cheapest option.

You should not be having to save £11M; you are £11M under-funded. You should be fighting the budgets, not closing hospitals! Why are you not fighting for more money?
We do fight for every penny but we have to live within the money available. The NHS nationally is charged with being more efficient. We do challenge our financial allocation and went to arbitration with the CCG to fight for our budget. However, we now have to operate within the agreed budget and this means finding £11M of efficiencies.

Have you thought about other ways of saving money? What about the waste of resources such as replacing equipment that could be used again?
We are absolutely looking at all the ways we can save money. The reduction of inpatient community hospital beds is only one part of the overall cost reduction programme. We have to make efficiencies right across the board, across the acute hospital as well as the community, and our staff has come up with some good ideas of how to save money.

With regards to equipment, we have regulations about what we can and can't use again – sometimes we are prevented from reusing equipment due to risks of cross-infection but we recognise that it can seem like a waste.

Why don't you get rid of business consultants and expensive project managers instead of closing beds?
We don't employ business consultants or project managers and operate a very lean workforce in terms of layers of management..

Everyone who works at the Trust contributes towards patient care, even people with a "back-office" function, such as finance or IT.

What are the potential costs of bed blocking in the acute hospitals?

The teams at NDDH are actually very good at managing in times of high demand for our services. Bed blocking is often due to factors outside our control such as family decisions, social care availability and transport availability.

The CCG monitors the cost of this as it relates to more than one organisation and is used as a sign of how well the local health system is working.

Have you costed what care in the community will cost in this rural area? What if the cost of care at home is more expensive than hospital beds?
Yes, we have costed the different alternatives and care at home is not more expensive than hospital beds.

Holsworthy specific questions

How many out-of-area patients come into Holsworthy?
Very few out-of-area patients come into Holsworthy.

Holsworthy hospital was built only a few years ago. It is a modern facility and the site of the brand new Long House (hospice) was chosen due to its proximity to the hospital.
We agree that Holsworthy is an excellent hospital. The quality of the hospital facilities is one of the criteria by which we are encouraging people to explain their choice of option.

The community has contributed £75,000 the Long House Trust. We were led to believe that if someone became ill there they could go into Holsworthy hospital. In 5 years' time we might well be saying, 'What are we going to do with the Long House?'
From our understanding the Long House will be a fantastic facility for the local community. Again, we are consulting on how to deliver safe, effective care within the budget in this financial year and this is unrelated to the services offered by the Hospice.

However, it is clearly an issue that is important to the community so we would encourage you to raise your concerns in your consultation response.

Other

You talk about rehabilitation – what about end of life care?
We agree that there are some people who wish to die in a community hospital and for areas that don't have good hospice care, the hospital will often take more end of life patients. Some people prefer to die in a hospital but many people tell us that they would prefer to die at home. Our teams work with patients and their families to support them in their wishes.

Why are you going against the strategic direction of the NHS where community hospitals are "flavour of the month"?

The strategic direction of the NHS is encapsulated in the Five Year Forward View. The Five Year Forward View mentions the benefits of small hospitals and locally available services which means a shift of care to outside of hospitals. However we understand this was referring to small District General Hospital, such as North Devon District Hospital. There is no prescription on community hospitals.

Why is that when we ask for services to come from Barnstaple to Stratton Hospital, you won't come there?
We are not commissioned to deliver services in Stratton Hospital and so are unable to set up services there. If Cornwall's CCG were to commission us to deliver services, we would be more than happy to explore this. We agree that all parts of the NHS need to consider how we can work together to deliver the best possible services.

The hospital is nearly always full and when Barnstaple is full, people come here. If all the beds are at NDDH, that will make bed blocking worse.
Winter was very challenging and we would need to think about how option B may impact our A&E and operations at NDDH. However, this option was presented by our clinical teams as it does offer a great deal of benefits to patients in terms of continuity of care. We therefore have to consider it as an option.

Different people need different things from hospital. For some patients it is important to see relatives every day; for others, having streamlined, specialist care is more important. The fact that this option has been suggested does not mean we think there is no need for local provision – some people will always need a community hospital.

Can you please provide data about bed occupancy in your info pack?
Average bed occupancy for the Northern community hospitals in the last 12 months is as follows:

Hospital	Occupancy rate
Bideford – Willow ward	90.70%
Holsworthy	90.43%
South Molton	87.13%

This data is now included in our information pack.

If beds stay in our town this time, we'll be here again in a few years with the next cuts. What can we do to secure our beds in the future?
Yes, you are right that this is a very challenging period for the NHS. There are many changes happening in the health environment in Devon. You will have heard of the Success Regime, which will take a more strategic approach to

the entire system across Devon in order to save £430million. We sincerely hope that this will set a long term direction for health services in the county.

In terms of what you can do, in places where beds have closed there are steering groups who are working with us and other bodies on the future of their hospitals (for example One Ilfracombe). This could happen regardless of having beds or not and we would encourage communities to get involved in shaping a more joining up health and social care system.

Who are the Trust Board accountable to?
The Trust Board is accountable to several bodies. Our immediate accountability is to the Trust Development Authority, however we are also responsible to the Care Quality Commission, the heath watchdog, and of course the communities we serve.

How did the CCG come up with 40 beds?
The CCG did extensive modelling to come up with the figure of 40 beds and their paper explaining the process can be found here. We need to stress that this number is flexible. We do not have a contract to provide a set number of community beds and so we will offer the appropriate number of beds, according to the demand.

What will happen to the nurses at the sites where the beds close?
The nurses at the community hospitals where the beds close will be consulted with, their skills and work preferences will be considered and they will be found alternative positions, either in the community, or at the acute hospital. We have found that the staff who were moved from the hospital to community nursing in Torrington and Ilfracombe are very happy in their new positions.

The 2006 Durrow Report said sell the land at NDDH and build another hospital instead. What happened to that?
The Durrow Report suggested a PFI arrangement for building a new hospital, something which nobody would recommend these days. In addition, the plans would mean that there would have been no A&E, no helipad, no endoscopy, amongst other things and it was therefore ruled out.