Ilfracombe 18 August 2015

Questions and concerns

Specific to Ilfracombe

Who owns the freehold of the Tyrrell Hospital?

Northern Devon Healthcare Trust owns the freehold.

Refurbishment of the Tyrrell Hospital

Does it really cost £1.5m to £2m to refurbish a ward? Have you looked at all the options and configurations?

It is not possible to create a 16-bedded ward within the current space available at the Tyrrell.

We are required to adhere to strict NHS estates guidance which dictates how much space is needed between beds, male/female facilities, storage space, single bedded rooms etc.

The budget may seem expensive, but there are many unseen costs and – based on our experience of refurbishing wards across Devon and building new units (like Chemotherapy at NDDH) - we can assure you that this time and cost estimates are reasonable.

How did you come up with these costs? What are the plans?

We did the estimate based on the square footage. If beds at the Tyrrell was the preferred option, these plans would be worked up in more detail.

Would it not be cost-effective in the longer term to invest the money and completely refurbish the Tyrrell? You are looking at a very short term view.

Unfortunately, we have to look at the short term because we are charged with delivering safe and effective care within our budget each year. The option of refurbishing/extending Ilfracombe in this financial year looks unlikely which means it becomes a longer-term option.

Longer-term strategic decisions are taken by NEW Devon CCG and nothing we do now will prevent beds coming back to Ilfracombe in the future.

For 11 months you were saying that the closure of inpatient beds at Ilfracombe was temporary. Within 14 days you changed your mind. How did that come about?

Tyrrell beds were temporarily closed in November 2014 following our concerns about the risks of lone-working and our view that we would shortly not be able to fill the projected nursing rota due to workforce retirements and changes.

Through our subsequent engagement with the community we looked at ways in which we could resolve those safety concerns. The community asked us investigate two options: 1) could we rotate nurses between NDDH and Ilfracombe and 2) could we extend/refurbish the Tyrrell to fit 16 beds

The Trust's Director of Nursing confirmed that we were unable to consider rotational nursing posts because it would require more nurses at a time of a national nursing shortage.

The Trust's estates professionals then presented their assessment of the Tyrrell building and confirmed that it would take at least 18 months and £1.5-2million to deliver a 16 bed hospital in Ilfracombe.

Because this option was not one that would be possible in this financial year, the Trust discussed with stakeholders why this could not be considered an option.

However the stakeholders felt this was unfair and meant we were not allowing people to come forward with ways which may overcome the time and cost restraints.

We agreed and for this reason, and with these caveats, the Ilfracombe option was put back into the consultation process.

Why has Ilfracombe been allowed to get to this state? Why did you not refurbish earlier?

The Tyrrell is not in a run-down state. This is not about refurbishing to modernise, it is about having to increase to 16 beds from 10.

Is there any chance of accessing Lottery Funds to invest in the Tyrrell?

It is not normally permitted to use lottery funds to fund the NHS.

Why can't you refurbish little by little?

This is not a safe approach. When you have patients being cared for in a ward, you cannot have builders working alongside. You have to close the hospital and complete the building work before reopening for patients.

Do you have to keep male and female patients separate?

Yes, and this is non-negotiable national guidance. This is why any reconfiguration of the Tyrrell hospital would have to accommodate single-sex rooms with en-suite facilities.

Recruitment and staffing

Have you advertised for nurses locally?

Yes, we have been advertising recruitment open days in the local press, on our website and through social media. We also advertise on the NHS jobs website as we know that is where people look for nursing jobs. We go to recruitment fairs and national recruitment events as well.

How much does it cost to recruit from overseas?

It costs £3000 per nurse.

You are taking nurses from countries that need them.

That is not true. Some time ago, as part of the EU regulations, Spain, Portugal and Greece were forced to offer graduate training for nurses. Many of these nurses were trained and then did not have a job to go to once they graduated. Since then, the governments in these countries have reduced the amount of training available so in a few years they will be in the same position as we are.

The announcements that there has been an increase in national nurse training programme will still see us short of nurses for a further three years so there is no immediate solution to the national nursing shortages.

Torquay hospital has been very successful in attracting nurses from abroad. Why can't you do the same?

We have also been very successful in attracting nurses from Europe over the last two years but we have to recognise that almost every UK NHS organisation is now competing for the same nurses. However, we will ask Torbay what they have been doing to see if we can learn anything.

There are lots of unemployed people in Ilfracombe, could we not use them to assist nurses?

In the new world of regulation, post-Francis report, it is not possible to bump up the numbers of unregistered carers to replace the need for a nurse.We are mandated that we have to have a set ratio of registered to unregistered staff. Even if we have more health care assistants, you would still have to have the same number of registered nurses.

Home-based care

What happens to people who are on their own? They can't be looked after at home.

We are able to offer high-quality and safe care and support in people's homes. If necessary, we can offer 24-hour care if people need it, for a short period of time.

In this country we have a mean-tested social care system and so if someone needs long-term care, then they will be means-tested and an appropriate package of social care would be put in place. If someone is very ill, they will 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.

We understand that social isolation is a problem for older people who are restricted to their home. We are lucky in Devon to have the support of some fantastic voluntary groups who support people to live healthy and well in their own communities – for example transport help, befriending.

But people want to be looked after in a community hospital!

We know that 40% of people who are in a community hospital will end up being discharged to a care home. For people who are looked after in their own home, this number is considerably lower. People tell us they don't want to go into a care instution and we know we have to change the way our services are provided so we do more to support people remaining independent in their own homes.

Joining up health and social care is key to this. How can we ensure that people get the social care they need? Are you working together with the councils?

Yes, we absolutely agree. 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 Tyrrell who will go and assess that person and perhaps refer them to the strength and balance class at the Tyrrell.

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.

Since the inpatient beds in Ilfracombe have closed, we have trebled the number of balance classes run at the Tyrrell and the waiting has gone down from about 6 months to a couple of weeks.

What level of treatment would you be able to give patients in their own home?

There is health-funded care to enable people to stay at home for short periods of time – this covers night time and if necessary round the clock care for a week that replaces a hospital stay.

If, after that short time, someone needs ongoing care, 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.

We are losing care home beds so it's even more important that we keep our community hospital beds.

We know that this is a real problem for many communities in Devon. However, care homes offer different services and levels of care to community hospitals.

Isn't this the same thing as happened with mental health/care in the community? That was a disaster, with lots of vulnerable people being let down.

What we are proposing is different to that policy, which was a very radical removal of beds for people suffering from mental illness. We will still be providing beds for people who need them. There will always be a need for some beds – we are not saying that home based care will remove all bedded care.

The consultation process

What are you doing to advertise these meetings?

We have advertised these meetings on our website and have sent out a press release so that the meetings will be promoted in the local press. We have done an interview with local radio and BBC Radio Devon, and hope to do more to publicise the meetings as widely as possible. We have emailed stakeholders and also printed posters and flyers which have been distributed. We will continue to promote these meetings as we really want as many people as possible to get involved.

Every time we get asked to consult on something different. Things keep changing and we do not know what we are supposed to be commenting on. Why is the CCG not participating?

We understand that this is confusing. We need to make it clear that our consultation is separate from that of NEW Devon CCG, which is looking at the longer-term strategic direction of Care Closer to Home. We are consulting on the need to provide safe and effective care within the budget we are given.We

are having to move at a quicker pace than the CCG but entirely respect their decision to separate Care Closer to Home from this consultation.

We come to these meeting time after time, how much are all these meetings costing?

We have a legal duty to consult and are required to hold an accessible and equitable consultation process.. We try to keep costs down as much as possible.

Are you talking about permanent closures? Once our town has been ruled out we don't think this will ever come back.

As the CCG's process is now separate from ours, the outcome of their Care Closer to Home consultation may come up with a different outcome.

Therefore we have committed to the CCG that any change or closure we make, would have to be fully reversible. The success regime will also be looking at the wider picture and may decide that a community hospital is needed in your town. I'm afraid we are working in a period of great change in healthcare and we cannot really predict what will happen in the future.

The NDDH option

How much would it cost to refurb a ward at NDDH to provide the community unit in the acute hospital?

There is no requirement to refurbish a ward to provide a community/rehabilitation ward at NDDH.We would ensure there is sufficient capacity for the community beds and other specialities as part of the work we are doing to improve length of stay and improved pathways at the hospital. This means that there would be no additional cost for this option.

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?

The NDDH option still provides 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 ugently needing hospital admission, then using an empty bed in the community ward would be preferable to turning them away.

Transport and population

Travel is a real problem here. The other options are a long way away. It is such a long distance to any of the other hospitals.

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.

It is important that if you have a view on this that you state this when completing the consultation response form.

Have you taken projected population increase into your plans?

We have looked at the demographics of each town and representatives from Devon County Council, who are experts on population, public health, planning and housing, attended our Stakeholder Reference Group meetings to provide their input. NEW Devon CCG, as part of their Care Closer to Home consultation will take this type of thing into account from a strategic, long-term point of view.

Other

What will happen with the equipment that the community bought for the hospital?

Any equipment donated to the NHS becomes the property of the Secretary of State once it has been handed over. We are very grateful to the community for their continuing support via the League of Friends in particular.

We hope there is a way to ensure that equipment used to enhance patient care will continue to be used in delivering that care.

What is happening with the MIU? Is this closing?

We have no plans to close the MIU. It is true that the CCG is running a review of urgent care that includes MIUs and Walk-in-Centres as well as out of hour GP cover, but the procurement exercise has been paused. While there is not an outcome, we will continue to run the service.

Have you consulted with the other services – e.g. fire service?

We do try and work with other services. For example, in Ilfracombe, we work together with a range of different groups through a connected forum, called One Ilfracombe. A lot of feedback that we get from the police and fire services is very useful and we can learn a lot from other public sector bodies.

We also link in with Exeter with their ICE programme (integrated care in Exeter). The fire service plays an important part in this, e.g. for people who

are at risk of fire in their homes. So we are doing some of this, but we agree that there are lots of opportunities and we could do more.

Will doctors still visit their patients in a different hospital?

The plan would be that the GPs of the town in which the hospital is located would look after the patients in that hospital. We are also in discussion with Primary Care to review how GPs can support our Community Services.

How will the beds be split up? 20 each or 16 and 24?

The beds need to be in multiples of eight to enable safe and efficient nurse to patient ratios, so the likely configuration will be 16 and 24 beds.