Lynton 3 September 2015

Questions and Concerns

Consultation process and information

How much has the consultation cost? The money should be being spent on healthcare and patients. You are paid to make decisions you should make them.
We really value the opinions of all our stakeholders, and feedback from the public is very important in helping us come to the best decision. In addition, 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.

There is duplication in what you are doing with what the CCG have already done. We've told the CCG these things in the Criteria – why can't you use their criteria and the information we have told them? Why have the CCG dragged out so long?
We are using the criteria as put forward by the public in the CCG's consultation. We are trying to align ourselves as much as possible with the CCG but we have to move more quickly.

Why have the CCG paused their consultation and why are you no longer doing this jointly?
Running a service is different to commissioning a service. The CCG is looking at the longer-term strategic direction whereas we don't have the luxury of time. We need a plan before winter.

The public needs to realise that the CCG is asking theTrust to do more with less and the Trust needs to be clearer about the CCG putting it in this position. The internal market in the NHS is ridiculous!
The reason we are carrying out this consultation is to explain to people the financial constraints we are operating under, and to consult on how we can deliver safe and effective care within the budget available.

Does the information in the information pack refer only to the towns themselves or beyond to the parishes they serve? If it is only in the towns, there is potentially lots of missing data.
We agree that there may be information missing. This is why we are going out to talk to people across the area, for example to understand the realities for people who live in surrounding villages. We can look at the addresses of people who have been into the community hospitals to analyse where most people have come from. What we won't know is how these people felt, whether they were in their place of preference or if they would rather have been somewhere else.

Ilfracombe is not an option for Lynton really. It seems to be that Ilfracombe is not an option from what you have said?
During previous engagement we have considered various solutions to the safety problem in Ilfracombe. The only solution we have come up with is to refurbish the

hospital into a 16 bedded unit. This would cost between £1 - £3 million and would take up to three years.

If a member of the public came up with a solution as to how Ilfracombe could provide 16 beds within the financial year we would absolutely consider it as an option.

NDDH as an option for beds

Alison Diamond was quoted in the Journal saying there would be no beds in any community hospitals and all beds were going to NDDH.
If this is what it said, then this was a mis-quote. It is absolutely not the case that all beds are going to NDDH. We have to wait until we hear the outcome of the Board decision on the 6th October, but the NDDH is only one option on the table.

If beds are go to NDDH, what will happen to other services at NDDH? Patients from here who have a stroke currently go to NDDH. If all the stroke beds were to go to Bideford, it would be very difficult for people to visit their loved ones. Friends and family are a matter of life or death for patients.
Stroke beds are not currently part of this consultation, for now they will remain in Bideford regardless of the outcome of the consultation. Long term however, the plan is for all stroke rehabilitation to be located at NDDH.

'Current plan' sounds like it might change…?
This is currently the plan within the estates strategy. We can only call it current because we don't know when it might happen or what else might happen in the coming months and years. But as we stand today, this is what the plan is.

Beds at NDDH have been described as virtual beds, what does this mean?
This means that rather than have a ward entirely for community hospital beds, they would be dispersed around the hospital amongst different wards. We do not currently have an empty ward where all of these beds would go.

If all beds are at NDDH then if there is a time of surge will the community hospital beds be replaced by acute beds? Will there be a guarantee that rehab beds at NDDH would remain as such if NDDH came under serious pressure?
The ability to flex up and down has come up a lot in the consultation.
In North Devon we are very proud of our winter planning. Unlike some other hospitals in the area, we haven't gone into black in the last three years and our red alerts have significantly reduced. However, there are times when the system is under great pressure. When this happens, we get a pre-warning at red alert so we boost community services to prevent people going into hospital where we can and to support people so that they can come out of hospital as soon as possible.

We also flex beds up and down in our hospitals according to demand which means we meet the needs of our 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 urgently needing hospital admission, then using an empty bed in the community ward would be preferable to turning them away.

Will putting all the beds at NDDH be putting all your eggs in one basket and therefore more risk? No flexibility for surge and high infection risk
This is a really good question and one that will be going into the risk assessment of options B and C. We have contingency plans for these cases. Our teams are continually working to ensure that we manage any issues with infection prevention and control. Norovirus is just as likely to spread through a community ward as an acute one so this is something that affects all hospitals.

This is a very valid point and one that would need to be considered carefully by the Board when making their final decision. While there are positive of having all services under one roof, there are of course drawbacks and this is could be one of them.

What guarantees do we have for our other community hospitals if we go for NDDH and one other?
We cannot guarantee that there will not be further closures of inpatient beds in the future, but all community hospitals will remain open, irrespective of whether the inpatient beds have been closed. The current services, such as outpatient clinics, will continue to run within these hospitals and health and wellbeing hubs will be developed.

For Lynton it is obvious to say that we should have beds at NDDH.

Home based care

How will you staff more nurses etc for the community? If there are more people needing that care in the community then we need more people to look after them
We already have teams set up that look after 6000 people in their own homes. The additional amount of people that need to be looked after from a community hospital is a small addition to this. Plus we will redeploy nurses from the community hospitals into the community, so we will not have to hire more nurses.

Lynton doesn't have a community hospital or any care homes or social care – how can we ensure that the community care will be in place to look after people? We had problems getting any carers from North Devon to help my Dad.
We have heard that people have concerns over social care provision; however we need to remember that this is about short term care – the intensive interventions from healthcare professionals (nurses, therapists etc) not to be confused with longer term social care which is not affected by this consultation.

Lynton has second lowest emergency admission rate in Devon, despite there being few care home places available, so we must be doing something right.

To address some of these issues, we have starting to move into the social care market and now deliver 300 hours of domiciliary care per week, as the provider of last resort, to help meet this need.

Are hospitals going to be turned into hubs if they don't have beds?
The CCG's consultation has suggested that this is their long term commissioning intention. They've stated no buildings will close but will be concentrated into publicly funded service hubs to make them the most financially viable.

Inpatient beds are just one small part of the community hospital services. At each of the four sites there are lots of outpatient clinics which are used extensively and prevent patients having to make trips to Barnstaple. Where we can we will continue to develop these outpatient services and clinics.

There is no evidence to say that Care Closer to Home provides better health outcomes. Two reports 2000 and 2007 give results which were inconclusive. If you are going to change things then make sure it is as good if not better.
We believe that the care we can offer is at least as good. We now have data from several hospitals where inpatient beds have been removed and we have not seen an adverse impact. For example, in Torrington and Ilfracombe we see an average of 2 admissions per month to another community hospital. A&E admissions from people in these towns are in line with rest of Devon and we receive feedback through our Friends and Family Test that there is high satisfaction from patients receiving care in own home. In addition, our community teams are identifying and supporting patients earlier when their health is deteriorating, which is reducing unplanned admissions to NDDH.

People from Lynton used to go to Ilfracombe but now they go to South Molton.

Finances

The decision here is about this year but will you be re-evaluating next year? Does it only last until March?
In previous times, we used to have a 3-year planning cycle and now we have a yearly planning cycle which does create more uncertainty. We have community and acute contracts which are both up for renewal in March 2016 when we will once again go through the renegotiation process with the CCG.

The move from three year to 12 month contracts was a national change that all contracts went to.

Have you done any financial forecasts on the options and how this is going to help you save?
Each of the options will result in a saving of approx. £700K per 16 bedded unit that we close, and the difference between the options is marginal.

We have an indication from the temporary closures of how much each unit might save, but we do not have the exact figure for each option because we do not want the outcome of the consultation to be purely driven by finance. We do not just want

to go for the cheapest option; we want to go for the option which best meets all of the criteria.

Accessibility and transport

Transport is a big issue – we had transport booked from the hospital which was cancelled, so they sent a taxi instead which cost £45.

My husband was in South Molton for a month and I drove to see him every day, in the car it is the same time to NDDH or South Molton. If you are a driver, the parking is free at South Molton but if you don't have a car you can only get to South Molton if you go via Barnstaple and the last bus is at about 6:00pm and there is no transport on Sundays or bank holidays.

To visit someone at South Molton without a car is a day's outing.

The health centre and MIU in Lynton are excellent and well used.

It is clear that Holsworthy is very remote and why it would need to have services there, but while that helps people in Holsworthy it doesn't help the rest of us.
This is why there are no options that say all beds in only Holsworthy, where else would be beneficial?

Workforce

Have there been problems in South Molton with recruiting and retaining staff?
In our information document, we detail the use of agency staff in each hospital. Please look at the "Workforce" section. It shows that South Molton was using higher levels of agency staff in September, October and November of 2014, but since then it has been doing better than the other hospitals in terms of percentage of agency staff used.
http://www.northdevonhealth.nhs.uk/consultnorth/supporting-information/