South Molton 25 August 2015

Questions and Concerns

Decision-making criteria

South Molton hospital serves a wide geographical area and is a strategically central position in terms of the link road access. During the winter, South Molton serves a huge area that is affected by the winter weather. These people cannot get to Barnstaple.
We face this issue almost every year and have extremely robust plans. It is for this reason that access and transport is listed as one of the important decision-making criteria. This means it will be taken into account when we make the final decision.

If the population is increasing, why do we need fewer beds?
People tell us they want to avoid being in an institution if possible. They want to maintain their independence as long as possible. We don't equate a growing population with more beds as that model of care is unaffordable.

This is because 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 16-bed 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.

You are using old figures for population etc.
We took our information from all of the publicly available information and invited representatives from planning and development to the first stakeholder meeting to enable stakeholders to ask questions. If you have more up to date figures, please do provide them to us and we will update our documentation.

Home-based care

How we deal with people in their own homes when the weather is bad?
We regularly visit people in very rural areas. Each winter we face challenges but our community teams and the care agencies we work with have very robust contingency planning for bad weather. Our community teams are very used to getting out to visit people in difficult conditions. When the weather is really bad we use our knowledge about where staff live to ensure no patient is missed. We have never missed a patient.

When we know bad weather is coming we make a plan with each patient, their family and carers, for how we will deal with these situations. These plans are shared with our partners so that we all know what we will do in an emergency.

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. However, we are talking about the short term health need that people have following a period of ill-health or injury – instead of rehabilitating in a community hospital we

are putting forward the clinical evidence that people recover far better in their own homes, with support, where safe to do so.

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.

How do you stop people from falling through the gap? How much consultation is there with the hospital and the family to make sure that the right level of care is in place for each person?
Our complex care teams consist of community nurses, therapists and social workers who are supported by a coordinator to make sure no one falls through the gap. The team knows when a patient from their caseload is admitted into a hospital and they will work with the wards to make sure that the patient gets the right level of care. They also work with the patient and their family to get patients home as soon as possible.

We recognise that not everything is perfect. In areas where there is no inpatient unit, we have one number you can contact to access care. We are looking at how to roll this out across all areas as it is a much better system for GPs, patients and staff.

If a care package is not working for someone, you should feed this back to Devon County Council through Care Direct.

There are significant numbers of people being cared for at home with only occasional visits by care givers. The families are under extreme pressure and feel unsupported. The care homes have been closed to save money. It seems that this is all about going for the cheapest option, not for the safest care.
It's really important that we don't confuse the services offered by care homes with that of the community hospitals. People receive as many visits in their own homes from our physios or nurses as they need. Everyone is different and we aim for everyone to get the support they need.

We will not be picking the cheapest option but the one that provides the best possible care within our budget.

We often hear that people can't get a care package in place to get someone out of a hospital bed. If someone is being cared for at home, will you continue with the short-term care until the long-term care package is available?
Yes. The health-funded care will continue until the longer-term package of care can start, in exactly the same way we would continue to support them in hospital until the package was in place.

We provide data on delayed discharges every month to Devon County Council and the Clinical Commissioning Group so drives to reduce delays can happen at a strategic, county level.

Where are patients going to go when they need a bed or can't be cared for at home?
There will always be a need for some community rehabilitation beds. If a person needs to be in a community hospital, but there is no unit in their town, they will go to a nearby community hospital.

If we're trying to look after people at home, what plans would there be to ensure patients can still get day-care at the hospital?
Day treatments and clinics are already happening at South Molton and all our community hospitals. For example, people can receive blood transfusions at the hospital. We are looking to offer more and more of this type of service locally and that is absolutely how we want to be using our community hospitals, moving forward. We are always looking at options of what other day services we can deliver locally and will put plans in place for this, regardless of whether or not the hospital had beds.

What happens when Barnstaple is on red alert?
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 CCG's paper mentions spot-purchasing of nursing home beds. When it's two in the morning and someone doesn't need A&E or an acute ward, who would find them a bed and who would fund it?
In such a case this would be funded by the NHS, but it is unlikely that you would be spot-purchasing a care home bed at 2am. If a patient had a need for this sort of care we would put in a rapid response worker overnight to stay with the patient in their own home. This is far less disruptive for the patient and their family.

Option of beds at North Devon District Hospital

The car parking facilities at NDDH are really appalling.
There are occasions when the car park at NDDH is full but we can assure you that the car park is far more accessible and available than those in other hospitals. We have some of the cheapest hourly rates and for those returning within the week, a weekly pass is £5.00

If you put all the community beds in NDDH what would happen if you had really bad norovirus in hospital?
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.

Do you have capacity for a frailty unit at NDDH and would it involve more cost?
Yes we have capacity and no it would not involve more cost.

Last winter was really difficult across the country and in February we started our planning for the next winter to ensure that we learnt from our experiences.

We brought in a national team to help our staff put in place an action plan which is already working really well. We monitor patient 'flow' through our hospital and the upshot of all of this work is that we're freeing up capacity at NDDH which has led the teams to consider the frailty unit at NDDH.

We will pursue our plans for frailty assessments, regardless of the outcome of this consultation because when people turn up in hospital, getting a rapid assessment of their health need is really important and will mean they get the right care in the right place.

Elderly people can't visit loved ones if it's in Barnstaple.
We know that travelling to Barnstaple is a real issue for some people and would urge you to feed this back as part of the consultation. The reason the operational teams felt it might be an option we could explore is that they felt it could provide a more rapid assessment for people, meaning they would get better sooner and so be able to return home more quickly.

Unless you happen to live next door to a hospital, travel and access will always be an issue so we need to understand how people cope with this.

Consultation process

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 will consider all the feedback about the different options and then the Trust board will make a decision on the 6th October.

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). Therefore the CCG has confirmed it supports our right to consult on delivering services within the budget we were given this year.

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.

The finances

What about option D – keeping all the hospitals open and finding the savings elsewhere?
We have to live within the money available and this consultation does not deliver the full amount needing to be saved – there already are plans to save money through efficiencies across all our services.

The NHS is required annually to make efficiency savings and this will continue for the foreseeable future. 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 £11million of efficiencies.

Can you be sure that these proposals are properly costed?
Yes, all the proposals will be properly costed. The anticipated cost savings offered by reducing community hospital beds in one 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.

This is how we plan to address the demographic increases in our population and 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.

CCG has withdrawn support for what you're proposing so are you sure you're going to get the funding from the CCG?
The contract has been agreed with the CCG so yes we will get the funding. We are not yet at the point of identifying the preferred option(s) so the CCG will shortly get the opportunity to review our plans and confirm whether it is satisfied they are robust and safe.

You will need the same number of nurses whether in community or hospital so how will you save money, especially when you have to pay for the nurses' travel?
We have done extensive monitoring of visits and travel time and we know that we will be able to visit more people in the community.

Have you costed in the fact that loneliness leads to depression, which will result in more cost to the NHS?
We agree that social isolation is something society as a whole has to tackle. We don't think that inpatient beds will solve social isolation. Some communities are doing fantastic things to support isolation and the voluntary sector is essential in this.

Have the Board considered going back to the commissioners and saying this isn't right?
Yes – we were the last to settle out contract. It was escalated to the Department of Health and we fought tooth and nail for the best deal we could get for our patients.

Recruitment and staffing

Lots of students are coming to our hospital, but uncertainty affects the attractiveness of the hospital as a place to work.
Yes, we absolutely agree that uncertainty is a real issue. We need certainty which is why we have to make a decision.

What steps is the Trust making to reduce agency costs?
We spent £11million on agency staffing last year, and this has been recognised as a huge issue for the NHS at a national level.

We know that we need to reduce our spend on agency as it is unaffordable and does not offer the same continuity of care on our wards when we become over-reliant on agency staff. We are bringing down this spend by improving our recruitment, promoting return to work packages and ensuring that we support and develop our staff so they want to stay working for us.

What happens to the nursing staff if you close South Molton?
We will work with the staff to look at their skills and competencies and agree with them where they would like to work, whether it is at another community hospital, in the community or at the acute hospital. We understand that working out in the community is very different and may not suit everyone but we will give staff the help and support, through training and work-shadowing, to support them through this transition. In Ilfracombe, the nursing staff were redeployed into the community and they have been very happy with the move.

Member of staff: I've been involved in a centralisation like this before. Can the trust afford to lose the 20-30 skilled nurses that you will lose and will go elsewhere if we lose the beds?
We don't envisage losing any of our staff. The patients will still exist and we need the fantastic skills and knowledge of our staff to continue supporting and providing excellent care to these patients.

Member of staff: I trained to be a community hospital nurse and I love it I don't want to be community nurse.
That is absolutely fine and we know that there will be other staff who feel like this too. We have done this before in Ilfracombe, Torrington, Axminster and Moreton – we will ask those staff to come and tell you how they felt so you can be reassured about the process we go through to ensure you are supported to take the opportunities and fulfil your career aspirations.

Numbers of beds

How many beds are we talking about? Will the remaining units have more beds?
There will be a reduction in the number of inpatient beds. The CCG has indicated that we need 40 community beds in North Devon, whereas there are currently 74. We are clear that there will be ability to flex at times of demand.

Please remember that, where the beds are removed we will put in additional health and social care resources so people will not lose out.

How many beds are they losing in South Devon?
When we benchmark against the country we have a high proportion of community beds so this is a national direction of travel.

How can you make the statement that we do not need as many community beds in north Devon that we currently have, when the population is increasing? Where is the long term view for we might need them again?
The health service is constantly evolving. Ten years ago someone having a hip or knee replacement would be in hospital for 10 days. Now it's 2 to 5 days as we know that to get better now you need to be on the move.

Healthcare has changed and there is so much more we can do in terms of monitoring and providing care and therapy support in the home setting. A lot of research over the last few years has looked at how we can deliver care differently so people do not need to be in a hospital bed.

How can you deal with an increase in demand, for example if there is a flu epidemic?
We never ever have an average day – we are continually dealing with peaks and troughs in demand. Flu epidemics are really rare and the plans involve lots of organisations – from the Red Cross, to the ambulance service and hospitals. We have extremely robust contingency plans.

How is this going to affect bed blocking in the main hospital?
There will always be delays in some people leaving hospital and it is typically delays in social care, waiting for families rather than waiting for community hospitals.

South Molton specific questions

The present renal unit is situated at South Molton hospital. It was built by public subscription. We have received lots of donations because of the excellent care people have received at the hospital. We would like to help fund an extension of the hospital into the current renal unit.
The RD&E run the renal unit and they have not yet served notice on us. We are not clear when they will move out. After that, we will look at what we can do with the building. We are really grateful for all the donations that people give to our community hospitals. The Leagues of Friends do a terrific job and we hope that people would continue to support the hospital even if there are no inpatient beds.

Other

A community hospital used to be for a community, now it will be a "unit" serving a wider area. It will no longer be for the community and will be very different.
You are right that we should not lose sight of the community feel. Please remember that the hospital will still exist. There are lots of other services that people can access through their hospital and these can be tailored to the needs of the community. There are a lot of other community services as well as health. Inpatient services form a very small part of the healthcare that people access.

How long can you assure us that if inpatient beds go we will keep our hospital – are you asset stripping?
We have no intention of closing any hospital and believe that these buildings will continue to benefit the community.

You do not seem to be taking a long term view
The CCG is responsible for the long-term strategic direction. As a provider we have to operate within the budget provided and are aiming to align our preferred option with the CCG's Care Closer to Home strategy.