Frequently Asked Questions

This document details the questions and concerns raised during the public consultation, both at public meetings and through correspondence received.

We will update this document regularly and will post the most recent version on our website at: www.northdevonhealth.nhs.uk/consultnorth/supporting-information/

Decision-making criteria

What will happen to people in rural areas, with poor access to transport? Can you assure us that people living in areas of rural deprivation will not be adversely affected by any decision to remove community hospital beds?

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.

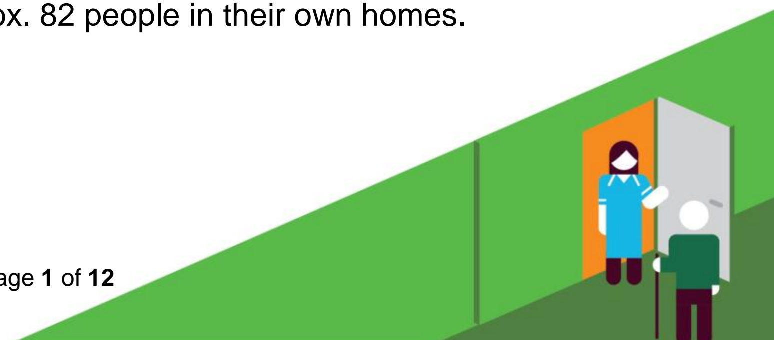
Why do we have to have 16-bedded units as a minimum?

There is a comprehensive and growing body of research and evidence indicating that nurse staffing levels has a significant impact in terms of patient outcomes. Our Director of Nursing and Medical Director are confident that nurse staffing levels of one registered nurse to eight patients is the minimum we will recommend as a starting point for planning, and there should be no units where only one registered nurse on duty. Therefore, the minimum safe unit size is 16 beds.

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.

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.



Ilfracombe

Is Ilfracombe included in the consultation?

Since the Tyrrell's inpatient beds closed in September 2014 we have worked really hard with the community to ensure people understood what safer staffing and lone-working meant and why we considered it meant we could not offer inpatient services at the Tyrrell.

The engagement report from these discussions with the community is available on our website. As well as requesting that we introduce more services to develop the Tyrrell into a health and wellbeing hub, the community also asked us to explore how to alter the hospital building to accommodate the minimum 16 beds. Our estates team produced this assessment which concluded that it would take at least 2 years to refurbish or extend the Tyrrell and would cost at least £1.5million.

Because it could not be done within this financial year, we felt this option was not feasible because we could not deliver a 16-bed unit within this financial year. If, during the consultation, people suggest ways in which we can deliver a 16-bed unit at the Tyrrell this year, this option will be included in the consultation.

The permanent decision on Ilfracombe inpatient services remains with NEW Devon CCG.

Home-based care

Can you provide an example of a typical care package?

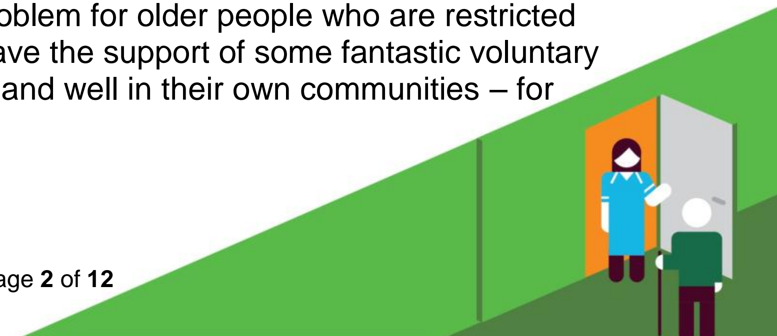
It is very difficult to do this as people have very different needs. People have nursing needs, rehab needs, physio needs and care needs. All of these are offered through a package of care that is designed around the individual needs of the patient. This could involve night-sitting if someone needs help throughout the night. These care packages are for a short period of time, to replace the care that someone would have had whilst in a community hospital.

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 means-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!

When people really need to be looked after, there will be a bed for them.

However, being in hospital is not the safest option and we need to debunk that myth. Long stays in hospital beds cause increased risks of muscle wasting, and a reduction in cardio-vascular capability. There is also an increased risk of infection, pressure damage and falls for people who stay in hospital for more than 11 days.

People who stay at home have better levels of independence. We know that about 40% of people who enter a community hospital will end up going into a care home, as their independence has deteriorated so much. We know that people would much rather live at home than in a care home.

What we are talking about is an exchange. We are talking about exchanging 21-26 days in hospital for care at home. We are replacing these beds with enhanced community services.

For example, in Barnstaple, where we do not have a community hospital, we have a 'Pathfinder team' in the acute hospital. This team pulls patients out of hospital and supports them leaving hospital and back to their home. Not everyone needs to be in a community bed. The evidence suggests that we are successful in supporting people in their own homes, reducing the risk of harm and getting them home so that they can benefit from rehab support, physio etc.

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 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.

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.

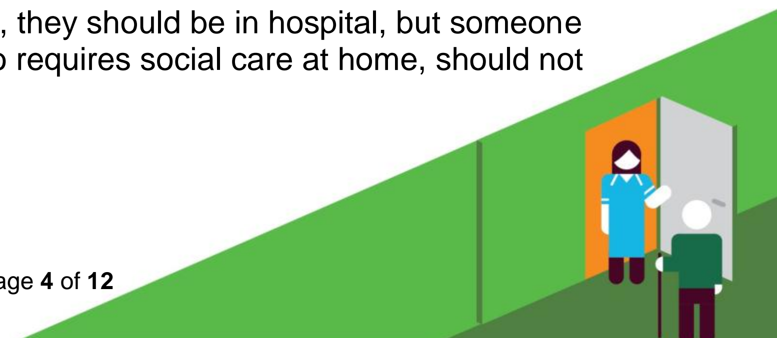
We have concerns over the availability and quality of social care in our area.
We have heard people's concerns about access to social care in the local area. Whilst social care is the responsibility of Devon County Council, our services offer care either immediately before, after or instead of a hospital 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.



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.

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.

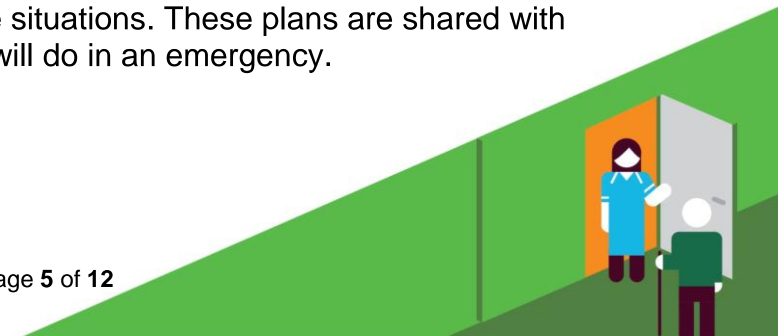
We do not have the same problems recruiting nurses into community nursing roles as we do in our community hospitals.

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.

How do you 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.



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.

The North Devon District Hospital option

Why was NDDH put forward as an option for locating community beds?

During any engagement process, it is important to remain open to ideas put forward by people – both staff, public and stakeholders. The Trust's operations team suggested that we consider NDDH as an option for the location of community beds and the Executive Director team agreed to include this in the consultation to ensure we gathered sufficient information and clinical input as to whether this option could work and would benefit patients more than the others.

How much would it cost to refurbish 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 have to 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.

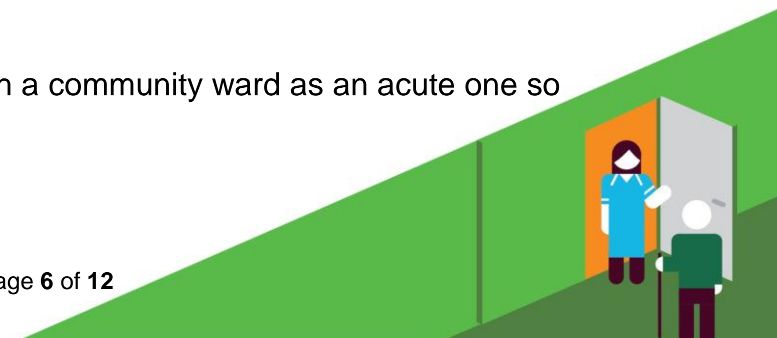
How would it work if there was a "community" ward in NDDH and the hospital was suffering a period of extra demand, for example in winter? Would the "community" beds be taken over by the acute patients?

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.

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.



Consultation process

Why has the CCG withdrawn from the joint consultation?

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 CCG's Care Closer to Home consultation remains ongoing at this time, whereas the Trust's process is constrained by the budget for a financial year ending in March 2016.

This means we are proceeding at different paces. 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 rejoin 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 were told by the Clinical Commissioning Group (NEW Devon CCG) that a decision would be made in February 2015 for implementation in April 2015. Why is this taking so long?

It is precisely for this reason that we have embarked on our separate consultation. We are very much aligned with the direction of the CCG but have to move more quickly.

In May 2015, the CCG concluded the first phase of its consultation on Care Closer to Home and signalled that the number of beds should reduce. This would release resources for home-based care and create a more balanced community service.

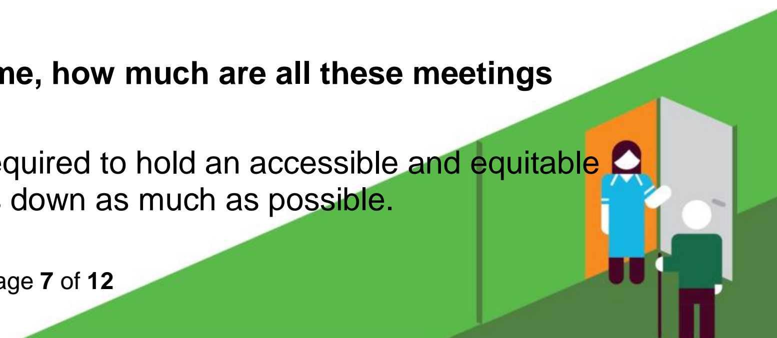
In order for us to be able to deliver safe and effective care within the budget, we now have to consult on where the community inpatient beds should be located in Northern Devon. Best practice and the law demands that we consult properly and give sufficient time for people to put forward their views and opinions. We will be making a decision on the 6th October 2015.

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.

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.

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.

Why is this happening before winter?
We feel that it is important to make a decision about the future configuration of community services before the busy winter period. We believe that looking after more people in their own homes reduces the likelihood of unplanned hospital admissions and would therefore be of benefit to get this up and running before winter.

The finances

What is the budget?
NEW Devon CCG's budget is £1.2 billion
Our budget is around £230 million

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.

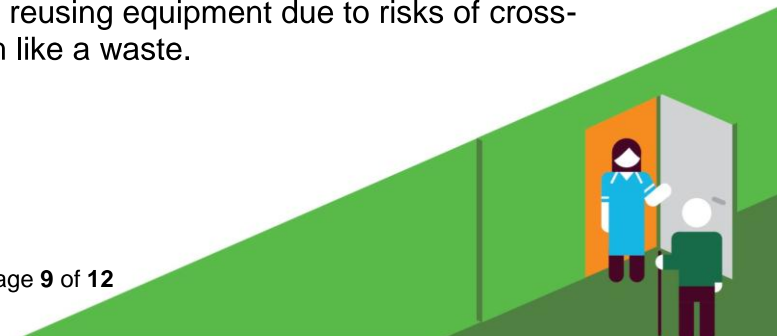
However, this is not just about the money. We truly believe that this is a better model of care. We would like to assure you that safety is our paramount concern and we will not just go for the cheapest option.

How are you separating the £5 million between North and East?
The split is 1:3 so North is £1.25 million and East is £3.75 million.

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.



Recruitment and staffing

How can it be more cost-effective to provide nurses in the community rather than in the hospital? Wouldn't you need to recruit more nurses? We thought you had a problem recruiting nurses.
This is a question we are often asked and can assure you that it is more cost effective to deliver community services in people's home because we can spend longer and see more patients than a hospital would.

We already have community teams in place across North and East Devon that are supporting 7000 people in their own homes at any one time.

Replacing community hospital beds with enhanced community services will only add a small number of additional patients to the 7000-strong case load.
We will redeploy nurses from the community hospitals into the community so we know we will have the nurses we need to provide this care.

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 £2,500 to £3,000 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 shortage.

There are lots of unemployed people in our town, 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.

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.

Other

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.

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.

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.

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.

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.