

BRIEFING NOTE

**Community Hospital Inpatient Beds**

There is a vibrant future for our community hospitals, but it will need to look different than it is today to support the needs of our communities into the future. We want our communities to work with us to help us shape that future.

We know our community hospitals are highly valued by the local community and receive excellent feedback from patients. However we also know that it is not good for people to be in hospital for longer than they need to be.

We know from evidence nationally and locally that patients recover faster when cared for at home and we can care for more people at once. For example, the early work in Carlisle shows that patients recover twice as fast when they are cared for at home and we can care for twice as many patients at once.

While we are improving care provided in communities, we need to be able to provide a sustainable bed base for our patients given our current challenges of recruitment, safe staffing levels, our estate and geographical need.

The preferred option outlined in the consultation outlines how our clinicians and our partners think this can be best achieved.

*QUESTION: Why have Alston, Maryport and Wigton been identified to have no beds in the preferred option?*

Alston, Wigton and Mayport have been identified to have no beds following a comprehensive assessment process by clinicians and partners against a number of criteria developed by NHS Cumbria Clinical Commissioning Group.

The preferred option retains at least one bed base in each geographical area (west, north and east Cumbria) and minimises the number of units closed to make them sustainable and safe in the future.

The criteria included the deliverability of providing units with a minimum of 16 beds. To assess the current condition of the buildings, national benchmarking (PLACE standards) was considered along with the financial implication of changing or updating the building. The PLACE standards are Patient Led Assessments of the Care Environment and rate units based on a number of environmental criteria.

Alston  
Although there are not major current estate issues in Alston, the cost of expanding the building to meet the minimum of 16 beds was high in comparison to other units. In addition to this the local population size does not warrant a larger unit and, because this is our most isolated unit, it is very difficult to use the beds efficiently across the east network.

Maryport  
The building at Maryport requires significant improvement and scores poorly against national PLACE standards required to deliver 24 hour inpatient care. The current layout of the unit does not adequately support additional beds to meet minimum 16 beds criteria due to a lack of space and facilities. The cost of extending and refurbishing the building to meet the privacy and dignity and facilities requirements for 16 beds means that Maryport did not meet the set criteria.

Wigton  
Wigton Hospital building scores poorly when assessed against national standards (PLACE) and scores the lowest of all our buildings with five out of eight standards of PLACE and building assessment rated as red. This includes suitability for observation of patients, privacy and dignity, facilities, maintenance and a dementia friendly environment required for providing inpatient care.

We acknowledge that Wigton could easily meet the minimum of 16 beds criteria set. However, the age, condition and suitability of the building mean that it will require significant investment or replacement in the near future. The remedial work required to improve this building would cost more than re-providing the building. The high cost of replacing the building to provide a modern appropriate unit meant that Wigton did not meant the criteria in comparison with other units.

*QUESTION: What do we mean by safer staffing and the 1-8 rota?*

In order to provide safe staffing to care for patients safely particularly in small units Cumbria Partnership NHS Foundation Trust (CPFT) has adopted National Institute for Health and Care Excellence (NICE) guidelines in relation to staffing levels which state that there should be one registered general nurse per eight patients.

The NICE guidelines are designed for acute trust use, however CPFT has adopted them following recommendations of an independent assessment of our units by staffing expert Keith Hurst. The findings of the assessment were that the patient group (except for delayed discharges) had a similar dependency to an elderly care ward in an acute trust. In addition to this finding, the Trust also recognised the isolation of the units with no ability to call for back up, and having sole responsibility for the building and staff on duty out-of-hours. It was therefore agreed from a quality and safety perspective these staffing levels would be adopted. The ratio drops to 1-12 during the night.

*QUESTION: Why is the minimum size of units 16 beds?*

Our community hospitals operate on a standard of one registered nurse for every eight patients. We do not believe it is feasible to operate an isolated unit with just eight beds. This is because they are more vulnerable to closure in the event of staff sickness and it is difficult to release staff for essential training and supervision which puts pressure on our staff working there.

Where beds are consolidated and managed as larger units it creates a better working environment for our staff and the units become more resilient in terms of clinical expertise, offering staff greater opportunity to develop and maintain skills, and offering patients a better service.

*QUESTION: Where will patients from Wigton, Alston and Maryport go?*

Patients from those communities who require a community hospital bed will be able to access one from one of our other community hospitals.

The historic placement of community hospitals has never provided inpatient beds for each community and so the bed base is utilised for the whole population of west, north and east Cumbria, not just the communities in which they are situated, and this approach would need to continue. Whilst each hospital does take admissions from their local area, they also take a significant amount of admissions from the wider west, north and east cumbria to ensure that the system uses capacity wisely and efficiently. In 2014/2015 less than half of admissions to community hospitals were from within the postcode town of the hospital.

At the same time, our plans to develop more care within communities will mean less people needing to be in hospital at all.

*QUESTION: How will we cope with fewer beds?*

In reality, the community hospitals have been running with fewer beds for some time due to staff shortages (as indicated below) and we are already managing with fewer beds across all of the sites. The table below shows beds that have been open over the last 18 months and the bed numbers proposed by the preferred option.

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| **Quarter** | **Bed numbers open (commissioned for 133)** |
| Apr–Jun 2015 | 131 |
| Jul–Sep 2015 | 131 |
| Oct-Dec 2015 | 131  Dropped to 116 on Dec 2015 |
| Jan–Mar 2016 | 116  Dropped to 111 February |
| Apr-Jun 2016 | April - 113  May – 117  June - 117 |
| Jul–Sep 2016 | July – 101  August – 110  Sept – 111 |

The table below shows bed numbers in each community hospital that are commissioned, currently operate and proposed in the preferred option.

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| --- | --- | --- | --- |
| **Unit** | **Commissioned beds** | **Current beds** | **Preferred option** |
| Alston | 6 | 7 | 0 |
| Brampton | 15 | 12 | 16 |
| Cockermouth | 11 | 8 | 16 |
| Copeland | 15 | 10 | 16 |
| Keswick | 12 | 12 | 16 |
| Maryport | 13 | 10 | 0 |
| Penrith | 28 | 28 | 24 |
| Wigton | 19 | 14 | 0 |
| Workington | 14 | 10 | 16 |
| **Total** | **133** | **111** | **104** |

In addition, the direction of travel nationally and locally is to deliver far more care in the patient’s home. Monitoring supported by internal and external reports shows that at least one third of our patients could be supported in the community, and that there are flow problems preventing patients from moving to the next stage of their pathway or care, particularly where this requires intermediate or community care.

The development of Integrated Care Communities (ICCs) is designed to address this problem, with health and social services working together to ensure patients are cared for in the correct environment, and that community bed admissions are based on clinical need, not filled as an alternative to the correct care package or environment being in place. As a result, fewer beds will be required in the system as a whole.

Half of the money saved through changes to inpatient beds will be invested into the development of ICCs.

*QUESTION: What is the size of the recruitment problem?*

The recruitment of staff is a very genuine problem for us; there is a national as well as a local problem in recruiting staff, particularly trained nurses. The table below shows the number of registered general nurse (RGN) vacancies we had in August 2016.

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| **Unit** | **RGN gap numbers whole-time equivalent** | **RGN gap percentage** |
| Alston | 3.07 | 55.5% |
| Brampton | 3.16 | 35.4% |
| Cockermouth | 4.70 | 70.9% |
| Copeland | 2.00 | 25.9% |
| Keswick | 2.60 | 35.2% |
| Maryport | 6.64 | 78.7% |
| Penrith | 2.80 | 19.4% |
| Wigton | 3.60 | 32.5% |
| Workington | 0 | 0 |
| **Total /Average** | **28.57** | **39.2%** |

*QUESTION: How often do beds have to close due to staffing issues?*

We have been monitoring bed closures due to staffing issues since 2013 when recruitment difficulties first started to become a problem. At this time three beds temporarily closed at Wigton Hospital because we were unable to recruit RGNs. We opened an additional bed at Alston to mitigate against the problem. The chart below highlights the difficulties we have had during that period of time. In August 2016 we had 24 beds closed due to staffing difficulties.

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| **Unit** | **Commissioned Bed Base** | **Open Beds Dec 13** | **Open Beds Dec 15** | **Open Beds**  **Jan 16** | **Open Beds April 16** | **Open Beds May 16** | **Open Beds Jun 16** | **Open Beds July 16** | **Open Beds Aug 16** |
| Alston | 6 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 0 |
| Brampton | 15 | 15 | 15 | 8 | 8 | 10 | 10 | 10 | 12 |
| Cockermouth | 11 | 11 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |
| Copeland | 15 | 15 | 14 | 14 | 14 | 14 | 12 | 10 | 10 |
| Keswick | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 |
| Maryport | 13 | 13 | 8 | 8 | 10 | 10 | 10 | 10 | 10 |
| Penrith | 28 | 28 | 28 | 28 | 28 | 28 | 23 | 23 | 28 |
| Workington | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 10 | 10 |
| Wigton | 19 | 16 | 12 | 12 | 12 | 14 | 14 | 14 | 14 |
| Total | 133 |  |  |  |  |  |  |  |  |
| Total open |  | 131 | 118 | 111 | 113 | 117 | 110 | 104 | 109 |
| Total closed |  | 2 | 15 | 22 | 20 | 16 | 23 | 29 | 24 |

*QUESTION: What have you done to improve recruitment?*

We have undertaken numerous initiatives to recruit staff to the wards over the past few years. These include:

* Advertising via NHS jobs including leaving posts open for extended periods of time until applications are received
* Advertising in local media
* Nurse cadet scheme
* Taking nursing students with a view to encouraging them to work for us in the future
* Transferring staff between units when vacancies arise to ensure retention
* Offering nursing students posts prior to completing training so they have guaranteed work
* Recruiting to bank to entice staff into permanent roles
* Working with Erasmus scheme to support nursing student placements from Germany and Italy
* Providing placements for return to nursing candidates
* Attending recruitment fairs
* Working with wider colleagues to develop recruitment strategies

We have been successful in recruiting some staff, however we have also experienced retirements and we remain understaffed overall.

*QUESTION: What is the impact on travel?*

A travel analysis has been completed against all of the options and, although it is not possible to make changes with no impact on travel, option 1 has the least impact overall. It is acknowledged for Wigton particularly that this will increase travel time for patients and carers using their own transport. However we must remember that the future aim is to have as few people as possible in hospital and for a short period of time – unlike the current system where patients can spend more time in community hospitals than they need to.

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*QUESTION: What is your evidence that it is not good for people to be in hospital?*

National evidence shows that 10 days in hospital for someone over the age of 80 leads to the equivalent of 10 years of muscle ageing, reducing people’s mobility and independence and so it is not good for patients to be in a hospital environment when they do not need to be. The elderly, who are often in a hospital bed longer than needed, are then no longer able to return home but instead get discharged to long term care when it was not previously needed.

*QUESTION: I have seen that CPFT is talking to joint League of Friends, local staff and GPs about alternative proposals. Will this affect the consultation?*

Claire Molloy, the chief executive at Cumbria Partnership NHS Foundation Trust is currently meeting with representatives from each of the community hospitals and the League of Friends to look at proposals that have been made by the group for the future of the hospitals. This piece of work is exploring possible solutions that the League of Friends, local GPs and staff have proposed.

Although this is a separate piece of work to the Success Regime consultation process, we will feed the outcome of this work into the consultation process.

*QUESTION: Will any staff lose their jobs?*

The new community hospital model will require less staff. However, we are already starting at a point where we have a large number of vacancies across our units and we know that in areas where beds are lost there will be reinvestment back into the community which will lead to more jobs in the community. We will make every effort to retain all of the staff affected by the proposals, working with them individually to provide appropriate redeployment opportunities to suit their needs.

This will follow the approach we took when we closed the 14-bed unit at Reiver House in Carlisle and moved the staff into the Hospital at Home service. This included supporting two members of staff to drive so that they could work in the community.

*QUESTION: What will happen to the rest of the community hospital services? Some of the teams work into the hospital – will they need to be reduced in size?*

The proposals relate to community hospital inpatient beds only. The consultation does not propose to change the wide range of other services provided from the community hospitals.

*QUESTION: How much money will this save?*

The preferred option will save £2m over five years with half of that (£1m) being reinvested into ICCs. After the reinvestment there is therefore a relatively very small saving of around £1m annually from 2021/22 onwards. Whilst this will help with the local health economy deficit, it must be remembered that the main reasons for the changes to the community hospitals are the long term stability of the service and safety of patients and staff.

*QUESTION: What will happen to the units that close?*

There is a vibrant future for all of our community hospitals regardless of whether they have inpatient beds on site. As we work with our communities to develop ICCs Communities, it is our ambition to utilise this space to provide services needed by the local community, with the community hospitals acting as hubs from which to co-ordinate the health and wellbeing needs of the population.

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