healthwatch Stoke-on-Trent

Community Hospital Beds

My Care My Way - Voices from The Stoke-on-Trent Health & Social Care Economy

Paul Astley - March 2017

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Additional Media -

My Care My Way Event 10th Nov 2016- https://www.youtube.com/watch?v=wl8Aqve1uYo

(note - comments shared in this video do not form part of this report)

Healthwatch Stoke is a local consumer champion, empowered with statutory powers to strengthen the voices of health and social care service users.

Its website can be found at: www.healthwatchstoke.co.uk

Disclaimer - The comments inside were shared with Healthwatch Stoke-on-Trent by citizens. These are not necessarily the views of Healthwatch Stoke-on-Trent.

Executive Summary

Healthwatch Stoke-on-Trent is pleased to present this report which has collected the views (many extended) of over 100 people who responded to a survey about proposals to close some community hospital beds. We are very fortunate indeed to have had a good response to our call for opinions around this issue and thank all the respondents, both members of the public and professionals who work in our local health and care economy for taking the time to share opinions.

Healthwatch Stoke-on-Trent's role is to seek the views of users of services in the health and social care economy and use those views to inform and influence the way that services are provided. It acts as a conduit between service users, providers and commissioners. Healthwatch represents service user voice.

In conducting this work, Healthwatch Stoke-on-Trent has found that broadly speaking, respondents understand the need for change, but they have concerns around several themes outlined within, such as capacity in the community amongst many others.

In this case, Healthwatch Stoke-on-Trent has been able to communicate the concerns of the public about these proposed changes and offer the opportunity for the CCGs to address them, thus offering assurance. It is intended that this report will enable ongoing dialogue between service users and commissioners so that the current pressing issues within our health and care system can be progressed and services remain sustainable.

Healthwatch Stoke-on-Trent

Introduction

Healthwatch Stoke-on-Trent's role is to ensure voices are heard when they concern health or care services. This is even more so when important, impactful changes are taking place. Healthwatch is keen to enable people to participate in the design of services in a meaningful way. In doing this, it is carrying out its prescribed duties. The rights of the community to participate are enshrined in The Health and Social Care Act 2012 as well as the NHS Constitution. Not only this, but Stoke-on-Trent and North Staffordshire Clinical Commissioning Group's constitutions state they will,

"Make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements."[1]

This report assists this process. Indeed, there are good reasons for including community voice in decision making. It is acknowledged that:

"Services are better designed around the needs of patients, service users and carers when they are involved in the commissioning process" NHS England[2].

Recently, a local topic of concern has been the status of community hospital beds. In the future, local CCGs have suggested that it may be the case that there will be less reliance upon these beds, indeed there is speculation that some may close. As an alternative to community beds, it is proposed that people will be helped to remain in their own homes or use alternative arrangements such as nursing homes. This program is called 'My Care My Way', its focus being upon the principle 'home first'. It has been in development for several years.

In a city such as Stoke-on-Trent which has historically low levels of civic engagement, it has been significant and reassuring in the way in which this issue has inspired a lot of interest amongst the populous. Indeed, this has been reflected in the local media[3] and has led the local Clinical Commissioning Groups (CCGs) to place a statement on their website in response:

[1] http://www.stokeccg.nhs.uk/consitution-
[2] https://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf
[3] See an example at - http://www.stokesentinel.co.uk/closure-of-beds-at-north-staffordshire-community-hospitals-are-slammed-at-pensioners-meeting/story-29773884-detail/story.html

"We recognise that there is significant concern within the population of Stoke-on-Trent and Northern Staffordshire about the capacity available for community-based services. We are keen to discuss this with people and consider any suggestions about the future shape of services."[4]

Healthwatch Stoke-on-Trent has been engaged in work concerning 'My Care My Way' for some time already, for example carrying out independent pieces of work to try and better understand the impact. In 2015 a project was carried out in partnership with the University Hospitals of North Midlands (UHNM) that explored the experiences of frail and elderly whilst going through the discharge process[5]. It found that a significant amount of work could be done to improve the communication needed to help patients participate in their own care and inspired some changes in procedures at the UHNM. It suggested that there is a risk that people may not understand what is happening to them or their medication and will need significant support in the community. This paper was added to the ongoing engagement[6].

Healthwatch Stoke assesses that although there is a considerable effort to consult on behalf of the local CCGs[7] and Healthwatch Stoke-on-Trent has supported this[8]; it also has a responsibility to continue this work independently. To further this, in constructing this report, Healthwatch Stoke has carried out a survey separately, asking members of the public and professionals to share their opinions about the proposals.

Opinions shared in the survey are pulled together and tell a story of citizens who are generally accepting of the need for change but set out a series of concerns. These concerns are compiled as questions so that the CCGs can give reassurance.

[4] http://www.northstaffsccg.nhs.uk/my-care-my-way-implementation
[5] http://www.healthwatchstokeontrent.co.uk/wp-content/uploads/2015/06/Healthwatch_Discharge_Step-Up-Step-Down-Consultation-FINAL.pdf
[6] http://www.northstaffsccg.nhs.uk/my-care-my-way
[7] http://www.northstaffsccg.nhs.uk/my-care-my-way#What have people told us so far
[8] Healthwatch Stoke has also been active facilitating voices, for example providing an independent chair for a recent event – See here - https://youtu.be/wl8Aqve1uYo

Respondent Story

‘Community hospitals have supported older people to make the transition from acute care to returning home. This needs to be done in stages so that reablement is monitored by professionals. My father was 5 months in hospital after surgery and it was only with the intensive support from Longton Cottage Hospital and Brighton House that he was able to return home and live independently for a further five years. Care at home is highly desirable but as a relative who has had to attend to every call out via the red button it is not a practical solution for people who wish to live at home but have care needs greater than those available from care workers.

The issues that families experience are very significant particularly when there is insufficient support and expertise from the care givers who have been allocated to a patient. At one point my father was locked in his house and the deep fat fryer left on - fortunately it was new and the thermostat was excellent.

Here is a real example - we thought that the care arranged for my father was more than adequate. I needed a break. We went on a three night holiday. Two hours after arriving we had a call from Care Call to say that my father needed support. We were 93 miles away. It was a Friday night and therefore Care Call contacted the over stretched ambulance service to attend and help him back into his bed. This was fine until he needed to use the toilet again later in the night.

The carers attended and sorted out the issue on Saturday. Between Friday night and Saturday 10.00pm I had made or received 34 phone calls. There was no-one available to add an extra visit at 10.00pm. The emergency duty team at Stafford could not locate any help. I phoned the care company who I was paying privately via SCC - they couldn't send anyone because they needed authorisation. The EDT finally said they had a solution and I was to phone the District Nurse administrator who very kindly said they 'would do me a favour' and send out two district nurses to put him back into bed. They were unable to get him into bed, sent for the ambulance and he was taken to A and E. He spent one night in a single en suite room in A & E followed by two nights in Leek. We cut our holiday short. On Tuesday he was sent home - no improved care facilities and the same pattern followed one day later.

So, several ambulance call outs, District Nurses doing us a favour!!! care givers not available, EDT had no solutions. Finally our GP organised three weeks at Brighton House. What a joy to receive excellent support. In that short time he was walking again and able to enjoy a seaside holiday at a respite care centre.
There was no clear pathway for his care. It was all ad hoc. And it was also a case of whoever has the time and knowledge to push for support, gets it.

Yes there is a strain of the finances of the NHS, but there needs to be a clear generic pathway that will suit the majority of people. All that we needed was confidence building, reablement, care giving in the home and a good back up emergency care giving service when there was a crisis in the home. The numerous ambulance call outs, nights in hospital and adhoc delivery of inappropriate duplicated equipment were all using resources that could have been better utilised if there had been a coordinated care plan produced by a team supporting the individual.

Community hospitals and Brighton House are essential establishments to manage the transition and back up to home care.”

Findings

Data

There was a total of 106 comments submitted to the online survey (many extended).

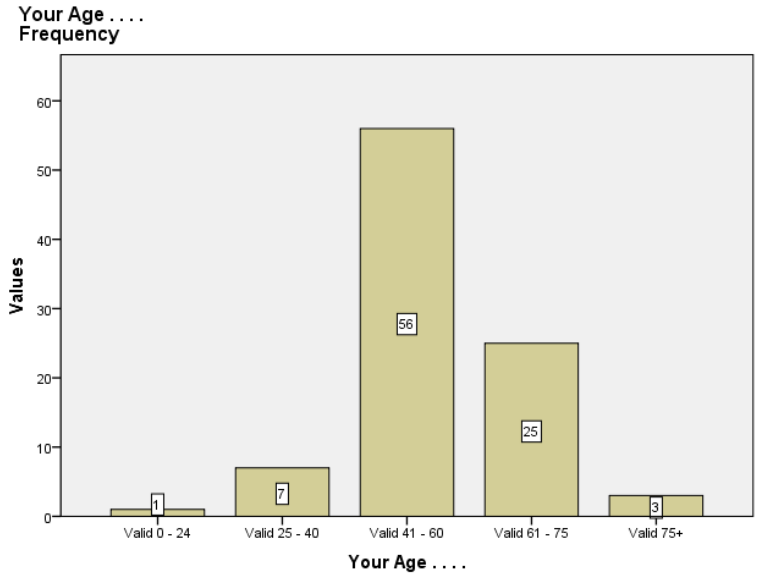


Fig 1 - Age distribution of respondents (who shared their age)

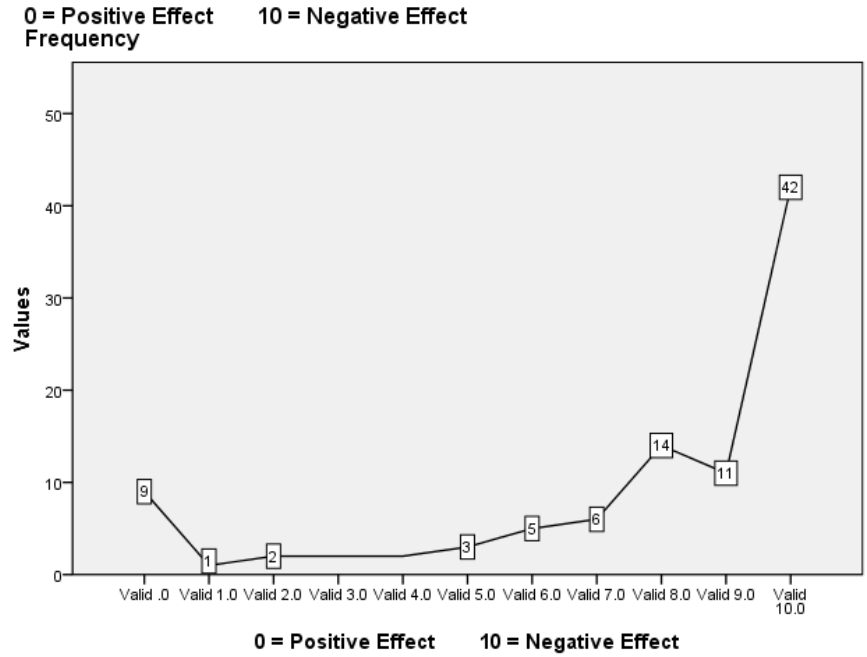
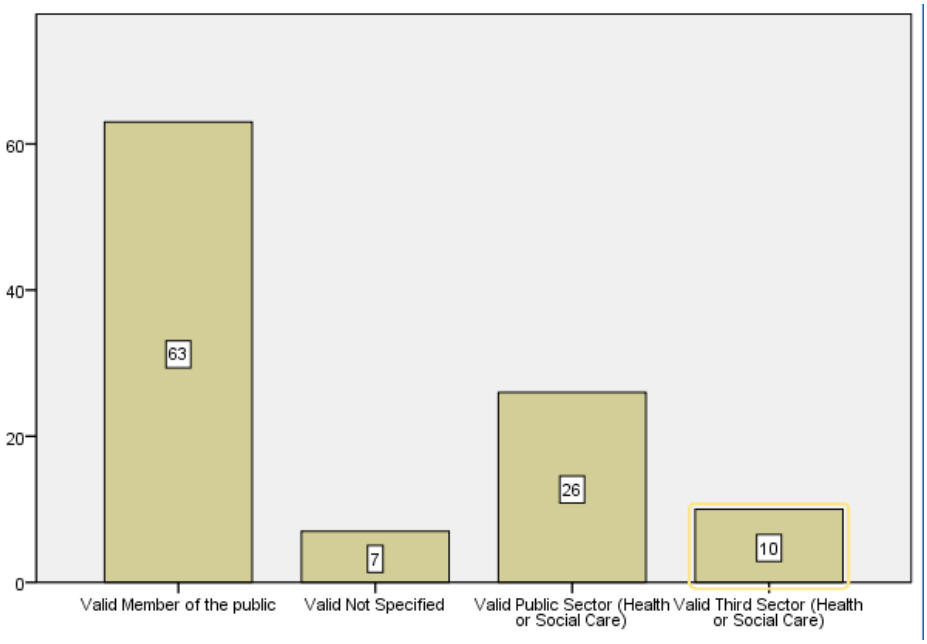


Fig 2 - Sentiment Overall (frequency pos/neg score)

When asked if the proposals would have a negative impact (10) or positive impact (0), overall 43.3% (42 respondents) scored the proposals the highest negative mark of 10.

Fig 3 -Survey Responses by Profession



The bar chart above shows that the comments were well populated by those who describe themselves as members of the public.

A Note on Bias -

It should be considered that this survey took place at a time when some NHS staff may have considered their jobs as at risk and there was much local media coverage of events intensifying debate[9]. This may have influenced the tone of some comments

This report is intended to reflect the views of our citizens who may not have had access to all the information available. To help achieve balance and understand the view from the CCGs, a suggestion would be to read documents at;

http://www.northstaffsccg.nhs.uk/my-care-my-way

[9] Example - http://www.stokesentinel.co.uk/bradwell-hospital-campaigners-stage-protest-outside-council-meeting/story-29947393-detail/story.html

Summary of Respondent Comments

*The following consists of **opinions** gathered via the survey. They does not necessarily reflect the views of Healthwatch Stoke-on-Trent. For the full comments from which this was extracted please see the appendix (p43), or page 25 for those filtered by theme.* ***These opinions are addressed via a series of questions and answers beginning on page 12.***

It is safe to say that many respondents to the survey do not disagree with plans to move care closer to home. In reading through the comments many recognise that there is a case for change but are concerned about the timing of and capacity to deliver. The following narrative is guided by comments shared in the survey.

There are many reservations and doubts expressed about a variety of issues. For example, there are many questions about capacity in the community with people expressing concerns about the ability of the system to cope presently, before these changes are put in place. When comments reflect upon recent personal experiences, such as having relatives currently on waiting lists for care support in the home, or the lack of quality care packages, despite the CCG communicating about extra investment, it is easy to understand why these people would have doubts. Public sector employees mention things such as a lack of capacity in care agencies and the growing lack of GP's in Stoke-on-Trent. There are also concerns about capacity, specifically in rural areas where people may be more isolated. However, one respondent mentions how the individual worked in the black country where there are no community hospitals and that if social care and community nursing were funded well, the proposals could be a good thing.

The most comments received are about the quality of care. Some comments express a concern that the case for change presented does not do enough to reassure about quality and that the focus is upon economic realities. Respondents seem aware of these realities although for some, there appears to be a perceived disconnect between commissioners and the front line.

A lack of 24-hour care has been pointed out by respondents. This is seen to impact upon things such as continence care, but also importantly, despite evidence[10] offered by the

[10] See here – http://www.stokeccg.nhs.uk/my-care-my-way

CCG that risks are reduced at home, respondents fear falls as people go to the toilet or fetch drinks for example. Respondents see this as even more important if people have other conditions such as Parkinson's or Dementia. People understand well that a fall may well mean a stay in acute care.

Respondents mention strongly the availability of care in community and how this compares with hospital care in terms of quality. These expressed concerns are based upon the duration and reliability of visits taking place as well as concerns that some workers may sometimes be young, ill equipped and untrained. The shortage of quality care packages also adds to this. Questions are also asked about who coordinates this care, is it the GP?

Respondents raise questions about accountability, such as who is responsible for the coordination of this care, as well as how practical it is to monitor quality in people's residences.

There are also questions regarding the quality of care in nursing homes and a fear that people may be sent to nursing homes by default, with less chance of receiving rehabilitation. It is feared that they will just be warehoused. There is also a lot of continuation of treatment that currently takes place in community hospitals that people are concerned may not necessarily be duplicated in a nursing home, such as managing pressure damage and monitoring tissue viability or providing 1 to 1 care. Respondents fear that the quality of that delivered in nursing homes is not on a par with current provision.

The private sector is also understood by some to be driven by profit, with targets to be hit and risk of impacting numbers and quality of staff. Respondents question the motivation for people to be moved on from nursing homes.

Respondents spoke highly of the quality of palliative care currently delivered in the community hospitals. They express concerns about the ability of nursing homes to be able to deliver in the same way when addressing complex needs.

Some respondents chose to shine a light on to social issues, pointing out that the needs of the elderly are quite specific and that there are risks associated with social isolation and loneliness. It is pointed out that it is not always the case that this group have an effective support network and even if they do, respondents are aware of cases where relatives have not been alerted when discharge has taken place.

http://www.northstaffsccg.nhs.uk/download.cfm?doc=docm93jijm4n10494.pdf&ver=15070

Respondents had a lot to say about systems resilience. Indeed, there is apparent anxiety expressed regularly through the responses about how the system will cope should hospital beds close. There is the sense that the appropriate measures are not in place and this will simply mean that elderly patients find themselves back at A&E further affecting 12hr waits. One respondent suggests that falls may mean individuals circulating in the system, in and out of hospital, not helping the situation by putting further strain on the system.

So called 'bed-blocking' is predicted by some respondents to increase in line with pressure on acute care. An ongoing need for step up care is foreseen by some as critical in avoiding pressure in this regard. Doubt is expressed about evidence of infrastructure to avoid this.

Specific risks are identified around funding being in place quickly enough for nursing homes. One respondent describes a push to get nursing homes to take patients before funded nursing care is put in place. However, if these patients are taken before this then they "fall off the social workers' radar and funding never gets sorted". Again, this possibly presents a risk of warehousing patients.

Finally, some respondents have their own view on the bigger picture, mentioning privatisation or surmising that costs that would have previously been absorbed by the NHS are now being moved into Social Care.

Questions from Respondents / Answers from Commisioners

These questions were generated from the responses shared with Healthwatch Stoke-on-Trent in the survey.

How will a lack of capacity be addressed in a health economy that is already short of GP's and care agency staff?	There is a safe staffing policy in place and there is no indication that the health economy is understaffed. CCGs have continued to invest (over £15m in the last 2 years) in Local Authority care provision, district nursing etc. Some of the problem is exacerbated by the national picture and pressure on the whole health economy.
Is the communications infrastructure in place to enable the coordination of care?	Track and Triage is a new process introduced to co-ordinate care from front of house thru discharge and beyond which is having a positive impact on the coordination of care throughout the whole patient journey.
As there are already shortages of care packages and waiting lists, how can the public be reassured that this will be addressed before changes are put in place?	Additional Social Care packages have been funded in the community. However, the CCGs are working closely with the Local Authorities and this is their area of expertise.

Are there any measures in place to address capacity issues in rural areas where people are more isolated?	Services are commissioned based on patient need and not location. Wherever people live, there is a team of people that patients will be discharged to known as an 'enablement package'. This gives the opportunity for safe assessment to be undertaken at home. This makes sure that people are referred to the correct wrap around services. There is a strong commissioned voluntary sector network, eg Saltbox and Revival. The services they provide include a be-friending service and people to take patients home, make follow up contact and make sure there is food, warmth etc at home.
In the context of significant cost savings? Can the public be guaranteed that there will be no fall in the quality of care delivered?	CCGs always make patient safety a top priority. All individual needs are assessed and appropriate checks are in place.
How can 24hr care be maintained when patients are at home?	If patients need 24hr care, they would not be at home.
Is there any mitigation in place to protect against an increase in falls in people's homes?	Why would people be more likely to fall at home? The fire and rescue service provide home safety assessments in line with the Falls Prevention Strategy which has been adopted across the local health economy. There is a Falls Responder and social care team in place.
How can quality be guaranteed in people's homes?	Robust quality monitoring processes are in place via both the CCG and Local Authorities across all contracts with providers.

How can patient experience be monitored in people's homes?	All provider organisations are required to provide evidence of patient experience in all contracts. Patient feedback is gathered in social care, CCG home visits, PALS and Complaints and via Healthwatch.
Will there be any reduction in the amount of rehabilitation delivered in nursing homes in comparison with current provision?	No, there is an MDT (Multi-Disciplinary Team) approach taken at each care home including occupational therapy, social worker, CPN, GP and an individual care plan is undertaken for each patient.
Can Nursing Homes choose who they take?	All nursing homes have admission and discharge criteria. They will only take those patients whose needs can be met.
Are there any skills deficits in nursing homes in comparison with current provision? For example, monitoring tissue viability or providing 121 care?	All nursing homes are registered with the CQC. We have a CCG commissioned nursing home matron who is supporting all care homes. We are only responsible for CCG commissioned nursing care. Long term needs will be assessed for their ongoing nursing requirements.
How can we be sure that in nursing homes, the 'profit motive' will not impinge upon quality in the long term? For example, maintaining staffing levels or skills in them?	The profit motive is conjecture. Each nursing home will have to comply with contractual standards of care.
Is funding always in place before patients are moved to Nursing Care?	There is NHS provision in place whilst patients are in nursing care. This changes when it becomes a social care package is required.

How will 'patient experience' be monitored in addition to quality in nursing homes? How will this data be communicated to the patient and the public?	All quality monitoring includes patient experience. In addition to CQC inspections, the CCG Quality Committee (which includes non-executive directors and patients) monitors patient experience and a quarterly report is made to the public Governing Body.
In Palliative care, do nursing homes have the skills to be able to deliver the sort of care needed to handle complex cases, thus avoiding repeat visits to acute care?	Those nursing homes that have been commissioned to deliver this specialist service have qualified and competent nurses. They also have support from agencies such as Douglas MacMillan and a specialist nursing team that includes a consultant nurse.
Although there is lots of work done in the third sector to address issues such as loneliness, social isolation and issues associated with a lack of a support network is there anything that has been specifically commissioned to address these issues?	A broad range of voluntary services have been commissioned and for example, programmes such as Exemplar Front Door, all discharges, GP's and Care Homes can refer into the voluntary sector.
What measures are in place to address things such as winter crisis and what short notice provision is available?	The Local Health Economy Winter Plan has been developed and is assured by NHS England. There are twice daily good calls across the system when pressures are at a high escalation level.

What We Did

Methodology

A simple web form was set up inviting people to share their opinion on whether changes would bring about a positive or negative effect. To facilitate this, the proposed changes were explained in the following text.

"Community Hospitals tend to be used to provide intermediate and rehabilitation service beds for people when they have received all the treatment they can at the main acute hospital, in our case the Royal Stoke. Locally, Community Hospitals include Bradwell, Haywood, Cheadle and Leek.

In the future, it may be the case that there will be less reliance upon these community beds, indeed some may close and you may have seen articles about this issue in your local paper or heard a discussion on the radio. As an alternative to community beds, it is proposed that people will be helped to remain in their own homes or use alternative arrangements such as nursing homes.

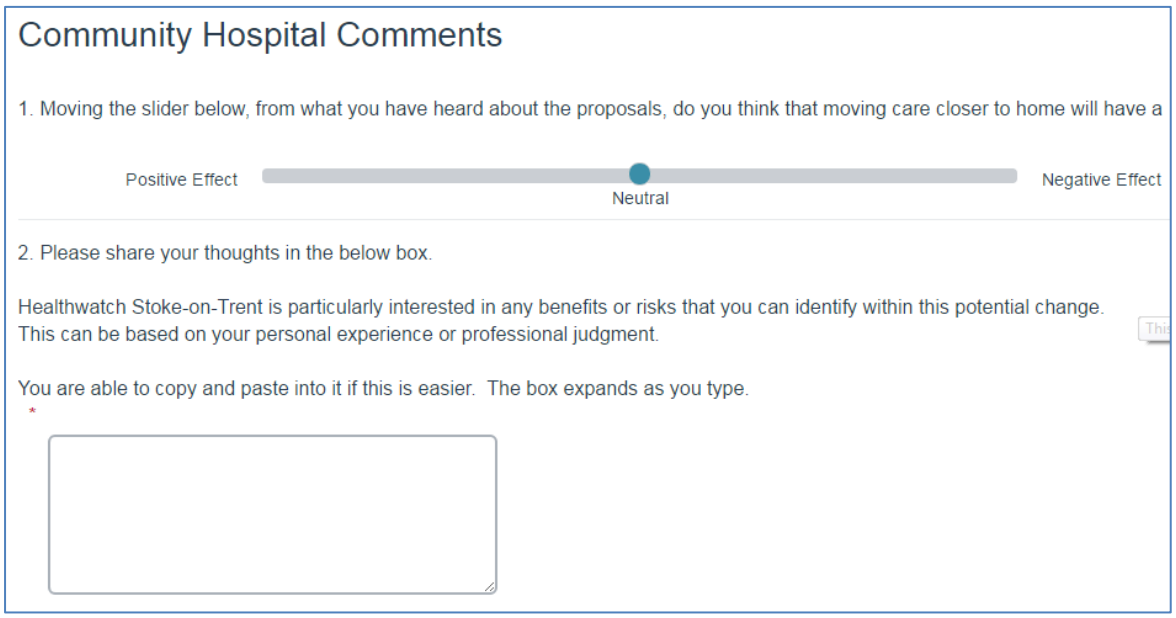
Simmy Akhtar, Chief Officer, Healthwatch Stoke-on-Trent said "We are really keen to ensure that the public voice is heard and would urge people to either complete our survey or contact us by email or telephone with their thoughts so that we are able to feed this back to local commissioners who make decisions such as this, within their timescales. It is imperative that commissioners are aware of the specific concerns that people have as the public is well placed to comment on what does and doesn't work well in health and social care services".

Healthwatch Stoke is keen to understand what people think about these potential changes. Stories and views received will be shared anonymously *with commissioners and decision makers. They will also help to guide the work of Healthwatch Stoke moving forward."*

After reading the preamble, respondents were invited to move a slider on screen to illustrate what effect they think the changes would have, 0 being a positive effect and 10 being a negative effect. After doing this, respondents were able to comment on the suggested changes.

The form also collected whether the respondent was a public or third sector worker or a member of the public as well as asking about their age.

All respondents remain anonymous.



This online form was then promoted through Healthwatch Stoke networks including local newsletters produced by third sector organisations. It was also promoted through existing email networks such as those associated with groups like the dementia steering group at Stoke City Council. 106 responses were received[11], most extended.

Comments received were classified into the following themes for analysis;

- Capacity;
- Systems Resilience;
- Quality of Care;
- Social Factors.

It is possible to draw a narrative using these themes as a basis and develop questions to be shared with the local Clinical Commissioning Groups.

[11] Letters and emails were also received (see appendix)

Some Selected Comments

Capacity

It is not the case that all respondents disagree with principle of 'home first'. Much of the resistance is orientated around a clear perception of a lack of capacity. Respondents mentioned this in various guises throughout the responses. A lack of capacity presents risks understood by the public and professionals alike. The Clinical Commissioning Groups are aware of this concern and have an event organised to discuss it[12].

"Once we have provisions in place I will then fully back the my care my way proposal till then I'm fully against" - Member of the public

"The services that would be needed are not out in the community that's why we have people bed blocking because they waiting for care package's!!!" - Public Sector Worker

"There isn't enough community resource" - Member of the Public

"we all know there are not enough community services." - Member of the Public

"Current community services can barely cope with current demand making it impossible to provide safe effective care for those discharged from Bradwell and other hospitals if they are closed.." - Public Sector

"While care closer to home is commendable the systems in place struggle to cope now managing people at home." - Public Sector

". . . there is nowhere near enough community care provision available. There are long waits for care packages now never mind when the community hospitals close." - Public Sector

[12] http://www.northstaffsccg.nhs.uk/my-care-my-way-implementation
See a vid of the November event - https://www.youtube.com/watch?v=wl8Aqve1uYo

These fears are significant and will require a lot of reassurance, especially when they are based on lived experience.

"My 95 year old Auntie & Uncle have recently both been inpatients at Royal Stoke. Currently they are both at Bradwell awaiting arrangements for them to be transferred to a nursing/residential home. My Auntie & Uncle are no longer able to care for themselves & their flat in sheltered accommodation is too small for the equipment needed. Currently there is a waiting list for care support in the home. Without the excellent care at Bradwell my Auntie & Uncle would still be at Royal Stoke in much needed acute beds needed for ill patients." - Member of the Public

This is reflected in the experiences of professionals who work with a variety of different community services.

"I live in a rural area in the Staffordshire Moorlands and know from my work at local GP Practices just how stretched already the District Nurses are. ." - Public Sector

"I know of patients waiting care packages in the more remote villages who have sat in beds as there is no service provision" - Public Sector

"Care agencies capacity is also already not meeting demand and this closure would only make matters worse and prove detrimental to patients." - Public Sector

"There is a national shortage of GPs and community nursing numbers have halved in the last 5 years, care agencies cannot cope with demands." - Member of Public

"Insufficient quality care in the community at present placing the elderly or vulnerable at risk." - Public Sector Worker

Quality of Care

It could be argued that a lot of discourse around these issues so far, especially that of the CCGs has been perceived by some to be orientated around addressing issues of capacity so that it achieves safety and minimises risk. However, the most comments received about 'My Care My Way' are firmly focussed upon quality.

24 Hour Care

There is significant concern about what will happen in terms of 24 hour care when patients are in the community.

> *"no overnight calls"* - Public Sector Worker

> *"There isn't a 24hr service for people who are at home."* - Public Sector Worker

Respondents identified several risks associated with this, such as falls, continence care or dealing with other conditions such as Parkinson's or Dementia.

> *"Take incontinence care for night. Pt have to stay in wet beds if they live alone as no service maintained care is out there I checked!"* . . Public Sector Worker

> *"Following an acute illness older people need a period of rehabilitation to increase independence daily, especially night time. This is never going to be available in their own home."* -

> *". . . if relatives can't stay they have to stay on their own and this is the problem because lots of them try to get up for toilet or drink and fall this happened to my mum on numerous occasions."* - Public Sector Worker

Some have lived experience of the risks (see also page 6).

> *"24 hour care is not going to be provided in people's homes leaving those in recovery at risk of their health worsening or life threatening complications being unnoticed/untreated. home is not a safe environment for recovery who many people who these beds are used for. For example, my 91 year old frail, unstable on his feet grandfather or my old neighbour who has severe Parkinson's. going home would slow down and hinder their recovery ultimately landing them back in hospital, so not saving any money."* - Member of the public

Nursing Homes and Rehab

Respondents mentioned the use of nursing homes on many occasions, questioning the extent to which the services they offer compare with community hospital beds when thinking about rehabilitation. A common concern seems to be that nursing homes may not offer effective rehabilitation services.

"people with rehab potential may simple be written off and sent to residential or nursing settings instead of providing the care and rehab to enable them to live their lives safely at home.." - Public Sector Worker

"Where is the incentive for nursing homes to get patients home when they are getting paid to have people in these beds?" - 3rd Sector Worker

"Sticking people in nursing homes will mean they will just stay in those nursing home without the rehabilitation they require to get home. Not giving rehabilitation at the correct time for patients will in the long run cost health and social care more money as people become less able and more dependant. Sticking patients in nursing home beds will just mean they will stay in nursing homes." - Third Sector Worker

"These patients the CCG would have us believe can move to private nursing homes to wait care 'a cheaper option' in reality these patients will not get the full assessment they need" - Public Sector Worker

" . . nursing homes are an unsuitable alternative to the professional intermediate care provided by our community hospitals." - Member of the Public

"Whilst I agree that people should ideally be cared for in their own homes the lack of services available is either going to force people into nursing/residential homes before they are really needed"- Member of the public

Nursing Homes and Quality

Respondents shared a concern for the quality of care in nursing homes in comparison with community hospitals.

"Whilst residential/nursing care homes are a valuable resource, the quality of care frequently falls below the standard of care given within the NHS community hospitals."- Public Sector Worker

"There is a huge difference between being "medically stable" and being "back to previous ability" / achieving potential. The NHS is not just about meeting acute needs; it includes people being able to rehabilitate. If the model of rehab and recuperation delivery must be within patients' own homes, fine, but the home-based services must be funded, staffed and operational to allow this to happen. We can't just take away a service without the new services being in place. - Public Sector Worker

"Community Care hospital beds are not warehouses for the elderly , when a patient is admitted a full assessment takes place and we carry on from where the acute sector has left off with continuation of medical treatment such as IV Antibiotics and fluids, blood transfusions, Medication review and monitoring, Monitoring of nutrition, Hydration, weight, ECGS, Dementia screening, Continence assessments, Stoma and catheter care involving teaching patients to manage these at home, Referrals to other services both socially and medically, Kitchen assessments, washing and dressing assessments, Pressure ulcer treatment and prevention , full assessments of a patients night time needs as this is when the aged are most vulnerable, teaching and giving advice to relatives on a whole host of subjects, and so on, all aiding patients to return home safely and staying at home for as long as possible." – Public Sector Worker

> *"our care home sector also need to step up to the mark as they often have stringent criteria for acceptance and often the most complex patients are the ones who require 24-hour care yet many homes cannot cater for their needs."* - Public Sector Worker

> *"beds bought at Stadium court and Hill Top are not providing adequate therapy, private nursing homes are going under and cannot recruit, NHS Community Nurses are not staying because of pressure."* - Public Sector Worker

Some are concerned that nursing homes do not have the skills to manage pressure damage and tissue viability?

> *"I know from personal experience that many of these homes have issue with pressure damage and are unable to care for many patients I have had contact with"* – Public Sector Worker

There is a question about staffing arrangements in place in nursing homes.

> *"Whilst partly agreeing to nursing at home, I have experienced and found that with limited staffing levels and targets to be hit. The service is at the moment a poor alternative with staff popping in on short client based time and tending to be rushed and very sporadic"* - Member of the Public

> *"Nursing homes do not provide the specialist staff needed to aid recovery. Most are understaffed . . 1 to 1 care time is needed to improve patient's mobility so they can recover and become self-sufficient. In reality, nursing homes provide very little of this."* - Member of the Public

One respondent was rightly anxious.

> *"What about the stress on the family from seeing their loved one potentially not cared for appropriately? I've experienced this myself - my Mother moved to a step-down bed in a Residential Care home. This was a disaster - safeguarding process initiated by me. It almost certainly led to my Mother's dementia becoming worse earlier than if she had been properly cared for + resulting additional costs for her estate and the NHS."* - Member of the Public

Palliative Care

Respondents shared concern about the quality of Palliative Care moving forward.

". . . Palliative services at Bradwell (also) critical to getting end of life care right" – Public Sector Worker

"The Palliative Care offered and given on Sycamore Ward is Professional. respectful, individualised and client centred and all work towards a pain free positive experience in End of Life Care." – Public Sector Worker

"I am a Mental Health Nurse with 30 years experience of mostly community care and have first hand experience of the care on this ward, as my Mum was nursed with dignity and care with her pain effectively managed on not only a daily basis but hourly by experienced efficient caring staff. She had multiple pathology and complex needs, including medical, Neurological, and Mental Health needs. The access to a Palliative Nurse Specialist was especially beneficial and necessary as this vulnerable client group have very specific changing needs, which can be hourly. I know with no doubt at all that the private sector nursing homes would NOT be able to offer the level of specialist input that is required when an individual faces complex needs which I believe can only be catered for in a Nursing environment with the back up and support of the multi agencies. They are able to assess, re assess treat, risk assess, care plan and adapt to ever changing needs, where the person being cared for is the focus, and care is individualised and not catered by too few in an environment where people are admitted with a wide range of nursing needs. I know without doubt that my Mother would have been re-admitted to The Royal Stoke University Hospital on numerous occasions had she been in a Nursing Home or indeed at home." – Public Sector Worker

Care in the Community

Respondents have various concerns about what will happen in the community and the quality of what will be delivered.

"With an aging population and increasing complexities, community services: a, are not funded / staffed sufficiently b, have skills / expertise to manage many complex comorbidities" - Public Sector Worker

"Good community care - compared with the community hospitals DOES NOT EXIST - and what is more the public and the professionals are aware of this." - Public Sector Worker

"In hospital the hospital is ultimately responsible for the patient's care. At home there is no one person responsible for co ordinating all the care a discharged patient may need." – Member of the Public

"From experience the carers do not arrive at an appropriate time to get dressed for the day and also to get ready at bedtime." – Member of the Public

"as they are always on a timed visit, care is often rushed and inadequate. It is not practical to leave bed bound people at home on their own for long periods of time either." - Member of the Public

"Private care providers are not necessarily of the best quality many are young, ill equipped and untrained -when asked if they enjoy their jobs, 'its better than the dole' is not a good response - 35 different carers into a lady with dementia is not good when continuity is key, a gentleman having a stroke and sent home with a peg feed and no carers visited for two days is poor quality care, funding for social care not available" - Public Sector Worker

> *"There is also an acute shortage of care packages and many of those in place are of poor quality."* - Public Sector Worker

However, not all are negative but acknowledge that there needs to be a significant investment in community services.

> *"I trained as a nurse in the black country and they did not have community hospital and there were some respite facilities. There was more emphasise on care in the community and community physio. I think because in Stoke on Trent they have had community hospitals for a long time it will be a shock. If more money goes into social care and community nursing I think the planned proposals could be a good thing."* - Public Sector Worker

How can the monitoring of care in the community be improved?

> *"Homes of people not monitored good enough. Standards may drop, health would deteriorate."* - Member of the Public

Social Issues

Some respondents chose to shine a light on to social issues, pointing out that the needs of the elderly are quite specific.

"…. I would like commissioners to realise that support in the community leaves folk socially isolated, lonely & often depressed, their nutritional state & skin integrity suffer as a result." – Public Sector Worker

"…. family support is not always an option leaving some older people very vulnerable and at risk" – Public Sector Worker

"…. there are many patients who we receive in the moorlands area who are often living alone or live with elderly family" – Public Sector Worker

"…. families also no longer live near each other and if they do chances are they to are working to make their own ends meet and will simply not have the time to care for their loved ones as they wish." – Public Sector Worker

"…. Carers in hospital or ill themselves and houses that need deep cleaning and that's not to say for those who are discovered to have further medical aliments that need treating" – Public Sector Worker

Systems Resilience

Respondents had a lot to say about Systems Resilience. Indeed, there is apparent anxiety about how the system will cope.

"What happens when these Hospitals close and then the "System" can not cope, what evidence do you have to support this proposal as the best option available. The Royal Stoke Hospital is currently a nightmare to attend, either as a Patient or as a Family Member trying to visit or support a loved one, how about addressing some of those issues first. I fear that you seem to be putting all of your eggs into one basket and do not believe that you have a suitable infrastructure once any of these proposals are implemented to be able to cope adequately with the added demands that would be required in order to make this proposal a success." –
Member of the Public

"I have evidence that people's care now has not been put in place before they have been discharged from Royal Stoke to home this is in recent weeks. This is why we have still have some community beds supposedly so what will happen when we have none is very worrying. Services need to be put in place before all beds are closed and so a gradual reduction in beds - 3rd Sector Worker

The government purely need to invest large sums of money to get community services up and running via voluntary, social care and health sectors working in a joined up way.
Public Sector Worker

A&E and UHNM.

Respondents feel that the proposed changes may just result in moving problems elsewhere in the system. Especially through A&E.

"No care packages available before closing community hospitals, poor people will end up back in A&E"

Public Sector Worker

"there is a real danger of the older vulnerable person being discharged too quickly, not medically fit with an inadequate package of care this in turn will result in a return to A&E which then has a negative impact there"

Public Sector Worker

"By decommissioning the community beds, all that will happen is that there will be an increased volume of patients coming back in through A&E who will need to be admitted. This will have considerable knock on effect on 12 hour waits in A&E as the hospital is already at capacity and unable to discharge anyone anywhere if they are waiting for care packages or a complex discharge as there are no community beds Patients will be inappropriately and unsafely discharged back into the community with insufficient care resulting in emergency admissions coming back through A&E and the whole cycle will start again."

Public Sector Worker

"many patients cared for will be sent back to AE if they become unwell where the community hospital have now but in more skills so patients are kept in their wards if they become unwell they even treat sepsis!"

Public Sector Worker

Bed Blocking

Respondents are concerned that the proposals might not have the expected effect on bed blocking.

"By closing the wards in the community hospitals they are removing the only alternative to care for the patient. Those who can't be cared for at home will have to stay in acute care and block beds. At present there is no evidence of the infrastructure being in place nor the appropriate qualified carers employed,"
Member of the Public

"We've had lots of patients that just keep round and round the system because they can't cope at home or they keep falling".
Public Sector Worker

"Risk of readmission to the Royal Stoke University hospital would be extremely high if the Community beds shut."
Public Sector Worker

"Given the issue with bed blocking caused by people who cannot be discharged as there are insufficient beds in care homes/nursing homes, it is a ridiculous proposition to close services which help this situation. More pressure will fall on acute beds if this is taken forward."
Member of the Public

"I believe that moving people nearer to home would only bring a small advantage. Simply that people if asked will say they want to go home. However, without a step up and step down for most people will return to crisis wards quite swiftly. There will be a very small percentage of people who will return to home care and remain there. We are noticing it now that people who would have taken up a resource community bed for a short period, either entering or leaving services, instead are being put straight into a crisis ward which I believe is not a place for people who are purely distressed and not critical."
3rd Sector Worker

Resource

One professional points out some important potential systemic risks in nursing homes that could affect the health economy more broadly.

"From personal experience, there is a big delay in the discharge of patients due to lack of funding from the social care team. As a previous Registered Manager of a nursing home, I had two residents admitted to the home where 10 months later, their funding still had not been agreed and we had yet to be paid for their care. A further resident had his discharge from hospital delayed by 2 months due to the social work team failing to get FNC agreed. There is a big push on homes to take residents before FNC is agreed and in place to prevent delays in discharge, however if homes do take residents before funding is agreed, the resident then falls off the social workers' radar and funding NEVER gets sorted therefore homes are no longer accepting residents until everything is agreed and in place. There are increasingly complex patients being discharged into nursing homes and they are more costly to manage, both in staffing and equipment resources. Yet budgets are being cut or held and not increased in-line with growing needs, causing nursing homes to decline residents based on affordability"

Public Sector Worker

Emergency Provision/ Winter Crisis

Respondents point out risks around provision of short notice beds in times of need such as winter crisis.

> *"what is available at potentially very short notice for people deemed fit for care in their own homes or if applicable private care beds?"*
> Member of the Public

> *"I fear that the closure of the community hospital beds will impact on the patient flow in the acute sector creating further "bed blocking" and increasing the pressures of any impending winter crisis"*
> Member of the Public

> *"As winter approaches more beds will be needed not less and A&E is already at busting point with long queues in corridors."*
> Member of the Public

Paying for Care

What impact will this have on paying for care?

"Patients are assessed prior to discharge from Royal Stoke. In some cases patients need ongoing nursing care at a suitable Community Hospital - which currently to my knowledge occurs no cost to the patient. If all Community Hospitals beds are closed, then patient may have to bear proportion of cost of nursing care at a suitable nursing home. Stoke City Council assesses each case on clinical need and states it has only limited number of places and has only places for patients 'in most need'. Closing Community Hospital beds will only put further demand and increased strain on Stoke Council nursing home places. Inevitably this would lead to more patients having to pay for their ongoing nursing care. Care at home is fine for those patients who are able to adjust and cope - but some patients need nursing care similar to that currently provided by our Community Hospitals, and a clearer policy needs to be outlined from City Council and NHS Stoke CCG as to where these patients are going to end up, and who is paying for what. Further events and discussions are needed to clarify before any Community bed closures".

Member of the Public

Appendix

Members of the Public - Comments

1	Care in the community is fine if it works. There is not enough staff for it to be effective e.g. District nurses care plans are frequently set up when people move out of hospital, not before. How can this work?? If the sick have no relatives to speak up for them I fear for their future.
2	Don't believe CCG have not fully undertook consultation. I'm worried for my future and the elderly. Our community beds are essential for our community. We are an aging population and who is going to be left to deal with the mess they are currently making? People like me. It is not acceptable or appropriate at this time. Once we have provisions in place I will then fully back the my care my way proposal till then I'm fully against. Community hospitals can be used in a more structured way to help prevent sub-acute admissions to the UHNM so freeing their beds up for those emergencies and specialist needs. From a very worried 21 year old!!
3	There isn't the community resource. Following an acute illness older people need a period of rehabilitation to increase independence daily, especially night time. This is never going to be available in their own home. One not enough staff and two too expensive to provide night time support. Two weeks' maximum having daily therapy increases patient safety and better potential to stay at home following an acute illness.
4	The negative about this plan is the people most at need could easily fall through the net and because of this how many of our elderly residents will pass away through the neglect of the so called better system it seems that to me that is what the NHS want anything to save money to spend on unnecessary management and agency staff
5	Good community care - compared with the community hospitals DOES NOT EXIST - and what is more the public and the professionals are aware of this.

6	In hospital the hospital is ultimately responsible for the patient's care. At home there is no one person responsible for co ordinating all the care a discharged patient may need. We have seen cases where vulnerable people have been discharged to cold homes where there is no one to care and no food in. This move will increase the risks to patients because adequate care packages are not in place before discharge.
7	community hospitals have become the default position for older people in stoke on trent the default position should be in a persons own home
8	I am concerned that insufficient home care is in place and that nursing homes are an unsuitable alternative to the professional intermediate care provided by our community hospitals. I speak from personal experience of elderly friends, one of whom died in a nursing home, having deteriorated whilst in the home, and the other who was kept in Royal Stoke for 13months and then died in that hospital.
9	With the current fluidity of community bed availability there are already shortfalls in what is available at potentially very short notice for people deemed fit for care in their own homes or if applicable private care beds. If community beds are closed there will be an even greater increased pressure which will in turn lengthen the acute bed stay??? Is this not common sense? Is a community bed by its very nature as close as possible to the patients home and family with increased focus on rehabilitation ensuring they are fitter and more able to go home sooner??? As a younger person with a chronic respiratory disorder I have found myself in lengthy queues in the Urgent care 'corridor' the longest being 13 and 1/2 hours. Amongst those waiting with me were a great number of older and vulnerable patient and whilst the staff are dedicated and do as much as they can, c to be more secure corridors are surely not places for real 'care' to be given? If community beds were to be more secure could there not be another pathway were some patients were directed to these first line thus easing in some small way the pressure on the urgent care centre? I know this in the short term may seem expensive but the quality experience and overall outcome for patients and families must surely be improved. The 13 and 1/2 hour wait in the urgent care centre was in the summer, goodness knows what will happen with winter weather conditions. Please look to the longer term quality of all patient care experiences and not just speed of flow and 'targets' which were arbitrarily set by who?? No one who works in todays NHS of that I'm sure
10	Closing these community hospitals will put extra pressure on Royal Stoke and as for wanting to care for people in there own homes, how will this work? There isn't a 24 hr service for people who are at home. There isn't enough care homes either for our older generation.

11	Removing community beds will increase the bed blocking in hospital by patients who are awaiting care packages etc. As winter approaches more beds will be needed not less and A&E is already at busting point with long queues in corridors.
12	The infrastructure is t in place for community yet, closing the beds at Bradwell with have a major detrimental impact on the lives of patients who need rehabilitation and also the relatives who struggle to care for them.
13	We need the services available at Bradwell in our area
14	It is a facile argument to suggest the level of care and support currently given at a community hospital can be provided at home or a nursing home. A community hospital is an intermediate stage where suitable care and support, which may be very significant, before a person returns home or into long term care. These proposals are another example of the BUS which we all pay for transferring it off loading responsibility to other sectors.
15	Closing these hospitals is foolish and ill advised especially as it must be easier and cheaper for nursing care to take place in one place such as these hospitals. If care is given at home nurses will have to move about to various homes with costs of petrol, car and car expenses having to be borne by the taxpayer via what is left of the NHS. What about the over burdened A & E and the hospital beds situation this winter. Can the hospitals cope? Answer ..... of course not. Please do not close these valued and much needed hospitals.
16	Care in the home will isolate older and vulnerable people leaving them at risk because quality service provision is not in place, without a halfway house and the level of services needed the Royal Stoke will be undermined and will collapse as people won't be moving out of beds.
17	There is a national shortage of GPs and community nursing numbers have halved in the last 5 years, care agencies cannot cope with demands, so how is shutting the desperately needed rehab beds going to help any of this? A lot of elderly people are carers for each other and go into crisis each day, with little or no support because they are not ill enough, but they often end up in hospital having fallen and then they admit to not coping, which is usually why they get stuck in hospital, how is not having community beds helping this.

18	24 hour care is not going to be provided in people's homes leaving those in recovery at risk of their health worsening or life threatening complications being unnoticed/untreated. home is not a safe environment for recovery who many people who these beds are used for. For example, my 91 year old frail, unstable on his feet grandfather or my old neighbour who has severe Parkinson's. going home would slow down and hinder their recovery ultimately landing them back in hospital, so not saving any money. Nursing homes do not provide the specialist staff needed to aid recovery. Most are understaffed . . 1 to 1 care time is needed to improve patient's mobility so they can recover and become self-sufficient. in reality nursing homes provide very little of this.
19	I strongly suspect this is going to have a negative impact. Based on my own experience, it is difficult to obtain a suitable care package for someone at home (+ will probably rely on relatives and neighbours for additional support - what about those who don't have?). There are limited places available in Residential and Nursing homes + funding is becoming a major issue (if not self funding), such that some Homes have already closed due to insolvency. What about those who have moved to a Community Hospital bed to ensure a dignified death, with the appropriate Nursing care in place? Will they simply be placed in a Nursing Home, assuming a bed is available? What about the stress on the family from seeing their loved one potentially not cared for appropriately? I've experienced this myself - my Mother moved to a step-down bed in a Residential Care home. This was a disaster - safeguarding process initiated by me. It almost certainly led to my Mother's dementia becoming worse earlier than if she had been properly cared for + resulting additional costs for her estate and the NHS. Why were Community Hospitals first established? Any reasons still applicable? How will this assist the beds crisis that already exists at the Royal Stoke Hospital?
20	From experience the carers do not arrive at an appropriate time to get dressed for the day and also to get ready at bedtime.
21	Patients, Especially the elderly require support following an acute hospital admission. They can't always manage at home and we all know there are not enough community services. It makes moral and financial sense to step down from an acute setting to a community hospital. Allowing rehabilitation, support and assessment to get people home safely. Free up acute beds and prevent people being readmitted.
22	I think we should encourage people to stay at home. There is too much waiting time and demand on current provision.

23	My 60-year-old husband waited 3 months for an appointment to clarify if he was able to have further treatment or was to be treated as palliative. Whilst waiting for this appointment he deteriorated quickly and we asked for a care package to be put in because I was his main career and worked full time. We were assessed for the care package and agreed to have four calls per day and a financial assessment showed that we would be self-funding at a cost of £267 per week for a total of 13.5 hours of care. We waited for over two months for this care package to put in place and we still had not got one prior to him being admitted into an acute care bed in Royal Stoke Hospital where he died two weeks later. Due to the doctors in the acute hospital wanting to try and treat his acute condition they did not put him as palliative until 6 hours before he died. Whilst having his treatment options clarified may have gotten him fast tracked for both funding and a care package the delay into putting a care package in shows that there are not the services in the community for people to be cared for at home, and with the planned closure of the community beds including the palliative beds can only further put pressure on the community services that are not able to provide the required services now. Whilst I agree that people should ideally be cared for in their own homes the lack of services available is either going to force people into nursing/residential homes before they are really needed to or that it will lead to unsafe discharges.
24	Risks mean further problems with bed blocking for older vulnerable people. We know of one patient recently who has had to stay in hospital when previously staff said she would have moved to Bradwell to aid her recovery
25	Community beds need to remain looking after patients at home is alright if there is enough input to keep them safe, At the moment this is not in place ,also, patients should have the right to decide if they feel they want the safety of a hospital bed, savings could be made by cutting out some of the higher management which did not happen 20 years ago, and hospitals ran a lot better for the community that it was for
26	The CCGS are putting people at great risk closing the community hospitals. 1-They have plan in place to increase more care in the community. 2-The people who are in the community hospitals are there because they need the appropriate assessment for their needs, some which are complex. 3- What have the CCGS done with the money saved from Longton and Cheadle hospital. They certainly have not put this to use within the community. 4. Patients are waiting months in community hospitals for care packages, so how can they justify this.
27	My 95 year old Auntie & Uncle have recently both been inpatients at Royal Stoke. Currently they are both at Bradwell awaiting arrangements for them to be transferred to a nursing/ residential home. My Auntie & Uncle are no longer able to care for themselves & their flat in

	sheltered accommodation is too small for the equipment needed. Currently there is a waiting list for care support in the home. Without the excellent care at Bradwell my Auntie & Uncle would still be at Royal Stoke in much needed acute beds needed for ill patients.
28	When people are still in need of 24 hour care, or need convalescent time to regain their strength, this service, if done well, is invaluable. The Haywood get top marks in my opinion for the way staff interact with patients to build up their confidence. Bradwell have a lot to learn from the Hayward's methodology and patient interaction. Losing this valuable service shows so clearly that the Government are keen to reduce even further the resources for the disabled and elderly. Why try to get people to live healthy, longer lives and abandon them when they grow old?
29	Its ok being sent home if family are close by.. Twice a day by carer is insufficient if alone without family. A friend recently had a fall and had to have hip replacement, he was sent home after a few days with a care plan and a walker. He only had use of one arm as the other arm/. shoulder socket kept coming out . such difficulty for him to undress, wash, etc. If this is what we have to accept in the future then many elderly people will die before their time due lack of care.
30	Patients are assessed prior to discharge from Royal Stoke. In some cases patients need ongoing nursing care at a suitable Community Hospital - which currently to my knowledge occurs no cost to the patient. If all Community Hospitals beds are closed, then patient may have to bear proportion of cost of nursing care at a suitable nursing home. Stoke City Council assesses each case on clinical need and states it has only limited number of places and has only places for patients 'in most need'. Closing Community Hospital beds will only put further demand and increased strain on Stoke Council nursing home places. Inevitably this would lead to more patients having to pay for their ongoing nursing care. Care at home is fine for those patients who are able to adjust and cope - but some patients need nursing care similar to that currently provided by our Community Hospitals, and a clearer policy needs to be outlined from City Council and NHS Stoke CCG as to where these patients are going to end up, and who is paying for what. Further events and discussions are needed to clarify before any Community bed closures.
31	People, especially the elderly sick feel less vulnerable if cared for in a community hospital. Nursing homes sometimes focus more on profit than on patient so therefore maintaining a good level of care and rehabilitation in the community hospitals is imperative. Home care doesn't

	always work because so many things can go wrong but if the care is provided in the community hospital the patient has more confidence that there is help at hand 24/7.
32	I feel that there are not enough quality care workers to support people in the home, and as they are always on a timed visit, care is often rushed and inadequate. It is not practical to leave bed bound people at home on their own for long periods of time either.
33	How many nursing homes have beds ready? How many homes have the staff to cater for the required needs? Hospitals such as Bradwell have very experienced staff, my own mum was very well looked after there.
34	When my ninety year old father was taken ill I was unable to provide additional care for him as I was too ill. He was put into Cheadle hospital where his care was exemplary. As a family we shall always be grateful to this hospital. He was allowed to die with the dignity he deserved. There is no way that this could have been provided at home. These small community hospitals are a vital facility, under no circumstances should we allow them to close.
35	I think losing community hospitals in favour of care at home is not a good thing. Hospitals essential for life saving doctor/nursing care. Homes of people not monitored good enough. Standards may drop, health would deteriorate.
36	Whilst partly agreeing to nursing at home, I have experienced and found that with limited staffing levels and targets to be hit. The service is at the moment a poor alternative with staff popping in on short client based time and tending to be rushed and very sporadic. Ideally in client/patients should be decided on individually whether home or community hospital based care is best and agreed. Perhaps shaving 15 - 20% off the administration salaries would put more funding into the ground based service.
37	The Community Hospitals must remain open. My mother went into Cheadle having suffered a severe stroke. She could not have received the 24 hour care she needed at home, and she no longer required the care Royal Stoke were providing
38	By closing the wards in the community hospitals they are removing the only alternative. Those who can't be cared for at home, and there are several reasons why this is, will have to stay in acute care and continue to be bed blockers. The infrastructure is not in place nor the appropriate lyrics qualified carers

39	Have u got staff for community and not all got familys who can help
40	This box isn't big enough for all my views! I appeal to you to take weight of public opinion! See 'My care, my way, home first' open letter from several bodies! I feel that this questionnaire is futile and my opinion has no bearing!
41	I think that is is very bad to have the community hospitals are going to close as when the people who might need more help will have to go it to care homes and pay private and the staff in a care home can't do the same work as a nurse in hospital as I have see where people come out of hospital to there care home and if anything happens where they have to go back to hospital to get the right care and if they go to the community hospitals then they will get the help they need so when they are fully better then they can go home to have family and friends helping them and they might have to be moved to where the nearest care home is which might be a long way from there family and friends
42	My 95 year old mum has recently completed a stay at Bradwell hospital following a fall. The proposal misses a very important point and that is that Bradwell hospital was there to make my mum better, which they did very well. The care she needed after being discharged from the Royal Stoke, could have not been given at her home, or in my view, anywhere other than a medical hospital as she had a particularly bad wrist break. I have left my email address below and would like to be able to assist you further, as I have about 6 month's worth of experience in respect of my mums fall to be give you!!
43	It makes treatment more accessible and frees up the main hospital. Better for visitors too. Having community mental health beds meant that the step up step down process for hospital was far more effective. Care in the community does not mean in your home and currently it is not effective. Do not close the likes of Bradwell hospital and reinstate mental health bungalow beds.
44	People will need 24 hour care before being sent home especially if they are alone so losing the beds is a massive loss
45	I think it is imperative that some help is given to patients after they go home after an operation. Last year I had my ovaries removed on a Friday afternoon as was discharged the next morning. I felt myself going downhill and after 3 more days I requested a visit from my GP. He came, and was furious that someone of my age (over 80), wth no relatives in the area , was sent home without putting in any support. He arranged for carers to come in but this was too late as I was taken in to the N Staffs, as an emergency, 6 days after coming out of hospital.

	The Paramedics said I was on the verge of 2nd stage sepsis.. I was quite ill, and spent nearly 2 weeks in hospital followed by 4 weeks in a rehabilitation centre. I do think it was false economy not to have some supervision when I came out after my operation. This would have saved 6 weeks of an NHS bed. Therefore the support MUST be available.
46	recent experience: My sister had a procedure at The University and was then moved to Stafford: I am nearly eighty and still fit enough to visit her from Trentham. BUT it must isolate relatives and loved ones who are unable to make the 32 mles round trip. Not a very good experience.
47	What happens when these Hospitals close and then the "System" can not cope, what evidence do you have to support this proposal as the best option available. The Royal Stoke Hospital is currently a nightmare to attend, either as a Patient or as a Family Member trying to visit or support a loved one, how about addressing some of those issues first. I fear that you seem to be putting all of your eggs into one basket and do not believe that you have a suitable infrastructure once any of these proposals are implemented to be able to cope adequately with the added demands that would be required in order to make this proposal a success.
48	I do not think it will make any difference. My 89 year old father was effectively killed by neglect at Cheadle Hospital after being moved there from the Royal Stoke Hospital, after a hip replacement operation. He had Alzheimer's and Vascular dementia and was left to get dehydrated, which caused his kidneys to fail. It was too far away for me to visit him, and I may have been able to intervene and get him some attention from the Staff. If he had been at Bradwell or Cobridge I could have visited him. Nobody cares and if you're seriously ill in hospital or a "Care" Home with no-one capable and assertive visiting you from outside, you may as well kill yourself to reduce your suffering. Make no mistake about it, he was euthanized by the Staff at Cheadle Hospital.
49	If it was achievable it would be great, but I suspect the offer to have care closer is a carrot to allow the closer of beds when the staff are not in place to deliver the carrot.
50	The closer to home the more visitors are likely to visit. For the patient it can be seen as an indication that they are on the mend / getting better. Negative possible lack of required skill if there is relapse.

51	Given the issue with bed blocking caused by people who cannot be discharged as there are insufficient beds in care homes/nursing homes, it is a ridiculous proposition to close services which help this situation. More pressure will fall on acute beds if this is taken forward.
52	In 2015 I had a knee replacement operation and although the operation was a success I had serious after effects due to the drug Wareferin. As I was unable to get out of bed and had mobility problems I was transferred from the Royal to Bradwell Hospital. The time I spent in Bradwell was excellent. I received intensive physiotherapy and within 3 days I was able to return home. As I am 73 and a widow and live on my own, the Discharge Facilitator arranged an excellent support- care package. The 3 days spent at Bradwell were so beneficial to me and helped to rehabilitate me much quicker. It will be a dreadful action to close this hospital. Also had experience with Haywood and again the care given there is excellent.
53	My 95 year old Mum has recently completed a stay at Bradwell hospital following a fall. The proposal misses a very important point and that is that Bradwell hospital was there to make my mum better, which they did very well. The care she needed after being discharged from the Royal Stoke, could have not been given at her home, or in my view, anywhere other than a medical hospital as she had a particularly bad wrist break. I have left my email address below and would like to be able to assist you further, as I have about 6 months worth of experience in respect of my mums fall to be give you!!
54	if anything happens where they have to go back to hospital to get the right care and if they go to the community hospitals then they will get the help they need so when they are fully better then they can go home to have family and friends helping them and they might have to be moved to where the nearest care home is which might be a long way from there family and friends
55	This box isn't big enough for all my views! I appeal to you to take weight of public opinion! See 'My care, my way, home first' open letter from several bodies! I feel that this questionnaire is futile and my opinion has no bearing!
56	Have u got staff for cominty and not all got familys who can help

57	By closing the wards in the community hospitals they are removing the only alternative to care for the patient. Those who can't be cared for at home will have to stay in acute care and block beds. At present there is no evidence of the infrastructure being in place nor the appropriate qualified carers employed. The patient must come first in the STP yet all we hear is the economic reasons.
58	The Community Hospitals must remain open. My mother went into Cheadle having suffered a severe stroke. She could not have received the 24 hour care she needed at home, and she no longer required the care Royal Stoke were providing
59	Whilst the premise of MY Care My way can be supported its implementation is fare from satisfactory there are a number of concerns which I feel need greater clarity , the CCG have failed to produce evidence that the number of care packages required to support My Care My way can or have been supplied in a timely and appropriate way . The real of assessment for the more complex needs of clients and how this will be supported in the community setting without a full range of input ,the speed and total lack of meaningful consultation ,the use of closed questions on surveys. Over all whilst in general agreement with the direction of MY Care MY WAY it has fled to successfully show how this could be cared out without putting clients welfare at the forefront.
60	Community hospitals have supported older people to make the transition from acute care to returning home. This needs to be done in stages so that reablement is monitored by professionals. My father was 5 months in hospital after surgery and it was only with the intensive support from Longton Cottage Hospital and Brighton House that he was able to return home and live independently for a further five years. Care at home is highly desirable but as a relative who has had to attend to every call out via the red button it is not a practical solution for people who wish to live at home but have care needs greater than those available from care workers. The issues that families experience are very significant particularly when there is insufficient support and expertise from the care givers who have been allocated to a patient. At one point my father was locked in his house and the deep fat fryer left on - fortunately it was new and the thermostat was excellent. Here is a real example - we thought that the care arranged for my father was more than adequate. I needed a break. We went on a three night holiday. Two hours after arriving we had a call from Care Call to say that my father needed support. We were 93 miles away. It was a

Friday night and therefore Care Call contacted the over stretched ambulance service to attend and help him back into his bed. This was fine until he needed to use the toilet again later in the night.

The carers attended and sorted out the issue on Saturday. Between Friday night and Saturday 10.00pm I had made or received 34 phone calls. There was no-one available to add an extra visit at 10.00pm. The emergency duty team at Stafford could not locate any help. I phoned the care company who I was paying privately via SCC - they couldn't send anyone because they needed authorisation. The EDT finally said they had a solution and I was to phone the District Nurse administrator who very kindly said they 'would do me a favour' and send out two district nurses to put him back into bed. They were unable to get him into bed, sent for the ambulance and he was taken to A and E. He spent one night in a single en suite room in A & E followed by two nights in Leek. We cut our holiday short. On Tuesday he was sent home - no improved care facilities and the the same pattern followed one day later.

So, several ambulance call outs, District Nurses doing us a favour!!! care givers not available, EDT had no solutions. Finally our GP organised three weeks at Brighton House. What a joy to receive excellent support. In that short time he was walking again and able to enjoy a seaside holiday at a respite care centre.

There was no clear pathway for his care. It was all ad hoc. And it was also a case of whoever has the time and knowledge to push for support, gets it.

Yes there is a strain of the finances of the NHS, but there needs to be a clear generic pathway that will suit the majority of people. All that we needed was confidence building, reablement, care giving in the home and a good back up emergency care giving service when there was a crisis in the home. The numerous ambulance call outs, nights in hospital and adhoc delivery of inappropriate duplicated equipment were all using resources that could have been better utilised if there had been a coordinated care plan produced by a team supporting the individual.

Community hospitals and Brighton House are essential establishments to manage the transition and back up to home care.

61	Seems to me this government is carrying on where Margaret Thacher &her crowd left off if people haven't got the money or means to afford private health care also to be able to pay for the after care when discharged from hospital. Which to me that is what it will come to. Next thing they will be doing is Privatising every thing in the Health Service In other words if people haven't got lots of money or a good health insurance folks wont be able to get treatment. What have we been paying our insurance while at work for years for. Talk about Great Britain if the soldiers who lost there lives in the last 2 wars could see the state of the country now im sure they all would have thrown down there arms and refused to fight 4 a country that when the fighting was over these same men were forgotten. I myself am utterly disgusted with what this government is doing to the health service .
62	Benefits - known environment, close to friends Negatives - ensuring guaranteed high quality care daily or more frequently Being at or near home does NOT guarantee that friends or family are available to help out (work/ commitments to their own children)
63	The patients destined for these hospitals are usually the elderly who can present complex health issues. In my opinion the doctors at the local hospitals do not have the in depth knowledge to care for these patients, putting them into a vulnerable state.
64	Not sure what 'moving' care closer to home really means. You are either at home or in a care facility
65	Not everyone has family support. Not everyone has appropriate circumstances in their house. There can be too much haste to discharge, as I have personally experienced. There is inadequate community care. Community Hospital beds are needed to bridge gaps. The Hospital at Home project has also been cancelled. Too many services going!!
66	If "moving care closer to home" means elderly patients being cared for in residential or nursing homes rather than in hospital, or discharged with a "care package" then this is negative. these elderly patients need rehabilitation - expert and consistent care from the physiotherapy and occupational therapy teams - and that can't be delivered with consistency or intensity at home or in non-specialist care homes. the population of Cheadle and the surrounding moorlands NEED the in-patient and out-patient facilities of Cheadle hospital.
67	I am a concerned member of the public who spent 30years working within the local NHS and as such have been apart of discussion on usage and closure of community based beds in the past. It sounds great community care, but it varies considerably dependant who where and how it

	is delivered. When integrated with social care it can increase thr early access to rehab and a better outcome for patients and fasmily a like. This needs to be consistent, proactive and driven to gold standard outcome of maintaining the patient in their own home if that is what they want and is feasible. Open access to information as to what 3rd party support networks and practical solutions ccould also improve this. What is frustrating is the swing from yes/no to community beds leading to mistrust and frustration and I would think cost with NO gains. Make yourmind up and have the drive to folllow it through, be honest with people and engage them as early as possible. We aren,t thick cost is an issue but have we looked at all the options??/
68	I think community hospitals are an essential service & closing them down is a mistake and disaster for users & a step in the wrong direction once closed they will not reopen again!
69	Care homes are not necessarily staffed by qualified personnel. They are primarily run to make a profit and thus may run on a shoe string with a lack of emphasis on quality care.
70	Firstly the above question is misleading. What do you mean by closer to home? This could mean absolutely anything! Does it mean at home or round the corner? Closing community beds is insanity - even if - which is clearly not the case - alternatives like brilliant care at home was in place. Of course it is not and is getting worse by the day due to the large scale privatisation of home care services and the subsequent poor quality of care which frequently results. (as widely evidenced). Community beds such as at Bradwell provide an invaluable opportunity for people who have had an operation or a crisis in their lives to recuperate before they are ready to return home. A halfway house - simple common sense! My father would never have so well recovered unless he was able to spend 6 weeks - no less - in a community hospital in Frenchay near Bristol after a near death experience through an aneurism. That was years ago - have we learned nothing? We ditch our wonderful facilities, cut our frontline services and skilled work force in favour of what? Mediocre sketchy care provided by an unskilled underpaid set of people usually on zero hours contracts. This is madness and obviously only a cynical cost cutting exercise. I wonder if it has to be contemplated to pay for the other ludicrous waste of money - the 'cancer and end of life' outsourced privatisation project. Lets pray that the Health Secretary puts a stop to this madness though I don't hold out much hope of that.

Third Sector -Comments

1	If you move people too far from a hospital, which has probably become a place of safety to them, it has a negative effect, on the other side people normally prefer to be at home but they need to know there is help near to them. Therefore, the person needs to feel in a safe place no matter what.
2	This will dilute the likelihood of patients receiving the expert support they need to receive optimum recovery. It is easier to provide this is a few key areas rather than spreading it over many areas.
3	There are already many people struggling at home after a hospital stay as adequate support services aren't available and many do not have family support. The community beds provided a safe space for patients to recuperate and to get back on their (feet). There doesn't appear to be any recognition that many people's homes are not suitable for them to return to because of the lack of adaptations, poor inadequate heating and homes that are a non-decent standard.
4	You need to put the community services in place before closing more beds. The CCGs have not done this. You get a very different answer from asking people where they want to receive treatment when they are well compared to asking them when they are ill, vulnerable and have no support at home. Sticking people in nursing homes will mean they will just stay in those nursing home without the rehabilitation they require to get home. Not giving rehabilitation at the correct time for patients will in the long run cost health and social care more money as people become less able and more dependant. Sticking patients in nursing home beds will just mean they will stay in nursing homes. Where is the incentive for nursing homes to get patients home when they are getting paid to have people in these beds? The 50 nursing home beds the CCGs have commissioned will soon get blocked up and then where are the next 50 beds coming from? The acute hospital is already at breaking point. The CCGs have tried to rush this through with very little consultation in order to avoid the opposition. It is very short sighted and is all about saving money and not about improving or providing safe health services.

5	Take away the community hospital beds and you take away any chance of some patients ever getting home. We need safe community services in place before hospital beds are closed which we do not have. Nursing home beds are not going to give patients the rehabilitation they require to get patients home. These patients will end up costing the health and social care economies more money This strategy is so short sighted. The CCGs have treated loyal NHS staff working at these community hospitals disgracefully
6	In principle, I support moving care closure to home but what I have heard so far doesn't fill me with confidence that this will be done properly. I have evidence that people's care now has not been put in place before they have been discharged from Royal Stoke to home this is in recent weeks. This is why we have still have some community beds supposedly so what will happen when we have none is very worrying. Services need to be put in place before all beds are closed and so a gradual reduction in beds should be done while at the same time community services are strengthened. If this is not done people will suffer and could potentially cost lives.
7	The main problem I see as that vulnerable people will be left for long periods alone . Experience of home care is that people receive a quick visit then the carer disappears. Families cannot cope which causes illness in the wider family. There are not enough suitable nursing homes available for vulnerable people to be cared for. For some people a spell of recuperation after illness is needed while they regain their strength. This often needs intense support. Left on their own for long periods frail individuals often deteriorate.
8	I believe that moving people nearer to home would only bring a small adventage. Simply that people if asked will say they want to go home. However, without a step up and step down for most poeple will return to crisis wards quite swiftly. There will be a very small percentage of people who will return to home care and remain there. We are noticing it now that people who would have taken up a resource community bed for a short period, either entering or leaving services, instead of being put straight into a crisis ward which I believe is not a place for people who are purely distressed and not critical.
9	It is a fact that people are always quicker to recover in the comfort of their own home, however the systems which need to be put in place need to work smoothly and like a well oiled machine if this is to work. No extra time or money appears to have been put in place to improve/ increase home care. No money has been made available for preventative services or rehabilitation to improve wellbeing. These fundamentals need to be in place before closures take place.

10	With cuts being made to funding for community services, the demand will be too great, people will have a diluted care plan, the is the likelihood of person-centred care not being a priority.

Public Sector - Comments

1	I have nursed patients on a number of occasions who were admitted to a community bed for assessment for 24hr care, with our nursing & therapy input they have returned home, had these patients gone directly to 24hr care from UHNM I do not believe that would have happened hence affecting future quality of life. Also I would like commissioners to realise that support in the community leaves folk socially isolated, lonely & often depressed, their nutritional state & skin integrity suffer as a result.
2	I think the commissioners don't live in the real world. They need to go work on a ward. Yes (it would) be lovely if the patients could go home and be properly looked after but it doesn't work. We've had lots of patients that just keep round and round the system because they can't cope at home or they keep falling. Getting a care package is a nightmare too. Takes ages depending on area you live then there are no overnight calls. So if relatives can't stay they have to stay on their own and this is the problem because lots of them try to get up for toilet or drink and fall this happened to my mum on numerous occasions. Bradwell hospital is the best not saying that because I work there but because the care is top notch. My mum ended up in Bradwell and got best care there better than down big hospital.

3	I fully support the idea of rehab and recuperation in the home. However, this relies on: A. The rapid availability of community disability equipment B. Access to effective medical care to ensure the stable medical status of the person C. Access to quality health and social care services in the community and D. Increased provision of rehab services such as physiotherapy, OT, Speech Therapy, Falls prevention, tissue viability and continence services. It is my understanding that these four things are just not in place at an appropriate level to ensure safety. I feel that there may be an unnecessary death, fall or another catastrophic event. Furthermore, people with rehab potential may simple be written off and sent to residential or nursing settings instead of providing the care and rehab to enable them to live their lives safely at home. There is a huge difference between being "medically stable" and being "back to previous ability" / achieving potential. The NHS is not just about meeting acute needs; it includes people being able to rehabilitate. If the model of rehab and recuperation delivery must be within patients' own homes, fine, but the home-based services must be funded, staffed and operational to allow this to happen. We can't just take away a service without the new services being in place. It can take weeks to assess for, order and provide simple disability aids into the home. For more significant adaptations months or even years. Unless social care and community equipment services are invested in, then we will have people either blocking expensive acute beds or taking huge risks managing without equipment in their homes.

4	The main issue that many patients on stoke suffer from long term health conditions this makes needs for beds high than some rural areas. The UHNM covers a lot of areas. Many patient are medical fit for discharge but are not therapy or nursing fit or social service fit! These patients the CCG would have us believe can move to private nursing homes to wait care " a cheaper option " in reality these patients will not get the full assessment they need. I wonder and have asked what the readmission rates are when this option is used as previously as winter beds (many of these nursing homes appear to have reoccurring vacancy as winter approaches every year I wonder why) what the Qcc reports on these homes? From experience placing certain patients with challenging dementia is very difficult to do. The specialist skills of health professional is needed to assess these patient in a non-profit true NHS place where the patient is put first not how quickly can I get the next patient in. I know from personal experience that many of these homes have issue with pressure damage and are unable to care for many patients I have had contact with. And many patients cared for will be sent back to AE if they become unwell where the community hospital have now but in more skills so patients are kept in their wards if they become unwell they even treat sepsis! The truth is we all believe that care is better in patient's home but care packages and support needs to there and in just not there yet. Take incontinence care for night. Pt have to stay in wet beds if they live alone as no service maintained care is out there I checked! The role the community hospital can play in not only enhancing care undertaken by UHNM but in preventing admission is massive. Imagine a hospital like Bradwell with a mini assessment unit that Gps Dn SW can ref to 24 hours a day. For sub-acute assessment where they can admitted pt straight to Bradwell staff wards for ivi antibiotics for chest or UTI for example. SW on site to start the care package for home. These hospital are excellent at not deconditioning pts as all are encouraged to dress and the environment is more able to promote socialisation to help a totally well-being so help patients recover quicker. Assessment will be in depth and met the patient needs. Yes this may not be cheap option but I do believe it the best for North Staffordshire. (I) also believe it should be with the UHNM but SSOTP as we can then sell the difference to the public so they see it as not a hospital but a community service that promotes home first my care my way.
5	It is cheaper and safer to nurse people in their own home makes sense to close all community beds

6	Home is always the optimum choice for recovery with less exposure to healthcare related risks and evidence does support that individuals do recover more quickly from illness / surgery in their own environment with the right level of support as needed. However, the current situation within Staffordshire is that community services are under an enormous amount of pressure with insufficient workforce to support people in their own homes. Many schemes are being developed to plug this gap but not quickly and safely enough. Our A&E is bulging at the seams on daily basis and although I am an advocate for not being admitted to hospital unless absolutely necessary, in some cases there really is no other option in order to keep the person safe. Closing the community hospitals so close to the winter months will be put additional pressure on already exhausted system. But we do need to ensure we are not reliant on these environments moving into the future. The government purely need to invest large sums of money to get community services up and running via voluntary, social care and health sectors working in a joined up way. Some schemes already exist depending on your post code such as intermediate care at home, hospital at home (which i believe is being decommissioned), care home therapy service. If the insistence is to close the inpatient bed stock at Bradwell et al then perhaps look at them providing day care services as an alternative and clinic settings to promote wellbeing and therapy input. I guess the analogy of the CCG is closing these hospitals will provide surplus staff who could be tuped into the community teams but the sad reality is that this will only plug existing gaps and not increase workforce. My final comment is that our care home sector also need to step up to the mark as they often have stringent criteria for acceptance and often the most complex patients are the ones who require 24-hour care yet many homes cannot cater for their needs. There needs to be system wide education and a community focus on wellbeing in complex care and it being everyone's business from the GP practice, relatives and neighbours.
7	By decommissioning the community beds, all that will happen is that there will be an increased volume of patients coming back in through A&E who will need to be admitted. This will have considerable knock on effect on 12 hour waits in A&E as the hospital is already at capacity and unable to discharge anyone anywhere if they are waiting for care packages or a complex discharge as there are no community beds. Patients will be inappropriately and unsafely discharged back into the community with insufficient care resulting in emergency admissions coming back through A&E and the whole cycle will start again. For there to be effective care closer to home, the resources need to be in place NOW before the beds are decommissioned. There needs to be increased community support. From personal experience, there is a big delay in the discharge of patients due to lack of funding from the social care team. As a previous Registered Manager of a nursing home, I had

	two residents admitted to the home where 10 months later, their funding still had not been agreed and we had yet to be paid for their care. A further resident had his discharge from hospital delayed by 2 months due to the social work team failing to get FNC agreed. There is a big push on homes to take residents before FNC is agreed and in place to prevent delays in discharge, however if homes do take residents before funding is agreed, the resident then falls off the social workers radar and funding NEVER gets sorted therefore homes are no longer accepting residents until everything is agreed and in place. There are increasingly complex patients being discharged into nursing homes and they are more costly to manage, both in staffing and equipment resources. Yet budgets are being cut or held and not increased in-line with growing needs, causing nursing homes to decline residents based on affordability. CHC is increasingly difficult to get agreed and is challenged every step of the way. Moving on to care in the community. For an vastly increased number of people having care closer to home rather than being in a community bed, GP's will need to make increasingly more difficult care decisions. A lot of GP's are not prepared to do so, defaulting to requesting homes dial 999 and get the frail elderly patient to wait 10 hours in A&E on a hard trolley rather than come and do a home visit. GP's have huge pressure on capacity as it is so will need more support if they are to help avoid admissions. GP's will also need better training on DNAR's and formal care plans detailing a "ceiling" of care where escalation is inappropriate, therefore avoiding unnecessary admissions to hospital. Nursing Homes are so worried about Social Workers instigating a vulnerable adult referral on them for not escalating care- (most of which end up being unsubstantiated or inconclusive in my experience) that their default position is to send the person into hospital to avoid going through a full Section 42 investigation which takes months or years to complete and puts a black mark against the home for having an increased number of safeguarding referrals made against them. Care Homes need more support from Advanced Nurse Practitioners or GP's to avoid unnecessary admissions and Social Workers need more training on what is reasonable to safeguard. Where support packages are being arranged for the person to remain in their own home, there needs to be a significant increase in the available resources. Already we are seeing patients' discharges being delayed by weeks and months through lack of availability of appropriate care packages. If the community beds are withdrawn, this will only further increase these issues in the acute setting.
8	The services aren't in place to support this and LA finances are tight so look likely to get worse not better. Use of private sector will not support the very complex pts whose conditions are unpredictable and require sub acute care. Community hospitals could provide this and avoid acute admission.

9	first of all there is nowhere near enough community care provision available. There are long waits for care packages now never mind when the community hospitals close. the quality of what is available is also questionable at times. family support is not always an option leaving some older people very vulnerable and at risk . there is a real danger of the older vulnerable person being discharged too quickly, not medically fit with an inadequate package of care this in turn will result in a return to A&E which then has a negative impact there
10	Current community services can barely cope with current demand making it impossible to provide safe effective care for those discharged from bradwell and other hospitals if they are closed. Palliative services at bradwell also critical to getting end of life care right. Care agencies capacity is also already not meeting demand and this closure would only make matters worse and prove detrimental to patients.
11	While care closer to home is commendable the systems in place struggle to cope now managing people at home. There are not enough nurses, physiotherapists or Occupational therapists to provide rehab in the home in a safe and meaningful way. Patients will come home and be managed rather than rehab carried out. There is also an acute shortage of care packages and many of those in place are of poor quality. I fear this change will lead to more admissions to the acute trust and greater incidence of falls and deterioration in patients.
12	I think proposal to close the community hospitals is just an outrage!! Of course people want to be looked after in their own homes anybody would but however sometimes it can't be done!! The services that would be needed are not out in the community that's why we have people bed blocking because they waiting for care package's!!! Winter crisis hasn't reared its head yet, but when it does they will have to open beds up again, which costs double because they will then have to be staffed by agency!! It's ludicrous.!!! People out there are going to be in a vulnerable prediciment and not safe!! These people who want shut them want to come on the wards for a while see what goes on!! Not just pop up for a day, then decide what's best when they obviously have no idea!! Just wait till one of their relatives need looking after, and there is nowhere for them to go.!!😩
13	I live in a rural area in the Staffordshire Moorlands and know from my work at local GP Practices just how stretched already the District Nurses are. Elderly Patients are already at home with not enough of a care package in place and until more care at home is GUARANTEED on discharge then the closure of any step down beds is criminal.

14	there are many patients who we receive in the moorlands area who are often living alone or live with elderly family, being at uhnm means they cannot visit and patients often do without essentials such as clothing toiletries never mind the physchological implications of this. once in a community bed in the moorlands family can visit we do take patients from as far as ashbourne border, I know of patients waiting care packages in the more remote villages who have sat in beds as there is no service provision, those who have care packages in the nearer community have there care packages stopped as they have been in hospital and I have witnessed some very horrible cases of neglect from patients not eating to very poor hygiene standards as carers simply do not have the time to spend with them.. of these patients who we receive from uhnm some patients are returned back to uhnm as they are not medically stable for example suffering from sepsis. some are very demented and wander and are unsafe to be left unattended even at home never mind in hospital. these patients can be very physically and verbally challenging. community hospitals are not just for patients in the local area of the hospital they are for everyone. Further more redeployment of staff is taking its toll on staff who have transferred to uhnm with added time travelling and the absolute ridiculous scenario of parking. as for those going into the community added extras of paying for business car insurance is a added expense with petrol fees on the increase, the chief exec mr Courtney harris has added his concerns on what care at home will do to the uhnm with increased bed blocking. the sentinel reported on the 27 October 2016 that it costs 2100 to use a hospital bed but for care at home 210 pounds, from experience my mum paid 210 pounds just for 8 and a quarter houses per week she was lucky she could afford it.. families also no longer live near each other and if they do chances are they to are working to make their own ends meet and will simply not have the time to care for their loved ones as they wish. also reported is the extra pressures of the community staff already working in the field, there is simply not the staff to cope with the work load. district nursing jobs fine on paper but the travelling, lone working inclement weather paper work alone is taking its toll and as for carers two cases highlighted in the sentinel this week with one agency employing carers who should not be even in the country and one taking money from an elderly lady. thankfully not all carers are like this but simply when questioned do not have the time to spend with patients. further more closure of nursing and residential homes and the added pressures of having to bid for the patient and cost cutting to social care funding.. the Nuffield trust made its report in 2016 and it makes excellent reading on health and social care provision.
15	I trained as a nurse in the black country ans they did not have community hospital and there were some respite facilities. There was more emphasise on care in the community and community physio. I think because in Stoke on Trent they have had community hospitals for a long time it will be a shock. If more money goes into social care and community nursing I think the planned proposals could be a good thing.

16	I am glad you are conducting this survey, though feel it might be too late.... From a personal point of view, I have been caring for my elderly disabled mother for the past 3 years, this last year has been particularly stressful, resulting in her having to leave her home of 60 yrs + as was unable to cope with 4 visits of carers per day, with increasing falls x 1 per month, resulting in numerous visits to A&E and rehab in Haywood Hospital x3. The support and treatment at the Haywood was brilliant and her mood and health improved considerably on each occasion, and gave family respite. I do not think it always possible to treat people in the community, and that was with my mother having considerable family support around her, I dread to think what would happen for those who don't.... The council respite homes are closing in addition (Brighton House) again this was a lifesaver, I feel my relationship with my mother was beginning to break down as things 'were getting too much' (having to do more because of decreased physical health, poor set of carers that we had last time). It is very apparent that the Royal Stoke is struggling to copy with elderly population, from the hours spent in A&E to waiting for a bed, for the staff to have time to attend to an elderly's persons mental and health needs. These community hospitals are a life saver for both the elderly population and the family's and friends who are doing their best to support them and also the Acute medical hospital who is on it's knees at present. I am more than happy to share my experiences if you wish to discuss further.
17	With an aging population and increasing complexities, community services: a, are not funded / staffed sufficiently b, have skills / expertise to manage many complex comorbidities c, the Royal Stoke rarely gets below a L3 alert so complete and utter lunacy to close local hospital beds d, Yet another example of CCGs having no choice to 'prop up' the Royal Stokes' finances in a similar way that the better care funding was withdrawn from PHE e, We have to be questioning our local CCGs competence to commission local healthcare that is representative of the population it serves
18	The community care just isn't there. There will be preventable deaths if these proposals go ahead.
19	I must start by saying although I whole heartily agree with the theory behind My Care My Way home first, as it stands at the moment the rapid closures of community care beds is sure to ensure this strategy is set to fail, with dia consequences. There are simply not a enough provisions in place both in the community and social care and is wrong on so many levels.

Firstly, when a patient is admitted to a community care bed, that patient is supposedly medically fit, this has been found to be untrue on many occasions, and they have to be returned to the acute sector rapidly as their condition is potentially life threatening. These are the patients which under this strategy would be going straight home and left to wait for a visit of a care provider, which may be some hours later if at all, as I have heard of cases where instead of an actual visit care providers have simply phoned to see if everything is alright.

Point of example to this: When Longton Cottage hospital closed (sorry moth balled) a elderly gentleman came forward and told us of his experience only two weeks previous, his elderly wife in her 80's had been ill so he had taken her to the A&E he had been there with her all day, she was diagnosed with a urine infection, at 10pm he decided that she wasn't going to be sent home, and that she would be admitted, so went home. At 1am he was awoken by a knock at the door to find ambulance men with his wife, he was told she didn't need acute care, he put his wife to bed, the next morning he woke to find her dead next to him. As you may be aware 35,000 die a year of sepsis.

Secondly, Community Care hospital beds are not warehouses for the elderly , when a patient is admitted a full assessment takes place and we carry on from where the acute sector has left off with continuation of medical treatment such as IV Antibiotics and fluids, blood transfusions, Medication review and monitoring, Monitoring of nutrition, Hydration, weight, ECGS, Dementia screening, Continence assessments, Stoma and catheter care involving teaching patients to manage these at home, Referrals to other services both socially and medically, Kitchen assessments, washing and dressing assessments, Pressure ulcer treatment and prevention , full assessments of a patients night time needs as this is when the aged are most vulnerable, teaching and giving advise to relatives on a whole host of subjects, and so on, all aiding patients to return home safely and staying at home for as long as possible.

Thirdly, apart from all of the above on many occasions patients arrive to Community Care beds having not got dressed for the whole time they are in the acute sector, many are still mobilising with two nurses for just a few steps. How is this preparation to return home and giving them the chance of reaching their full potential? If a patient is not given appropriate time and input to return to their homes safely they will return to acute sector with further problems.

Point of example to this: If a person cannot mobilise safely and get to the toilet they may become distressed and frustrated leading to falls, they may start to become incontinent this may then lead to pressure ulcer development, dehydration and malnutrition because they do not

feel safe in getting drinks or food. This then has wider reaching implications carers such as husbands, wife's, children also become distressed and in turn their health could suffer.

Fourthly, the provision in the community is simply not there, beds bought at Stadium court and Hill Top are not providing adequate therapy, private nursing homes are going under and cannot recruit, NHS Community Nurses are not staying because of pressure, Private care providers are not necessarily of the best quality many are young, ill equipped and untrained -when asked if they enjoy their jobs, 'its better than the dole' is not a good response - 35 different carers into a lady with dementia is not good when continuity is key, a gentleman having a stroke and sent home with a peg feed and no carers visited for two days is poor quality care, funding for social care not available, added to the fact in 5 years there will be a crisis with the nursing staff due to retirement and a increasing aged population, to steam roll these closures so quickly is total stupidity.

I would not dispute there are patients that are in both acute and community care beds that really don't need to be there, but to say they are all awaiting care packages is not all together true, some require EMI stay at home, equipment, adaptation to their homes, patients who when assessed no one will take on because of various issues, Patients whose families realise they may not cope so discharge it delayed. Carers in hospital or ill themselves and houses that need deep cleaning and that's not to say for those who are discovered to have further medical aliments that need treating, Patients awaiting funding, and those waiting intermediate care team – another service to go by the end of the year. But patients remaining in hospital due to the fact nurses are not doing their jobs correctly is a very upsetting and demeaning statement.

Our A&E department cannot cope now and we are not in winter yet, "ready to implode" was used on A&E to describe the situation this week.

The people of Stoke on Trent and Staffordshire deserve the right to be heard over 8,000 signature petition against the bed closures as opposed to 400 letters the CCGs offered as consultation is an obvious vote as to the public's preference and concerns, the CCGs should be held accountable, they should provide up to date information be open, honest and transparent as those in the NHS have to be.

Hold off on the closures of the beds at Bradwell, reassess and re-evaluate.

Thank you

20	The infrastructure of quality home care staff provision, an adequate mix of care staff, nurses, physio's and occupational therapy staff - with direct access to medical staff if required need to be in place before this move could begin to be effective. While recovery at home may be more pleasant, in familiar environments and therefore more comfortable, it could also be more risky and result in a re-admission to hospital if adequate support is not provided and home environments are not assessed as safe options with appropriate adaptations where necessary. An intermediate / step down bed, if used effectively and staffed adequately with therapists, enables individuals to practise lost skills and re-gain confidence in their function before a transfer to home.
21	No care packages available before closing community hospitals, poor people will end up back in A&E
22	Risk of readmission to the Royal Stoke University hospital would be extremely high if the Community beds shut. The Palliative Care offered and given on Sycamore Ward is Professional. respectful, individualised and client centred, and all work towards a pain free positive experience in End of Life Care. I am a Mental Health Nurse with 30 years experience of mostly community care and have first hand experience of the care on this ward, as my Mum was nursed with dignity and care with her pain effectively managed on not only a daily basis but hourly by experienced efficient caring staff. She had multiple pathology and complex needs, including medical, Neurological, and Mental Health needs. The access to a Palliative Nurse Specialist was especially beneficial and necessary as this vulnerable client group have very specific changing needs, which can be hourly. I know with no doubt at all that the private sector nursing homes would NOT be able to offer the level of specialist input that is required when an individual faces complex needs which I believe can only be catered for in a Nursing environment with the back up and support of the multi agencies. They are able to assess, re assess treat, risk assess, care plan and adapt to ever changing needs, where the person being cared for is the focus, and care is individualised and not catered by too few in an environment where people are admitted with a wide range of nursing needs. I know without doubt that my Mother would have been re-admitted to The Royal Stoke University Hospital on numerous occasions had she been in a Nursing Home or indeed at home. Those of us who work in the Community have seen services decimated over the past decade, and as austerity is and continues to impact us all, our Community hospitals are and should be preserved.
23	No care packages available before closing community hospitals, poor people will end up back in A&E

24	1) Insufficient quality care in the community at present placing the elderly or vulnerable at risk. 2) I believe the demand on acute hospital beds results in pressure to discharge patients in the shortest possible time scale. However, some of these people need a longer period of recovery within a 24 hour care and rehabilitation facility. 3) Whilst residential/nursing care homes are a valuable resource, the quality of care frequently falls below the standard of care given within the NHS community hospitals. 4) There are also financial implications for the NHS as patients' may not be discharged in a timely manner and there may be a conflict of interests within the private sector. 5) I fear that the closure of the community hospital beds will impact on the patient flow in the acute sector creating further "bed blocking" and increasing the pressures of any impending winter crisis
25	To close community hospitals is going to be unsafe and leave people at risk. People are going to be sent home or into a home without the appropriate assessments for their needs, leaving them very vulnerable and at risk of harm. I believe that the proposed plan can work for some people but certainly not all. If the CCGS visited these community hospitals they would realise what an important part they play in getting people into the correct care setting, whether that is home, Residential care or Nursing care. Assessments carried out to identify individual needs. If this process is not completed around individual needs then they could be placed in a care setting that puts them at risk.
26	Some people may not be able to adequately cope at home during an illness
27	The infrastructure of quality home care staff provision, an adequate mix of care staff,nurses, physio's and occupational therapy staff - with direct access to medical staff if required need to be in place before this move could begin to be effective. While recovery at home may be more pleasant, in familiar environments and therefore more comfortable, it could also be more risky and result in a re-admission to hospital if adequate support is not provided and home environments are not assessed as safe options with appropriate adaptations where necessary. An intermediate / step down bed, if used effectively and staffed adequately with therapists, enables individuals to practise lost skills and re-gain confidence in their function before a transfer to home.

Other

1	By closing the wards in the community hospitals they are removing the only alternative to care for the patient. Those who can't be cared for at home will have to stay in acute care and block beds. At present there is no evidence of the infrastructure being in place nor the appropriate qualified carers employed. The patient must come first in the STP yet all we hear is the economic reasons.
2	Letter from Stoke-on-Trent Network for Disability (STAND) STAND Member's Concerns About the Closure of Community Hospitals and the Proposed Sustainability and Transformation Plan 8.11.2016 Stand Members have many concerns about the closure of Community Hospitals linked to STP 1. Many community groups expressed concern about the plans of the new hospital as it was seen as being too small to meet the needs of the population it was intended to serve. The answer given was that more use would be made of the community hospitals to deliver care in the community. Royal Stoke has now taken over many of the service that were delivered in Stafford, it is also a major trauma unit so how can it be considering closing Community hospitals when Royal Stoke is not big enough to deliver the care and beds needed? 2. A visit to A&E shows people on trolleys stacking up waiting for beds because there are people in hospital who still need care but do not need a hospital bed. These people could have gone into Community Hospital beds while a workable care plan could be put together and checked to see if it could be delivered before discharge. 3. Members have reported going to hospital for an operation and being sent home again because there were no beds available, thus increasing both the backlog for operations and the problems for the patient.

	4. Patients must NOT be discharged before a deliverable care plan is in place. 5. Members tell of relatives who have been discharged without them being informed, so the patient is taken to a cold home with no food, no one to care for them, no emergency number to contact in case they deteriorate and no care plan in place. 6. There is a mismatch between the care available and that which is needed, so professionals have to prioritise which patients to visit, this is a very dangerous thing to do as someone who is deemed to be fit enough for discharge one day might not be so fine after spending time in a cold home with no food and no one to care. Community hospitals can provide this care. 7. Rehabilitation at home. Even if there is a professional available for this service it is often difficult to achieve in the confines of a patient's home. 8. Who takes ultimate responsibility for a patient after discharge? There is a need for a named person to take responsibility for coordinating a patient's care at home. Coordinating medical, social, charitable and emotional support for a patient is beyond the ability of a vulnerable patient discharged from hospital, but this is needed for the patient to be safe and feel safe. 9. Not enough support services, ie shortage of district nurses, GPs, podietrists, domestic care, etc. in place now, this is putting an intolerable strain on these service as they struggle to cope with the extra demand. Insufficient money for aids and adaptations that will be needed to ensure the safety of patients at home. 10. Not enough money or planning has gone into the transition stage and this means IT IS NOT SAFE FOR PATIENTS until all the services needed are fully staffed and integrated. 11. Communication is abysmal at the moment even within the hospital. This needs to be improved drastically or vulnerable people will fall through the net as GP services do not understand or even tell other services who need to be involved. The hospital discharges patients without

	ensuring that there is someone at home to care. (hence the need for a person to take responsibility for coodinating care) Our Local Authority knows that there is a problem in delivering safe care, health professionals are also concerned about the safety of patients and the patients themselves are also telling you that there is a problem of safety. Please take note. 12. There is a fear that unless these issues are addressed we could have the situation of Stafford hospital again, as a race to ensure financial viability put patient safety at risk. 13. Members want to know "Who will be prosecuted when patients die as a result of rushing this through?" Pam Bryan (secretary for STAND following STAND general meeting 8.11.16)