Mr Ray Chalmers Head of Communications and Strategic Engagement SD&T CCG

Dear Mr Chalmers,

Thank you for your e-mail of 11-08-16 and the attached pdf (2) 16-08-16 about the subjects for consultation with meeting times. “Feedback from the consultation is likely to be considered by the CCG’s Governing Body at a meeting in public in January/February 2017”.

I will not be attending. I make my final observations in this letter. This process, which started at the end of 2012 has been wearing. I have spent thousands of hours on it and on the wider NHS, which is in crisis. (The latest bad news amongst some good is that GP practices in parts of Plymouth will close for lack of GPs http://www.plymouthherald.co.uk/three-plymouth-gp-surgeries-could-close-in-bid-to-save-money/story-29639056-detail/story.html) Some of my input has been via the small group which has stood for the value of the Ashburton and Buckfastleigh Community Hospital. I have used fact and observation rather than assertion, and what is best for OUR NHS in South Devon as against sentiment for a hospital that has served the population for over 100 years.

'Consultation' and 'engagement' should be two way. This has not been the case; all that we have had is assertion and the nebulous language handed down from NHS England. 'Test of change' and 'care at home' being two. There have been no costings and few facts. I deal with the salient matters,finally, below.

Cutting costs

No one disputes this aim as long as essential medical services are maintained, and where necessary enhanced. It is obvious that the CCG proposals to close Paignton, Dartmouth (extraordinary), Ashburton and Bovey hospitals are based on cost. Dr Roberts said so in the WMN last week – “....but as we all know, the funds that are available can't match this increasing need.” He speaks of people living longer and their need for more complex care. A constant refrain but see the Edinburgh study.

But the costing of CHs is very doubtful. It is given with broad brush as being £275 per bed day and the DGHs at £250 nationally. Few would believe these figures and they would know there are big variations between hospitals, both DGH and CH, nationally and locally. About 60 CH beds will be closed and patients cared for at home. Those that do need care between Torbay DGH and home * in the BFL, Ashburton and Bovey districts will be cared for in NA where there is the benefit of a resident GP during office hours and where there might then be insufficient beds. But what of the Torbay people? There are many poor families and single elderly in Paignton especially. I know that. Some were my patients.

The accounting of the cost per bed day in the CHs has never been shown publicly. It must be revealed in this consultation period, and quickly. It is the same for 'care at home'. We know this will vary from patient to patient but a hundred cases could be audited and an average obtained.

Political influence on cost in the NHS

Having qualified in 1964, I have seen at least 8 major convulsions in OUR NHS, the last being the worst. That is the Health & Social Care Act of April 1st 2012. 'Cutting red tape' is often promised.

The 'Internal Market' of a Margaret Thatcher government was the first step in privatisation. Alone

among Torbay consultants, I opposed this vigorously having researched it. I forecast that it would at least double the budget for administration, drive wedges between patient, GP and hospital, and damage morale by installing more chiefs with long titles. It was rammed through against the advice of all the professional bodies. It doubled the cost of administration as I had predicted, adding £1.3 billion to a total budget of £30 billion in the first year. Very few know this. It was equivalent to about 400,000 hip replacements.

The Blair government ran with PFI which the former Conservative government had started. This was an illegal and very costly system as against using direct Treasury funding. The debts were moved off the balance sheet and lead boots fitted to hospitals, schools, courthouses etc. As you know the capital charge at NA is £1.4 million before service charges are added, and all for the benefit of an 'off shored' company. The Royal London and Barts, for instance, has a massive PFI debt; costs are spiralling out of control.

The H&SC Act has added administrative and consultancy costs but more important is at the root of the destabilisation>demoralisation> and dismantling, as intended. This is the context against which this consultation is being held.

Why should anyone believe that 'care in the home' will cost the NHS and DCC less, even when that care is good? Pilot studies should be mandatory in OUR NHS with its total budget of £110 billion. The Resource Management Initiative was piloted by the Thatcher government in six hospitals, one of which I served in, but it was 'rolled out' before it was analysed!

The recurrent upheavals driven by the dogmas of the political class have harmed OUR NHS greatly. Professionals of all types are confused and feel powerless. There are good grounds for believing that this proposed closure of 60+ CH beds will not save any money at all but instead add to distress and further lowering of morale.

The money OUR NHS is losing – a few examples

The epidemic of obesity is costing billions especially for the resultant diabetes. The newly published plans re sugar and high energy snacks are typical of the lack of grip, and the obeisance to manufacturer's interests ie profit. No useful action has been taken.

HIV is costing upwards of 0.9% of the total NHS budget. The other 4 STDs are increasing in incidence. Chlamydia is burdening the service with great cost through investigations and treatment of tubal scarring – IVF etc. All this is related in large part to promiscuity and absent barriers. I raised this at an Ashburton 'CCG' meeting and offered to teach secondary pupils about sexual health based on knowledge and mutual respect. No response.

A friend took his wife to a podiatry clinic at Castle Circus. There was a large queue of young woman waiting for the "GU" clinic. Any savings of money and misery to be made there by NHS England? Third world. NHSE is bankrupt of real initiatives whilst the costs of preventable disease soar.

We learn there are over one thousand 'interim' executive posts. One is held currently by a Mr Steven Leivers at the Royal Surrey County Hospital. He lays waste to the maternity department there. A national paper tells that he earned £60,000 per month, enough to fund a smaller CH. A flavour via an FOI to North Bristol 'Trust', whilst he was being employed by 'Hunter Healthcare Resourcing' - https://www.whatdotheyknow.com/request/turn_around_consultants_mr_steve And some have easy tax arrangements.

Annual management/administration costs NEW CCG £19 million SD&T CCG £6 million

What are the pros and cons of CH closure compared with 'care at home'?

Pro. The benefits of the CH were listed in a letter from 8 retired GPs and 3 retired surgeons (3), and more briefly in a leaflet for 'locals' -

The functions which would be lost and which cannot be provided elsewhere?

- **At least 20% of all acute illness can be treated in the CH**
- The life that is ebbing might best be cared for in the CH
- There is often a need for medical care in a CH between the DGH and home. But 'care in the home' and not in the CH is the CCG/NHS mantra. At present this is worse than patchy. The DGH's are in constant trouble with 'delayed discharges'. The CHs are the logical and professional safe harbours. Close the CHs - cripple the DGH.
- Beds can be booked in the CH for the single elderly person undergoing planned major surgery. Speedy transfer after surgery to the CH frees up a precious bed in the DGH.
- Respite care - that might save the health of the carer.

I add this, and I know it so well from my own work in hospital. There are some patients in the DGH, mostly elderly, who are not recovering or even failing. They are NOT fit to go straight home especially if they have no spouse or friend, but that DGH bed needs freeing. The CH is there for immediate discharge whilst the condition is stabilised and whilst a nursing home is found.

Contra

- Alleged costliness (accounts for CHs not seen)
- Small cf with Totnes, Newton Abbot etc
- Some difficulty with recruitment of nurses and their further career development - but the former is shared with DGHs (District General Hospitals)

'Care at home' will result in greater 'federation', a regrettable move nationally that is being driven by the NHSE. In these localities, the GP might be able to maintain the link to any one patient, but with district nurses working from 'hubs' rather than practices, patients and nurses will lose the personal connections. A man in this parish was dying slowly from COAD. There was no complaint of the care given but he was looked after by <u>fifteen nurses</u>. This is unacceptable.

Loss

The hospital has been the caring heart of Ashburton and Buckfastleigh, and the country around since 1876.

- Loved ones and friends have been able to visit patients with all manner of conditions easily. (Visit Torbay by car and find no space whilst the loved one frets.)
- The nursing staff, the local GPs and clerical staff know the patients when they are well -

and the relatives.

Complexity in transferring patients from DGHs

I attach an analysis from NDDH. It shows the complexity attaching to these patients in the DGH and was obtained through an FOI request. (4)

This category of 'delayed transfers' is far from cut and dried.

The storm and the wrecking

The GPs on the CCG board will be fully aware of the buffeting the NHS is getting. These are two very recent examples.

http://inews.co.uk/essentials/news/health/nhs-childrens-healthcare-going-backwards/

"The paediatric workforce is at breaking point and children's healthcare is increasingly being compromised. Since [then], we have evidence from the College's existing recruitment data that **morale is at an all-time low**.

http://www.telegraph.co.uk/news/2016/08/11/nhs-in-grip-of-worst-bed-blocking-crisis-on-record-figures-show/

Mr Stevens, NHS England CE, shows himself to be a Pilate – washing his hands. He says that bed blocking will be 'with us' until 2020. He is accepting, without thought and action, the vast misery of cancelled operations and the massive waste of resources and money. Indeed, NHSE policies are adding to it.

The SD&TCCG has been pressed to attempt a very doubtful saving by closing 60+ beds whilst billions go down the drain. There is no logic, no principle and very little humanity. Restriction of provision is the game.

I quote Prof Nigel Standfield, the head of the postgraduate school of surgery at Imperial College, London, said:
"This government lacks insight. Its health service policy is in ruins and failure has nothing to do with the dedicated workforce trying to maintain an NHS by hard work and passion.
Gross underfunding with financial wastage, poor non-clinical and specialist advice, and top-heavy management need to be urgently reviewed. Talk to the juniors and resolve this immediate crisis by diplomacy."

Is this consultation valid?

In a letter dated 29 July 2010 Gateway number: 14543 from Sir David Nicholson KCB CBE

Chief Executive of the NHS in England -

Dear Colleague - Service Reconfiguration (att worth reading)

The four rules for reconfiguration laid down were

• support from GP commissioners;

• strengthened public and patient engagement;

• clarity on the clinical evidence base; and

• consistency with current and prospective patient choice.

This consultation fails in its validity on the last two.

Have all "stakeholders" working within OUR NHS been informed of the plans and all the details, and will they be free to give honest opinions which might be counter to those of the CCG (5)

I have been shocked to hear from some staff that they fear being disadvantaged in their posts. A good many, sensing the intimidatory atmosphere, leave.

Conclusion

1. There is no doubt that OUR NHS is being dismantled and in the most vicious way. What is happening in the SD&T CCG area is a microcosm of the whole. Many techniques are being employed. One is burdening a tired doctor with complexity and opaque profuse language.

At the end of that surgery the GP has seen a man whose depression is worsening, with some suicidal ideation. There are no in-patient beds. There is a call to see a 'care at home' elderly lady with cardiac failure, leg ulcers and now cellulitis. This has come onto his screen :-

https://www.england.nhs.uk/south/info-professional/medical/dcis/sustainable-gp/ SEVEN pdfs

https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/gp-sust-hlth-check-tool.pdf

latter 33 pages, and including rubbish like "provide evidence based understanding of whether your business model is sustainable'

2. Some patients with a spouse or friend and a good home will benefit from these plans. But on balance they will be harmful in so many ways. I pick out the 20% of acute illness which will no longer be treated in the CHs (extraordinary – further overwhelming DGHs) and the inevitable increase in 'delayed transfers' with all the knock-ons.

3. This plan was first imposed in Devon on Torrington 3 years ago. Retired nurses collated the experiences of 'care at home' in patients and families there. I have 19 of them on this disc. The discharges were unsafe and distressing. In one, a neighbour was called in on arrival of the patient with a complex problem and in the absence of a district nurse. This 83 yr old lady, who was alone at home, had had abdominal surgery and was sent home with a drain in situ at 6 days.

The board is composed of experienced and thoughtful GPs. Surely they will turn these plans down.

Yours sincerely

David Halpin MB BS FRCS Retired orthopaedic and trauma specialist – Torbay and Exeter

* I brought a BBC SW report to the CCG officers in which 10% of houses in the SW were reported as being in very poor condition or classed as uninhabitable.

ps the attachments include the letter from the 11 retired doctors and a recent submission to the Public Affairs Committee of the House of Commons. I respectfully ask that these be taken into account, along with the other direct submissions I have made.

Copies to Dr Nick Roberts CE, Dr Derek Greatorex Chairman, Dr Sarah Wollaston at the Health Select Committee, Mr Mel Stride MP for Central Devon and Mr Kevin Foster MP for Torbay