7th September 2015

FAO Dr Alison Diamond MB ChB CE of the Northern Devon Healthcare NHS Trust and Dr George Thomson MB ChB Medical Director

Dear Dr Diamond and Professor George Thompson,

We write as doctors to doctors, with over 250 years of service in final NHS posts between us, because the service is in crisis. We have especial concern about the closure or downgrading of Community Hospitals (CH) and how that will effect the competence of the District General Hospitals to deal with the ever increasing need for medical care. We list just a few signs of this crisis for brevity. We have no conflicting interests, our concern being only for the maintenance of good, rational services for all patients.

We know the duties of your public body were made clear by Sir David Nicholson KCB CBE Chief Executive of the NHS in England on 29 July 2010

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

We will return to these rules later.

Context

We list below some of the main factors.

A high standard of general practice is the bedrock of medical practice and service in the UK. Now GPs have longer working days, morale is low, many are retiring early, and at least 10% of posts and GP training posts are unfilled. Formerly, many dozens of young GPs applied for a West Country job, particularly with a CH close by.

The National Health Service is short of nurses in all disciplines, including crucially in midwifery and on the 'district'. In one poll of several, TMP reported in February 2014 that just one in seven of 1,600 nurses were happy in their role. More than half admitted they would leave if they could. The pay freeze was unlikely to have been the only reason. 17 Spanish and Italian nurses have just been engaged at Torbay Hospital and it said that at the RD&E there are 200 Italian nurses and more than 200 Spanish ones in a country of 61 million. Nursing has previously been a most popular calling.

Mental health services are under 'unprecedented strain'. The Royal College of Nursing says there are now 3,300 fewer posts in mental health nursing, and 1,500 fewer beds, than in 2010. At the same time demand has increased by 30%, the RCN said.

The GP and the CH

1. About 20% of acute illness can be dealt with by GPs in their local hospitals. With the latter closed or downgraded, those patients who are mostly elderly, will add to the queues in A&E and the 'assessment' ward. GPs have been trained to a high standard and relish using their skills directly.

2. Some patients whose lives are ebbing who cannot be managed at home or who are far from a hospice, have been cared for by the doctor and nurses they know in the CH. This duty is one of the most sacred for the family doctor.

3. The third function of the CH is the care of the patient needing an 'intermediate' or 'step-down' bed. The doctor and those local nurses will know the patient and family, and what recovery can be gained with good medical and moral support, not to mention closeness and practicability for visiting relatives and friends. There is great scope for enlarging this function in face of growing demand.

There is also potential for greater simplicity.

The patient and the CH

It is likely the patient will regard the CH warmly. Relatives have been cared for well within it, and that hospital which often pre-dates the DGH by many years, is at the centre of civic activity with generous giving a part. Those citizens who have supported the CHs in so many ways will feel betrayed by our NHS, as at Torrington, Ilfracombe, Winsford, Crediton, Budleigh, Ottery St. Mary and Axminster. The building, and more importantly the people within it, have a warm individuality compared say with Derriford hospital and its tall chimney.

The DGHs of the RD&E, NDDH and Derriford

The **RD&E** had two newly built wards commissioned in 2013. 28 beds were for acute medicine and 20 for 'Short Stay Rehabilitation'. Executive Summary – Short Stay Rehabilitation Ward – June 2012 *"Rationale - At any one time the RD&E has significant numbers of patients who are medically fit for discharge. Many of these patients are complex cases and because they are split over a number of individual wards, they are not receiving a coordinated, focussed re-enablement level of intervention and discharge planning."*

Early this year the orthopaedic and trauma surgeons had operating sessions booked in 2 theatres on the Saturday and Sunday, morning and afternoon. ALL 8 lists were cancelled for lack of beds. Norovirus had closed one ward but pressure from acute medical cases and 'delayed discharges' were likely to have been the main causes. In spite of the new SSR ward, and the 28 'acute medical beds' in June this year 69 'delayed discharges were counted'.

'Integrated Performance Report 29 July 2015 9.1, Public Board meeting'

*"**The number of patients waiting for onward care deteriorated in June with a median number of 69 on the medically fit to be discharged list compared to 51 in May.*** (NB – Summer time) *The Trust continues to seek to work closely with the CCG and providers of onward care services to manage the current patients and improve the turnaround time for onward care.*
An intensive multi agency work programme is planned to be undertaken as a priority in July and August in order to expedite improved performance across the system."

The NDDH. One of the two 'Hobson's' choices for CHs in North Devon is the closure of 4 CHs and the establishment of a ward of intermediate care beds within the NDDH. This plan can be nicely compared with the foregoing. The nursing and other professional staff in the DGH are most unlikely to know the patients taken under their care. Many of them will be far from home.

Derriford had a 'black alert' for the first three months of the year. (The other 3 DGHs had such alerts but for much shorter times.) There was no overwhelming 'flu epidemic affecting the elderly. In February alone, 745 operations were cancelled (Ann James CE). The waste of resources cannot be computed, but neither can the distress or **the threat to health or life.**

Torbay anecdote. Inquest reported last week in MDA. A lady with a likely scirrhous carcinoma of the colon, which might have had a good outcome, had her operation cancelled for lack of an ITU bed – two empty. Perforation with a faecal peritonitis followed shortly and she died after several procedures. This case emphasises, of course, the potential risk of delay.

Torbay has enlarged its bed compliment by using 24 beds in the private Mt Stuart Hospital for elective surgery. It should be noted that there have been two series of harm done to patients.

Costs

We are very well aware of the imperative to contain costs in the face of escalating need – real or supposed. In earlier times we worked in practices and hospitals where economy was respected. We saw the cost of administration double after the 'Internal Market' was brought in and we are aware of

the billions spent on re-organisations since involving management, policy, grandiose IT schemes, PFIs, purchaser/provider splits etc. Quiet consultation with those at the coalface would provide many practical ways of cutting costs without loss of service or of its quality.

Widespread substitution of CHs with 'care at home' and with 'hubs'

' Care at home' has been provided by GPs, excellent DNs, and Community Psychiatric nurses. Devon County Council provided an excellent home care service consisting of long serving personnel. Where it is possible and appropriate, 'care at home' should be the ideal. What exists now is short of this: eg poor houses, time spent in the home by the carer, time available for the GP to visit etc.

'Hubs' have existed widely both in CHs and in general practices. The range of functions steadily expanded. There were many advantages including easy liaison between the GPs and the visitor.

One signatory below visited 4 practices in semi-retirement to diagnose and often treat patients with musculo-skeletal troubles. Another carried out many arthroscopy lists in a CH. We note that there has been difficulty in finding functions for these 'hubs' in vacated CHs. It is likely they will be judged 'financially' non-viable and the buildings and land put on the private property market. Lynton CH is now housing tourists.

Consultation by the CCGs with the Public: Information

The public are bewildered with the profusion of NHS management bodies, and those purportedly representing the patient. Few know of the 'CCG' and even fewer could translate the acronym. The number of people who have attended the public meetings arranged by the CCGs, especially the poorly attended ‘drop-in sessions', must be only a few percent of the total adult population.

There was no proper consultation in the catchment about the closure of Torrington Hospital and we are not aware that there has been an expert and independent analysis of the 'care in home' which followed it. Cost is plainly the main driver for CH closure. What has been the true cost of 'care in the home' - are the humans being looked after well and how many Torrington patients have been discharged from NDDI to other CHs? STITCH have catalogued poor care in the home and inappropriate discharges.

Conclusions

We believe the CCGs have largely failed these rules set by Mr David Nicholson NHS CE in 2010

- **strengthened public and patient engagement**
- **clarity on the clinical evidence base**
- **and consistency with current and prospective patient choice.**

The public has not been told that the policy of closure of CHs, part or complete, is driven by economy. And neither has the public been shown that accurate costings might lead to a conclusion that savings are illusory. The best care of the patient has not been the priority.

Above all, we believe that closure of more than a few of the CH beds existing before 2012, will cripple the DGHs to such an extent that bed crises will be commonplace throughout the year, though even worse in the winter. Thus medical services in the hospitals will be greatly impaired.

We come to the conclusion that the only basis for a policy of CH closure is if there is an intention to restrict provision of those medical services.

We ask you as fellow doctors to reconsider this policy, which left to proceed, can only add to the crisis in our NHS.

Given the depth of our concern and the urgent need for wise action, we ask for a timely reply to the last signatory for forwarding.

Yours sincerely

David Halpin MB BS FRCS Retired orthopaedic and trauma surgeon Newton Abbot

Denis Keane MB ChB Retired GP Teignmouth

Christopher Maycock MA MB Chir MRCOG Retired GP Crediton

Asad Aldoori MB ChB MRCGP Retired GP Holsworthy

Richard Newell BSc MB BS FRCS Retired Orthopaedic and Trauma Surgeon Exeter

David Jameson Evans MB BS FRCS Retired Orthopaedic and Trauma Surgeon Exeter

Harry Cramp MBE MB ChB MRCGP Retired GP Great Torrington

Nicholas Lamb MB BS MRCGP 29 years as GP in Great Torrington

Benedict Armstrong MA BM BCh MRCGP Retired GP Great Torrington

Peter Edwards MB ChB FRCGP Retired GP Ashburton