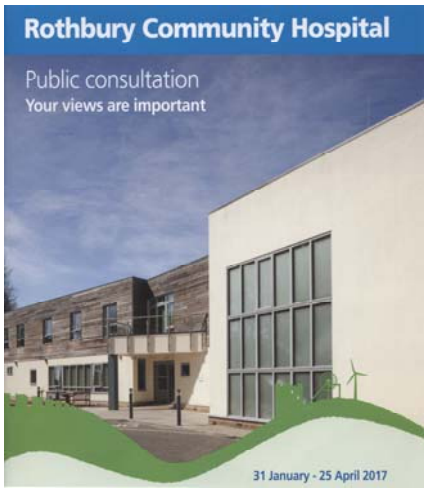

NHS Northumberland
Clinical Commissioning Group
Proposed changes at
Rothbury Community Hospital

Save Rothbury Community Hospital Campaign Group

Response to the proposed changes at Rothbury Community Hospital

April 2017

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INTRODUCTION

Background and History

A hospital was established in Rothbury in 1904 and this was later transferred into the National Health Service. The hospital has served the community of the Coquet Valley and beyond for over a century. In 2007, it moved from a central location within Rothbury to a purpose-built hospital on the outskirts of the village. The new building was funded by a Private Finance Initiative (PFI) loan. The amount borrowed to finance the scheme was approximately three million pounds, (£3m), repayable over 25 years, at a rate of interest of 7% per annum. (*Freedom of Information Response Reference 1228 8.2.2012*). It cannot be doubted that the National Health Service saw a need for the new hospital at that time.

The need for a community hospital in Coquetdale was clearly established for at least the next 25 years.

The hospital was named 'The Rothbury Community Hospital'. It was built with 12 beds at first floor level. Each bed is in a separate room with en-suite facilities and appropriate moving and handling equipment. The beds have been used for 'Step Up' and 'Step Down' and for end of life care with appropriate nursing. The beds have been available for all age groups in the community, but it has been the elderly who have been the main users.

The ground floor has been partially used for occasional outpatient clinics, and as a base for community paramedics and services.

Decision to 'suspend' the inpatient ward

On 9th March, 2017, Mr Philip Dunne, MP, the Minister of State for Health, confirmed to the House of Commons that in July, 2016, the NHS Northumberland Clinical Commissioning Group (CCG) established a steering group *'to consider the use and function of community hospital beds in Northumberland'*.

The CCG's terms of reference were to consider, not merely the Rothbury Community Hospital, but also other community hospitals in the county. These include: Alnwick Infirmary, Berwick Infirmary, and the Whalton Unit (Morpeth). It would normally be expected that such a wide-ranging exercise would take some considerable time, and would involve the collection and collation of an extensive quantity of data and factual evidence.

The CCG suspended the use of the beds at the Rothbury Community Hospital and transferred its patients and nursing staff to other hospitals **only four weeks later**. This was with no discussion with the Rothbury GP practice, and with only 7 days' notice of its intention.

Reaction to the 'suspension' of the beds.
On 7th September, 2016, the **Rothbury GP Practice** issued a statement:

'…*We believe the suspension of in-patient services at Rothbury will have* ***significant adverse consequences*** *for our local population. We think it is our duty to state the Practice view of its effects'. The suspension '…will mainly impact a frail and vulnerable group of patients' and* ***'we are wary of the long-term implications of this measure'.***

The Practice also confirmed that it had only been informed of the CCG's intention on 26th August, 2016.

The CCG's peremptory action also brought an immediate public protest. A demonstration was held at the hospital. The decision of the CCG was received by the public at large with a mixture of shock, anger, and incredulity. This sudden and unexpected attack on the much loved and highly regarded facility provided by the hospital was considered to be an act of wanton vandalism. It was incomprehensible that anybody could or would suspend the use and function of a brand-new purpose built hospital after it had only been in use for nine years. Such a destructive act relating to a public service was widely considered to be unacceptable. **The Save Rothbury Community Hospital Campaign group** was formed and the group immediately launched a petition against the bed closure.

This stated:

'We, the undersigned, call upon the NHS Northumberland CCG and Northumbria Foundation Trust to safeguard the future of Rothbury Community Hospital and re-open the ward with immediate effect.

Why this is important?

The Save Rothbury Hospital Campaign believe that the suspension of in-patient services at Rothbury is having significant adverse consequences for our local population. We want to protect this precious and valuable resource. We ask the NHSCCG and NHS Foundation Trust to think with their hearts - not with their wallets.

The immediate effects the sudden closure are:

1. Patients are not being admitted to a low-tech facility close to home. This will cause a higher rate of acute admissions to the new Cramlington hospital.
2. Patients are unable to return to a low-tech facility for rehabilitation, and discharge planning, close to home after an acute admission elsewhere.
3. Most crucially of all - we are left with no facility to provide end of life care for patients close to home, if circumstances, including patient choice, mean they cannot be cared for in their own homes.

The people who are suffering (and will continue to suffer) as a result of this heartless decision are our frail and vulnerable residents of Rothbury and Coquetdale. We refuse to allow this to happen - we care about all of our people.'

The petition was signed personally by over 3,452 people and electronically by 1,741, giving an overall total of 5,193.

Catchment area.
The catchment area of Rothbury Community Hospital - as shown on the diagrammatic map on page 6 of the CCG's Consultation Document - contains twenty civil parishes. The census of 2011 recorded that there were then 7,756 people living there. Approximately 80% of these were aged 18 and over, i.e. approximately 6,200. The great majority of the signatories to the petition live within the catchment area. It follows that about 84% of the resident adult population signed the petition.

The consent of the people of Coquetdale and its surrounding area is not given to the proposal of the CCG.

The result of the petition shows unanimous support and cannot be ignored. It must be an important and overriding consideration in the deliberations of the CCG.

Views from Coquetdale.
The CCG held a Public Meeting in November, 2016 to explain their decision to close the beds. The meeting was attended by over three hundred people, who were packed into the Jubilee Hall, in Rothbury. The proposals outlined by the CCG were met with anger and hostility. The CCG 'explanations' were held in contempt and disbelief by local residents.

Further public meetings were held on 16th February and 30th March, 2017. Again, at each only condemnation of the CCG's proposal was shown.

Objections to the proposal have also been put forward by a number of parish councils within the catchment area. Objections have also been made by the Rothbury Hospital League of Friends, by the respected Northumberland and Newcastle Society, and by many other organisations.

Such an expression of public opposition should not be seen as only an outpouring of raw emotion. It must be understood that Rothbury Community Hospital is a well loved and respected friend. The care and treatment provided there have been appreciated by numerous residents, their families and friends, over many years. The community's views are, therefore, not subjective, or based on sentiment. These views and opinions about RCH have been formed as a result of practical and personal experience. **These views should not be disregarded. They should be listened to and acted upon.**

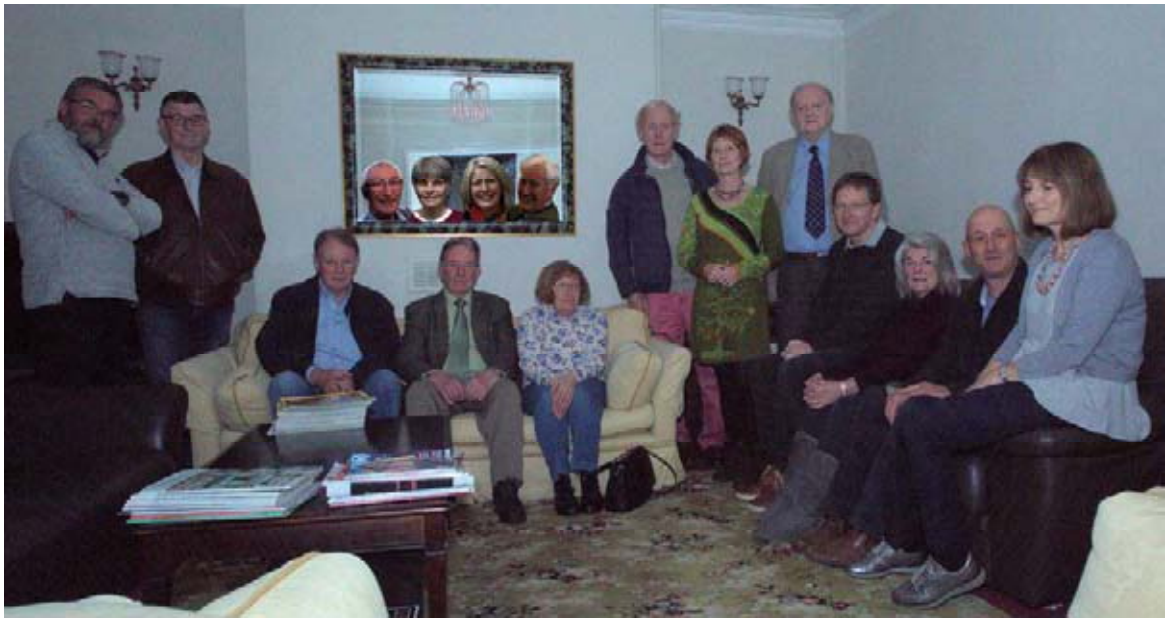
View from our M.P.
Mrs Anne-Marie Trevelyan, Member of Parliament for the Berwick-upon-Tweed constituency, which includes the Rothbury area, has expressed her concern at the proposed inpatient bed closure, in the House of Commons.

No evidence has been produced by the CCG to show that a single member of the public, or any authority, or any other body, company, or organisation has given written support to the proposal of the CCG to close the community hospital's beds.

Such is the intense objection to the CCG's proposal that a broad-based team of local people, who have considerable experience of medical, financial and management matters, has been charged with the preparation of an objective statement showing how a better outcome than that outlined in Option 5 of the Consultation Document can and should be achieved.

The Save Rothbury Community Hospital Campaign Team (SRCH).

Name	Background
Dr Angus Armstrong	Retired Rothbury GP
David Blakeburn	Woodland Ranger, Author
Chris Butterworth	Retired BT manager, formerly responsible for broadband policy.
Maurice Cole	Borough Council Chief Executive and Solicitor (Retired)
Rev Frances Dower	Retired Rothbury GP
Alan English	High Tech business consultant
Maureen Hine	Senior contract manager for Newcastle Health Authority (retired), General Manager Helen McArdle Homes (retired) J.P. (retired)
Dr Billy Hunt	Rothbury GP
David McKechnie	Hepple Parish Clerk, Systems Director, Grattan PLC (retired).
John Monaghan	Consultant Gynaecological Oncologist (retired)
Julie Porksen	Previously global research manager for an international health charity.
Steve Proctor	Emeritus Professor of Haematological Oncology, Newcastle University (retired)
Alison Rutherford	Retired NHS worker
Cllr John Rutherford	Senior Management in Health and Social Care (retired)
Katie Scott	Educational Consultant (retired)



POINTS OF AGREEMENT

SRCH agree with parts of the Consultation Document
The Team accepts that Options 1, 2, 3, and 4 by themselves are not viable and should not be pursued. None of these options have been actively put forward by the Team. Questions may have been raised about such possibilities by members of the public before the issue of the Consultation Document, it is now appreciated by all that they should not be considered. Pages 16 and 17 of the Document may, therefore, be ignored.

The Team also accepts that respite care is not provided by the National Health Service as indicated on page 19 of the Consultation Document and has no bearing on the use of the hospital's beds.

What *is* being consulted on?
The only matter upon which there is actually *public consultation* is set out on page 19 as **Option 5**. That is - *'permanent closure of the 12 inpatient beds and shape existing health and care services around a Health and Wellbeing Centre on the hospital site'.*

No other proposal has been put forward by the CCG. Therefore, the SRCH team is not called upon to consider such types of care that are suggested in the text of the blue coloured paragraph on page 19.

> We also acknowledge that some people feel strongly that there should be some provision for respite and end of life care in Rothbury and that they have already described potential models. Respite care is not provided or funded by the NHS and experience shows that very few end of life care beds would be needed. However, as the consultation progresses, we would be very keen to hear more from people about how they think we could develop a community based service which would provide beds for patients requiring these types of care.

Option 5.
Within Option 5 there are also a number of matters with which the Team agree.

We wholeheartedly support the commitment of the Trust and the Rothbury Practice to use part of the building for general practice purposes.

It is known that this has been the subject of discussion between the parties for some two and a half years. We know that an advanced stage has been reached in the negotiations and funding, and, indeed, that a planning application in respect of a change of use of the existing practice premises to housing has been submitted to the Planning Authority.

We know that Northumbria Healthcare NHS Foundation Trust submitted a planning application for this development to the NCC on 21.2.2017. **This was during the consultation period.** The detailed plans which accompanied the

application show that the Rothbury Practice will occupy the ground floor, together with the paramedic, and that physiotherapy and existing clinics will continue to be offered at that level.

Accommodation for nurses and services.
The community nurses and services will be provided with an office on the first floor. This will be situated in a room which was formerly designated as a dining room, but which has not been used for that purpose.

Before 21st February, 2017, discussions had taken place between the Rothbury Practice and the SRCH Team, which had confirmed that the former intended to be accommodated on the ground floor of the hospital. It was understood by the Team that the community nurses and staff, the paramedic, and all the existing clinics and physiotherapy would also be sited there.

The precise siting of the community nurses' office accommodation has never been mentioned by the CCG. It has not been referred to the Consultation Document or at any of the public meetings.

However, the proposal to use the dining room on the first floor does not impinge upon any accommodation which has actually been used in connection with the hospital and, consequently, the Team is happy with and approves of the decision to use that part of the building as offices for the community nurses.

There is, therefore, no need to give any further consideration to the accommodation of other services provided at or from Rothbury Community Hospital as set out on pages 7 and 8 of the Consultation document, as there is total agreement on these matters.

The twelve in-patient rooms.
The Team is also pleased to see that the deposited plans reveal that the CCG has no intention to use the twelve rooms which contain the beds and en-suite facilities for any other purpose. Also, that there is little change to the nurses' and sister's office accommodation and facilities. All are designated in a similar way on both the existing use and the proposed use plans which accompany the planning application.

This is, therefore, a public statement by the CCG during the consultation period that, whilst it wishes to close the beds, it has no plans to use the twelve rooms and the nursing accommodation for any other purpose.

OTHER ASPECTS FOR CONSIDERATION

Costs, Finance, Staffing

The cost of providing 12 beds in RCH is one of the two reasons which have been advanced in the Consultation Document for their permanent closure.

Page 4 states that the service must *'make the best possible use of the NHS skilled staff and money available to us' and that 'this is particularly so given the financial challenges facing the NHS both nationally and locally'*.

Page 12 states that *'it is vital that we make the very best use of all available resources, staff, facilities and finances'*.

It also says that there are *'considerable financial pressures facing the health and care system in Northumberland'*.

Page 16 states that one of the criteria used to assess each of the five Options referred to in the Document was *'additional resources required/cost'.*

Also: *'In addition, a second assessment was also carried out, focussed specifically on the requirement for CCGs to ensure efficient, effective and economic use of resources'* (the three E's test).

This latter assessment states in respect of Options 3, 4, and 5, that the economic benefits are as follows:

'The CCG would make an annual saving of £500k which NHCFT have calculated as the staffing costs for running the 12 inpatient beds'.

This figure is repeated in relation to each of these options on pages 17 and 18 of the Consultation Document.

This round figure of £500,000 is expressed on six occasions to be the only financial saving which would arise from the permanent closure of the twelve beds. It is entirely attributable to the staffing costs for running those beds.

Page 14 of the Consultation Document specifies that *'the number of staff available for the 12 inpatient beds is 6.77 whole time equivalent (WTE) qualified nurses, 6.27 WTE healthcare assistants and 0.56 WTE nutrition assistant'.*

The Team submitted a Freedom of Information (FOI) question which asked:

'Details of individual salaries are not being sought. However, please supply a list of national grades within which the various categories of officer are employed' and;

'What percentage on cost is applied to directly employed staff and what factors does such an on cost include'?

An answer to these questions was declined.

The FOI reply stated:

'We have had a number of meetings with staff as part of this process which has included information specific to individual members of staff and their personal circumstances and it would not be appropriate to share this publicly'.

Clearly the reply did not relate to the question. It is suspected that it was realised that, if the requested information was released, it would be easy for the recipient to show that the figure of £500,000 was wildly inaccurate.

However, local enquiries by the Team have revealed that the normal staffing at the hospital is

- 1 sister
- 6 qualified nurses
- 6 healthcare assistants.

(The nutrition assistant, attends for only half a day per week and not 0.56 WTE).

Further enquiries have revealed that, according to the 2016/2017 NHS salary scales for nurses and healthcare assistants, the staff at Rothbury Community hospital are paid within the following Bands:

- Sister - Band 6 - £26,302 - £35,225.
- Nurses - Band 5 - £21,909 - £28,462.
- Healthcare Assistants - Band 2 - £15,251 - £17,978.
- Nutrition Assistant - £21,909 - 28,462.

If every member of staff were in receipt of the maximum point of their Bands the total salary bill would be built up as follows:

- Sister: £35,225
- 6 nurses: £170,772
- 6 healthcare assistants: £107,868
- Nutrition Assistant: one tenth of £28,462.

The total salary cost, therefore, would be £316,711.

It is understood that the NHS add an on-cost figure of 22% to salaries. When this is added, the total cost of salaries and, therefore, the maximum amount of savings would be **£386,387.**

The precise salary levels of each individual are not known by the Team, but it is

likely that not all the staff were paid at the maximum level of their Bands when the Consultation Document was issued.

If, on average, the staff were paid at the median level, the total salary cost would be reduced to £282,906 and, with an on cost of 22% added, would be **£345,146.**

So, what actually IS the financial saving?

The only alleged financial saving from the closure of the beds, namely £500,000, is overstated - probably by between £113,613 and £154,854.

The precise salary figures could have been easily calculated by NHCFT and checked by the CCG. To use a 'ball park' figure of £500,000 and to rely on it as the only financial saving to be achieved by closing the 12 hospital beds illustrates that the initial estimate and also the three E's test have not been carried out properly.

That test merely repeats the round figure of £500,000. It does not show by way of any hard-factual evidence how that amount has been calculated. It is not, therefore, an additional assessment as claimed in the document, but is merely a repetition of an unsubstantiated figure which has not been precisely calculated.

Consequently, proper consideration has not been given to the cost of the only alleged financial saving put forward by the Consultation Document.

Such loose and careless estimating can be easily discredited and, indeed, throws considerable doubt on the veracity, accuracy, and quality of the rest of the contentions outlined in the document.

There is also one further matter which should be considered. This is to examine whether or not the staffing levels are correct.

It is noted that in the Whalton Unit there are 30 beds which are tended by 12.69 WTE nurses. In other words - one nurse cares for 2.36 beds.

At Rothbury there are 12 beds which are tended by 6.77 WTE nurses. That is, one nurse cares for only 1.77 beds, even though the Rothbury patients' cases appear to have been less complex.

These figures suggest that perhaps the nursing establishment at Rothbury could be reduced to 5 WTE nurses. This would result in each nurse caring for 2.4 patients. This would be almost an identical staffing level to that of the Whalton Unit.

If this were found to be viable, up to a further £69,448 (inclusive of on cost) per annum could be saved. **This would increase the CCG's overstatement of savings to between £183,061 and £224,302.**

It is noted that each Healthcare Assistant at the Whalton Unit looks after 1.8 patients and that at Rothbury the figure is almost identical: 1.9. This would appear to strengthen the case for examining the nursing staff complement closely at Rothbury. **However, this does not appear to have been done by the CCG.**

Transfer of patients and of staff.
The transfer of patients to another hospital does not automatically bring a saving in overall staffing costs.

Some of those costs transfer with the patients. The cost of their care is not merely absorbed into the usual running expenses of the other hospital.

If, say, 6 patients, who would have been admitted to RCH are admitted instead to Alnwick (or elsewhere), it is likely that there will be staffing implications there. The number of permanent nursing and healthcare assistant posts will need to be increased appropriately and in line with a proper ratio of nursing staff to beds and patients.

No consideration has been given to this likelihood in the Consultation Document and, therefore, no estimate of the likely cost has been set against the alleged saving of £500,000.

For example - if the cost of one half of the nursing staff were to be transferred with the patients, the reduction to the assumed saving would be approximately £171,000 based on median salary levels.

If one third of the cost were transferred, the reduction would be about £114,000.

If only one quarter of the cost were transferred, the reduction would be about £85,500.

If maximum salary levels were used, then the transfer cost would be significantly higher and the reductions to the assumed saving much greater.

It is obvious that significant sums will be added to the budgets of the hospitals to which Rothbury patients are transferred. **These costs should have been accurately estimated and shown in the Consultative Document, but have not been.**

Community nursing.
If more patients are discharged from acute hospitals direct to their homes instead of being cared for in a community hospital, there will be a need to increase the number of community nurses by an appropriate number.

Yet again the Consultative Document gives no consideration to this. There is no estimate of the number required, or of their salaries, or the cost of their travelling.

There is no mention of how many such nurses will be needed in an extensive rural area, or of how many visits per day are likely to be necessary per patient.

Without such estimates being done in a realistic and detailed manner it is impossible to know what the additional cost of this enlarged service will be.

If, say, three nurses were to be engaged for the additional work, the cost calculated at the median point of salary Band 5, together with on cost, would amount to £92,590. Travel costs would increase this figure to over £100,000 per annum.

Clearly there will be considerable extra cost in extending the community nursing service and this should have been estimated and deducted from the alleged saving of £500,000.

Relocation of Rothbury Practice.
The proposed relocation of primary care into the building will bring primary care premises funding to benefit NHCFT building running costs by approx. £50 000 per annum (although the District Valuers nominal figure was approx. £100 000pa, there is no additional funding to meet this nominal figure).

This move is 'cost neutral' to the CCG/ NHS England, as the funding is already in place. This will only partially offset the loss of income to NHCFT resulting from any bed closure, but is a separate issue as the relocation could equally take place without bed closure. The consultation document is misleading in appearing to link the primary care relocation with any particular option (such as option 5)

Cost of the *Health and Wellbeing Centre*.
The Consultative Document suggests that the RCH should be converted to a *Health and Wellbeing Centre*. No specific functions have been identified. Therefore, it is currently impossible to estimate the cost of the different services which may be provided.

If, however, the community hospital beds are permanently closed, the majority of the first floor of the building will become unoccupied. If it is the CCG's intention to utilise fully all of the building, then uses will have to be provided in twelve rooms with en-suite facilities, the nurses' rooms and other rooms, which are currently used for hospital purposes.

Clearly any additional use will need staff, equipment, heating, lighting, and maintenance, etc., all of which can only be provided at a cost.

It is necessary to identify these additional and new uses precisely and to cost their provision.

That estimated cost should then be set against the alleged financial saving which the Consultation Document claims. However, this does not appear to have been done by the CCG or the Health Trust.

Private Finance Initiative (PFI)
At the public meeting in November, 2016, the CCG stated that the annual payment made under the **PFI loan was £600,000**. They added that over the ensuing fifteen years, up to the end of the loan period, **a total of £9,000,000 would be paid.**

Both these figures were wrong.

An FOI response, dated February, 2012, stated that, at that time, the annual payment was **£464,000.**

A recent FOI request asked why there was a discrepancy between the 2012 figure and the November, 2016, estimate of £600,000?

The response to that question revealed that **currently the annual payment is £516,000** and that this is subject to an annual variation based on the retail price index.

The Estates Management Services are charged each year with the cost of the maintenance of the building and that cost is incorporated within the overall annual payment.

The CCG cannot forecast accurately what the annual charge will be in any future year, as the actual cost will depend on the inflationary increase in the retail prices index. The Team accepts this.

However, an examination of the variations in the index over a number of years has established that there can be wide swings. Recently the index increases have been comparatively low, but they are now rising. Given the recent fall in the value of the pound, the fact that the country imports more than it exports, and the purchase of oil in dollars, such a trend is likely to continue. If that occurs, then if the retail price index increases by, say 3% per annum, **the amount which remains to be paid over the fifteen-year period would be almost £10,000,000.**

There is no evidence to show that the CCG has considered whether or not it is possible to buy out this financial arrangement or to refinance or restructure it.

If it is possible so to do, there could be a significant financial advantage in future years and this in turn would result in making savings in the running of the hospital.

If nothing is done to address this huge annual financial liability, it will continue to rise and be payable over the next fifteen years. This is irrespective of whether or not the hospital beds are closed permanently. The CCG has publicly accepted that this is so.

Confusing and contradictory messages from the CCG.

At the public meeting held on 30th March, 2017, the CCG revealed itself to be a body of contradictions. Dr Alistair Blair, the Clinical Chair of the CCG, emphasised on a number of occasions that it was necessary for the NHS to save every penny, wherever possible. *However, when closely questioned on the payments to be made under the PFI loan, he said that,* ***even if it could be shown that a restructuring of those payments would result in covering the annual cost of providing twelve beds at the hospital, the CCG would not alter its view on the proposed closure of beds*****.** He said that ***"the CCG was not prepared to fund empty beds".***

He also stated that the paramount concern was the quality of care which could be provided for patients in a 12-bed unit.

That statement contradicts the opinion of the CCG previously advanced about the quality of care at the hospital. In the efficiency, effective and economic appraisal which has been published relating to the five options considered by the CCG the effective section of Option 1 stated that it had:

'No issues with quality of patient care prior to the service suspension'.

It also seems to be strange that the CCG was prepared to change the terms of a PFI arrangement relating to Hexham Hospital through the good offices of Northumberland County Council, but is not prepared even to consider the possibility that savings might be achieved by seeking to restructure the Rothbury loan.

These astonishing replies unfortunately disclose **the CCG's <u>recalcitrant determination to close the beds</u> irrespective of any evidence or suggestion put in front of it**.

The CCG cannot, on the one hand, claim that it wishes to save money by the bed closure, but, on the other hand, decline to consider a possible way of doing so. It cannot cry out for financial savings - and then abandon that plea and subordinate it to a demand for 'better patient care'. It cannot in support of this spurious argument renege on its previously stated satisfaction with the quality of patient care provided at the hospital.

The CCG should be consistent in its views and should examine every possibility to manage its finances well, but obviously, it is not doing so.

Savings made by bed closure?
The points made above demonstrate beyond doubt that the **CCG has not established that the closure of 12 beds at the Rothbury Community Hospital will result in a financial saving of £500,000.** This round figure estimate has been plucked out of the air and has no foundation in fact. **Indeed, there is absolutely nothing in the Consultation Document which shows conclusively that there will be any saving at all.** It could be argued on the basis of the figures and factors advanced by the Team that the closure could actually result in an overall increase in cost.

A detailed study is currently being carried out at present by Leeds University and there are early indications that the change of policy towards more home care may not in practice prove to be cost effective.

Decisions should not be made on the basis of mere guesses. Estimates should have substance. They should show in some detail how they have been calculated and should be capable of bearing realistic scrutiny.

The alleged savings estimate put forward by the CCG does not satisfy such tests. It has not been substantiated. Indeed, the three E's test which was carried out can only be described as a farce. It was not additional. It did not scrutinise. All it did was merely repeat a flawed estimate.

'Round figure estimating', which is prevalent throughout every aspect examined above, should be set aside and be replaced by accurate figures which have been properly calculated and can be substantiated.

Other social costs.
Any other costs which arise because of action taken to increase community nursing in the home are, of course, not the direct responsibility of the CCG.

However, the result of such action will inevitably lead to the need for more home care provided by either NCC or by a private provider. So, this will pass a cost burden on to either the Council or the patient.

According to the Information Sheet published by the County Council in 2016/2017, any patient with savings of £23,250 is responsible for the full cost of his or her care. Any patient who is in receipt of all disability benefits is responsible for the payment of between £59.00 and £73.00 per week.

Depending on personal financial circumstances some patients make no contribution to the cost and the burden is borne then by the County Council.

So, while perhaps the CCG may make a saving to its own budget, it passes a cost burden elsewhere. This could result in a greater overall cost for patient care and that extra amount could be borne by public authorities collectively.

The Consultation Document does not address this issue and, therefore, makes no attempt to quantify the resultant likely overall cost.

There would also be an additional cost to the relatives of patients through extra travelling expenses, the wear and tear to their vehicles, and the economic loss of their own personal time.

It is high time that such broader social issues were taken into consideration properly, rather than each organisation merely looking at cost from its own narrow perspective.

DEMOGRAPHIC PROJECTIONS

The population.
The Consultation Document at page 14 rightly identifies the problems arising from an ageing population and quotes population data obtained from the Office of National Statistics (ONS).

These establish that 30.4% of people living in Rothbury are currently aged 65 or over.

This is a significantly higher percentage than other parts of Northumberland (at present 23.1%) and of the North East (19%) and of England (17.7%).

The ONS estimate that over the next 10 years the percentage of people living in Rothbury aged 65 or over will increase by 22.8% above the current percentage figure and over the next 20 years will increase by 44.8% above that figure.

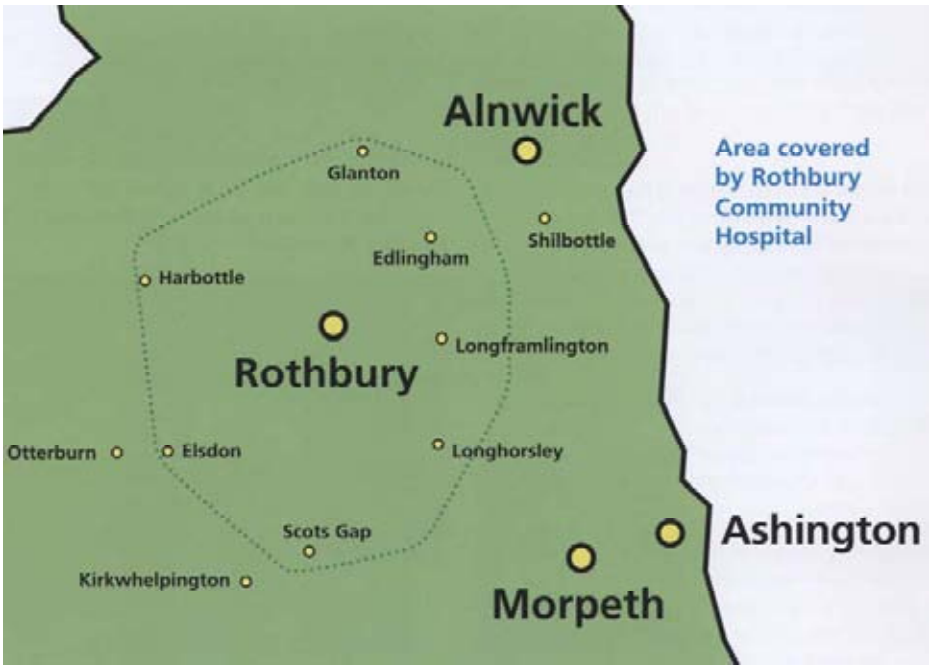
The Team also accepts the above data produced by the ONS and so there is no dispute between it and the CCG about the basic population figures or about their likely percentage increases.

The Consultation Document, however, has utterly failed to calculate what the likely impact of these future changes will be. It has not addressed what the actual size of the 65+ population will become in the area covered by Rothbury Community Hospital. As a result, it has produced no evidence whatsoever of a viable solution to this ever-growing issue and, therefore, has not sought to cost it or to show how it will be staffed and managed.

There is, therefore, a total absence of forward planning by the CCG for the next ten or twenty years.

The Team, however, **has** made a detailed demographic projection of the likely numbers of 65 or over people over such periods of time. This has been done by examining the precise details contained in the 2011 Census relating to all the parishes lying within the area covered by the diagrammatic map shown on

page 6 of the Consultation Document. And also by applying the percentage increases shown on page 14.



It is therefore possible to ascertain an actual population level in 2011 and estimated levels in 2027 and 2037 relating to the elderly sector.

2011 Census		
Parish	**Number of residents**	**Number of people aged 65 and over**
Biddlestone	177	32
Brinkburn	222	32
Callaly	235	53
Edlingham	191	43
Elsdon	242	43
Glanton	239	61
Harbottle	256	55
Hepple	144	36
Longframlington	1032	297
Long Horsley	887	192
Netherton	185	51
Rothbury	2017	603
Rothley	160	25
Snitter	108	30
Thropton	458	141
Wallington Demesne	369	88
Whittingham	525	101
Whitton and Tosson	219	39
Totals	**7756**	**1922**

The 2011 Census established that at that time the number of people aged 65 or over who were living in the Rothbury catchment area was 1922, or 24.78% of the total population.

It is significant that in 2011 a cluster of parishes had a much higher incidence of people aged 65 and over than elsewhere in the catchment area, namely:

- Thropton - 30.8%,
- Rothbury - 28.6%
- Snitter - 27.8%
- Netherton - 27.7%
- Hepple - 25.0%

Four of these lie immediately to the west of Rothbury itself. It is clear that the elderly residents living there rely on the excellent facilities and services in Rothbury, including the hospital, and have settled close to that small town because of them.

The total population figure of 7,756 will currently be higher than in 2011 because of the building of houses in the area between that year and 2017. In the absence of any figure for such an increase, the Team propose to use 7,756 as the basis of its projected population estimates. This will result in lower forecasts than those which would have been likely to occur had it been possible to know actual current population levels. Consequently, the Team cannot be accused of an attempt to inflate any of the figures shown below.

An increase of 22.8% on the current ONS figure of 30.4% amounts to 37.33%. An increase of 37.33% on 1922 (the 2011 level of the elderly population in the area) would mean that **by 2027 there will be 2,639 elderly people resident in the catchment area. This is an increase of 717.**

An increase of 44.8% on 1922 would mean that **by 2037 there will be 2,783 people aged 65 and over in the catchment area, an increase of 861.**

It should be recognised that, as people continue to live longer and longer, their needs will become more complex and demanding of medical attention.

New homes, new residents.
The above projections are not an underestimate only because of the use of a 2011 figure as a base, but also because of the planned number of **new houses** which are to be built in the hospital's catchment area.

The Core Strategy Plan of Northumberland County Council (drawn up in accordance with government housing policy) specifies that within the period 2011 to 2031 some 200 new houses should be built in Rothbury. Another 1,250 houses will be constructed in the remainder of the northern area of the county (excluding Alnwick, Berwick-upon-Tweed, Belford, Seahouses, and Wooler, all of which have separate allocations).

A comprehensive examination of NCC's planning records has revealed that between 1st July, 2011, (the commencement date of the twenty-year period of the Core Strategy of NCC) and the beginning of 2017 **there have already been 475 planning permissions issued or planning applications validated for housing development within the Rothbury Hospital's catchment area of twenty civil parishes**. 144 of these are mainly in respect of extensive development sites on the boundaries of Rothbury and Thropton.

During the same period, a number of satellite parishes of Alnwick (which lie outside the hospital's catchment area, but within the Council's northern planning area) have been the subject of planning applications for **402 new houses**. These are:

- Acklington
- Alnmouth,
- Eglingham
- Felton
- Lesbury
- Longhoughton
- Newton-on-the-Moor & Swarland
- Rennington, Shilbottle
- Warkworth.

There have been particular pressures on Newton-on-the-Moor & Swarland and on Warkworth, both situated adjacent to the River Coquet.

One third of the housing allocation for north Northumberland for a twenty-year period has already been absorbed in the hospital's catchment area alone within only six years and it is inevitable that further planning applications will follow.

If the Core Strategy is adhered to, then the rate of development in the catchment area should slow down over the next fourteen years. If it does not, however, the number of houses built in the catchment area between 2011 and 2031 will be 1,425.
That will produce an increase in population of 3,135 at a house occupancy rate of 2.2. The ONS estimate that 37.33% of that increased population will comprise people aged 65 or over. That means that **there will be 1,170 more of that age group by 2031.**

If the rate of development is slowed to a rate more in line with that envisaged by the Core Strategy, then the number of new properties within the catchment area could realistically be in the region of 900, between 2011 and 2031.

Such a lower rate of development would result in a population increase of 1,980 at a house occupancy of 2.2.

So - the aged population would increase during that period by 37.33% of that figure, namely by 739.

The figure of an extra 739 people aged 65 or over by 2031 compares very closely to the estimate of 717 in 2027 arrived at by applying the ONS estimated percentage increases to the population figures contained in 2011 census.

In addition, it is vital to understand that the Core Strategy document also envisages the construction of **1,100 new houses in Alnwick and a further 2,100 houses in Morpeth.**

It is inevitable that the building of so many houses in these two major towns will have a significant impact on the medical services in those areas. Alnwick Infirmary and the Whalton Unit at Morpeth may be inundated by extra patients and, therefore, unable to assist in the accommodation of patients living in Rothbury and its satellite parishes.

The CCG's Consultation Document does not take any of these factual issues into account. There is no mention of any forward planning which either recognises these impending problems or considers any policies to deal with them.

The Team submit that **no consideration should even be given to closing permanently the 12 beds at Rothbury Community Hospital before the CCG has done a full appraisal of likely population growth (particularly that of the elderly)**. And also of the consequential further demands both on beds - plus community care - by the building of substantial numbers of houses in the Coquet Valley and in Alnwick and Morpeth and their satellite parishes.

TRAVEL ANALYSIS

We did our own.
The Consultation Document states on page 5 that *'in the early stages of consultation, we will carry out a travel analysis to further assess the impact of the proposal on local people'*. It continues: *'the results of this will be made public as soon as they are available'*.

Clearly the steering group did not carry out such an analysis in July, 2016. Nor had one been undertaken by the CCG when the Consultation Document was issued. Indeed, despite the passing of ten months, none has as yet been produced.

Bus

A few minutes spent with bus timetables and Ordnance Survey maps numbers 80 and 81 would have revealed the true situation. There is one direct 'bus service from Thropton and via Rothbury to Alnwick. This is currently operated by PCL. There are four journeys each day as follows:

Daily bus journeys		
Thropton	**Arrive Alnwick**	**Leave Alnwick**
07.45	08.15	09.00
09.30	10.00	10.20
11.45	12.20	14.15
15.50	16.20	17.40

The PCL service also runs a circular route through Snitter, Netherton, Alnwinton, Harbottle, Holystone, and Hepple twice each day. This connects with the Thropton to Alnwick Service at 11.45 and 15.50. The circular route takes one hour which increases the journey time to Alnwick to one and a half hours.

These timetables mean that a resident of Thropton or Rothbury wishing to visit a patient at Alnwick could use either the 9.30 or 11.45 service and return at 14.15 or 17.40.

Any resident of the outlying parishes listed above could only use the 11.45 service and return at 14.15 or 17.40. In either case **their total journey time would be three hours**.

Residents of Thropton and Rothbury could use an hourly service to Morpeth and from there, by using a different service, could go to Alnwick. The journey times are 42 minutes and 44 minutes respectively and there is a usual additional waiting time at Morpeth of 37 minutes. **The total travel time is, therefore just over two hours, or four hours for the round trip.**

There are no direct bus routes to Alnwick from either Longframlington or Longhorsley. The only route by bus is via Morpeth and from thereafter, a wait to Alnwick.

The Whittingham to Alnwick bus service is as follows:

Whittingham	**Arrive at Alnwick bus station**	**Leave Alnwick**
9.26	9.45	9.55
11.26	11.45	11.55
13.26	13.45	13.55
17.31	17.50	18.15

For visiting purposes only, the 11.26 returning at 13.55, or 18.15, and the 13.25 returning at 18.15 are realistically useable.

Taxi
There are two taxis for hire in Rothbury. One of these advertises their charge for a journey to Alnwick as £23.00.

Private car
Anyone using a private car to go to Alnwick would invariably take the direct route along the B6341, which runs from Elsdon and through the Coquet Valley via Thropton and Rothbury. The distance to Alnwick from Elsdon is approximately 25 miles, meaning **a round trip of 50 miles.** The distances from Thropton and Rothbury to Alnwick are respectively about 14 and 12 miles, a round trip of around 28 or 24 miles. **It is disingenuous for the Consultation Document to cite only the distance from Rothbury to Alnwick, as many parts of the catchment area are far more remotely located.**

The B6341 runs over wild, open and windswept moorland in various places. It has a number of very steep hills which rise to 900 feet above sea level. In winter the road has frequently been closed because of snow and ice. It can sometimes be impassable to cars and to the PCL bus service.

The likelihood is that most patients and their spouses will be elderly. It is surely unreasonable to expect them to make such long and possibly hazardous journeys to visit loved ones in hospital. If the CCG do close our beds, Coquetdale patients at Alnwick risk being isolated from their relatives and friends.

It would be far better and more humane to care for patients in the Rothbury Community Hospital. Better both for the patients themselves and for their visitors.

Under utilisation of the beds
It would also be better, if there were ever to be *under occupancy* of the beds at Rothbury Hospital, to transfer to it a few step-down patients whose homes are in the south east of the county. Their relatives could visit, either by public transport or by car, far more easily. There is an hourly bus service from Morpeth to Rothbury throughout the day. The B6334 runs along the valley next to the River Coquet as far as Weldon Bridge where it joins the A697 to Morpeth. These roads are much more likely to remain open in winter.

Bring ‘step down’ patients to Rothbury.
Step down patients used to be transferred frequently to Rothbury. A former local ambulance driver has assured the Team that he used to bring patients whose homes were in the south east of the County perhaps five or six times each month during his ten-year service. He also commented that often the families of the patients liked to come to Rothbury, as it gave them the bonus of a pleasant day out.

It seems unreasonable to require the family of every patient whose home is in the Rothbury area to make the difficult and time consuming journey to Alnwick, but not to expect the relatives of a much smaller number of patients occasionally to make the safer and more convenient journey either by bus or car from the Morpeth area to Rothbury.

Choice?
When pressed on the question of transfer of patients at the public meeting, the CCG maintained that this could only be done with the patients' consent. The Team consider that there are many patients who would be very happy to have the privacy of their own room with en-suite facilities and a pleasant outlook at Rothbury Community Hospital.

It is also fair to comment that the patients who were in our hospital in September, 2016, were not given any choice. They were removed unceremoniously to other hospitals.

Looking to the future, if the Rothbury beds are closed, what choice will patients from this area have? The answer is none locally; they will be moved to Alnwick or Morpeth - if beds are available – and - if not, either will take up beds at Cramlington or at the Wansbeck Hospital. Or, worse still, be moved to far more remote locations.

Travel by community services staff.
The Consultation Document has not given any consideration to the amount of additional car journeys which community services staff will need to make, if the volume of care at home is increased. Inevitably there will be more journeys, but no estimates have been made of the additional transport costs by the CCG.

GP input.
When the beds were in use at Rothbury Community Hospital, doctors from the local general practice could attend patients there quickly and easily, if called upon to do so. **In future, if more patients are cared for at home, those same doctors will sometimes have long and time consuming journeys to effect the same level of treatment.** The extra time and expense required will have an adverse effect on the usual daily work of their surgery. Again, the CCG has given no consideration to this additional and disruptive workload.

EQUALITY IMPACT ASSESSMENT

Monitoring negative impact?
Under the provisions of the Public Sector Equality Duty of the Equality Act 2010 and the Equality Act 2010 (Specific Duty) Regulations 2011 all listed public authorities, including CCGs, have a responsibility to assess their activities and to set out how they will monitor any negative impact and protect people from discrimination on the basis of, amongst other things, age and infirmity.

The Consultation Document does not show that the CCG has prepared an Equality Impact Assessment in respect of its proposal to close the beds in the Rothbury Community Hospital.

The CCG is, therefore, in breach of its statutory duty and the consultation process is thereby flawed.

The various enforcing bodies, namely the *Commission for Equalities and Human Rights*, the *Audit Commission*, and the *Care and Quality Commission*, may well have a view on this defect in procedure in due course.

Such an assessment is important because of the rural nature of the hospital's catchment area and of the high proportion of people aged 65 and over within it.

Extra travelling in distance or in time either by bus or car for visiting purposes will impact far more on the elderly than any other section of the community. It is not reasonable to expect old people to spend two or three hours on difficult journeys, perhaps often in inclement weather.

Car ownership, ability to drive.
The only certain figures about the incidence of car ownership are to be found in the 2011 census. This shows that at that time 18.3% of the households in Rothbury itself did not own a car. However, there were no figures then available to show how many of those households consisted of people aged 65 or more. The statement on page 14 of the Consultation Document that ..*85% of elderly people have access to a car* is not supported by factual data.

The implication in the Document is that most elderly people will be able to use their own car for visiting purposes. **However, the fact that a car may be kept at a patient's home, does not necessarily mean that his or her spouse is able to use it**. Some old people either do not drive or have ceased to do so because of their age.

The most recent ONS figures for the Rothbury Ward compiled in January, 2013, revealed that 1,299 people were aged 65 or more. Of these, 358 (namely 28%) were single, or widows, or widowers.

The ONS has also revealed that across all age groups 50.3% are female. However, such a percentage figure needs further refinement when the elderly population is being considered. When a man reaches the age of 65, he has a life expectancy of a further 18.6 years. In the case of a woman her life expectancy is then 21.1 years, i.e. some 2.5 years longer than that of a man. Also, most men marry women who are younger.

It follows that of the 358 single households considerably over 50% are likely to be women and it is also likely that a proportion of these will be unable to drive.

Discrimination against elderly women.
An NHS policy to discharge more patients from hospital direct to their homes will also inevitably mean a greater burden falling upon elderly married women when called upon to look after their partners when recovering from illness or needing end of life care. Many may not be physically able to do so. Having looked after their partners, and now widowed these elderly women will have no-one at home to care for them. The CCG has failed to assess the disproportionate and therefore discriminatory effect on women living within the catchment area.

The CCG has not considered these factors which are very relevant in an area with a high elderly population.

BED OCCUPANCY

CCG figures.
It is accepted that there was an under occupancy of the beds at Rothbury Community Hospital, principally between 1st April, 2015, and 31st August, 2016.

The Consultation Document suggests that the reasons for this are:

- medical advances
- the opening of the new Northumbria Specialist Emergency Care Hospital at Cramlington in June, 2015
- greater use of home care.

However, if those were the sole reasons for a reduction in the use of the beds at Rothbury**, those same reasons should have resulted in similar percentage reductions at Alnwick Infirmary and the Whalton Unit (Morpeth).**

According to the statistics provided on page 14 of the Consultation Document, the converse was true.

September	2015	2016
Rothbury Comm. Hosp	38.9%	
Alnwick Infirmary	89.8%	95.3%
Berwick Infirmary	74.9%	65.0%
Whalton Unit (Morpeth)	67.6%	72.7%

In September, 2015, the bed occupancy at Alnwick Infirmary was 89.8%, but had risen to 95.3% by September, 2016.

Similarly, in September, 2015, the bed occupancy at the Whalton Unit was 67.6%, but had risen to 72.7% by September, 2016.

The criteria relating to Step Up and Step Down patients are broadly the same at each of the three hospitals, yet one has experienced a reduction in work load, whilst the other two have seen an increase, despite the improvement in medical treatment and the opening of the Cramlington Hospital.

Safe bed occupancy.
It is recognised within the NHS that the safe average for bed occupancy in community hospitals is 85%. The Community Hospitals Association Research & Media paper of 5th March, 2017, puts such an average at only 80%.
Yet Alnwick Infirmary has consistently been running its beds in excess of these percentages.

Indeed, it is known that, during some of this consultation period, its 30 beds have been wholly occupied.
Why the under-utilisation?
There must, therefore, be other reasons why the use of the beds at Rothbury Community Hospital declined during 2015 and 2016.

Confidential evidence received by the Team has indicated that the criteria for admission as a patient at RCH have been too strictly applied and that this has resulted in patients, who otherwise would have been accepted at Alnwick Infirmary (which is Consultant led), not being able to receive the same treatment at Rothbury. The Team holds a number of examples of where this has occurred.

On 24th February, 2017, a reply to a FOI request stated that '*the average length of stay in a community hospital is 29 days'.* The Community Hospitals Association, however, put such a stay, on average, as 28 days.

The reply also stated that the average length of stay in the Rothbury Community Hospital during 2015 was 15 days.

It is difficult to accept that the standard of care in Rothbury Hospital was perhaps so much better than elsewhere in 2015 that on average its patients could be discharged in only 15 days.

The questions which arise are:

1. Were too many patients being initially excluded from receiving care at the hospital?
2. Were only patients who were in less need of step down care being admitted?
3. Were some patients being discharged too early?

If the answer to one or more of these questions is in the affirmative, then clearly that would have had a major impact on the rate of bed occupancy which would normally have been anticipated in such a hospital.

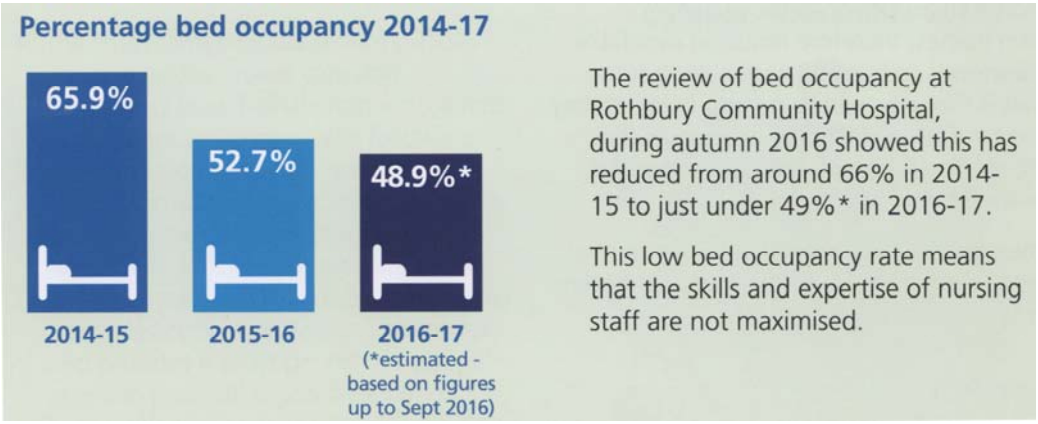
The CCG itself cannot absolve itself from the low bed occupancy rate at the hospital.

It is clear that it had the monthly figures for the bed occupancy rates during 2015 and 2016, as some are referred to in the Consultation Document. It should therefore, have been aware of what was occurring at Rothbury over the whole period of seventeen months. Yet, apparently, it took no action to remedy the situation.

If it did know, but took no action, it was guilty of management ineptitude.

If it did not know, it was equally guilty.

There is some evidence to suggest that the CCG had not recognised the problem because, according to page 14 of the Consultation Document, it was not until September, 2016, i.e. after the use of the beds had been suspended on the 2nd of that month, that *'total community hospital bed occupancy was reviewed'* by the CCG. The green coloured paragraph on page 10 also states that *'the review of bed occupancy at Rothbury Community Hospital during autumn 2016 showed*……'.



Adjournment debate: Mr Phillip Dunne, MP.
These two published statements, however, contradict the briefing which was given to Mr Phillip Dunne to enable him to reply in the adjournment debate on 9th March, 2017. Mr Dunne said that the steering group *'to consider the use and function of community hospital beds in Northumberland'* **was established in July, 2016**. The Consultation Document itself also contradicts the two statements on pages 14 and 10, for on page 9 it declares that *'during the summer 2016 we set up a steering committee to look at how beds are being used in community hospitals across Northumberland'*.

When asked clear questions at the public meeting on 30th March, 2017, Dr Alistair Blair either could not or would not say what research had been done by the CCG into bed occupancy prior to the suspension of the use of the beds on 2nd September, 2016. He persisted in only talking about work which he claimed had been done after that date, but, despite the obvious annoyance of the audience and being asked repeatedly for an answer relating to the period prior to 2nd September, he continued to avoid making any answer.

The only conclusion to be drawn, in the light of known events and of his failure to respond to a straightforward question, is that **nothing was done to identify and correct the under-utilisation of the beds until after a decision had been made to suspend their use**.

It seems to be clear that, whenever the steering group was established, its creation was not merely as a result of known low bed occupancy at Rothbury, but was probably connected to wider national policy issues.

The CCG must, therefore, bear responsibility for the situation in which the hospital, the patients, and the public now find themselves, as it seems that it probably did not identify and deal with the under occupancy of the Rothbury beds over a protracted period.

Bed management.
It is also apparent that the Northumbria Health Trust has not managed the staff resources at the hospital in a proper manner. Answers given by Dr Blair at the public meeting on 30th March, 2017, revealed that sufficient training had not been given and there had been no rotation of nursing staff around hospitals to enable them to obtain wider experience.

He claimed that certain patients could not have been admitted to the Rothbury Hospital because of the lack of skilled staff, **but that surely was the fault of the NHC Trust and not of the patients or the public.**

It is noted that the efficiency section of the three E's test under Option 1 states:

'Bed usage will remain low therefore beds likely to be over staffed'.

This is a dogmatic statement. If properly managed, the hospital can be made to run efficiently and at the right occupancy rate. New admission criteria and

digital beds data mentioned below, coupled with oversight by doctors, would solve the under-utilisation problem in the future. Thus, the dogmatic statement is a *non-sequitur*.

Also, no consideration has been given to a likely additional use of the beds because of a growing population and of the forecast rise within that population of the number of people aged 65 or more.

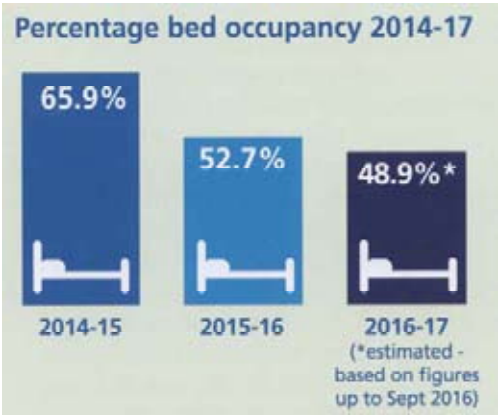
Given that the bed occupancy rate in community hospitals should normally be 80% or 85% and that Rothbury Community Hospital has twelve beds, ten of them should usually have been filled.

However, it is perhaps somewhat unfair only to consider occupancy on the basis of percentage.

For example, if a thirty-bed hospital has 3 beds or 6 beds empty, it records an occupancy rate of 90% or 80% respectively. But if a 12-bed hospital fails to use 3 or 6 beds, it has an occupancy rate of only 75% or 50% respectively.

30 bed hospital	**Occupancy**	**12 bed hospital**	**Occupancy**
3 beds empty	90%	3 beds empty	75%
6 beds empty	80%	6 beds empty	50%

The figures shown on page 10 of the Consultation Document establish that in 2014/15 on average eight of those ten beds were always occupied.



In 2015/16 and in the first five months of 2016/17 six of those ten beds were usually in use, but ironically in August, 2016, the month before suspension, the figure reached 8 beds.

The Whalton Unit (Morpeth) has thirty beds. Page 14 of the Consultation Document gives the occupancy figures for that Unit in September, 2015, and 2016.
In both cases, they show that twenty-one of the thirty beds were in use.

This is the same rate of occupancy as the Rothbury Community Hospital throughout 2014/15.

Yet the use of beds at the Whalton Unit has not been suspended and there are no proposals to close them permanently. **It follows that about a 70% occupancy rate is acceptable to the CCG, whether that is at the Whalton Unit or at Rothbury.**

It further follows that the only reason for citing a low bed occupancy rate at Rothbury as one of the two principal reasons for bed closure is the reduction over a seventeen-month period of their use from eight to six, a difference of only two beds.

The probable reason for this reduction has already been addressed and can be solved without resorting to total bed closure.

It is obvious that such a trend can and should be easily reversed by a more realistic admission and discharge policy under proper control. It is noted that the CCG has recently indicated that it is *'developing clearer criteria around the use of beds at community sites to ensure consistency of use'*.

It is also noted that the CCG is *'improving bed management across the system with a new digital solution which will show live bed data at any point of time*'.

The Team welcomes both of these recent announcements.

Of course, had both the criteria and the digital bed management system been in place during 2015 and 2016, the problem of bed under occupancy at Rothbury would not have arisen. The Team had already identified these defects in relation to the situation at Rothbury before this announcement was made by the CCG and has outlined them above. The fact that the CCG has now also recognised them confirms and strengthens the evidence adduced by the Team to illustrate how the problem arose.

It is clear that, if the beds are restored, they can and will be operated fully and properly within the terms of the new criteria and digital system.

Also, and importantly, it is clear that Rothbury, as other community hospitals, should on occasion have spare bed capacity.

Proper daily liaison with other hospitals would result in spreading the burden of care between them. **It is ridiculous that Alnwick Infirmary is consistently functioning at over the 80% or 85%, and is usually at 95% or 100% of the recognised safety level, when there are available beds at Rothbury.** An appropriate transfer of two or three patients from Alnwick to Rothbury would ease the burden at Alnwick Infirmary and utilise staff skills more at Rothbury. If this were done on a regular basis, both hospitals would be functioning within accepted guidelines, but each would still usually have a small amount of spare

capacity to enable them to deal with contingencies. The new digital system will enable this to happen.

This approach is clearly illustrated by the following example.

Recent example.
In February, 2017, a member of the Team was admitted to Cramlington Hospital. Whilst there, an 87-year-old gentleman from a coastal village was due to be discharged to a step-down hospital. There was no bed available at Alnwick, or presumably in the Whalton Unit, and he was offered a bed at either Berwick upon Tweed or North Tyneside. He and his wife were distraught, as visiting would have been impossible at either hospital. The Team member persuaded the staff to defer the decision to the next day when, fortunately, a bed became available at Alnwick.

Of course, had patients from the Rothbury area not been using beds in Alnwick, but had been cared for at Rothbury, this stressful situation would not have arisen, as there would have been spare capacity at Alnwick Infirmary.

Also - had the patient lived in Rothbury - he too would have been offered a bed at either Berwick upon Tweed or North Tyneside. He would have been isolated over thirty miles from home in a place which has no suitable public transport connection.

This is the kind of problem which is being, and will be, encountered in the real world, but is not recorded in official figures and which can be avoided or mitigated by sensible planning and provision.

NHS official figures for Northumberland reveal that there is some ‘bed blocking’ in its hospitals.

Delayed transfers to non-acute hospitals

- 7 in October 2016
- 5 in November 2016
- 7 in December 2016
- 5 in January, 2017.

These had been rising over the months since the beginning of the year 2016/2017.

The figures for three of these four months accounted for over 50% of all the delayed transfers, i.e. those described in the statistics as non-acute hospitals, public funds, residential care, nursing care, care at home, and patient choice. Indeed, in January, 2017, the total of all such delays amounted to 12 compared to a sum total of only 1 in May, 2016. These increases in delays jumped suddenly in October, 2016, i.e. in the month immediately following the suspension of the use of the beds at Rothbury.

Had the Rothbury beds been available during those months, more patients could have been transferred there and that hospital would have been operating at almost full capacity.

Community nursing and short term support service.
The figures relating to community nursing and short term support service referrals which are outlined in the Consultation Document on page 11 also need comment.

The increase in the number of community nurse face to face contacts appears to be considerable when expressed in yearly terms, rising from approximately 6,500 in 2013/2014 to 7,500 in both 2014/2015 and in 2015/2016.

However, those figures convert into approximately 18 rising to 20 visits per day in 2014/2015 and 2016/2017 respectively and they seem to have levelled out.

The Consultation Document does not indicate whether the figures for total visits relate to all the community nurses working from Rothbury, or whether they are the average number of visits per nurse.

It is understood that in March, 2017, the CCG received a consultants' report on the work undertaken by community nurses in the Hexham area. That report indicated that **each nurse was contracted to undertake a minimum of eight visits per day, but that each was doing on average twenty visits each day and was working at maximum capacity.** The Rothbury area is similar to the rural area around Hexham and it appears, therefore, that the five nurses based at Rothbury are each undertaking a similar work load of about 20 visits per day. If that increases, then extra staff will be needed.

There is no evidence that there has been any significant increase in this workload since the opening of the Cramlington Hospital in June, 2015. The figures quoted in the Consultation Document show an increase of only 131 visits in the year October 2015 to September, 2016, or one extra visit every two days.

Also, there has been no attempt to illustrate how many of these patients would have become patients in Rothbury Hospital had they not received community nursing at home. It may be the case that none of these would have been admitted as step down patients, but that all were actually discharged to their homes in the normal course of events.

More home nursing may have arisen in the later years because of a general increase in overall workload caused perhaps by an increasing or ageing population.

Suffice it to say that it is apparent that the figures do not give any reliable evidence on the question of bed occupancy or the need for inpatient beds.

The figures relating to short term support also do not help us. The increase in therapy referrals was 3.5 to 4 per week. Referrals for care rose from 1.5 to 2 per week.

The chart showing the number of people living in the Rothbury area and receiving home care is also misleading and unhelpful. Care at home is provided either by the NCC or by the CCG. The figures given do not show how many of these people received their care from each. Without knowing the extent of the CCG's involvement, it is impossible to form any opinion on whether or not such care has any bearing on bed occupancy in the hospital.

So, we see that all the statistics produced in relation to community services are either inconclusive or of minimal effect and cannot be given any weight.

Very recent national reports have established that 900 staff are leaving home care services throughout the United Kingdom each day and that there have been over 23,000 recorded cases of abuse of patients by carers over a six-month period. The system is at breaking point now. **Yet it is into this worsening and unacceptable system that the CCG wishes to release more patients, many of whom are elderly**.

HEALTH AND WELLBEING CENTRE.

Definitions.
The term 'Health and Wellbeing Centre' is capable of meaning anything to everybody, but nothing specific to anybody. The Consultative Document does not seek to define what it actually is.

Firstly, it refers to the commitment of the Northumbria Trust and the Rothbury Practice to relocate the latter within the ground floor of the hospital. But there is no certainty at present that this will definitely occur. If that relocation takes place, it will do so whether or not there are twelve inpatient beds with offices and facilities for nurses at first floor level. **The proposed move of the doctors' practice has, therefore, nothing whatsoever to do with the proposed permanent closure of the beds**.

Most of the other existing uses at ground floor level, namely accommodation for the paramedic, for physiotherapy, and for the usual clinics, will also continue mainly on the ground floor. Only the community nurses will be moved to an unused room at first floor level.

So, the only possibilities of other future activities at the hospital are said to be:

- more physiotherapy
- more outpatient clinics
- a video link to a specialist.

None of these are definite. They may or may not happen.

A *requirement* for more physiotherapy has not been shown in the Consultation Document. No work has been done to show what services would be provided and how often they would be available.

Answers to questions at the public meeting on 30th March, 2017, revealed that no specific outpatient clinics have even been discussed and, therefore, they have not been identified or costed. No actual need for them has so far been shown.

A video link to a specialist can only be provided if a number of different specialists also possess the same facility in various hospitals. It is submitted that, if in future such provision can be made, it will be on a wide scale and the links to those specialists will be via equipment in doctors' surgeries throughout the whole of the county. The service will have no connection with the concept of health and wellbeing, but will be a standard use of the technology throughout general practice within the area of the CCG. Again, it has no bearing on the proposed closure of beds.

It should be understood that, if the beds are closed permanently, most of the first floor of the building will be empty. Is it realistic to believe that twelve separate and purpose built rooms each with en-suite facilities, two offices, and other rooms will all be put into use with the provision of new NHS services? It is obvious that at best only a fraction of this accommodation will be used. If full use is being sought, it will be necessary to make structural adaptations.

Any such adaptations and any use of the existing accommodation for new services will result in cost, as yet totally undefined.

Consequently, **as nothing certain or relevant is put forward by the Consultation Document within Option 5, there is nothing upon which to comment.** The allusion to a Health and Wellbeing Centre is irrelevant and meaningless at present. It merely changes the name of the building *from Rothbury Community Hospital* to *Rothbury Health and Wellbeing Centre*, but puts absolutely no guaranteed new services back into the premises to replace the community hospital beds.

Indeed, it is clear that the CCG has no positive idea what is meant by a Health and Wellbeing Centre in the context of the premises built and known as Rothbury Community Hospital. Dr Alistair Blair, has recently attempted to bolster the concept of such a centre by writing in the parish magazine, Over the Bridges, and by speaking to the press.

He said:

"*We heard a lot of comments about the proposal, particularly around the inpatient beds and the need for respite care provision in the community. Some people also shared their ideas about the kind of services we might include in a Health and Wellbeing Centre, for example, chiropody and eye care services*

and more services for children and people with mental health conditions".

By the word 'we', he meant the CCG.

Such comments are aimed at suggesting that the CCG might provide these expensive and specialised services if the inpatient beds are closed permanently and as such are pure 'spin'.

The provision of such services is not mentioned in the Consultation Document and they are not currently on offer to the public by the CCG.

Dr Blair knows that respite care is not offered or funded by the NHS. Indeed, that fact is mentioned in the blue coloured paragraph on page 19 of the Consultation Document. It is disingenuous of him to refer to it in such a way in order to seek to persuade the public that it may become available if the beds are permanently closed.

> **We also acknowledge that some people feel strongly that there should be some provision for respite and end of life care in Rothbury and that they have already described potential models. Respite care is not provided or funded by the NHS and experience shows that very few end of life care beds would be needed. However, as the consultation progresses, we would be very keen to hear more from people about how they think we could develop a community based service which would provide beds for patients requiring these types of care.**

The fact that such tactics are being employed suggests that the CCG is aware that there is no public support for its proposal and that, consequently, it is endeavouring to suggest that perhaps other service inducements might be available.

The truth is that the CCG has no idea at present what to do with the bulk of the first floor of the hospital building, if the beds are closed permanently. If it had, it would have said so positively in the Consultation Document. It would have specified what the new services would be and would have costed their provision. If that had been done, the public would have known exactly on what they were being asked to comment.

The public, however, is being asked to support and agree to something which is undefined and uncertain and to accept either a non-use or an unidentified use of parts of the building in place of the well-known and much appreciated service which has been provided by the hospital for over a century. Such a leap into the dark is unacceptable.

NHS RULES REGARDING BED CLOSURES

New conditions.
From 1st April, 2017, CCGs are required to show that proposed hospital bed closures which are the subject of formal public consultation meet one of the three following conditions before approval can be given to proceed:

1) Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or

2) Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or

3) Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care.

Mr Simon Stevens, the NHS England Chief Executive, when speaking at the Nuffield Trust Health Policy Summit before introducing the above changes, is reported to have said:

"*Hospitals are facing contradictory pressures. On the one hand, there's a huge opportunity to take advantage of new medicines and treatments that increasingly mean you can be looked after without ever needing hospitalisation. So of course, there shouldn't be a reflex reaction opposing each and every change in local hospital services.*

But on the other hand, more older patients inevitably means more emergency admissions, and the pressures on A & E are being compounded by the sharp rise in patients stuck in beds awaiting home care and care home places. So, there can no longer be an automatic assumption that it's OK to slash many thousands of extra hospital beds - unless and until there really are better alternatives in place for patients.

That's why before major service changes are given the green light, they'll now need to prove there are still going to be sufficient hospital beds to provide safe, modern and efficient care locally."

This change to the rules relating to hospital bed closures is fundamental to the CCG's current proposal.

Both the announcement and the implementation of the new rule occurred during the current consultation period and it is obvious that the CCG has not addressed any of the three alternatives in its Consultation Document.

There is no evidence to show that there will be increased GP or community services in place before bed closures and that a new workforce will be in place to deliver them.

Indeed, it is understood that in March, 2017, the CCG received a consultants' report on the work of the community nurses in the Hexham area. This had been commissioned to assess current workloads and the likely future pressures on the service in ten or twenty years' time arising from a growing and ageing population. The report is understood to have concluded that currently each nurse is struggling to deal with a work load of about twenty visits each per day, the service is at breaking point, and in future will not be able to cope.

It is obvious that in the future a like situation will apply in the similar rural area of Rothbury. **Yet the CCG, in the full knowledge of the content of its own consultants' report, is still maintaining that the Rothbury beds are not needed because of an increase in community nursing and that this will continue to be the situation.** It has not examined and has ignored the known demographic trends, and believes that the hospital beds will not be needed over the next twenty years.

Honesty?
At the public meeting held on 30th March, 2017, Dr Alistair Blair (who said in the Consultation Document "*we want to be honest with local people*") had an opportunity of telling his audience what the true position on community nursing in the future is likely to be, but he failed to mention it.

Also, the Consultative Document does not mention any specific new treatments or therapies.

Nor does that Document put forward any credible plan to improve the performance of the beds without affecting patient care. Indeed, the very opposite solution is advanced.

The CCG is thus debarred from making a decision to close the beds at the Rothbury Community Hospital following the consultation period, as it has not consulted the public in its Consultation Document on any aspect required by the three alternatives set out in the new rule.

If it attempts to do so, then **its decision to close the beds will be liable to challenge by way of Judicial Review.**

Flawed consultation.
Consequently, it is submitted that, if the CCG wishes to continue with its intention to close those beds, it must start the whole consultation process afresh. In a new consultation, it will have to provide evidence to show that its intention complies with the new current rules and that the public have had an opportunity to scrutinise and comment upon that evidence.

When questioned on this new NHS rule at the public meeting held on 30th

March, 2017, Dr Alistair Blair maintained that it did not apply to the current proposal of the CCG to close the Rothbury beds permanently. He said that it only applied to hospitals where there was full use of beds, but not to a situation where beds were being under used.

This statement must surely be regarded as nonsense.

It is worth repeating that Part 3 of the rule states specifically and unequivocally that a CCG must show ***'where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care*'.** The use of the beds at Rothbury has been less than the national average and no credible plan has been produced by the CCG to improve performance there without affecting patient care.

Reopen, or continuing suspension of the beds?

The question of the continuing suspension of the use of the beds now arises.

The original reason for a temporary suspension was because of their under-utilisation. There is no doubt that unfortunately in September, 2016, the CCG had power to do so.

This has led to a suspicion that the three-month suspension of the beds was a deliberate ploy which was used in the hope that, if a consultation period subsequently followed, they would be out of use for up to or more than a year. If so, that might then enable the CCG to assert that the service had managed adequately during that period and that consequently the beds were not needed.

The result has been that both the Alnwick Infirmary and the Whalton Unit have been functioning in excess of the safe occupancy rate of 85%. This is not 'managing'. It is irresponsible, especially given the amount of housing development which is in prospect and which can only result in a worsening situation in those hospitals.

However, had the current rules been in place at that time, it could not have suspended their use, but would have had to prepare a 'credible plan to improve performance without affecting patient care'.

Given that the CCG should now start the whole consultation process anew, it must do so in accordance with the rules which currently apply. That means that the CCG must prepare a plan which does not affect patient care. But patient care at Rothbury has been adversely affected for local people and it should be restored. It behoves the CCG 'to prove that there are still sufficient hospital beds to provide safe, modern and efficient care locally', i.e. in the catchment area of the hospital.

That means that, for patients in the extensive rural area shown on the map on

page 6 of the Consultation Document, the Rothbury Community Hospital beds must be useable now and not possibly at some time in the distant future.

The power to suspend the use of beds temporarily was really available to CCGs to enable them to take action in short term emergency circumstances, such as unexpected staff shortages. It was never intended to enable the effective long term closure of beds and thus to manipulate consultation procedures.

The decision.
If the CCG wishes to attempt to decide to close the Rothbury beds permanently, that decision cannot be made until June, 2017, at the earliest and, therefore, the beds will have been unused for almost a year.

If the decision is to open a new consultation period, but to leave the beds closed during it, they will have been out of use for more than a year. Such an approach would be completely against both the spirit and the intent of the new rules.

It is clear, therefore, that the beds should be reopened with immediate effect and that a decision about their long-term use should be made in due course in strict accordance with the current rules.

The Save Rothbury Community Hospital Campaign Team's view.
The Team insists and expects that, without wasting further large amounts of money on more consultation, it would be far more sensible for the CCG to accept the collaborative solution which is put forward later in this Statement.

Such a way forward would also be wise because of the impending involvement of the Care & Wellbeing Overview and Scrutiny Committee of the Northumberland County Council. We believe that it is highly unlikely that the Committee could give the CCG's current proposal support, given both the NHS's new rules on bed closures and the numerous weaknesses which have been exposed in the Consultation Document.

Similarly, it seems inconceivable that subsequently the Joint Locality Executive Board and the governing body of the CCG could or would endorse a decision which had been made contrary to the rules which have been laid down by the NHS itself and, by doing so, would render themselves also liable to challenge.

COMMENTS ON THE CONSULTATION DOCUMENT AND THE PROCEDURE

The process itself.
The process of consultation is unsatisfactory and defective in relation to proposed bed closures and needs to be reformed.

At present a CCG, under the umbrella of the NHS, is the prosecution, judge, jury and executioner, and the defence has no right of audience. A CCG is able to pay lip service to the procedural rules which it is supposed to follow. The information it gives can be limited or partial and it can ignore any publicly voiced opinions or any factual evidence put before it. There is no scope for early redress available to objectors. They have one opportunity to oppose a weak proposal and that single attempt can be utterly ignored.

A far more open and fair system is necessary. This should give the objectors the opportunity of appearing before an independent inspector at a Public Inquiry where the proposal of a CCG can be properly tested by cross examination and where evidence can be adduced to counter it.

The following comments will demonstrate the unsatisfactory nature of consultation on the proposal to close beds at Rothbury.

The Consultation Document is 24 pages long, but is lacking in substance and objective factual evidence.

Page 9 gives the reasons for suspending the use of the beds as:

1. *medical advances which are reducing the length of stays in hospital*
2. *national and local policy to reduce admissions to hospital and discharge patients home as soon as possible*
3. *financial and operational pressures in the health and care system*.

These reasons are NHS mantra.

Medical advances have been taking place gradually over many years. The actual need for beds in community hospitals did not suddenly cease with the issue of the 'Five Year Forward View'. And this **did not give carte blanche to close community hospital beds either temporarily or permanently**. Such action should only be taken after full consideration of all the local circumstances, including location, population make up, need, facilities, true cost, travel, and the wishes of the population.

No consideration was given to such factors before the suspension occurred.

Indeed, the above detailed analysis in this Statement has revealed the paucity of consideration given to them in the Consultation Document itself and this is emphasised by the following brief examination of its overall content.

The Consultation Document.
Page 1 is a photograph of the hospital. Page 2 describes the CCG. Page 3 is an index. Pages 4 and 5 give a general introduction, all of which is repeated elsewhere.

Page 6 gives a thumbnail sketch of the work within the building prior to September, 2016, and contains an incorrect diagrammatic map of the hospital's catchment area.

Pages 7 and 8 outline the availability of care by doctors, lists the types of patient who are unsuitable for admission to the hospital and lists the other services which are currently within the building. All of these are unaffected by the proposed closure of the hospital's beds.

Page 15 lists some of the concerns raised by local people, principally at the public meeting in November, 2016. However, these have clearly been disregarded, as none are acknowledged as relevant. We find that only Option 5, namely permanent closure of the beds, has been put forward for consultation.

Pages 16 and 17 outline Options 1, 2, 3, and 4, but, as none have been presented for consultation, they are all irrelevant.

Page 21 describes how the public's views can be made known.

Page 22 describes the steps which will occur after the consultation period.

Page 23 lists the public events.

Page 24 gives the CCG's address.

The whole of the CCG's case for putting forward Option 5 is, therefore, contained within small parts of nine pages of the Document.

Page 9 admits that the beds were closed temporarily in September, 2016, before a '*thorough*' review was carried out. The absence of such alleged 'thoroughness' has been revealed in the topics dealt with above.

Page 10 only puts forward a chart of bed occupancy and gives the percentage of emergency patients who were discharged directly home from Cramlington Hospital during its first year of operation. These figures have already been analysed fully above.

Page 11 gives the number of face to face community nursing contacts and short term support service referrals over a period of three years and five months. These too have been analysed and discredited above.

Page 12 shows the number of people receiving home care during those years.

Again, these figures have been examined and questioned above.

The CCG depiction of end-of-life care.
Page 13 is subjective. In a chart, it purports to show a declining number of deaths in Rothbury Community Hospital and, as a result that there is a reduced need for beds there.

This is a completely false premise which is based solely on the fact that in 2015-2016 there were 14 deaths there and between 1st April and 31st August, 2016, there were 9 deaths compared with totals of 19 and 20 in 2013-2014 and 2014-2015 respectively.

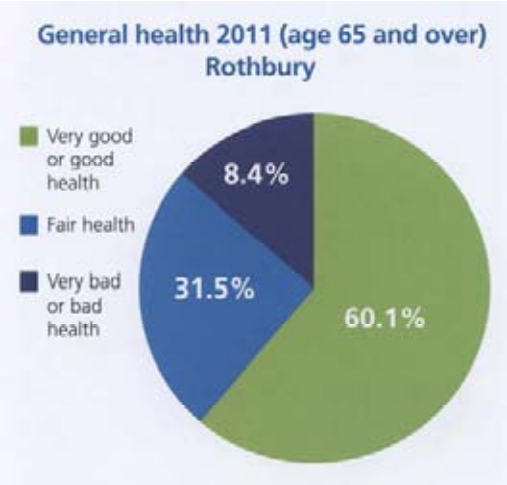
It is, of course, impossible to forecast precise death rates in any year. However, as the CCG has attempted to show a trend, it is appropriate to show the reality of the figures upon which it relies.

In five months in 2016-2017 there were nine deaths. If this was a trend which was expected to continue, then over a full period of one year a total of 22 deaths would have occurred. **In other words, there would have been more deaths in the hospital in 2016/2017 than in any of the three previous years and, consequently, it is wrong for the Document to conclude a decline in hospital death rates. It is a fake statistic.**

So, page 13 can be ignored as both irrelevant and inaccurate.

ONS estimates
Page 14 gives the ONS estimates for percentage increases in the aged population over the ensuing ten and twenty years. A detailed projection of these has been produced above by the Team, whereas the Consultation Document is silent.

The page, however, also purports to show the general health of people resident in Rothbury in 2011 who were aged 65 and over.



CCG health figures 2011	
Very good and good health	60.1%
Fair health	31.5%
Very bad or bad health	8.4%

An examination of the 2011 census for Rothbury has, however, revealed that these figures are wrong.

Corrected health figures 2011	
Very good or good health	80.5%
Fair health	15%
Very bad or bad health	4.5%

The Team cannot understand why any such figures are even shown in the Consultation Document. An individual's view of his or her personal health is subjective and, in any event, has no bearing on whether or not beds are needed in the community hospital. **Therefore, this is another fake statistic.**

The page also touches upon the perceived impact of the closure of the beds across the system and outlines the staff working at the hospital. These matters have already been dealt with in detail in this Statement.

Page 18 mentions some possible future uses for the building, but makes no commitment to any of them.

At long last on that page the annual financial saving to the CCG is said to be £500,000. Earlier analysis has refuted this.

Page 19 merely sets out the precise proposal which is the subject of consultation.

So it can be seen that the 24-page Document scarcely mentions any fact. There is much opinion and subjective comment, but little accurate or reliable detail. Most of the statistics which have been advanced either do not bear objective scrutiny or are capable of a different interpretation, or bluntly - are fake. Much of the nine relevant pages can only be described as packing.

Page 16 states that a second assessment was carried out focussing specifically on the requirement for CCGs to ensure efficient, effective and economic use of resources (the three E's test). The tables showing the assessment of the efficiency, effectiveness and economy of the five options considered by the CCG can only be viewed in a table on an internet site.

All that is claimed in that table in relation to efficiency of the Option 5 proposal is:

'Nursing staff able to be dispersed to areas of need within the health economy'.

This assumes that there is no need for nursing staff in the Rothbury area, which is not accepted.

The suspension of the use of the beds has been so efficient that some of the Rothbury staff are now either ill, or have retired, or have left the health service.

The Table defines 'Effectiveness' as:

'Evidence suggests that hospital care carries more risk than care at home. Some examples are an increased risk of hospital acquired infections, risk of undermining confidence and immobility'.

There is no evidence that this has been the case at Rothbury. The three E's document itself states in Option 1 that there are *'no issues with quality of patient care'* at the hospital.

Surely the fact that each Rothbury bed is in a separate room with its own facilities reduces the chance of a hospital acquired infection.

The '*Effective*' section to Option 5 continues:

'The low utilisation of the ward beds is a positive reflection to the significant investment to developing integrated community teams who can keep people well and safely looked after at home. In order to further support and develop out of hospital services a local office base and increase in outpatient activity as appropriate would enhance the community based offer to the people of Rothbury'.

It is unsurprising that such an incomprehensible mauling of the English language does not appear on the face of the Consultation Document itself. The words can only be described as gobbledygook. They do not provide any confidence in the effectiveness of the proposal.

The '*Economic*' section of Option 5 states:

'Closure of the beds would release a cost saving'.

As shown above, that statement has not been proved by the CCG. Even if there is any saving, it has not been properly quantified, and indeed the only amount which has been put forward has been shown to be wildly incorrect.

It continues:

'Shape existing health and social care services around a health and wellbeing centre would ensure the long-term lease would deliver value for money'.

Surely this cannot be a serious proposition! The Private Finance Initiative loan has fifteen years to run and is likely to cost perhaps in the region of ten million pounds over that period. Can it really be said that a totally undefined use of the available space in the building at first floor level will give such value for money?

The section continues by referring to the application for funding which has been made to enable the Rothbury Practice to move to the ground floor of the hospital building. **This has nothing to do with the proposal to close the beds.** All the discussions which have taken place over two and a half years have been on the basis that the hospital beds would continue on the first floor and the doctors and other existing uses would be based solely on the ground floor.

This section of the test is, therefore, irrelevant.

The section then continues:

'The CCG would make an annual saving of £500k which NHCFT have calculated as the staffing costs for running the 12 inpatient beds'.

This figure of a net saving of £500,000 has not been 'calculated'. Had it been, it would have been accurate. However, it is merely a crude guess and has been discredited in this Statement. It is just a repetition of the figure appearing on page 18 of the Consultation Document.

Lastly the section declares:

'Any increase in activity within community services would be cost neutral due to the contractual framework in place'.

No specific contracts are mentioned. No amounts are referred to. The community services are not identified. The paragraph is thus meaningless**. Such general statements cannot be accepted as a rigorous separate assessment of economy**. The statement is no more than unexplained words.

At the public meeting on 30th March, 2017, Dr Alistair Blair said that the CCG's proposal "*could not be signed off if it does not comply with the three E's test*".

The above comments have demonstrated that the test which has been carried out is a farce. There has been no critical scrutiny of the proposal and no accurate or sensible statements made relating to efficiency, effectiveness or economy.

It appears from the table that, on the face of it, the requirement to undertake an

assessment has been carried out. However, in reality a true separate and independently assessed document has not been prepared.

As a result, the processing of the CCG's proposal is flawed and is again open to challenge by way of Judicial Review.

The questionnaire.
The questionnaire issued with the Consultation Document contains many questions which invite answers which are impossible to give definitively or which can only be used as support for the CCG's case. Many questions are incapable of proper statistical analysis.

For example, Question 19 asks for a view on the CCG's proposal to reshape services around a Health and Wellbeing Centre. This is incapable of being answered, as nobody knows what is meant by that term.

Questions 20 and 24 refer to physiotherapy and a possible video link. However, no information is given about the extent of such mooted services or their need when set against the requirement of hospital beds. Nor is there any indication given about the number of people who have enquired about such services.

Question 26 has no bearing on the issue of bed closure. Respite care is not available as an NHS service. Answers suggesting a need for this can be interpreted as demonstrating that the public consider respite care to be more important than community hospital beds.

Question 27 refers to end of life care. This question puts the cart before the horse. It presumes that the community beds will be closed and, therefore, that end of life care will have to be provided elsewhere in this area. It also indicates that the CCG has no idea how such care should be provided, although the Consultation Document hints at greater use of charities.

The simple fact is that the Rothbury Community Hospital has always provided end of life care and that there is and will be a continuing need for that. There will always be patients who require end of life care in hospital because of the nature of their condition or because of their particular home circumstances.

Consequently, the question answers itself. The beds should be retained.

Question 28 is a ‘fishing question’. Detailed costed answers cannot be given by members of the public, but any answers provided can be said to have been considered, but rejected as unviable, thus allegedly strengthening the CCG's policy.

Question 29 is also disingenuous. Any sensible person is likely to agree strongly with the concept of efficient use of available resources, including staff and money.

However, the nub of the question is precisely how that efficient use is achieved. **The proposal put forward by the CCG is not the most efficient use and it should not, therefore, be assumed that anyone strongly agreeing with this question is supporting and endorsing it.**

The same comments also apply to Questions 31 and 33.

Question 33 should not be asking whether more care should be provided at home. It should be asking whether care should be provided at home or in hospital as medically appropriate in individual cases.

Questions 35 and 36 on personal health and ethnicity are irrelevant. A person of any ethnicity who is healthy today may need a hospital bed tomorrow.

The Team is concerned that the tenor of the consultation has been that of a sham.

The views of over 5000 people as expressed in a petition, the hostility shown at the public meeting in November, 2016, and the opinion of the Rothbury Practice were all ignored prior to consultation being opened with a view to closing the beds permanently.

The questionnaire is a document which has been drafted to suit the case propounded by the CCG.

Consequently, in view of the 'spin' issued by the CCG through the press and the slanted content of the questionnaire, the Team requests that the detailed responses to it be published and released for scrutiny and, in particular, that the number of people who have responded with support for the proposal to close the beds should be cited.

It is questionable whether real consultation has taken place. The fact that public meetings have taken place and a questionnaire has been issued may tick the box which calls for consultation, but has it been genuine and meaningful? If it is considered not to have been for all the reasons expressed in this Statement, then the CCG is also open to challenge by way of Judicial Review.

The Team has been able to reveal in this Statement that the CCG has failed in their proper and appropriate consultation:

Failed during 2015 and 2016 to identify the low bed occupancy at the Rothbury Community Hospital,

Failed to take any action to remedy that situation,

Failed to carry out a survey of bed occupancy at all community hospitals before suspending the use of the Rothbury beds,

Failed to calculate staff salaries accurately,

Failed to take into account the value of the proposed relocation of the Rothbury Practice,

Failed to consider the cost of the transfer of some nursing staff to the budgets of other hospitals,

Failed to assess the cost of additional community nurses and their travelling expenses,

Failed to consider the possibility of refinancing the Private Finance Initiative loan and its associated annual expenditure,

Failed to define accurately the notional catchment area,

Failed to carry out a study of likely population increases resulting from new planned housing development,

Failed to examine the likely percentage changes within an increased population by a demographic study,

Failed to carry out a transport survey,

Failed to undertake an Equality Impact Assessment,

Failed to define the term 'Health and Wellbeing Centre' and to cost its work.

Failed in their duty of honesty to the public to explain clearly that the primary care relocation is not part of option 5, but a completely separate development which has already undergone a separate public consultation process.

Failed to provide evidence of any strategy to fill the beds.

Failed to take into account the additional rule 5 with which there must be compliance before any bed closures can take place.

Failed to show any forward planning for any of the topics listed above.

Failed to take other broad social costs into account.

The Consultation Document is a catalogue of failure. It is an ill-prepared attempt to justify an ill-considered action. It is not fit for purpose and its content should not be relied upon.

The Team considers that no responsible public body should make any decision on the basis of the information contained in that Document.

THE ALTERNATIVES AND THE SOLUTION.

Co-operation and dialogue
Over recent years the ground floor of the hospital has been grossly under used. A relatively small area has been used as office accommodation for the community nurses and the paramedic, and some rooms have been used for occasional clinics.

Also, at first floor level there are rooms which have not been used and which are not needed for the hospital nurses.

Such extensive under-utilisation of the building has not been caused by or associated with the use of part of the building as an inpatient hospital.

If the proposal of the CCG to close the hospital beds is adopted, one of two things will happen.

Either:

a) the Rothbury Practice will move to the ground floor of the building and share that accommodation with the paramedic and existing clinics, but the first floor will be largely unused,

or:

b) the Rothbury Practice will not relocate to the hospital premises, which will mean that the ground floor will continue to be grossly underused and the first floor will be completely unused.

In the circumstances shown at b) only a tiny part of the building will be used for the community nurses', the paramedic and for intermittent clinics. The remaining extensive bulk of the building will be unused.

The premises will thus become the most expensive office accommodation in Northumberland.

The CCG will, however, still be liable to make payments under the PFI loan and its associated liabilities for the next fifteen years. The annual payment is currently said to be £516,000, but this has been rising since 2012 when it was £464,000. The amount is set to rise considerably over the next fifteen years in accordance with the retail price index and, therefore, the total liability of £9,000,000, estimated by the CCG for the remainder of the term, is likely to be considerably higher.

The third choice for the CCG is to accept the following common sense solution which the Team puts forward below.

The consultation is only about the CCG's proposal to close 12 beds permanently in Rothbury Community Hospital and to shape existing (not new) health services around a Health and Wellbeing Centre.

Before the decision was made on 2nd September, 2016, to suspend the use of those beds, the CCG had already agreed that the Rothbury Practice should be relocated on the ground floor of the hospital. It had further decided that the other existing health services which are currently using accommodation on that level should continue to do so, but with the exception of the community nurses. The plans which have been submitted with the recent planning application confirm that that to be the case.

The Team accepts and approves these long-standing decisions.

There remains the question of which NHS services should be provided on the remainder of the first floor of the building.

The Solution which is put forward by the Team is an amendment to Option 5 and it can be referred to as **Coquetdale Cares – The Community's Vision (CC-CV).**

Save Rothbury Hospital Campaign:
Coquetdale Cares – The Community's Vision

This is basically a combination of the CCG's Options 1 and 5; an option which has not been considered yet by the CCG, but which has the flexibility of being able to add other services which may become required from time to time. The whole building would operate in an integrated way with all services having immediate access to each other in order to enable maximum efficiency, effectiveness, economy, and co-operation.

The general details of the ***Coquetdale Cares*** - ***The Community's Vision*** are as follows:

In view of the change in the NHS rules relating to any proposal to close beds in community hospitals, the 12 beds in the Rothbury Community Hospital should be reopened immediately.

The impending relocation of the Rothbury Practice should not prevent this from happening, as it has always been intended that the hospital should continue to care for patients while the structural alterations to the ground floor were being carried out.

It is sensible to use the twelve rooms containing the beds for nursing. They were built for that purpose and to seek to use them efficiently for other services would inevitably result in the need for costly structural alterations and the removal of the en-suite facilities.

Two offices used by the nurses would continue to be needed by them.

However, some changes would be necessary.

Firstly, once the Rothbury Practice is relocated, the new admissions and discharge policies and the digital bed data scheme, both recently specified by the CCG for community hospitals, should be supervised daily, not by nurses, but by doctors.

Secondly, the structure of the nursing establishment should be examined to ascertain whether any financial savings could be made.

Thirdly, staff should be given training and should be allowed to gain experience by rotating around other hospital wards.

There are two rooms on the first floor which should be considered for other future uses.

These are described on the recently deposited plans as 'Group Room Bev' (formerly as 'Staff Seminar) and 'Interview'. It would appear that there are other generous staff facilities and we question the need for an interview room, given the existence of a sister's office.

These could be made available for the other possible outpatient clinics referred to by the CCG in relation to Option 5, if needed and if funding becomes available.

It is considered that, if a video link is provided in the future, it should be located within the offices used by the Rothbury Practice.

There is also the possibility that the interview room could be used as office accommodation for social workers employed by Northumberland County Council, if further integration takes place between the local authority and the NHS for home and community care services.

The CC-CV option would bring together in one building the Rothbury Practice, the community nurses and services, a paramedic, existing clinics, 12 community hospital beds and staff, and possibly new clinics and a video

connection, and links with local authority social services.

The proposal is, therefore, comprehensive and flexible. It ensures the maximum integration of services within one building which is modern and purpose built. It is a vision which is ideal for the people of Coquetdale for the foreseeable future.

Given that the building would no longer be considered to be a hospital only, it would be appropriate to rename the premises as *'The Rothbury Health and Wellbeing Centre'* and it would then be seen as, and would in reality be, a hub for medical services covering a large part of rural Northumberland.

The Team is confident that, had the ***Coquetdale Cares - The Community's Vision*** been put forward by the CCG, it would have had the universal support of the 5,193 people who signed the petition protesting against Option 5.

The Team considers that the CCG should prepare a fully detailed plan for the building which addresses the clinical and social needs of all of the community both now and in the foreseeable future and which is capable of early implementation. The evidence put forward in the Consultation Document demonstrates unequivocally that Option 5 fails to do that, and that the health needs of this rural community are being placed second to any modest financial saving which may possibly arise from a permanent closure of the hospital's beds.

The CC-CV option, however, provides a firm and achievable basis for such a detailed plan.

The Team also submits that the way forward for the CCG is to carry out a detailed study and accurate costing of Options 5 and ***The CC-CV Option***, so that a true comparison can be made between the two concepts. The study and calculations should take into account fully all those factors mentioned in this Statement in relation to:

- finance
- demographic projections
- travel
- equality
- bed occupancy.

It is essential in that context that, if the CCG wishes to continue with Option 5, it specifies precisely how the twelve rooms containing beds and en-suite facilities, together with the nurses' two rooms and the other spare accommodation, are intended to be used, and that the cost of such use or uses be identified.

The Team considers that the CCG should not confirm the closure of the beds in Rothbury Community Hospital, but should establish a broad based working group made up from its officers, from representatives of the Accountable Care

Organisation when formed and, say, four members of the Team, with a view to identifying which of these two Options best optimises the use of the building and satisfies the needs and views of all patients, doctors, the CCG, the ACO, and the public of Coquetdale and of its vicinity.

Such an approach is in line with the thrust of Mr Phillip Dunne's comments in the recent adjournment debate when he said, "*Rothbury patients can help themselves by encouraging Northumberland's highly regarded health leadership to reshape services to provide a facility that serves more of the community than has been the case*".

He concluded his Ministerial reply in the adjournment debate by encouraging continued engagement with the CCG.

The Team sees "*continued engagement*" as a two-way dialogue, with ideas being put forward and tested by both sides. Its members are genuinely looking for a collaborative approach and are confident that, with goodwill from all parties, the right answer will emerge.

The Team wishes to co-operate with the CCG by working towards a mutually agreed solution and it commends this approach.

The CCG will need to ask itself the following question:

On the one hand does it prefer to have a building which is just over half used or is scarcely used, but which is saddled with enormous annual costs for many years ahead, or,

On the other hand, does it prefer to have a building which is fully used and integrated and is giving more value for money?

The Team submits that the answer is simple and that discussion is the way forward.

The CCG is, therefore, urged to:

- ✓**STEP UP** to the plate,
- ✓**STEP DOWN** from the proposal to close the beds permanently,
- ✓ and to…

Save Rothbury Hospital!

The SRCH Team would like to thank the people of Coquetdale for their whole-hearted support. The information, often very personal and painful, which has been so generously shared, has been crucial in the writing of this document.

We would also like to thank Dr Helen Tucker, Vice President, *Community Hospitals Association*, for her generous advice and support.