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Save Rothbury Community Hospital Campaign

Report to the Health and Wellbeing Overview and Scrutiny Committee of Northumberland County Council.

Analysis of the *Decision Making Report* of NHS Northumberland Clinical Commissioning Group.

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Rothbury Community Hospital
Save Rothbury Community Hospital Campaign

Paper submitted for the Northumberland County Council 'Health and Wellbeing Oversight and Scrutiny Committee'.

"There are three kinds of lies: lies, damned lies, and statistics"
(attributed to Mark Twain)

Rothbury Hospital Bed Closure

The Northumberland Clinical Commissioning Group (the CCG) has consulted the public about its intention to close permanently the twelve beds in Rothbury Community Hospital and, after ignoring unanimous and extensive opposition to this, on 27th September, 2017, decided to implement its proposal.

It now falls to the Health and Wellbeing Overview and Scrutiny Committee of the Northumberland County Council to examine the method and legality of the consultation and to decide whether or not the decision of the CCG is in the best health interests of the people living in the vicinity of Rothbury and in the wider area of Northumberland.

This document will show that:

1. The CCG's decision is not in those best interests, and,
2. That the consultation process itself was fundamentally flawed.

The Health and Wellbeing Overview and Scrutiny Committee is, therefore, respectfully requested to decide as follows:

1. To request the CCG to reconsider its decision and to adopt Option 2 as set out in its *Decision Making Report*.

2. If the CCG declines to do so, then to refer the matter to the Secretary of State for a decision on the basis that the CCG's intention to close the use of the beds permanently is not in the best health interests of the people of Coquetdale in particular and of Northumberland generally and that there have been many legal defects in the processing of the proposal. Such a referral should be coupled with a request that he, in turn, refers the matter for advice to the Independent Reconfiguration Panel. **And/or -**

3. To recommend the Northumberland County Council to consider instigating Judicial Review Proceedings on any or all of the legal defects occurring before, during, and after the consultation process [redacted] should this be deemed to be necessary at any time.

Northumberland CCG
Both the decision and the process leading to it must be judged against the background of the status of the CCG itself.

On 8th July, 2016, the CCG received its Annual Report from NHS England.

The Report stated:

- That the CCG's financial control was **INADEQUATE**,
- That its planning function was **INADEQUATE**,
- That its leadership **REQUIRED IMPROVEMENT**, and
- That overall its functioning was **INADEQUATE**.

As a result, on 25th August, 2016, NHS England issued Directions to the CCG to mend its ways. Those Directions came into effect on 1st September, 2016.

The CCG is still *'in special measures'* and as such, therefore, is a failed body. The quality of its decisions should be judged against such a background.

CCG's treatment of RCH
This document will establish that, after the receipt of such an appalling Annual Report, the CCG embarked upon a course of action in relation to Rothbury Community Hospital which was peppered with falsehoods, deceit, inaccuracy, secrecy, and bias. Some matters have only recently come to light and demonstrate its continuing INADEQUACY.

Before the commencement of formal consultation, the CCG's Joint Locality Executive Board considered a Communication and Engagement Plan which contained the NHS pledge that the CCG would provide the information and support required by the public to enable it to influence and scrutinise the planning and delivery of health services.

The Plan also said that for the CCG *'to maintain credibility it must be open, honest and transparent throughout the consultation'.*

In his introduction to the Consultation Document Dr Alistair Blair said *'we want to be honest with local people'*.

Regrettably the CCG has utterly failed to comply with such promises.

In July, 2016, a steering group was set up to consider the use of community hospitals in Northumberland.

Initially the CCG stated that the group consisted of its Local Director North, Hilary Brown, and its Head of Commissioning Services, together with officers from Northumberland County Council and Northumbria Healthcare NHS Foundation Trust. It was said to be one of a myriad of such working groups carrying out the daily

operative business of the CCG. It had been established by its then Chief Operating Officer, did not need any permission from the Board to carry out its work, and did not need any terms of reference.

The answer to a further question, however, revealed that the additional officers to the group consisted of:

From the Trust:

- The Chief Executive (an officer earning in excess of £210,000.00 per annum),
- A Consultant Physician,
- A Consultant Cardiologist,
- A Consultant Community Geriatrician,
- The General Manager,
- The Director of Operations, and
- The Service Lead, District Nursing and Palliative Care.

From the County Council:

- The Director of Adult Social Care - Vanessa Bainbridge,
- The Senior Manager, Commissioning Wellbeing and Community Health.

Only Hilary Brown and the Head of Commissioning Services from the CCG.

These FOI answers revealed the first of a series of untruths.
Clearly this was a high profile gathering and not one of 'a myriad of working groups'. The first answer had obviously been economical with the truth to hide this fact.

The stated purpose of the group was never fulfilled. Over a year has elapsed since the inception of the group and a report on the use of the five community hospitals in Northumberland has never been produced.

Is it really to be believed that the then CCG's Chief Operating Officer had the authority to set up such a steering group and to bring together such a number of high ranking officers?

The real purpose of the group has never been revealed. It is probable, however, that it was actually a lynch party which was set up to try to show that something was being done in response to the CCG's designation as INADEQUATE and, in that context, to attempt to identify a possible financial saving.

On 2nd September, 2016, the day after the Directions to the CCG came into operation, the use of the twelve beds in the hospital was temporarily suspended for a period of three months.

On 17th November, 2016, the CCG held a public meeting in Rothbury at which it was stated that it was the CCG which had suspended the use of the beds. **This was untrue**. Neither the CCG's governing body, nor any committee, nor the Board had

given any authority for this to be done.

It was not until 23rd November, 2016, four working days later, that a written report explaining the suspension was placed before the Board.

That report did not relate to the use of all the community hospitals in the county, but was entitled 'Rothbury Hospital Inpatient Service Review'.

The extent of the 'Review' itself, carried out over a period of three months, merely consisted of the negative comments made at the public meeting and a bland assertion that the suspension of the beds had not caused any pressures on health services.

The report also made it plain that it was the steering group which had suspended the use of the beds and not the CCG itself.

Two other pieces of false information were given to the public meeting.

The first claimed that, if the beds were closed permanently, there would be a saving of £500,000.00 per annum on the salaries of the nursing staff. More will be said about this below.

The second was that the use of hospital wards can be suspended without any prior notice.

Power to suspend the beds?
The CCG has claimed that it and the Trust have the power to suspend the use of beds in a ward. The Save Rothbury Hospital Campaign Team (SRCHC Team) initially accepted this statement. However, it has recently learnt that the proposition is a myth. **As a matter of law, it is not true**. Even if there is an emergency, such as a viral infection or serious shortage of staff, the ward cannot be closed. It still remains the duty of the Trust and the CCG to consult the public. What form that consultation may take in such an emergency is a matter of debate, but the law is clear.

However, there was no emergency at Rothbury. The staffing complement was full, and the patients were not at risk from infection or from any other physical danger. The CCG was, therefore, under a legal duty to consult the public, but it failed to do so

Similarly, the use of such a ward can only be suspended after the County Council's Health and Wellbeing Overview and Scrutiny Committee has been consulted. No such consultation took place.

[redacted]

Indeed, there has never been any formal reference to the Health and Wellbeing

Overview and Scrutiny Committee of any matter relating to the planning, the consultation or the decision-making process before or during the consultation period. There is no record of any agenda item or minute of that Committee before the end of that period on 25th April, 2017.

The first time that the CCG appeared before the Scrutiny Committee was on 20th June, 2017, two months after the close of public consultation, and it then related the detail of the consultation with the public after the suspension of the use of the beds, but made no reference to any consultation with that Committee prior to 25th April, 2017.

Yet, on 2nd October, 2017, the NHS England Board Secretary wrote to the Campaign's Co-ordinator on behalf of the Board members as follows:

'As you are aware, Northumberland CCG is the statutory commissioner of NHS services for the population of Northumberland. As part of these responsibilities, the CCG is required to demonstrate compliance with national legislation surrounding the public consultation whilst working towards nationally published guidance around service change. The CCG has included information on how it has demonstrated compliance with this legislation and guidance in the decision-making documentation made available to the public ahead of their Joint Locality Executive Board on 27th September, 2017.

We understand that the planning, consultation and decision-making have been subject to local scrutiny by Northumberland CCG Overview and Scrutiny Committee ***throughout***.'

Clearly someone, somewhere, is telling lies, and also it appears that the NHS England Board does not know the difference between the County Council and the CCG!

On 27th November, 2016, the Board agreed to extend the suspension of the use of the beds until the results of the consultation had been considered and it deliberately set the consultation period at the maximum period of three months. It was decided that the options to be placed before the public would be considered at the Board's December meeting.

It must have been realised in November, 2016, that it was certain that the beds would be out of use for at least one year. Three months had by then elapsed since the suspension of their use. Consultation could not start until well after the Board's December meeting. Three months would be spent on consultation. Consideration would then need to be given to the results of that consultation and a decision made later on the future of the hospital. Lastly, the final decision would need to be examined by the Health and Wellbeing Overview and Scrutiny Committee.

Indeed, such a time frame of one year has been exceeded already. The Scrutiny Committee will meet on 17th October, 2017, over thirteen months after the effective closure of the ward.

It is considered that it has always been the intention of the CCG to make the process last as long as possible in the hope that it would be able to assert at the end of that period that no undue pressures had been caused elsewhere, no complaints had been received, and that, therefore, there was no need for the beds at Rothbury Community Hospital.

Board considering options
In December, 2016, the Board considered options for the future use of the hospital in camera. Its minutes (which were only obtained in response to a freedom of information question) record that Vanessa Bainbridge, as Director of Adult Services of Northumberland County Council, presented the report. She recommended that one option only should be put forward for public consultation.

This was: *'Permanent closure of the 12 inpatient beds and development of health and social care services at the hospital site'.*

She is reported to have declared that *'This option would ensure best use of the hospital site for Rothbury residents'*.

The Board decided to consider the matter further at a meeting on 13th January, 2017.

That meeting was also conducted in secret and its minutes have only been obtained yet again as a result of a freedom of information question.

The Board then considered a financial report which estimated that the annual saving which might be achieved by closing the beds permanently was £310,000.00 and not the £500,000.00 which had been quoted at the November public meeting. It admitted that the cost of treating patients elsewhere, either in hospital or at home, ought to be taken into account. It estimated a cost of providing some unknown new services and stated that the annual cost of the local GP Practice using the ground floor should also be taken into consideration.

However, this report was never made public and its contents were only revealed as a result of answers to further freedom of information questions received after the conclusion of the consultation period. Had these questions not been asked, the content of the report would have always remained hidden.

The SRCHC Team, despite not knowing of the existence of the financial report, correctly contended in its ***Response to the CCG's Consultation Document*** that these heads of cost should be calculated and taken into account when estimating whether or not any saving might be achieved as a result of the permanent closure of the beds.

Indeed, a realistic estimate of the salaries of the nursing staff showed that £500,000.00 was a huge over estimate and that the true figure was likely to be in the order of £345,000.00. Also, when realistic deductions were made from that figure for patient costs and for the doctors' surgery, it was shown that **the likely saving would**

be either minimal or non-existent. The CCG has never been able to contradict the Team's more realistic estimates.

Nevertheless, the Board of the CCG chose to ignore and to bury its own financial report and to approve a Consultation Document which set the annual savings as £500,000.00 arising from the salaries of the nursing staff.

Indeed, at the ensuing public meetings during the consultation period, Dr Alistair Blair continued to use the figure of £500,000.00 as the saving on nursing costs, a figure which he surely must have known was untrue.

On 27th June, 2017, Dr Blair appeared before the Health and Wellbeing Overview and Scrutiny Committee where he again set the estimated annual saving at £500,000.00, but on this occasion he said that it was the 'round figure annual cost of running the hospital'. Even this was incorrect, as the January financial report to the Board had set that annual cost at £680,000.00, exclusive of an annual PFI charge of £516,000.00.

More will be said later about the alleged saving of £500,000.00.

Health and Wellbeing centre?
The meeting approved a draft consultation document (Version 8) which altered the option to be considered by the public to:

'Permanent closure of the 12 inpatient beds and shape existing health and care services around a Health and Wellbeing Centre on the hospital site.'

The CCG, despite having had a year in which to define and cost a 'Health and Wellbeing Centre' had certainly not done any work on this by 27th June, 2017, when Dr Blair admitted to the Scrutiny Committee that he could not define it and said *'some flesh would have to be put on the bone*'. More will be said in this document about the amount of flesh which has recently *'been put on the bone'*.

Thus, the public has never received any definition of this proposed service and has had no opportunity to comment on it.

It is submitted that there can have been no valid consultation on the CCG's proposal to establish a Health and Wellbeing Centre in place of the 12 inpatient beds when the public does not know precisely what is being proposed, and even the proposer also has still little idea what it means.

Statistics

1. Financial Statistics

Every financial estimate which has been produced by the CCG has been proved to be wrong or a guess.

Wrong - The estimate of £500,000.00 for nursing staff salaries.

Wrong - The amount of the annual PFI payment quoted at public meetings of £600,000.00 payable each year for a further fifteen years, when the then actual figure was £516,000.00 rising annually in future by the unquantifiable increase in the retail price index.

Wrong - Failure to accept the fact that there would still be patient costs after closure of the beds and to include even its own guess of a cost of £87,000.00 in its consultation.

Wrong - Failure to include in the consultation its own guess of £43,000.00 in respect of the cost of any new health services to be provided at the hospital.

Wrong - Failure to include in the consultation its guess of the annual cost of the GP's surgery.

Thus, all the CCG's estimates which have previously been disclosed to the public have been discredited. No reliance can be placed upon any of them. All they showed was the CCG's continuing INADEQUACY.

£500,000.00
However, the CCG has now issued a *'Decision Making Report'* which contains new and different information relating to the £500,000.00.

It now states that the block contract which it has with the Trust has been reduced by £500,000.00 following the interim closure of the beds. It contends that, if the beds are permanently closed, that amount will be a permanent reduction from its annual payment to the Trust.

This is an illusion. It is a sleight of hand; a mere accountancy trick. It is true that, if there were an actual saving of £500,000.00 per annum arising from a permanent closure of the beds, the CCG would presumably be no longer responsible for paying that amount each year to the Trust and the yearly income of the Trust would be reduced accordingly. However, that is not the situation.

If the beds are permanently closed, there will still be costs arising from the treatment of patients (who otherwise would have been in the Rothbury Hospital) either at home or in another hospital. There will also be the cost of the provision of new services at any Health and Wellbeing Centre, and, according to the financial report submitted to the Board's meeting in January, 2017, there will be an annual capital cost of £60,000.00, which presumably relates to the servicing of the cost of providing

accommodation in the building for use as the GP's surgery.

It follows, therefore, that only the actual net annual saving, if any, can be reflected in the annual payment which the CCG will be liable to pay to the Trust under a revised block contract. **In reality there may be no saving at all.** The CCG's contention that the figure of £500,000.00 represents the actual net saving resulting from closing the beds is an obvious lie. The closure is being used as a device to enable the transfer of £500,000.00 out of the CCG's budget in order apparently to reduce its annual deficit. This charade can only be seen as a way of 'fiddling the books'. It has nothing to do with the true net cost to the NHS of any unused beds in the hospital and whether that expense is sufficient to justify the closure of the entire ward.

But the CCG has created even more confusion in its *Decision Making Report.*

It now maintains that there will be a recurrent annual cost of £48,972.00 in respect of a palliative care nurse and that this amount must be deducted from the figure of £500,000.00, so as to reduce the saving to £451,028.00.

But on page 51 of the Report it is stated that **two** additional nurses would be required in the proposed Health and Wellbeing Centre, i.e (*'end of life and also outpatient services nursing support'*). However, no provision has been made to fund the annual cost of the second nurse mentioned there and that cost also needs to be deducted from any saving.

No other revenue costs are estimated in respect of the proposed Health and Wellbeing Centre, but some are surely inevitable. The Report states that the *'CCG would continue to work with the Trust and the local community to explore the full range of central NHS funding options that may be available to fund future reconfiguration work*'. The report submitted in January, 2017, estimated that there could be a cost of £87,000.00 in respect of patient care and of £43,000.00 for the provision of new services.

It also said that there would be an annual capital payment to be made of £60,000.00 in respect of building costs.

However, this has disappeared from the figures produced in the *Decision Making Report*. Now there is an estimated one-off capital payment of £60,000.00 in respect of the *'redesign of inpatient clinical space'*. This estimate, however, is only *'based on a desktop exercise pending full business case'*.

Nursing staff

The CCG also puts forward another fallacious argument. It claims that, as some of the nursing staff have been transferred to other hospitals, this has saved recruiting to vacant posts there. It is, of course, true that, if the establishment is reduced, albeit temporarily, a saving can be made. However, once the beds are reopened, the staff at Rothbury will have to be replaced and, to enable the hospitals elsewhere to return to their original and proper level of service, they will need to fill posts which were previously vacant.

Suffice it to say the CCG's figures and thinking are highly contradictory and confusing. Perhaps there is some answer to this jumble of figures, but it is very difficult to see what this might be. It would appear that **throughout the last fourteen months there has never been any firm and clear estimating of what services will be provided and of their cost, and of what savings might be achieved.**

It is yet another demonstration of INADEQUACY.

2. Other Statistics

The Consultation Document includes a number of pie charts and graphics which are designed to allege or establish that the need for the beds in Rothbury Community Hospital has progressively become less.

Some of these are completely false or are based on guesses or which aim visually to convince the viewer of the correctness of their contention.

End of Life.
For instance, the end of life table purports to show a declining number of deaths each year in Rothbury Hospital and that, as a result, there is less need for the beds.

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

It is, of course, impossible to forecast precise death rates in any future year. However, the CCG has falsely attempted to show a trend and it is thus appropriate to show the reality of the figures upon which it relies to establish that pretended trend.

In five months in 2016-2017 there were 9 deaths. If that death rate had continued during the following seven months whilst the use of the beds was suspended, then a total of 22 deaths would have occurred. **In other words there would have been more deaths in the hospital than in any of the previous three years.**

This simple fact shows that the CCG's statistic is a fake. When properly examined, if anything, it displays the very converse of that which the CCG purports to show.

It also illustrates the CCG's very limited thinking. It has sought to make a bad point by only examining past history. Forward thinking, however, should take into account another statistic which both the CCG and the Campaign Team accept, namely, that produced by the Office of National Statistics which anticipates that over the next 10 years the number of people living in Rothbury aged 65 and over is expected to increase by 22.8% and over the next 20 years by 44.8%.

Such a demographic trend points to there being a continuing and growing need for the hospital beds both for step up and step down cases and, in particular, for end of life care.

The CCG's attitude towards the treatment of dying patients is expressed in one callous and compassionless sentence in its Decision Making Report which reads:

'The national direction of travel is to support as many people as possible to die at home'.

Subjective Views on Personal Health

The Consultation Document also contains another fake statistic. It maintains that in 2011 60.1% of people aged 65 or over in Rothbury considered their health to be very good, 31.5% believed it to be fair and 8.4% thought that it was bad or very bad.

In fact the 2011 census shows those figures to be 80.5%, 15% and 4.5% respectively.

However, the figures are meaningless. They are purely subjective. The views held by an individual about his or her state of health have no bearing on whether or not beds are needed in a community hospital. A person may be healthy today, but desperately need such a bed tomorrow.

Increase in Community Nursing

The figures shown in the Consultation Document relating to the number of 'face to face community nursing contacts' are very questionable. They purport to show an increase each year and culminate with the highest figure being in 2016-2017 with an increase of 131 or 1.7%. However, this latter figure was a guess, as the true figure was not known when the Consultation Document was issued.

Such a small increase would have supported the CCG's argument in favour of closure, because the closure of the beds had caused virtually no impact on the community nursing service.

However, the CCG has now published (at page 47 of its *Decision Making Report*) details of finished appointments and visits for the nursing staff based in Rothbury for the period September, 2016, to May, 2017, inclusive and also the comparative figures for the same months in the previous year.

Since the use of the beds was suspended there has been an average monthly increase of 6.25%, but during the winter months the increase averaged 10% and in January, 2017, the increase was 21%.

The recently published statistics can now be seen not to support or assist the CCG's argument that the beds should be closed. They show the very opposite to that which the CCG is contending. The number of visits is rising significantly and is likely to continue to do so as the population of the area both grows and ages.

Bed Usage
It has always been accepted by the Campaign Team that the use of the beds in Rothbury Community Hospital has not been maximised and was seen to fall in 2015/2016 and 2016/2017. The question of course arises - *why should this have happened?*

The CCG say that the answer is that medical advances and an increase in home care in those years have resulted in fewer beds being used in Rothbury Hospital.

But this cannot be the answer. Why did similar percentage reductions in the use of beds not occur at community hospitals in Haltwhistle, Alnwick, Blyth, and Morpeth?

In reply, the CCG opines that at Alnwick admissions are consultant led, but such supervision is only on an occasional basis. At Haltwhistle, just like Rothbury during those years, doctors were not present on site.

After considering much locally based information the Campaign Team consider that the answer lies within the system which the CCG has imposed in the hospital and has allowed to be interpreted.

Firstly, because the hospital beds have been nurse led, perhaps the criteria for admissions have been too tightly drawn. It would also seem highly likely that those criteria have been too rigidly enforced and possibly patients have been encouraged to leave the hospital a little too early. **Whatever the local answer is, the CCG should have monitored the situation and not allowed it to develop.**

The Campaign Team is absolutely clear that, after the local GP Practice has been relocated in the hospital, it can and will operate efficiently and effectively.

But how should the level of use have been measured and how should it have been compared with that in hospitals elsewhere? Consideration should also be given to the criteria for admission to such a hospital and how those rules are applied. There is, therefore, no absolute answer for the level of bed use to be set for any particular hospital. Circumstances will inevitably vary.

Nationally, it is accepted that, as a general rule, for maximum efficiency in a ward in a community hospital the level of use of its beds should be 85%. Clearly this will in practice vary upwards or downwards from time to time, but, if the level of use consistently is considerably in excess of 85%, that will create strains on the system. Equally, there should ideally not be underuse.

However, the adoption merely of percentage levels of use, as has solely been done by the CCG in the period before suspension of the use of the beds, is not the whole approach to be followed. The size of the hospital and the area in which it is located also need to be taken into account.

In the case of Rothbury Community Hospital which has 12 beds, an 85% level of use would suggest that on average 10 beds should be in use and only 2 should be empty.

But, by way of comparison Alnwick and Morpeth Hospitals, which each have 30 beds, should only have 25 occupied and there should be 5 unoccupied.

Berwick Hospital with 24 beds should have 20 occupied and 4 unoccupied.

There will also be seasonal fluctuations to take into account. In many instances admissions fall during the summer months, but rise during winter. Of course, when such fluctuations are taken into account, the resultant average figure for the year hides the true use of the beds during the periods of peak demand.

It is also known that the statistics used are based on occupancy rates at midnight each day. Consequently, as patients are usually admitted and leave during the day, some beds which are empty at midnight, are in full use during the day. This method of data gathering depresses the actual rate of use.

It follows, therefore, that the statistics used for bed occupancy rates have to be used with caution because of the varying factors which should be taken into consideration.

It is known that during 2014-2015 the average bed occupancy rate in the Rothbury Hospital was 65.9%. In other words on average there were between 8 and 9 beds occupied, or only 1 or 2 less than the recommended 85% level; not a serious underuse it is contended.

The question asked of Dr Blair at the first public meeting was:

'If the average use of the beds was 10 at Rothbury, would that be acceptable?'

Dr Blair replied that, if that were the case, the public meeting would not have been held or necessary.

It follows that the whole debate about the closure of the beds which has taken place over the last year relates to the funding of perhaps two or three beds. Surely, patients can be normally found to fill those beds. Indeed, the Team is aware of Coquetdale patients who should be in a community hospital, but are refusing to go, simply because they do not wish to be separated by distance from their friends and relatives in the valley.

Payment for beds?

It is understood that the block contract negotiated with the hospital Trust results in the CCG paying for the 12 beds at Rothbury and all other community hospitals, whether used or not. In the acute sector, the CCG only pays for actual activity, via the " payment by results" system.

It is suggested that the CCG should renegotiate the community hospital block contract and move it to a contract based on outcomes and/or usage. This would result in only paying for actual activity, as well as improving patient outcomes and cease payment for unused beds.

Bed use figures 2016-17
Figures of bed use for the year 2016-2017 have now been obtained for all the community hospitals in Northumberland.

In that year Alnwick Hospital had an average bed use of 90.9%. In other words, it appeared that there were always 3 beds available. But, when the midnight data gathering is taken into account, it means that the ward was constantly virtually full. In September, 2016, the month in which the use of the beds at Rothbury was suspended, the bed occupancy rate was 95.6%, showing that on most days there was probably only one bed available.

So it can be seen that **Alnwick Hospital** was under constant strain, always recording figures in excess of 85% use and that is still the situation.

The **figures for Berwick** reveal that its average bed use during that year was 75.6%. In other words, there were always six beds which were unused. For the first 9 months of the year the average use was 72%, meaning that seven beds were out of use. Its yearly average was only increased because of the last three months of the year being busy with an average rate of 87%.

Berwick Hospital, with an average of 72% use, always had an underuse of two or three beds. This was similar to Rothbury in the previous year.

Morpeth had a yearly average of 82.2%, with 5 beds often being empty. However, the overall percentage use virtually corresponded with the national guideline.

All these figures can, nevertheless, be treated with a certain amount of suspicion. The data relates to 'beds available' and not necessarily to the number of beds in the hospital. The answer to a freedom of information question reveals this fact. It stated:

'Please note that this is the percentage of the available beds, not necessarily of the total in a ward, as the number of available beds can fluctuate'.

The answer continued: ***'This is demonstrated in figures for the ward at Rothbury Community Hospital where following the decision to temporarily suspend inpatient admissions due to continued low usage, the number of available beds was reduced in the run-up to the ward being temporarily suspended.'***

It follows that the figures used for Rothbury are highly suspect, not only because of the above answer, but also because only questionable figures for April to August, 2016, the quiet period of year for admissions, are quoted. It is not known how many beds at Rothbury were 'available' from time to time or when their 'availability' changed. For instance, if the CCG has estimated on the basis of a total 12 beds, and, say, 6 were occupied, that would show a 50% use. But, if, say only 9 beds were 'available', then the occupancy rate would be 66%.
Hence the reason why this document uses the normal rate of admissions to the hospital which have been cited and accepted for a normal year like 2014/2015.

It also follows from the above figures that Alnwick Hospital is under pressure, Berwick Hospital is slightly underused in a similar way to Rothbury, and Morpeth is running at about the right level, but should not be pressured further.

Future pressures
However, looking to the future, there are going to be further pressures. The population is ageing and there will be a significant increase in it because of extensive new development.

It is appreciated that Northumberland County Council has withdrawn its Core Strategy, but significant development is still inevitable.

200 new houses were earmarked for Rothbury. Planning permissions have already been issued for over 200 dwellings in the area and development has commenced on two extensive sites. 500 new properties have been agreed recently in Amble. 1,100 houses in Alnwick and 2,100 houses in Morpeth were suggested in the original Core Strategy.

It is certain, whatever the finally agreed housing figure may be, that significant housing development will occur and that this in turn will place considerable extra pressure on the hospitals at Alnwick and Morpeth in particular and, indeed, to a lesser extent at Rothbury.

Consideration should, therefore, be given to the likely future demand for hospital beds. To reduce their numbers now is short-sighted and the height of folly.

The CCG at page 28 of its *Decision Making Report* brushes aside and rejects the need to consider the future in one sentence. It states that *'it would not be good use of resources to continue to run a service that is not being used fully in case it is needed in future years'*.

The Campaign Team on the other hand has put forward a detailed demographic projection in its Response Document, but the CCG has declined to prepare one, as it clearly considers such forethought to be irrelevant. **The CCG was found to be 'inadequate' for planning in the Annual Assessment mentioned above.**

'Underuse' as the criterion
If underuse is the criterion for closing the Rothbury Hospital, why isn't the same criterion applied to any other facility where there is similar underuse?

Under this heading of bed use it is right to refer to another rural community hospital in Northumberland, namely that at Haltwhistle.

Unlike the CCG, which set up a steering group 'to examine the use of all community hospitals in the county' (but failed to do so), the Campaign Team has given considerable thought to their use, as can be seen from the above statistics.

The figures of bed use given for the Haltwhistle Hospital again illustrate the unreliability of the system. **They cite that 17 beds are available, but it is known**

that the hospital normally has only 15 beds. The figure for November, 2016, is 106% which has the effect of pushing up the average annual percentage to 91.4%. Without that inflated figure, the percentage of use would average 90% and would show that the hospital is operating at just over the recommended level.

There are striking similarities between the Rothbury and Haltwhistle Hospitals.

Haltwhistle	**Rothbury**
15 beds. 7 in separate rooms, ensuite. 2 small bays, with 4 beds in each.	12 beds in separate rooms, en-suite
Purpose built in 2014	Purpose built in 2007
Ward on first floor	Ward on first floor
Day-time minor injuries unit	Had one, but it was removed
Provides physiotherapy	Provides physiotherapy
No GPs on site	GPs' surgery moving in
Step up and Step down care	Step up and Step down care
End of life care	End of life care
	Paramedic based on site

The Haltwhistle Hospital is proudly advertised by the Trust as a state of the art hospital with fully integrated care and as such is one of the first in the country.

Yet Rothbury Community Hospital with the same or slightly better facilities is due to have its beds removed and more than half the first floor unused. This will result in the rest of the building becoming the most expensive office accommodation in Northumberland.

Haltwhistle is favoured by excellent communications along the low lying Tyne Valley by both the A69 and the Newcastle to Carlisle railway. Coquetdale residents have much more difficult travel facilities if they need to go elsewhere for any medical treatment. Haltwhistle residents can also easily reach other facilities in Hexham, Carlisle and Brampton.

It is appropriate to ask why this is happening when similar facilities are available and why are Rothbury residents being treated in this way?

Surely the only answer can be a lack of vision and common sense on the part of both the Trust and the CCG. It is yet a further demonstration of INADEQUACY.

What a loss of an opportunity to provide another fully integrated state of the art facility of which we could all be proud and cherish!

Finally, on the subject of bed use, it is right to say that, whilst delayed transfer of care ('bed blocking') is not as great a problem in Northumberland as elsewhere in England, figures recently produced show that, **since the suspension of the beds at Rothbury Hospital, the delay in transferring elderly patients to other hospitals or care homes *has doubled*.**

Comments on the Procedure and the Topics for Consideration at the Meeting of the Joint Locality Executive Board 27th September, 2017.

Bias
In its response to the Consultation Document the SRCH Campaign Team said that under the current process the CCG is prosecution, judge, jury and executioner, and that the defence has no right of audience.

This contention is confirmed by an examination of the composition of the Joint Locality Executive Board which has the responsibility of making the CCG's final decision on the matter.

The Board appears to have a built-in bias in favour of the permanent closure of the beds in Rothbury Community Hospital and of more patients being cared for or dying at home.

This can be seen from the membership of the Board.

JLEB Membership

Vanessa Bainbridge
Ms Bainbridge is the Director of Adult Social Care for Northumberland County Council. She was a member of the steering group which suspended the use of the beds. She also presented the options for the future use of the hospital to the December meeting of the Board and recommended only one option, namely, permanent closure of the beds. It is understood that she became the **CCG's Chief Operating Officer** and is now its **Accountable Officer**. Consequently, she chaired the meeting of the Board on 27th September, 2017, and as such held the casting vote, if that had been needed.

Hilary Brown
Ms Brown was a **member and chair of the steering group**. She is a practice manager in Berwick and it was she who in September, 2016, submitted a report to the CCG's Resources and Performance Committee *'explaining the principles of a new model of health care which aims to support frail and elderly patients to remain in the community'*. This report was followed by a passing comment by the Chief Operating Officer that the use of the beds at Rothbury had been temporarily suspended. She was the Sponsor of a report to the December, 2016, Board meeting relating to future options for the hospital. That report recommended that Option 5 only, namely permanent closure of the beds, be taken to public consultation.

Siobhan Brown
Ms Brown is now the **Chief Operating Officer**. She is a manager who has worked in New Zealand. She placed a report before the September, 2017, meeting of the CCG's Governing Body in which she referred to the Canterbury New Zealand system which is aimed at avoiding admissions to and facilitates early discharge from hospitals. The report called for effective bed utilisation and a reduced bed base. She stated that there were too many beds in Northumberland.

Dr Frances Naylor
Dr Naylor, in November 2016, is recorded as asking for a longer consultation period which would give time to collect more evidence of the impact of closure. In December she said that the clinical strategy outlines that patients do better when cared for in the community and not in hospital beds. She was also the clinical lead in the Quality Impact Assessment.

Annie Topping
Ms Topping is the **CCG's Director of Quality and Patient Safety**. She declared a possible conflict of interest when the question of Rothbury Hospital was considered by the Board in November, 2016, but has taken part in discussions on the matter at subsequent meetings. She reviewed the Quality Impact Assessment and said that she was satisfied that *'the quality impact of the proposal had been considered and monitored during the temporary closure period*'. She also was the Director responsible for the Equality Impact Assessment and signed it off on 15th September, 2017.

Dr Alistair Blair
Dr Blair is the **CCG's Clinical Chair**. He has presented the CCG's case for the permanent closure of the beds at all the public meetings and he wrote the Introduction to its Consultation Document. He also put the CCG's case to the Health and Wellbeing Overview and Scrutiny Committee in June, 2017.

Other members of the Board have approved all aspects of the CCG's policy and the consultation process itself without demur.

The Board consists of ten voting members. The five members listed above, with the casting vote of the chair, had the power at the meeting on 27th September, 2017, to decide to close the beds permanently, and by doing so effectively 'mark their own homework'.

It is submitted that the wishes and views of the public and of objectors to the CCG's proposals probably had no chance of objective and fair consideration, given the known longstanding and preconceived ideas of the majority of the members of the Board.

Indeed, the unanimous decision of the Board to close the beds permanently has demonstrated the truth of this contention and can be seen only as an exercise in self-justification.

The very holding of the meeting in the Town Hall, Morpeth, has demonstrated an attitude of mind towards the people of Rothbury. The meeting could easily have been held in the Jubilee Hall, Rothbury, so that even more people could have attended. The Board clearly thought that either it was too far for its members to travel, but it was all right for over 150 people to travel from Rothbury to Morpeth, or it did not really wish the public to hear its deliberations.

The NHS Rule 5 Relating to Bed Closures

From 1st April, 2017, all 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.

Items 1) and 2) of the Rule can be considered together or separately.

Item 3), however, is separate from the previous two items and, therefore, has to be considered separately.

It is Item 3 which is most referable to the situation at Rothbury Community Hospital where there has been a less efficient use of beds, but where no alternative plan has been put forward and costed by the CCG.

Mr Simon Stevens, the NHS England Chief Executive, when introducing this new rule, said:

"*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."

The new Rule (which carries the same weight as the four other NHS Rules with which the CCG has complied) came into operation during the consultation period.

At a public meeting on 30th March, 2017, Dr Alistair Blair maintained that the rule did not apply to the situation at Rothbury Community Hospital.

However, when appearing before the Health and Wellbeing Overview and Scrutiny Committee after the end of the consultation period, he said that the CCG would have regard to it, but did not state how that would be done.

[redacted]

The CCG's response to the new Rule 5 is set out on page 44 of the *Decision Making Report.*

It firstly brushes aside the Rule with a few unprovable platitudes such as:

1. The decline in bed occupancy was due to medical advances.
2. There is a national drive to treat people out of hospital and it is anticipated that even more care will be provided in the home in future.

It also states that the interim closure of the beds has not produced pressure elsewhere in the health service.

It goes on to claim that it has 'been able to respond to some of the suggestions from local people about the kind of services that could be (**note** not 'will be') provided.

This 'response' will be dealt with in detail later in this document and will be seen to be nothing but an illusion.

Suffice it to say now that the only proposal made by the CCG is the appointment of a Macmillan nurse and another community nurse. The estimated funding for only one of these is mentioned and even that is not as yet secured.

The CCG has put its future intentions in a nutshell in its Equality Impact Assessment as follows:

Within three months after the final decision it will:

a. request nursing and care staff to inform patients' families of alternative methods of transport for visiting

b. provide a palliative care nurse (as yet unfunded and only for four days per week and for a three year period)

c. if the proposal is approved, will develop a post decision implementation plan.

It will also set up another working group *'to further discuss local general health and wellbeing needs'*. Given the disaster of the last working group, the prospect of another is daunting!

The Northumberland CCG has thus failed to demonstrate sufficient alternative provision to replace the beds closure. No extra services have been provided, or are likely to be provided, and no costing has been done in relation to either alternative home or hospital care.

The crude estimates of new cost which were made in January, 2017, by the Chief Finance Officer have not been accepted and have been ignored by the Board. The CCG, however, continues to claim savings arising from the closure of the beds, namely, the spurious amount of £500,000.00, less the as yet unsecured annual expense for one nurse for a three-year period only.

If the CCG has had regard to the new Rule 5, it has only done so by giving lip service to it. It has made no attempt to produce detailed costed and thought-through plans which demonstrate *'sufficient alternative provision to cover either present or likely future demand*'.

Indeed, it has specifically stated that unused beds should not continue to be available in case they may be required in the future. This demonstrates that it has ignored future trends of the growth and ageing of the local population.

The CCG has thus failed to comply with its duties set out in Rule 5 [redacted]

If the CCG still to wishes to close the beds, it must prepare a fully costed realistic plan and then recommence a public consultation.

However, in the meantime, there remains the question of the suspension of the beds and it would be necessary for the CCG to consult the Scrutiny Committee about any continuation of that suspension during what might be a lengthy period of preparatory work and fresh consultation.

Documents only seen by the Board, but not by the public

The CCG has stated that it has produced a number of documents such as a travel impact study and an equality impact study.

However, it refused to forward copies of these to the Campaign Team and, in an answer to a freedom of information question, said that all would be revealed at the Board's meeting on 27th September, 2017.

These documents should have been made available at the very outset of the consultation period and the failure to produce them before the issue of the papers to be considered by the Board at its meeting on 27th September, 2017, when it made its final decision, has debarred the public from commenting on their content.

This document, however, will make brief comments on each of the additional reports of the CCG.

The Rothbury Travel Impact Analysis

In his Introduction to the Consultation Document in January, 2017, Dr Alistair Blair promised to make a Travel Analysis available to the public during the three month consultation period.

The CCG failed to honour that pledge.

It took six months to prepare its Analysis document which is dated July, 2017.

It was not prepared by the CCG itself, but by the NHS North of England Commissioning Support Unit based in Newcastle upon Tyne. It displays a total lack of knowledge about the topography of the Coquet Valley.

It might have been better not to have produced it at all, for it consists mainly of drivel throughout its twelve pages.

The four authors and recipients of the Analysis who are named on its frontispiece have not displayed one iota of common sense in agreeing its content.

Do they really believe that a dying patient will take a bus to the centre of Rothbury and then walk for ten minutes to the hospital? Or do they think that such a patient will catch a train to Alnmouth and then consult a 'bus timetable on how to proceed to Alnwick?

Does the public really need to be told how to find Rothbury Hospital or which turning for Alnwick to take on the A1?

What relevance does the density of population in the North East or in Northumberland have in relation to difficulties of travel to the Rothbury, Alnwick, or Morpeth Hospitals?

The map produced in the Analysis differs from that in the Consultation Document. It displays seven areas marked in red which are mainly outside the periphery of the blue circle and which are said to be the areas most affected. What nonsense!

The areas which will be most affected by the closure of the beds will be those areas which have the majority of the population and which are nearest to Rothbury Hospital. Local knowledge, which is confirmed by the 2011 census, shows these to be Rothbury and its immediate satellite villages of Thropton, Snitter, Hepple, Netherton, and Harbottle to the west, and Longframlington**. It is these areas which have the largest elderly populations and it is some of these areas which are destined to have more housing development.**

That is why the Rothbury Practice has its surgery premises in Rothbury and Longframlington. That is why it is sensible to have community hospital beds in the same building as the main surgery of that practice in order easily to secure continuity of care of patients in appropriate cases.

Loved ones visiting?
The Analysis only considers travel by the inpatients themselves. There is not a single mention in it of the travelling difficulties for families. Nor is there any reference to the necessity or desirability of patients receiving visits from relatives or friends.

The Analysis admits that it does not know how patients travel to or from the hospital. The simple truth is that ill people do not go to and from there by 'bus or train, or on foot. They almost exclusively travel either by ambulance or car. Surely, even for such journeys, it is better for the inpatient only to have to travel as short a distance as possible to a hospital, and not have to be bumped about over many miles of moorland roads.

It is ironic that the CCG propounds the case for care in the community, so that patients can be at home with their family and among their friends, but at the same time makes it as difficult as possible for those same family and friends to visit them in hospital and thereby largely debars them from such contact.

The Analysis ignores the travelling difficulties of such families and friends ensuing after the closure of the beds. It gives no consideration to the amount of visiting time which the use of public 'bus services would allow. It ignores the problems faced, particularly by elderly people in visiting loved ones, if they need to rely on public transport.

It does not consider the difficult roads between the Coquet Valley and particularly Alnwick, roads which cross open moorland. These climb over two steep hills which were categorised in the recent Tour of Britain cycle race. These roads can be

difficult to negotiate, particularly at night and in the winter, and they can sometimes be blocked.

The report concentrates on the distance from a patient's home to the hospital and examines only the home locations of previous patients. **This is a ridiculous approach for two reasons.**

Firstly, the home location of a previous patient has no bearing on where any future patient has his or her home.
Secondly, many visitors will be members of a patient's family or his/her friends who do not live with them, but who live within the Rothbury catchment area.

If the concept of the worth and necessity of visitors to a patient in hospital is accepted, then it must follow that their travel difficulties and problems must be taken into account and not merely ignored as the CCG has done in its document.

A full and accurate assessment of travel difficulties was set out in the **SRCH Campaign's Response Document.** It showed that, in many cases, visiting via public transport, particularly at Alnwick, would be almost impossible or extremely limited, even during the week. Evening and Sunday visiting would be impossible.

For most people the total journey times per visit would range usually between three and four hours. Obviously, this would be untenable on a regular basis.

Costs
The cost of using a taxi for regular visiting is prohibitive. The Campaign's Response Document quoted £23.00 as the advertised fare from Rothbury to Alnwick. This is not a return fare and does not allow for waiting time. A return trip would cost £46.00. Clearly elderly people living on fixed incomes could not afford such an outlay.

The taxi fare figures quoted in the Analysis are meaningless and misleading. They relate only to the extra taxi fare payable if a longer journey was taken, but they do not show the total cost of the whole journey and its return.

Even the percentage figures shown in the CCG's Analysis appear to be contradictory.

Distance
Page 5 states 'based on the patients' ward of residence, 21% (43 of 203) would be closer to Alnwick Infirmary or The Whalton Unit, Morpeth, than Rothbury Community Hospital'. This suggests, therefore, that 79% were nearer to Rothbury.

However, page 5 also declares that '96% of the patients living in the Rothbury ward who had attended Rothbury Community Hospital would have had to travel further to Alnwick Infirmary or The Whalton Unit Morpeth'.

But page 7 then **further contradicts these figures** by showing in a segment of a pie chart that 71.4% of the 203 patients would have to travel further if the beds were permanently closed.

Whatever percentage of previous patients would have had to travel further is irrelevant. When looking to the future, common sense dictates that the great bulk of patients and their families affected by the closure of the beds will live in Rothbury and its vicinity and Longframlington and that the majority of these will dwell in the former area and, therefore, will have the furthest to travel to either Alnwick or Morpeth.

It is obvious that, as Dr Blair was unable to produce a travel analysis in January, 2017, no work had been done on it by the steering group either in July, 2016, or later, and that it has taken over a year for the CCG to issue some inconsequential words on paper.

It is also obvious that the Analysis which it has now produced is not fit for purpose. **Its content is worthless and is a further demonstration of the CCG's INADEQUACY**.

The document should be consigned to the CCG's extremely large shredder.

It is noted, however, that the CCG, albeit belatedly, has realised that the Analysis is grossly defective, for it has sought as late as the issue of it *Decision Making Report* on 20th September, 2017, and only seven days before its scheduled meeting, to address publicly and in a very minor way the issue of travelling difficulties for visitors. On page 35 of a 54 page document, it alleges that it has taken into account the concerns of the SRCH Campaign Group about such difficulties. On page 52 it at last specifies the extent to which those concerns have been taken into account when it mentions that the *Getabout Service* might be used by people who have real difficulty in travelling either to Alnwick Infirmary or the Whalton Unit and that health and care staff should make relatives aware of the availability of that limited service.

Unfortunately, the CCG does not seem able to get anything right. *The Getabout service* is advertised each month in 'Over the Bridges'. (OTB is the monthly community and church magazine of Coquetdale which is delivered to every household).

The advertisement states:

‘Help is available with transport to appointments at Rothbury Hospital or a local GP surgery. Please give as much notice as possible'.

This scheme, therefore, is **only available for medical appointments, and not for visiting**. It applies only to Rothbury Hospital and to the Rothbury and Longframlington surgeries, and not to hospitals in Alnwick or Morpeth. The website states that it is recommended that patients should give seven days’ notice, if possible.

Equality Impact Assessment

On 11th September, 2017 the CCG produced an *Equality Impact Assessment* which had been prepared by Stephen Young, Strategic Head of Corporate Affairs.

The Equality and Human Rights Commission in its Guidance Document on Equality Impact Assessments states that these should be prepared when policy is being designed or reviewed. The reason for such advice is that it enables equality considerations to be taken into account throughout the whole process of policy development.

Work on the CCG's policy in relation to the suspension of the use of the beds commenced in July, 2016, and was implemented on 2nd September, 2016.

It has been reviewed on a number of occasions by the Board which in December, 2016, decided that its policy should be amended from the suspension of the use of the beds to their permanent closure.

Yet, at no stage were equality issues specifically taken into account and it has taken more than one year for an Assessment to be prepared.

The public has never seen the document which only appeared on the CCG's website on 20th September, 2017, and has, therefore, had no opportunity of commenting on its content.

The CCG admits that the greatest impact will be on the elderly and claims that the rest of the community will more than correspondingly benefit from the establishment of a Health and Wellbeing Centre. But it produces no evidence for this claim and has been unable to say exactly what new services will be definitely provided and exactly what benefit they will provide.
What is clear is that the elderly will lose. Any hospital treatment will always be at a considerable distance from home and there will be ensuing travel difficulties for family visitors arising from distance, road conditions, local topography, weather, time, and cost.

The document emphasises time and time again that the national direction of travel is towards more home care and less time spent in hospital. It seems to want to brainwash the reader into believing that this is almost exclusively the right course of action. However, this is not accepted by the public.

The Assessment also mentions that concerns have been expressed that more care at home will impact more on women than on men. Also, many people, mainly women, will be sole occupiers of households. However, it fails to address such concerns.

The document also repeats the Travel Analysis document which has been described above as 'drivel'. It follows that this part of the Equality Impact Study can be ignored as irrelevant.

Respite care
It has always been accepted by the Campaign Team that respite care is not provided by the NHS. However, the Decision Making Report raises this red herring by suggesting that Rothbury House can be used for respite care. **Their website states that there is no nursing care is provided there.** Fees for a week's stay for RAF and ex RAF personnel amount to £500.00 per week. For other service personnel, that figure rises to £650.00 per week.

These comments again reveal the lack of reality displayed within the CCG. Elderly people in the main cannot afford such costs and most are not service personnel.

What a pity that the CCG has not understood and taken into consideration the impact principally on the elderly right from the very start of its deliberations.

The production of an unsympathetic Equality Impact Assessment at such a late stage of the procedure proves that the CCG has ticked an appropriate box in the process, but it also shows that it has no appreciation of and does not care about the real hardships and problems of the elderly.

Quality Impact Assessment
This is only a regurgitation of other discredited documents and does not, therefore, require any detailed comment.

Suffice it to say it is merely an internal certification that procedures have been followed and, as such, merely ticks another box.

Consultation Feedback Report
This document is silent on the fundamental point, namely that not a single person, council, body, or organisation has expressed the slightest approval of the CCG's proposal to close permanently all of the beds in Rothbury Community Hospital.

Over 5000 people signed a petition expressing their disapproval.

Six parish councils, namely:

Rothbury,
Thropton,
Hepple,
Netherton,
Biddlestone, and
Alnwinton

have objected to it.

The SRCH Campaign has submitted a thoroughly researched 54 page document condemning the CCG's policy.
(https://drive.google.com/open?id=0B_20GQSyf0bWelJuTG15SEVWX0U)

The Member of Parliament for the constituency opposes the plan.

Significant local groups such as:

the ***Upper Coquetdale Churches***,
the ***Coquetdale League of Friends***, and
Thropton Women's Institute
have all submitted their objections.

Healthwatch could not ascertain *any* support for the proposal from those whom it consulted.

An online and hard copy survey was organised by a company commissioned by the CCG. The results showed that 91% of the 376 replies received were very negative or negative, with 77% being in the former category.

Approximately 300, 75, and 120 people respectively attended the three public meetings organised by the CCG and at each unanimous outrage was expressed.

Recently on 16th and 20th September, 2017, the SRCH Campaign Team has held two further public meetings at which there was standing room only and in which there was nothing but expressions of total resistance to the CCG.

On 27th September, 2017, almost 200 concerned people travelled to Morpeth to attend the meeting of the CCG's Board. Again, there was only standing room in the large Corn Exchange in Morpeth Town Hall.

Yet the Report does not specify the obvious conclusion that no-one, other than the ten member Board of the CCG, is in favour of closing the beds.

Instead, it seeks to undermine the universal view of the public by casting doubt on the efficacy of the petition. It suggests by use of a map and the names of County Council wards that many of the signatories from Northumberland live a long way from Rothbury. However, what the CCG does not seem to realise is that the extensive geographical wards around Rothbury actually include significant areas of population which use the Rothbury doctors' practice.

The CCG should realise that these people do not live on the top of the Cheviots or beyond Kielder Water. **Their homes are in villages within easy reach of Rothbury.**

As the Campaign's ***Response Document*** pointed out, many of the questions in the survey were slanted so that their answers could appear to be in favour of the CCG's proposal. This was particularly so in Questions 19, 20, 24, 26, 27, 28, 29, 31, 33, 35 and 36.

For example, question 29 asked *whether the CCG should use its available resources, including staff and money, in an efficient way.*
Many people, of course, replied that it should. That is the obvious sensible answer. But the question was a trap and some inevitably fell into it. The Team stated that the CCG's proposal was not the most efficient way of using resources and that anyone agreeing with the concept in the question should not be deemed to be supporting or endorsing that proposal. However, that is exactly what the CCG has now alleged.

The only themes which have come from all aspects of the consultation is that the public are deeply concerned about the loss of palliative care and the step up/step down facility at the hospital. They are worried about visiting difficulties. They do not accept the level of financial savings outlined by the CCG. They are sceptical about the quality and extent of home care. They believe that, when the doctors are in situ at the hospital, the beds will be better managed. They consider that the growth and ageing of the population should be properly planned for.

These are common sense views and they should be accepted. So many people saying the same thing surely cannot be wrong!

Recently there was a major referendum in this country. A slim majority of less than 2% voted in favour of leaving the European Union. The legal position is that the result of that Referendum was not binding on Parliament, which is supreme. However, politicians of all parties have stated that the people have spoken and have accepted the result on the basis that it represents their democratic will.

Surely, as the condemnation of the CCG's proposal is universal, the will of all those people should be accepted and acted upon. If it is not, then democracy in Northumberland means nothing. And furthermore – what exactly was the point of the costly consultation if no notice is taken of the result?

The CCG's Decision Making Report

This CCG Report is very repetitive. It says the same things over and over again. There are entire pages which are merely regurgitated chunks from other already discredited documents.

Pages 4, 6, 8, 9, 11, 12, 13, 14, 15, 22, 29, 25, 30, 31, 36, 37, 38 39, and 40 consist entirely of regurgitation.

Pages 1, 2, 3, 5, 41, and 42 are mere padding.

Many other pages largely consist of similar material.

The NHS mantra that there is a national drive towards more home care is repeated ad nauseam.

Indeed, it is mentioned on pages 4, 7, 10, 17, 18 twice, 22, 27, 28, 41 twice, 43, 44, and 52, as well as endlessly in most of the Scheduled documents.

It follows that there is very little of substance in the Report which calls for comment.

The principal issues relating to the NHS new Rule 5, to bed occupancy, to the workload of community nurses, to the accuracy of the amount of alleged savings, to future planning based on demographic projection, equality considerations, and quality impact have already been dealt with.

There remain only a few of the CCG's responses and remarks upon which comment is desirable.

On page 10 it is claimed that GP member practices and, in particular those from the North Locality, accepted Option 5 at its meeting on 7th December, 2016, that is to say, even before the CCG's Board had even considered any options. The Board first saw the options a fortnight later on 21st December, 2016.

There was *no* Rothbury doctor present at either of these meetings.

The CCG's comments on pages 10 and 43 are clearly aimed at showing the support of the Rothbury Practice for its proposals. **This, however, is not the case**. The Report confirms that the practice has expressed its concern about the suspension of the use of the beds. Indeed, immediately after that suspension occurred, it issued a written statement expressing its disquiet and a copy of it has remained on display in the surgery.

At page 43 a quotation from Dr Hunt is cited again. However, a close reading of Dr Hunt's remarks shows that the practice does miss the availability of the beds in some situations. The remainder of his comments is merely a statement of general fact. 'Hands on' care has improved, but he was not saying that the use of the beds could be ended because of that fact.

It should be understood that Dr Hunt is a member of the Campaign Team and, as such, can scarcely be seen as an advocate for the CCG.

Page 15 of the Report may suggest that the Campaign Team has been uncooperative by declining to meet with the CCG. If this is the case, then that suggestion is repudiated. The facts are that the Team had asked for the release of documents, but this request was refused and a meeting was offered by the CCG to discuss material which the Team had not seen. The offer of a meeting came only after some of the Campaign team had had informative meetings with NHS England and NHS Improvement.

Pages 16-19 consider the Campaign Team's proposal and condemn every aspect of it.

This document will now refute every aspect of such condemnation.

Analysis of the chart on page 16 onwards in the CCG Decision document:

1. Feedback from residents.
The relocation of the doctors has no bearing on whether or not the beds are closed permanently. The doctors are moving to the hospital and the public and the Team welcome that. That move has nothing to do with the establishment of a 'Health and Wellbeing Centre', as the relocation was planned well before such a concept was invented in January, 2017.

2. Patient choice.
Residents would not have the same amount of choice as is outlined by the Campaign Team. They would not have the hospital beds and would only be able to receive such 'appropriate' health care which may be made available. However, nobody knows what that will be.

3. Staffing.
Of course staff would be required and, as some of the original staff have left the service, further recruitment would be required. This problem is entirely of the CCG's making and it cannot now cite recruitment difficulties in aid of its own case. Had it carried out a consultation without suspending the use of the beds, the problem would never have arisen.

4. Quality.
It is admitted by the CCG that there has never been any complaint about the quality of treatment at the hospital. The ward has twelve separate rooms and, therefore, carries less risk of infection than most other hospitals

5. Cost Effectiveness
No evidence has been produced to show that the development of health and social care services would deliver value for money. The statement that it would is no more than one of hope. Value for money cannot be ascertained because the CCG cannot say with certainty what services will be provided.

6. Additional Resources/Cost
It is confirmed that no additional resource is required to re-open the beds.

7. Timeline.
It is accepted that there would be a delay of 3 to 6 months in re-opening the beds. Again this is entirely because of the ill-considered actions of the CCG. The Team consider that the ward should be supervised daily by the local doctors. They will have relocated by December, 2017, and such timing will fit in well with a scheduled re-opening of the beds.

8. Strategic fit.
If every decision in future is to be governed by the NHS mantra that *'out of hospital care needs to become a much larger part of what the NHS does'*, there would seem

to be little point in considering whether or not to re-open the beds. Patients are clearly seen to be a nuisance, so just close all the beds!

Requirements to deliver the option.
The CCG admits that *'primary care services operating at the hospital would provide a long term sustainable model'*. However, it maintains that bed usage would remain low. **Again no evidence is produced to establish such an assertion.** With the local doctors working in the building there is no reason why the beds should not be used. Under such circumstances the use of the beds would be cost effective.

The other 'requirements' mentioned are merely a repetition of the spurious claims made above at 3, 4 and 6.

These claims are repeated throughout 'Option appraisal against the three Es' and can similarly be rebutted.

Thus the attempted dismantling of the Campaign's solution has entirely failed.
Mere repetition of dogma and unsubstantiated opinion by the CCG is insufficient to discredit an effective solution.

Pages 23 and 24 seek to establish that there have been no *'significant adverse consequences'* resulting from the suspension of the use of the beds. This may apparently be so.

Just as this document forecasted earlier, the CCG hoped for a long period of suspension so that it could claim that the system had managed without serious consequences.

Of course, whenever there is a retrograde change in any service, people manage and life goes on. People are stoical. They tend not to complain to authorities. They use the service which is available to them, despite the fact that it is inferior or inconvenient. Whenever instances of hardship or difficulty have been mentioned to the CCG at meetings, they have been dismissed as *'anecdotal'*.

There are social costs arising from the beds closure. Patients have been accommodated further away from home, families have had to travel over long distances at expense in time and money. More home care places a greater strain on members of families who are themselves often ill equipped to cope and put their own health at risk. **Such affects can never be costed, but they exist and cannot be dismissed merely because there may have been no formal complaint to the CCG or to a doctor.**

The CCG's Definition of a Health and Wellbeing Centre

Pages 32 to 34 of the Report relate to the proposed development of a *Health and Wellbeing Centre*. Since this concept was first mentioned in January, 2017, the CCG has failed to define what it would be. Dr Blair stated that the CCG would *'put some flesh on the bone'* prior to the Board's meeting on 27th September.

The extent of that flesh can now be seen. There is absolutely none. The whole concept of such a centre is an illusion.

The CCG admits at the very beginning that *'the health economy will provide limited investment*' and at page 44 the Report says *'every effort has been made to constrain costs associated with the development of a Health and Wellbeing Centre on the hospital site'*.

The report sets out the existing clinics as follows:

- Midwife-led antenatal - 3 hours per week.
- Physiotherapy - Available on Wednesday and Friday for unspecified times.
- Podiatry - 2 clinics per week of an unspecified time.
- Parkinson's disease - one clinic per quarter.

These sessions can scarcely be described as a full programme of work each week or use much of the ground floor which is available for them.

The amount of flesh on the bone which has been put forward by the CCG in the last three months since the June meeting of the Health and Wellbeing Overview and Scrutiny Committee is:

Palliative care
This amounts to the engagement of one Macmillan nurse working from the hospital on four days per week. The Macmillan charity has not as yet agreed to fund such a post for a three-year period at a cost of £48,972 per annum on band 7 and no appointment has been made.

The nurse would be accommodated within the hospital building, but would provide no direct nursing there. Nor would the nurse undertake any such 'hands on' nursing in the community, but would only advise families on aspects of palliative care and would put together care packages. The nurse's work would only relate to terminally ill cancer patients, but **would not be available to patients dying from other causes.** The duties would not be strictly area based and could, therefore, extend beyond Coquetdale.

At the end of the three-year period, if the service were to continue, it would have to be funded by the CCG, but at present it has made no commitment to do so.

There is, therefore, nothing certain about this mooted appointment and, if it were to be made, it would be only of limited assistance in the overall work of palliative care.

'Virtual' outpatients clinics
The Trust is exploring a range of technological options, but nothing positive has been put forward or costed. Indeed, page 45 states that these will be provided at no cost. The question arises, therefore, how will the equipment be funded?

Rheumatology
Outpatient blood monitoring for patients who require regular blood tests. It is understood that this service is already carried out at the Rothbury Surgery and will automatically transfer to the hospital as part of the doctor's relocation

Health trainer sessions
One half day per week dealing with smoking cessation, nutrition (which already takes place) and slips and falls. This officer would be 'borrowed' from elsewhere and so reduce the level of service there. Overall, therefore, there would be no increase in service.

These 'innovations' would all be put in place within three months of a decision being made to close the beds.

It is obvious that they amount to nothing and that the CCG has not the slightest idea about what could or should be provided. The public has been asked to endorse a mirage.

Looking to the future the CCG has said that the provision of an infusion unit is being explored. Also, that diagnostic testing is being examined. It states that consideration could be given to locating NHS dentistry services and also mental health clinics.

Very generally it is said that there could be discussions about a range of community and voluntary services. What does this mean? Clutching at any straw in the wind comes to mind!

It is clear that such scant proposals are not in the best health interests of the local population when set against the proper use of the hospital beds within a fully integrated building.

Comments on the Board's Meeting of 27th September, 2017

There is very little to say about this meeting of the Joint Local Executive Board other than to comment that **it was a sham, a shambles, and shameful.** Small wonder that at the conclusion of the meeting there were unanimous shouts of 'SHAME' from 200+ members of the public who had taken the trouble to travel from Coquetdale.

There had so obviously been a pre-meeting of the members of the Board to organise a series of questions and to agree who should answer them and what the replies should be. The whole meeting was predictably stage-managed and it was a very sorry performance.

It debased the whole concept of consultation, as it was obvious that a decision to close the beds permanently had been made in the summer of 2016 and that the CCG's consultation process was held just to establish that all the required boxes had been ticked.

However, none of the many points raised by the public had been accepted. Over 5000 people were wrong and they were right, and it mattered not what was shown to them, because they thought that they had all the answers. The fact that much of their documentation was factually incorrect was never going to be conceded and they continued to peddle the same old lies and misinformation. But, that didn't matter, for, after all, the requisite boxes had been ticked and they could now proceed to the prearranged outcome.

It was no surprise that the vote to close the beds permanently was unanimous. It was, however, also no surprise that at the conclusion of the meeting there was a prolonged slow handclap and vociferous calls for the resignation of the whole Board.

The INADEQUACY of the CCG had been laid bare before the public, as is exemplified by the content of a letter written to the press by Rothbury resident Dr John Lewis, MA, DipStat, DSc(Oxon), CStat (who is not connected to the campaign) and who witnessed the Morpeth debacle. It read:

'As a resident of Rothbury, I was shocked last year when the hospital beds in Rothbury were closed without warning. Today, however, I was professionally shocked when I attended the meeting at Morpeth Town Hall where the future of the Rothbury Hospital was decided. For most of my working life I was involved in medical research and the practical decision and flow from it. What I witnessed today broke every rule in the book.

Many questions have been raised, and were raised again at the meeting, about problems that the people of Coquetdale might suffer without the beds in Rothbury. So what was the answer? It was to look retrospectively for evidence of whether any problems had been flagged up since the beds have been closed. None was found.

In the world I worked in, that kind of retrospective, uncoordinated, informal investigation on an unsuspecting experimental population would have counted for nothing. As things worked out, it seems that the Rothbury beds were closed as an experiment without telling the people of Coquetdale that they were being studied. Unethical. The study was carried out without writing a protocol, without planning in advance what outcomes would be evaluated, without ensuring that the study and data would be sensitive enough to provide reliable information on the question of interest, without specifying how the data would be collected and analysed. Unscientific. Had anyone involved with this exercise ever carried out properly managed and peer-review research? The results were useless: essentially anecdotal and potentially completely misleading.

At the meeting one of the Board asked if the basis that they had been given for their decision was adequate in a world of 'evidence based medicine'. They were politely re-assured - a showcase for the audience, not a real conversation. Both questioner and respondent should have known (and probably did!) that this evidence did not even get to square one for supporting decisions about treatment of patients. If they did not know this, then they should not be making important medical decisions on our behalf.

It is to be fervently hoped that this unsupported decision will not stand, but will fall, either at the next stage or at a subsequent legal challenge, partly because of the unscientific and unethical nature of the evidence upon which it is based.'

What they DID admit.
However, a few admissions were inadvertently made at the meeting.

It was accepted that no one, other than the Board members, had expressed the slightest support for the CCG's policy.

It was admitted that no funding is in place for the proposed Health and Wellbeing Centre. There is no guarantee that a Macmillan nurse would be provided for four days per week for a period of three years. No funding had been provided for any other aspect (very limited though that is) of the development of that Centre. It was clear that the CCG is hoping that the **voluntary sector** will provide the new services and pay for them. It was dogmatically maintained that such a centre constituted a credible plan and would be better for everyone, yet there is absolutely nothing certain about it.

The Chief Finance Officer was not able to provide any answer of certainty or clarity about how the round figure of £500,000.00 would be dealt with within the block grant structure, nor whether the salary of the palliative care nurse could be taken into account at present.

Some utter nonsense was propounded as fact by members of the Board. Dr Naylor contended that Cramlington has the same travel difficulties as Coquetdale. Dr Blair considered that Amble (with easy communications by road to Alnwick and a twenty-minute bus service) is a rural village just like Rothbury. The *Getabout Scheme* was recommended as an aid to hospital visitors and Rothbury House was said to provide suitable respite care.

Dr Blair concluded by saying that the closure was an emotive issue and a balance had to be achieved between the wishes for a service and the amount of money available to provide it and also between competing financial claims elsewhere in the county.

The meeting lasted for one hour 15 minutes, but could have been over in five minutes. The audience saw the meeting as an insult to democracy and the intelligence of the people of Coquetdale.

Inequity in Northumberland
Later in the same day it was announced that the urgent care centres at the Hexham and Wansbeck Hospitals (the use of which had been suspended earlier in the year) were re-opening with immediate effect. What a cynical action on the day that the Rothbury beds were closed permanently! This can only be seen as an attempt by the CCG and the Trust to show that they are achieving the kind of balance of which Dr Blair spoke.

It is the usual type of disingenuous action which the Campaign Team has learnt to expect.

It is a continuation of a pattern of deceitful and manipulative behaviour within the National Health Service.

Since the meeting the CCG has issued a statement about its decision. It contains only the usual slanted propaganda, lies and gloss and, like so many other publications of the CCG, it should be ignored and committed to the dustbin of history.

In 2015 David Evans, now Chief Executive of the Trust, is on record in a video about the impending opening of the new Cramlington Hospital saying:

"*Our community hospitals will go on exactly the same way as they have before, being the focus for rehabilitation and returning people back to their local communities".*

This was probably the greatest untruth of all.

Just over a year later the same man was serving on a steering group which suspended the use of all the beds in the Rothbury Community Hospital and ultimately resulted in a decision being made to close them permanently.

The public, which has paid for this fictitious consultation, is entitled to ask **how much it has cost.** No figures have been produced by the CCG about this. But, taking into account such things as staff time in the preparation of voluminous reports, the engagement of consultants, and committee and public meetings etc, it is likely to have cost in excess of £100,000.00.

The public pays the salaries of the CCG's ten Board members, some of whom are only part time, and it is entitled to judge whether or not it is receiving value for money from them.

The CCG's Annual Report indicates that these ten members are in receipt of salaries which are graded in total up to £720,000.00 per annum.

The five lay members present at the meeting are in receipt of grades totalling up to £55,000.00.

This is a grand total of £775,000.00.

The salary bill of all of the CCG's staff is approximately **2.9 million pounds.**

These are the people who are assessing the best ways of spending money wisely and they have concluded that it cannot afford to fund an average shortfall of three in the use of beds in Rothbury Community Hospital, and, as a result, have decided to shut down the entire ward permanently to the disadvantage of the people of Coquetdale for many years to come.

Identified Failures of the CCG

The Campaign Team identified the following FAILURES of the CCG, none of which have been rectified:

Failed to identify low bed occupancy during 2015 and 2016.

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 consult the Health and Wellbeing Overview and Scrutiny Committee and the public about its intention to suspend the use of the hospital beds.

Failed to calculate staff salaries correctly.

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 prepare a three Es test in accordance with the terms of its constitution.

Failed to incorporate in the Consultation Document the details of the actual financial estimates which were placed before the Board in advance of the beginning of the consultation period.

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 such an increased population by a demographic study.

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.

Failed to provide 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.

Failed to establish a steering group with clear terms of reference and powers, and to control its work.

Failed to prepare a report on the use of all community hospitals in Northumberland.

Possible Action by the Health and Wellbeing Overview and Scrutiny Committee

The SRCH Campaign Team and the public of Coquetdale hold the work of the CCG relating to the proposed closure of the hospital beds in utter contempt; hence the reason for this hard-hitting document.

The Health and Wellbeing Overview and Scrutiny Committee will have to decide which side of the argument is right.

On the one hand -
is it an 'INADEQUATE' group of mainly part-time bureaucrats based in Morpeth who, from a reading of the CCG's minutes, seem to spend much of their time writing reports which are stuffed with jargon and 'buzz words' such as 'sustainability', 'transformation', 'reconfiguration', 'assurance', 'governance', 'care pathways', 'work streams', 'cohorts of patients', (the list is endless), and preparing pie-charts, graphs, and spread sheets?

Or, on the other hand -
is it a group of highly experienced individuals, including three doctors who have given over one hundred years of service in Rothbury and Coquetdale, a professor of and a consultant of oncology, four former senior NHS managers, a former solicitor and borough council chief executive, and others skilled at senior levels in management and business, all of whom have lived in the area for many years and who know the needs and wishes of local people?

There is only one ADEQUATE and ACCEPTABLE solution.

That solution is simple. Only the second option shown in the CCG's *Decision Making Report* is credible and acceptable.

Coquetdale Cares
This allows the use of the beds to be resumed and it enables the building to be used fully and in a desirable and integrated way. It matters not that it may in future be referred to as the Rothbury Health and Wellbeing Centre. After all, what is in a name? If it enables the CCG to save face by a change of name, so be it. The sole concern is to save the use of the beds for the present and future population of the area.

The people of Coquetdale are looking to their representatives on Northumberland County Council to give them total support in their fight to save the fundamental purpose of Rothbury Community Hospital. They urge the Council to do everything in its power to reverse the CCG's decision and, if necessary, to challenge it in the Courts by way of Judicial Review. This scandalous decision and the process leading to it cannot be allowed or accepted. It must be overturned!

The Health and Wellbeing Overview and Scrutiny Committee is, therefore, respectfully requested to decide as follows:

4. To request the CCG to reconsider its decision and to adopt Option 2 as set out in its *Decision Making Report*.

5. If the CCG declines to do so, then to refer the matter to the Secretary of State for a decision on the basis that the CCG's intention to close the use of the beds permanently is not in the best health interests of the people of Coquetdale in particular and of Northumberland generally and that there have been many legal defects in the processing of the proposal. Such a referral should be coupled with a request that he, in turn, refers the matter for advice to the Independent Reconfiguration Panel. **And/or -**

6. To recommend the Northumberland County Council to consider instigating Judicial Review Proceedings on any or all of the legal defects occurring before, during, and after the consultation process (which are listed above in this document) should this be deemed to be necessary at any time.

Save Rothbury Community Hospital Campaign Team.
3rd October, 2017.