This response is made on behalf of Hands Off Teignmouth Hospital and Save Our Hospital Services (Devon).

In this document, we show how the case for closing Teignmouth Hospital has been framed to support the desired outcome of NHS Devon CCG and refute each argument in the consultation document.

Summary

NHS Devon CCG insist that money for a new health and wellbeing centre can only be found if the hospital is closed. But the CCG told us in an email of 10/09/20: '*The construction of the Health and Wellbeing Centre in Teignmouth is not dependent on funds from the sale of the Teignmouth Hospital site.*' Minutes of meetings during 2018 show the CCG telling local GPs that the cash was dependent on their support for the '*vision'* of closing the hospital. Other minutes show the CCG planning to link the two issues during the consultation in order to overcome public opposition to the closure plan.

Teignmouth Hospital hosted the community response to COVID-19 in the first wave of infections, providing coordination for health, care and voluntary teams. Closing the hospital would not – as stated in the consultation documents – improve joined-up working. It would actually reduce the continuity between community and bed-based nursing, as people with complex needs would be sent to a private nursing home or out of the area.

Teignmouth Hospital provides essential NHS capacity, including many high-use community clinics, specialist clinics, a ward for 12 beds, and a day-care surgical unit. The Dept for Health and Social Care has commanded Trusts and CCGs to make full use of existing capacity to prepare for a second wave of COVID, whether they are nursing acute cases or managing other pressing needs such as community care and elective surgery. There is no sane case for closing the hospital at this time of national crisis.

Teignmouth Hospital is a much-loved community asset, the first NHS hospital to be purpose built with public funds. Since its founding in 1956 it has been cherished, maintained, improved, and equipped by the people of Teignmouth, especially through the fund-raising efforts of the League of Friends. The proposed new-build would be part-owned by a private investment company, leased back to the NHS on a long and expensive PFI lease. We still have no answers on what will happen to all the facilities paid for by local people, including many donations made since the start of the pandemic.

Refurbishing or rebuilding the hospital on the present site has never been fully costed or presented for scrutiny – the only case put forward has been to close it down.

The annual (revenue) costs presented in the consultation documents show that for a negligible annual saving (£14k) the locality would lose all the specialist clinics, surgeries and in-patient capacity of the hospital, and the associated staff and facilities. It would gain some extra consultation space in a building shared with GPs, a hotel and carpark. This does not seem like a compelling case.

The case for closing the hospital also rests on a claim that care in people's own homes is more successful than care in a community hospital setting. This case has never been proven. International and UK studies show that home-based care can work if it is funded to at least an equivalent level as hospital care. No assurances have been made that equivalent funding will be put into community nursing teams, to compensate for the loss of capacity at the hospital.

A survey by HealthWatch Torbay in January 2020 found that 44% of patients attending the hospital would find the new town centre site more difficult to attend, while 39% would experience little or no change. Meanwhile, moving specialist clinics to Dawlish would cause difficulties for 60% of respondents (23% little or no change). Specialist clinic users, who often come from beyond the immediate area, would find the move to Dawlish particularly difficult. These figures are missing from the main consultation document.

At present, the CCG's own figures show that the clinics at Teignmouth are treating a far higher number of patients than the equivalent clinics in Dawlish. Like Newton Abbot – the main beneficiary of earlier service removals – Dawlish is another PFI hospital.

We see a pattern across Devon of the CCG promising 'better care' in return for closing 'out of date' hospitals and services, only for these promises to be broken. When Teignmouth's Minor Injuries Unit was closed in 2015 it was justified as a new focus on rehabilitation and day surgery. The promised rehabilitation beds did not arrive, and the surgery unit is now deemed unfit for purpose. Meanwhile the MIU at Dawlish – supposed to offer a state-of-the-art alternative – has been suspended indefinitely. In Dartmouth, residents were promised a new health and wellbeing hub and 8 nursing beds to replace the hospital. The hospital closed in 2017 but the beds have never appeared, and the proposed new centre (still to be built) will not have any in-patient beds or an x-ray unit as originally promised. The same pattern has been repeated across Devon.

We support the provision of home-based community care, properly funded, and joined up with other health, primary care and voluntary services. We object to the loss of 12 community care beds and their nursing capacity from the joined-up care system in the Coastal locality. We object to a further cut in community hospital capacity in an NHS area (Devon) that has already lost 59% of its community beds, with knock-on effects on travel time for vulnerable patients, and on demand for the few remaining facilities. We object to a dependency on nursing beds in private care homes – a sector already struggling under the weight of COVID-19 deaths - for those people with more complex or serious conditions.

None of these objections, made many times before, are dealt with in the consultation documents.

Supporting evidence, claim by claim

5. ***'The joined-up way we care for people is so effective in keeping them at home and out of hospital that we don't need the 12 rehabilitation beds that were planned for Teignmouth Community Hospital'***

We salute the excellent quality of the community and home-based care teams in the locality. There are high levels of referral to the EIC Team, and they are providing a range of services, including referral to bed-based care where necessary. Currently this has to be in private nursing homes or out of area because the 12 rehabilitation beds promised for Teignmouth Community Hospital have never been opened.

Unlike Torbay, the Teignmouth area is not well served with nursing home beds. The case for dedicated rehabilitation beds put forward by the CCG in 2015 rested on projected increases in the frail and elderly population alongside the need to reduce delayed transfer of care from Torbay Hospital. These issues continue to be pressing. The Kings Fund has published numerous independent reviews that show the huge cut in bed numbers nationally has left NHS hospitals weakened and struggling to meet treatment targets – even before the arrival of the COVID-19 pandemic and the increase in patients needing acute, intermediate and rehabilitation care.

The evidence put forward in the Clinical Evidence submission does *not* show that home-based care is the *reason* for lower levels of bed occupancy, or that home care alone is *sufficient* without bed-based care also being available for respite, recovery, rehabilitation, intermediate and end-of-life care. It does *not* show that a private bed in a nursing home is a better option than a bed in a community hospital ward, alongside other services. It makes *no* promise to employ more community-based nurses to provide the additional resources that every model of home-based care says is necessary, if beds are to safely close. Our community health nurses, brilliant though they are, currently work at high capacity and under enormous pressure. Co-locating them with other care providers in an integrated team does not deal with the basic issue of nursing capacity.

Similar claims about the success of home-based care were used to support the closure of Dartmouth Community Hospital in 2017, and of community hospitals across Devon in 2016. The clinical 'case for change' that was used to defend all these closures was drawn up in 2016 by a member of the CCG in response to £556m cost savings demanded by NHS England (Devon's Sustainability and Transformation Plan). SOHS has challenged the robustness of the clinical evidence at every stage in the process.

In this consultation we once again see the non-standard, misleading and highly selective use of statistics, and of non-statistical judgements presented as statistics (see our detailed case below). The real rationale of saving costs is hidden behind service 'efficiencies' which in turn are passed off as enhancements to patient care. We can only hope that the South West Clinical Senate had access to more accurate and credible data when it drew the extraordinary conclusion that '*The impact of the Integrated Care Team has reduced the need for beds despite the demographic and demand*'.

We support the provision of home-based care, properly funded, and joined up with other health, care and voluntary services. We object to the loss of 12 community care beds and their nursing capacity from the joined-up care system in the Coastal locality. We object to a further cut in community hospital capacity in an NHS area (Devon) that has already lost 71% of its community beds, with knock-on effects on travel time for vulnerable patients, and on demand for the few remaining facilities. We object to a dependency on nursing beds in private care homes for those people with more complex or serious conditions, at a day rate that cannot be sustainable if the imperilled care sector is to survive in its current form. None of these objections, made many times before, are dealt with in the consultation documents.

Detailed notes

The charts shown from pages 8 to 11 of the Clinical Evidence document are introduced as though they are drawn from 'independent research' carried out by the Plymouth Institute of Health and Care Research (PIHCR)[1]. In fact they come from the CCG, as the independent researchers make clear when they refer to them.

The consultation document states that the PIHCR team found : '*A higher proportion of over-70s in the Teignmouth and Dawlish area receive bed-based care in their own bed compared with other areas, thanks to the way care is provided in the area'*. The CCG 2017/18 charts show that Coastal indeed had lower rates of in-bed intermediate care and higher rates of home-based care, but this is not surprising as the promised 12 community hospital beds had been mothballed, and local GPs were encouraged to refer people to home-based care instead. The research team found no causal link between care at home and low use of acute beds. It would be more truthful to say that the CCG's figures show more people are being referred to EIC and receiving care at home because that is how care is *allocated*.

The 2019 chart *does* show lower rates of acute bed use and bed use overall in Coastal, and might be persuasive if the figures for the whole 2018/19 year were used. But using data from just 60 days in April / May raises more questions than it answers. How many people were actually included in this data? Are the numbers high enough to draw *any* statistical inference relative to other localities? Why were these dates chosen, when they do not represent the most challenging time of year for keeping older people out of hospital?

We agree that figures for lower lengths of stay in intermediate care and lower attendance at A&E are good. However, an independent 2019 study from PIHCR noted that the figures for were based on a small volume and that *" fluctuations over time weaken attribution solely to EIC*". And the consultation paper itself admits that *'it is not clear if there is any correlation between low intermediate care bed days and high rates of referral to care at home'.*

This PIHCR study did not look at outcomes for people receiving different forms of care, but a second 2019 study from PIHCR *did* look at outcomes for a group of people referred to the EIC team. Many of these were referred for depression or bereavement. The two sub-groups in this study that might have benefited from bed-based care – deteriorating frail elderly people, and people nearing the end of their lives – were found to have had some negative

[1] Oddly, the only PIHCR study cited in the Clinical Evidence document is a methodological report into the Researcher in Residence approach, and as such it does not provide *any* findings relevant to the consultation. For this document, we looked at all the PIHCR studies that *were* potentially relevant to the consultation. We do not doubt the quality of the research, but we question its use to back up this claim.

outcomes during the study. It is not clear whether some of these people also received care in a private nursing bed, but in any case the study notes that no comparison (‘*counter-factual’*) was studied alongside care at home and says: ‘*Larger, better conceptualised, controlled studies are needed to strengthen claims of causality*’.

When comparative outcomes from home-based and bed-based care *are* systematically studied, as in the annual National Audit of Intermediate Care, we see that bed-based care generally provides greater benefits in terms of independence, mobility and reduced frailty, and that these differential benefits have increased in recent years. Intermediate care is one of the main reasons for having community beds available to those who really need them. As well as benefiting patients, the system-level benefits are to reduce the incidence of Delayed Transfers of Care and Delayed Discharges, issues that the Torbay and South Devon Healthcare Trust continues to struggle with, according to its own annual figures.

When we have asked for figures that allow direct comparison of outcomes from care at home with care in a community hospital bed, we have been told that the Devon NHS Trusts do not classify these people separately on referral. With community teams treating a wide range of people, most of them not requiring bed-based care, we question how the consultation paper arrives at the finding that ‘*community health and care teams… now care for four times as many people as they would be able to in 12 beds at Teignmouth Community Hospital’.* How have these people been classified as otherwise using bed-based care?

The quoted figure of 66% satisfaction among service users does not seem particularly high and would need to be compared with figures from other localities to be meaningful. Our previous queries about how these figures are arrived at suggest that service users are asked to complete a ‘happy sheet’ by the person providing their care at home. This is not a reliable way of judging clinical or quality of life outcomes.

In a 2020 study another team from PICHR looked at the reasons for the success of integrated care in the Coastal locality and recorded the ‘*history of collaboration’* between GPs, voluntary services and community hospitals as a prime reason. This study highlights the value of having joined-up care pathways and notes that this is not a cheap option: ‘*Resources are important to implementation success*’. Previous studies cited in the PIHCR report – along with studies by the BMJ and National Audit Office cited here – found that care at home requires funding, facilities, staff and leadership to be transferred from hospital settings into the community: in no case was this found to be a cheaper option.

The Financial supporting evidence shows that in fact 85 people being cared for by the EIC did need bed-based care last year, all apparently in private care-home settings. The costs of these beds are recorded, but not the outcomes for patients. Again, counter-factual evidence from a community hospital setting is not available, because the promised community hospital beds were not there.

By using the term ‘hospital’ and ‘hospital beds’, the consultation documents seem to deliberately confuse care in a community hospital – an integral part of community care – with occupancy of an acute hospital bed – generally seen as the result of a break-down in community care. Keeping patients ‘out of hospital’ is a wonderful aspiration, but when bed-based care is needed, a private care home bed or a hospital bed out of area is not a better option than care in a local community hospital, close to home and family, and with other services on site.

We respect the professional judgement of the EIC team in assessing the value of their own interventions, but find it harder to credit their judgement about alternative interventions that *might* not have been necessary, without any external audit or comparison. If these figures '*do not represent real costs or savings (or the marginal benefit of investing in an "Enhanced" IC)*', they should not be visualized as graphs or presented to two decimal points, suggesting carefully and accurately costed savings.

The Consultation document says:	We say
the highest referral rate into and use of the intermediate care team in the CCG, including of social prescribing.	The EIC team is doing excellent work, but that is the model of care that has been established. Community hospital beds are not available in the locality; social prescribing is not an alternative.
The lowest rate of hospital bed days used per 1000 population over 70 in the CCG.	Naturally the use of community hospital beds is lower when these are not available. The use of acute beds in 2017/18 was not significantly lower than in other parts of the CCG. The 2019 figures were highly selective, covering just the months of April and May, so no conclusions can be drawn.
A 6% reduction in emergency admissions compared to a 3% CCG average increase. This reflects that people's health and care is more under control with crises being anticipated and supported while the person is at home.	This is a good figure, and we salute the excellent care of the EIC team. But the number of people in the sample is low, and numbers fluctuate. The independent researchers cited in the Clinical Evidence document in fact said that this one-year effect could *not* be attributed to better care by the EIC team – the opposite of what is claimed.
[We have] Monitored patient satisfaction throughout the process.	Patient satisfaction was recorded to be around 66%. No comparison figure (e.g. for community hospital care) was offered. Our own investigations have found that this entails service users filling in a 'happy sheet' while the service provider is in their home with them. This is not a reliable indicator of patient outcomes.
Community health and care teams… now care for four times as many people as they would be able to in 12 beds at Teignmouth Community Hospital	We know from our own FOI queries that the CCG does not collect data separately about people receiving care at home who might otherwise have received a community hospital bed (e.g. on discharge from acute care). The figures for community and health care users include a wide range of people with many conditions for which bed-based care is not appropriate. Unless the CCG monitors which community care users might otherwise have received a hospital bed, this figure is meaningless and misleading.

In conclusion, there is no evidence here to support the contention that '*the way we care for people*' at home provides better clinical outcomes or keeps people out of acute care for longer. These claims have been made since 2016 to justify the closure of community hospitals around the country.

6. *'Any further waves of COVID-19 infection in Torbay/South Devon will not require the use of additional community hospital beds – and in any case Teignmouth beds would not be suitable.'*

The South West was lucky to have such a low rate of infections in the first wave of Covid-19. We were lucky that the Nightingale Hospital in Exeter was not required, as there was no evidence it was ready for use or could be appropriately staffed.

The most recent directive from the Department for Health anticipates a second wave of Covid-19 infections this autumn and requires all Trusts and CCGs to '*make full use of the NHS capacity currently available'.* Other NHS regions are reopening community hospitals and beds to cope with the anticipated demand. The CCG cannot be confident in its assertion that we will not need community hospital beds in a second wave.

Throughout the country, the Government is closing NHS capacity while it allows new privately-built 'Nightingale' hospitals to open and take on NHS staff. Day-case surgeries are being diverted to private hospitals such as Mount Stuart in Plymouth, while capacity in community hospitals is mothballed. This is an ideological project. To pursue it in the middle of a pandemic is to risk people's lives.

Teignmouth Hospital provided the hub for the community response to Covid during the first wave, refuting the consultation suggestion that closing the hospital will somehow support better joined-up working in the locality. With its fully equipped operating theatre, clinical spaces and ward, and its location at the heart of the town, it represents a significant asset at a time of public health crisis. Closing it at a time when the community faces unprecedented public health challenges would be an act of extraordinary recklessness.

Detailed notes:

Community hospital beds have been used here in Devon and across the country, sometimes for treating recovering COVID patients and sometimes to treat other conditions in a COVID-safe environment. Other NHS regions – Dorset, Stoke on Trent and Staffordshire for example – have reopened community hospital beds to meet the demands of the pandemic. This is no time to be closing down a hospital with a fully equipped surgical theatre, a range of clinical spaces and facilities, and capacity to care for in-patients.

The 'Impact of COVID-19' document recognises that '*Teignmouth Community Hospital was used to run the Primary Care COVID-19 hub for the locality*', providing a wide range of care to 208 people in the first wave: '*The hub was run from the outpatient department at Teignmouth Community Hospital where it was possible to isolate the area from other parts of the building and not disrupt other activities*'. We salute the extraordinary dedication and professionalism of the care teams at the community hospital and beyond, who played a

significant part in keeping infections and severe outcomes to a minimum. This undermines the argument that closing the community hospital will improve joined up working among health and care agencies.

The same document notes that only 8% of people discharged from acute care with COVID-19 received further bed-based care, and that this need was met by care homes. Across Devon, we know that some care home managers refused to accept people along this care pathway in order to protect other residents – and this may account for the relatively low levels of care home deaths. Is this another case of the *allocation* of care (i.e. to home rather than bed-based) being presented as a positive outcome for patients? We also note the lack of attention to the care required by the 15% of Covid-19 patients who had 'life-changing' outcomes from their illness. The as-yet unknown long-term health impacts of COVID-19 on the elderly population make it foolish to consider any cuts in community health capacity at this time.

During the summer, NHS England has prioritised elective surgery and community care, both carried out at Teignmouth Hospital, to take the pressure off acute beds with ventilation facilities. The care of recently discharged and 'long covid' patients, who may have complex and unpredictable needs, is increasing demand on community services. The CCG's own figures show that 8% of COVID patients discharged from hospital in our area need further bed-based care. Community beds need not be used for nursing live Covid-19 infections to make a crucial contribution to the local Covid-19 response.

The NHS response to Covid-19, as communicated to Trusts and CCGs in March, included community hospital beds explicitly in its capacity-building plans. The update sent to Trusts and CCGs on July 31 required them to prioritise elective surgery and community healthcare in the 'window' before an anticipated second wave of infections. This update demanded that all Trusts '*make full use of the NHS capacity currently available'.* It also highlighted the role of community health in supporting *'patients who have recovered from the acute phase of Covid but need ongoing rehabilitation and other community health services'.*

There is no good argument for closing NHS hospitals and wards while paying private providers to open new capacity (such as the 'Nightingale' hospital in Exeter, which has so far been used exclusively for private diagnostics). Nor is there any justification for paying private hospitals (such as Mount Stuart in Plymouth) to manage the backlog of day-care operations while there is surgical capacity in NHS community hospitals such as Teignmouth. The suspicion must be that the Government is closing NHS capacity while boosting the role of private providers in the NHS for ideological reasons, and doing so at a time when the country needs secure hospital beds, staffed by well trained doctors and nurses, who understand the needs of their locale.

While the NHS expects regions to boost their community care capacity, a recent (May 2020) study by the Kings Fund found that community care came under extreme pressure in the first wave of infections and faces possible collapse in a second wave:
"the capacity of some community services risks being stretched to breaking point as they support a high volume of complex early discharges from hospitals. Meanwhile… an increase in elective surgery would also have significant consequences for community capacity – it is

community nurses, occupational therapists, physiotherapists, and wider intermediate care teams who will be responsible for providing the post-operative wound care, discharge support and rehabilitation that will be required by many. At the same time, community services will be clearing their own backlog."

7. *'The [proposed Brunwick Street] new build is required to safeguard the future of GP services'*

All NHS and GP services should be provided from up to date, clinically suitable premises, and all NHS and primary care staff have the right to work in safe and clinically suitable settings.

However, the condition of GP premises has no bearing on the siting and provision of NHS hospital services. The CCG has deliberately linked the upgrading of GP premises to the closure of Teignmouth hospital as part of its strategy for managing local resistance to the closure plans. GPs were vocal in their resistance to closure in earlier consultations, a situation that the CCG wanted to avoid, as it undermined their clinical 'case for change' (i.e. that case that care at home was sufficient).

A formal response from the CCGs Governing Board to questions raised by SOHS in February 2020 states that '*The construction of the Health and Wellbeing Centre in Teignmouth is not dependent on funds from the sale of the Teignmouth Hospital site'*. Yet the minutes of several meetings held between the CCG and GP leads during 2018 show that this dependency was asserted as a fact, and that this was part of a deliberate attempt by the CCG to manage public opposition to the hospital closure.

Our belief is that any proceeds of sale will in fact disappear into the 'savings' still being demanded by NHS England - £400m further cuts were proposed to Devon County Council's Health and Adult Care Scrutiny Committee in April 2020, at the start of the pandemic.

Detailed notes
In 2015, doctors from three of Teignmouth's four GP surgeries joined the 'option three' group to argue against the closure of acute beds and the minor injury unit at Teignmouth. Two of these doctors were censured for their 'antagonistic approach' to the closure plans.

In 2017, before a promised consultation could take place, the Trust abruptly closed the hospital's rehabilitation ward and mothballed the 12 beds that had been deemed necessary in the 2015 review. This met with further local opposition, including from some of the same GP surgeries.

In 2018 the Trust decided that the hospital itself should be closed and sold. Minutes from CCG meetings show that the CCG began to see the value in linking this unpopular closure with the need for new premises for GPs. At a meeting with GP leads on 13/09/18: *Discussed the need to have all partners signed up to the vision, proposals [for the new Wellbeing Hub] and implications for Teignmouth hospital*. At a meeting with GP leads on 11/12/18: '*Have to release the hospital site to fund this'*. At this second meeting, the outcome of the (current) consultation was clearly outlined – not as desirable, but as though it was already assured:

'*the formal public consultation re rehab beds, moving services, therefore we no longer have need for the hospital… Where's everything else [i.e. clinics, surgery] going? Need to tell them what's staying and what's moving.* At an internal meeting on 14/09/2020: '*Jenny noted that although it suggests that primary care and CCG run different parts of the consultation it does need to be seen by the public as an interlinked project and dependent on each other. It would be helpful to have the financial interdependencies described.'*

In February 2020 we asked a direct question of the CCG's Governing Board regarding the financial interdependence of the investment in the new build at Brunswick Street and the sale of the existing Teignmpouth hospital site. We received the following response (email from the Consultation Team on 10/09/20 – ten days after the consultation began).

> *The construction of the Health and Wellbeing Centre in Teignmouth is* <u>*not dependent*</u> *on funds from the sale of the Teignmouth Hospital site.The financial paper states that the financial model has been developed and approved by Torbay and South Devon Foundation NHS Trust (TSDFT) Finance Committee on the grounds that TSDFT would be able to contribute £1.4million capital from the sale of community sites and the GPs £1million, secured from NHS England/Improvement primary care estates funding. TSDFT's joint venture partner will work to secure a developer/funder to support the remainder of the build costs. Sale of community sites is not specifically dependent on Teignmouth Community Hospital, but its sale will contribute to that pot.*

In the Options Evaluation document, the only substantial reason recorded for not siting clinics at a rehabilitated or rebuilt hospital on the existing site was access to GP services – services that have never been provided at that site and that there is no proposal to situate there:

> *Concerns were raised that the Teignmouth Community Hospital site presented a challenge in terms of accessibility, particularly if GP and primary care services were co-located there.*
> *GPs did not support the site as a location for primary care due to accessibility for patients*

8 Specialist clinics and day surgery procedures need to be moved because '*Dawlish Community Hospital is a modern, purpose-built hospital with space and capacity that can be better used.'*

The Currie and Brown survey from 2018 found the current Teignmouth Hospital building to be 'in reasonable condition': *The physical condition of the building was found to be sound, operationally safe and exhibits only minor deterioration'*. It did find that '*A number of improvements could be made to the layout internally to improve the reception and waiting areas and better use of the first-floor areas could be made to utilise the facility to its full capacity.'* In other words, the promised 12 rehabilitation beds could be installed and put to use. In the case of Teignmouth, under-use (through deliberate policy) is given as an argument for closure, while in the case of Dawlish, under-use is given as an argument for investment.

All the possible upgrades are costed by Currie and Brown at a lower level than the figure that appears elsewhere in the consultation documents (£1.5 million). This is compared with £360k to convert existing capacity at Dawlish Hospital. However, the refurbishment figures from the C&B report refer to the entire hospital, including the inpatient beds and all the clinical spaces. At Dawlish they refer only to creating day surgery capacity where it does not currently exist.

The 'Current Services' document lists 23 specialist outpatient clinics currently run from Teignmouth Hospital. Attendance figures are available for only some of these, and show the Trauma & Orthopaedics and Pain Management clinics being particularly well used. There are almost no figures provided for clinics at Dawlish Hospital, so comparisons are unavailable, but where there are clinics in common (Trauma & Orthopaedics, and Orthoptist, Audiology and ENT) it is clear that Teignmouth Hospital was treating far more patients in the last reporting year.

A survey by HealthWatch Torbay in January 2020 found that 44% of patients attending the hospital would find the new town centre site more difficult to attend, while 39% would experience little or no change. Meanwhile, moving specialist clinics to Dawlish would cause difficulties for 60% of respondents (23% little or no change). Specialist clinic users, who often come from beyond the immediate area, would find the move to Dawlish particularly difficult. These figures are strangely missing from the main consultation document.

9 Financial information

The Financial information document is woefully inadequate and seems intentionally unclear. The capital costs of the three options – upgrading the current hospital, building a new hospital on site, or closing the hospital and redistributing its services – are not clearly available for comparison. Only the third of these options was ever fully costed and scrutinised.

The annual (revenue) costs as presented show that for a negligible annual saving (£14k) the area will lose an in-patient ward, fully equipped day surgery unit, all its specialist clinics ,and all the associated staff and facilities – many of them paid for by local people. It will gain 300m2 of extra consultation space, in a building shared with a hotel and carpark. This does not seem to local people like a good deal. Meanwhile, money will be spent creating surgery facilities at the privately owned Dawlish Hospital rather than upgrading those that already exist in Teignmough.

The value of the current asset is not considered anywhere in the documentation. Nor is the source of its funding. The Hospital was originally built by the NHS, using public money – in fact it was the first purpose-build NHS hospital in the country. It remained with the NHS until in 2016, under new powers (from the 2012 Health and Social Care Act), then Health Secretary Jermy Hunt transferred the whole of Devon's community hospital estate to a new entity, 'NHS Property Services Ltd'. Naturally over the years the hospital has required maintenance, refurbishment, and the installation of modern facilities. Much of this money has been provided by local people via the TH League of Friends - for example, almost the entire cost of the physiotherapy and occupational therapy suite was raised by the LoF.

The total cost to the NHS of the Brunswick Street development will be many times higher than the initial cost of the capital outlay. Instead of a public asset, cherished for generations, the community will have a generation-long commitment to pay rent worth millions of pounds to a Private Finance Initiative partnership between Torbay and South Devon NHS Trust and venture capitalists Morgan Sindhall. Local people do not believe this is a fair exchange, and NHS campaigners do not believe it represents good value to the public purse.

Detailed notes

The financial information provided to the consultation process does not allow for an easy comparison of the capital costs of the three options available. With respect to the clinics and surgeries – which are the comment element in the three options, and the only directly comparable ones - the costs appear to be:

1. siting them at the existing community hospital: **£1.5m**
2. siting them in a new hospital on the current site: **£2.3m**
3. moving them to the Brunswick Street site: £1.4m and to Dawlish £359,383: **£1.76m**

This hardly makes a compelling case for the third option, given that the day surgeries and specialist clinics will be four miles away. We note that only the third of these options was fully costed and put forward for scrutiny by the Devon CC Health and Adult Care Scrutiny Committee, when two other viable options are clearly available.

The revenue costs are even more confusing, with the current costs of running GP surgeries lumped together with the full costs of running the current Community Hospital, including services that would be lost from the town in the option for closure. We note that the running cost figures for a building that is not even on the drawing board yet cannot be known as accurately as the table on p.4 suggests. However, the figures as presented show that for a negligible annual saving (£14k) the area will lose an in-patient ward, fully equipped day surgery unit, all its specialist clinics ,and all the associated staff and faciltiies – many of them paid for by local people. It will gain 300m2 of extra consultation space, in a building shared with a hotel and carpark. This does not seem to local people like a good deal.

The costs of leasing back a brand new hospital on the existing site appear comparable to the costs of leasing part of a building at Brunswick Street. Yet, again, the latter is the only option that has been costed and scrutinised. In this option, the Trust is taking on 25-40 years' commitment to revenue expenditure. The total cost to the NHS will be many times higher than the initial cost of the capital outlay, and will mean a generation-long commitment to repayments.

When challenged on why they would opt to take on another PFI contract rather than upgrade existing NHS premises or build new premises without long-term private financing, the Trust responded (email of 10/09/20):

> *The Trust is contractually committed to working with its PFI partners and will continue to do so…. It is a model that ensures that through life-cycle payments, the*

building is maintained to a suitable standard for the duration of the contract and avoids the need for up-front capital expenditure which is not always available.

We have many questions. How long would the Brunswick Street lease of (initially) £139,519 run? What will the total cost of that lease be (25-40 years would be usual for a PFI contract)? Why have different models for funding a new build (e.g. ratio of capital to revenue/lease costs) not been explored? Why is there no exploration of the relative costs and benefits – to patients and staff – of the different site options, e.g. travel times/costs/difficulties, car parking, the consequences of clinics sharing space in a building primarily designed for other purposes? Why are the proposed cost savings not assessed against the loss of services to the people of Teignmouth and surrounding area?

We note that the proposed new build at Brunswick Street is part of a complex set of real estate contracts established as SDH Partnership, an arrangement between the Trust, Arcadis and venture capitalists Morgan Sindall Investments. For the new build, this partnership will appoint *another* 'developer funder', which in turn will contract the actual building work, with profits to be extracted at every stage.

At current estimates, the NHS will pay a total of £82bn in interest on PFI contracts that it already holds (2018 figures from HM Treasury). Research from the Centre for Health and the Public Interest identifies a wide range of negative impacts on the delivery of NHS services, while a comprehensive review by the National Audit Office in 2018 found that construction, maintenance and service costs were all higher under PFI contracts than contracts directly to the public purse.

We note that the Brunswick Street site was originally earmarked by Teignbridge District Council for a hotel development and carpark, and the most recent minutes of the Council note a requirement that construction of the hotel should start there in January 2021 (though other details of this meeting have been removed from public scrutiny). The larger contribution of the hotel and carpark project to the up-front build costs must raise doubts about whether the specification of the building will prioritise the needs of primary care and NHS patients.

Nowhere in the financial documentation is there any attempt to value the assets currently represented by the hospital site and facilities. We note that the two community hospitals at Dawlish and Newton Abbot that remain open, and have benefited from the transfer of medical beds and facilities from Teignmouth in 2016 (to Newton Abbot) and from the proposed transfer of clinics/surgeries in 2020 (to Dawlish) - are both PFI hospitals with leases estimated at £1.5million per year. The League of Friends and local people are understandably keen to know who will own these assets that they have helped so generously to fund.

We finally note that GPs have always been responsible for their own premises, but that recent incentives to take on PFI arrangements have not always worked out to their advantage, even when these have been managed via NHS Property Services. We now consider financial matters more closely.

The consultation documents also strongly infer that selling the Teignmouth Hospital site is a financial reprequisite for supporting the Brunswick Street new build. As we have shown, this is not the case.

10 The consultation process

Minutes of Devon CCG Locality Commissioning Group throughout 2018 record their intense lobbying to secure a positive outcome from the next consultation process. They have faced strong opposition from local people since the first round of closures in 2015. The results of previous consultations have never actually been made public, but we can only assume that they have not been positive towards the closure plans. SOHS will be demanding through every legal route available that we are given access to the collated/anonymised responses to the current process.

Minutes from meetings with GP leads throughout the second half of 2018 corroborate that the focus was to secure their agreement to the ‘vision’ and that this was achieved at least in part by insisting that the £1.4m investment in the Brunswick Street development was contingent on selling the hospital site. We now have the CCG’s own statement that no such financial dependency exists. Since 2015 we have seen a series of broken promises from the CCG about ‘better care’ that will follow from the closure of NHS hospital services. Exactly the same approach was taken in Dartmouth where opposition to the closure of Dartmouth Hospital in 2017 was first ignored, then paid off with the promise of a new health and wellbeing centre. This centre has still not been built, and when it is, plans do not include any in-patient beds or the promised x-ray and diagnostics unit.

Detailed notes

The consultation documents on the closure of Teignmouth’s MIU and acute beds in 2015 made the case that these closures were necessary to secure funds for the proposed ‘new model of care’, with 12 rehabilitation beds and a focus on day surgeries. It was stated that the MIU at Dawlish was more up to date and would provide a better service, despite being a greater distance to travel for most of the population to be served. In fact the 12 rehabilitation beds were never opened, and the MIU in Dawlish Hospital has been suspended indefinitely and the nearest services are at Torbay or Newton Abbot. The day surgery unit at Teignmouth was not upgraded as proposed in the 2015 consultation – and this is now being used as a reason to close it altogether!

In 2017 the CCG argued that the axing of the proposed rehabilitation beds was to save the hospital as an ongoing viable concern. Now in 2020 the argument is that only by closing the hospital can the new GP surgery and wellbeing hub be funded. Yet we have evidence from the CCG that no financial dependency exists. Devon NHS has been challenged to make hundreds of millions of pounds worth of savings, across all of its services and estates. In making those system-wide savings, it has never ringfenced particular ‘savings’ to be spent in the same locality. What it has done, consistently, is to promise local people ‘better’ care in place of what has been cut - but those promises have proved hollow.

In Dartmouth, exactly the same consultation strategy was followed. A much loved community hospital was abruptly earmarked for sale, and the proceeds of sale were ‘required’ to fund a new health and wellbeing centre in the town. At consultation meetings

the CCG promised in-patient beds, X-ray, physiotherapy and other clinics, as well as additional care beds in a private care home, funded by the NHS. As soon as the hospital was closed in 2017 the promised care beds vanished, leaving the town's many elderly and frail residents with no bed-based care. The new health and well-being hub has not yet been started, but plans show that it will not include x-ray or any in-patient beds. Opposition to the hospital closure from GPs, councillors and voluntary groups was successfully overcome when funding for the new build was tied to funds from the hospital sale. But again, no such financial dependence actually exists, and again the NHS is left with the costs of a long term PFI lease. Meanwhile the town has been making do with an interim clinic for over three years, with vulnerable patients travelling for many hours by bus to access the care they need in Totnes and Torbay.

Torbay and South Devon NHS Trust has given over management of its estates to a public private partnership designed to set up new PFI arrangements, out-source new builds and collect private rents. It has no capacity to restore or replacing NHS buildings in the public domain, and it was not intended for that purpose. The Hospital at Teignmouth, like other closed hospitals in Dartmouth, Ashburton, Bovey Tracey and Paignton, was a public asset, gifted to and maintained by the people of the town. The proposed new builds are shared-use facilities where clinical users may not have priority. Over time, they will cost the NHS far more than restoring or developing new purpose-built facilities, but they suit the current Government's agenda of reducing the public estate and putting as much NHS business as possible in private hands.

This whole process has never been subjected to public scrutiny. Instead, a few details are presented to citizens in different localities, with different incentives offered for moving or closing services, in a bid to win support for what would be robustly resisted if the whole picture were presented.

We note that the CCG has had nearly two years to carry out the required consultation and we are concerned to know why the consultation process been timed as it has, when public meetings are banned. The cost of over £26k to distribute leaflets by post over a wide area, including in postcodes far removed from Teignmouth, also raises questions: is the hope that the inevitable objections raised by local people will appear as a low percentage of those 'consulted', when it comes to reporting on the outcomes of the consultation process?

The consultation publicity avoids any picture of the existing hospital, which might remind people of what they are losing. It does feature an artists' impression of how the new build '*could look'* on the Brunswick Street site. As no contractors can be appointed until the outcome of the consultation, we wonder whose vision this is and just how far plans have actually progressed. We note that Teignmouth District Council has publicly required the ground to be broken on the Brunswick Street site by January 2021. We also note the minutes of CCG meetings throughout 2018 in which the 'vision' for the option under consultation was presented to a number of stakeholders as fact.