Save Our Hospital Services www.sohs.org.uk

SOHS NEWS Redlines

Save Our Hospital Services Devon

No.10 - 12 November 2016

WELCOME

We have heard a whisper that the Publicity Department at the Success Regime is getting a little down in the dumps. Apparently they work very hard to churn out lots of nice little articles saying how tiny the health cuts are and how we will hardly notice them, and somehow the public don't believe them.

So SOHS is certainly making an impact, and we must continue campaigning. We cannot afford to lose. This is a battle to protect the health of your loved ones.

For the Success Regime publicity department we can offer some advice as to how to make the public believe you. It is simple, just three words: tell the truth.

The public has become very adept at smelling a rat, and can I say, some of their publicity has a very nasty odour.

A welcome to any new readers. We are glad to have you on board and thank you for joining us. I hope that you enjoy this newsletter and I thank everyone who writes in. It can be a little lonely pounding away on the keyboard, but I know that it is part of a vital campaign.

Material for future newsletters editor@sohs.co.uk by Thursday

SOHS-Save Our Hospital Services
(A non- party group whose aim is to campaign to protect our health services in North Devon)

STP – The Last Report

The publication of the latest "final" version of the STP report took place at the end of last week. Here at SOHS the wise men are still wading through it, so it befalls this humble writer to take a first look at it. Expect this article to be laced with cynicism rather than admiration. No it is not a great report: it is not going to win the Booker Prize for reports, indeed it probably wouldn't even make the "also ran" list. However, it has one star quality. It manages to sound important and influential whilst saying, well nothing.

I have commented before on what I believe to be a deliberate attempt at deception by creating a haze of smoke so that we are left wondering what it all means. It could be compared to watching a drama on stage at a theatre when the smoke machine runs amok. The actors disappear into the fog, and then the final curtain comes down. What was it all about? Who knows? But as a well bred audience we all clap and applaud, because, well, that's what you do. And some will undoubtedly clap and applaud and the STP group will puff out their chests with pride.

But not all of us.

Let's just pick out a few choice morsels from this glowing piece of epistolary. For those not familiar with the word, epistolary describes something that is presented as fact, but is actually mainly a fiction. The cynic in me feels it is rather apt. I'll take the pieces in the order in which they appear in the report.

> Almost a quarter of local GPs plan to leave the NHS in 5 years and there are significant pressures on primary care services. (Page 5.)

At face value this seems to be a fact, but the truth is that this has been engineered by making sure that not enough new GPs are being recruited and making pay and working conditions less attractive to existing GPs. It is a mostly fabricated situation.

> Some services such as stroke, paediatrics and maternity are not clinically or financially sustainable in the long term without changes to the way they are delivered across Wider Devon. (page 5.)

This is because the NHS is being deliberately underfunded. Why is NHS spending per capita at a lower level in the UK than in many third world countries? This issue is not even considered in the report, yet surely this should be the first question that is being asked. In addition it seems disingenuous to this writer that the wider question is not considered as to how the NHS funding has worked successfully for many years and now does not work.

If you went shopping successfully week after week, and then all of a sudden find that you

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do not have enough money to meet your shopping bill, then surely the first thing you would consider is whether you are setting enough money aside for the budget. Only if you are unable to put more money into the budget do you consider whether you should buy a cheaper brand of baked beans, or water down the milk. There is one thing you will not consider: employing someone else to do your shopping for you! (back to this later.)

> We will strengthen community health & care services so that they can both help people to avoid the need to access NHS and other provided care and respond swiftly when people become unwell. This means investing in more community-based services and associated technology so that they mirror the availability and reliability of hospital-based care. This includes enhancing our support to carers and delivering high quality end of life care, as well as building wider community support that can keep people well. (page 26.)

This sounds good, but no detail is provided as to how this will be achieved and no data is given to show trials of this type of care. In the real world it probably won't work. An analysis of a report confirming this is given elsewhere in Redlines.

> We also want to make sure that people do not travel further than they need to for care / treatment. Keeping people well and independent avoids the need to travel for care. The more community and primary care services we can provide in or close to people's homes the better. (page 26.)

The first sentence we agree with. The second sentence conveys two divergent concepts "keeping people well" which we do not disagree with, but what is meant by keeping people "independent"? No explanation is given.

If a person is independent, then he does not need community health care, since by needing it he would become dependent. There is no suggestion given as to how this independence is achieved, nor at what level this independence is to kick in. If you have had a stroke or heart attack, how would you be enabled to become "independent" earlier. This is an example of how the STP uses fuzzy language and unclear thought to mislead.

Moving discussion from 'what's the matter with a person?' to 'what matters most to a person?' means that we would adopt a person-centred and asset-based approach to care, promoting networks of support, skills and attributes of individuals that increase people's self - confidence to manage their health and care for themselves.

This is basically an attempt to dress up a poor service in fancy language. What matters most to a person who is unwell is that they are fixed. If you have broken an arm and a leg, it is a stupid question as to what matters most. Should we fix your arm first, or your leg? You want, and deserve, to have both fixed. Health services are not a commodity with a tariff and availability set by accountants. They should be need based - ah that's what is the matter with the person. Their proposal is ridiculous and insulting.

> Our voluntary and community partners are at the heart of our new care model. (page 26.)

Translated, this means that there are various people poised to make money out of this. OK the charities and voluntary organisations will not do so, but you can be sure there will be "administrative" groups who get a nice handout from the government purse. There is also a wider ethical issue of why care should be handled by voluntary and community groups who are funded by public donation and rely on free labour. We already pay for health care in our taxes and contributions and we should get what we have paid for.

Remember my shopping example? How can it be cheaper and better to outsource care than to do it with a properly run public not-for-profit organisation? Nobody has produced any study that shows that this is the case.

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Diary dates

Visit our new diary page on the website. More dates and pretty pictures!

Thursday 17 November
17:30 - 20:00
Why we need a Bill to bring back the NHS;Professor Allyson Pollock Lecture theatre, RILD Building, Exeter Medical School, Royal Devon & Exeter Hospital, Barrack Road, Wonford, Exeter EX2 5DW

Wednesday 23 November
19:00
SOHS Committee meeting at The Guildhall. **Please note the change of venue.**

Don't forget to send us your dates to include in the diary. If people don't know, they won't attend

Wednesday 23 November
Northern-Eastern Locality Clinical Commissioning Group (CCG) meeting, Broadclyst Victory Hall, near Exeter (about 6 miles north-east) EX5 3DX Time to be advised

Monday 28 November
19:00 - 21:00
Save Our Local Hospital Services - Public Meeting, Bideford
This informal meeting will be hosted by Bideford residents who support Save Our Hospital Services Devon.

Thursday 15 December
14:00
Devon County Council Health & Wellbeing Board meeting, County Hall, Topsham Road, Exeter EX2 4QD.
NEW Devon CCG Governing Body meeting

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> Activation measures have been linked to improved clinical outcomes and reduced costs of care. (Page 27.)

Be careful of sweeping statements like this. Note there is no citation. So where is the study and clinical data on which this is based? You can bet it doesn't exist. (STP people, I challenge you to submit the proof in plain English to show that you are not attempting to hoodwink the public. If you are telling the truth, you have nothing to fear.)

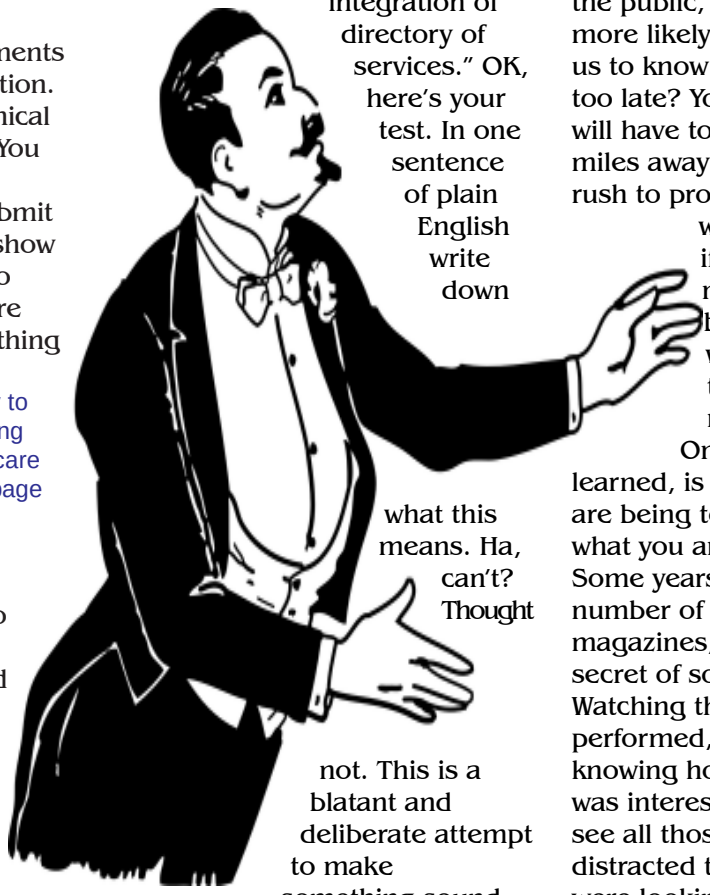
> Triage quickly and effectively to ensure that children and young people can access the right care appropriate to their needs. (page 43.)

How is this to be achieved if ambulances are stationed remotely and patients have to be taken to hospital 60 miles away? They speak with forked tongue.

> (There is) a growing awareness of the need for change by the public and staff. (page 44.)

This should be "a growing awareness of the need to oppose unreasonable change by the public and staff".

Look at the language used. Consider this (page 26) "Achieve a step change in patient activation and self-care. The South Devon and Torbay urgent care vanguard has a framework in place which includes consideration of social segmentation, a strengths-based approach to behaviour change and the development and integration of directory of services." OK, here's your test. In one sentence of plain English write down what this means. Ha, can't? Thought not. This is a blatant and deliberate attempt to make something sound as though it is saying something when it is actually saying nothing.



The final interesting observation is what has changed between this version of the STP and the previous one. A lot of detail has been left out (well, OK, not a *lot* of detail, as there wasn't much there to start with, but you get my drift). Why? we ask ourselves. Could it be that they have been listening to what we, the public, are saying? Or is it more likely that they don't want us to know the detail until it is too late? You see if they say you will have to go to a hospital 60 miles away for treatment, we all rush to protest and people get worried and angry. Yet if they say, we have to make a few changes because things aren't working properly at the moment, our response is different.

One thing I have learned, is never look at what you are being told, always consider what you are not being told. Some years back I used to edit a number of magician's trade magazines, and I learnt the secret of some of the tricks. Watching those tricks being performed, but at the same time knowing how they were done, was interesting, because I could see all those things that distracted the audience so they were looking in one direction while the real business was going on elsewhere. And let me say, it was no coincidence the magician had a glamorous assistant to divert attention. Now there's an idea STP people, bring it on!

The latest STP report will be added to the website shortly.

Stephen

Report on the two motions at the Scrutiny committee meeting

Phillip has given this report on the outcome of the Scrutiny Committee meeting.

In the past two weeks many of our activists and supporters were kind enough to lobby the 15 county councillors on the Health & Wellbeing Scrutiny Committee to ask them to approve two motions put to them at their meeting in Exeter on 8 December. SOHS is delighted to report that largely thanks to your efforts, the two motions with slight amendments (as below), were overwhelmingly carried, with 10 votes in favour, none against and four abstentions. The following day, DCC cabinet approved the motions for referral to the full council in a meeting scheduled for December 8th.

Once again, many thanks to all those who emailed, wrote or telephoned any or all of the councillors on the Scrutiny Committee. It worked and we got these motions approved because you took the time and trouble. We may be asking you to make the same request to many more county councillors in the coming days and weeks.

Meantime, Thank You again.

MOTIONS CARRIED BY DCC 8 and 9 November

Proposed Cuts to Devon Health Services and Impacts on Patients *(Councillor Biederman)*

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"This Council is deeply concerned about the impact the proposed cuts to Devon health services will have on patients – especially the loss of whole departments including maternity services at North Devon District Hospital – and the massive reduction in acute and community hospital beds across Devon, as set out in the sustainable transformation plan.

This Council also recognizes that Governments have not provided the NHS with fair levels of funding and now calls on local MPs to lobby government ministers to urgently and significantly increase the level of funding to the NHS, in order to protect our precious health services for current and future generations."

Passed by Health & Well-being Scrutiny Committee 10 votes in favour, 4 abstentions 8 November; passed by DCC Cabinet, 9 November.

NHS Success Regime

(Councillor Greenslade)

County Council believes that the NHS Regime project for Devon is now seriously flawed and accordingly calls on the Secretary of State for Health and NHS England to pause it forthwith. County Council further calls on Government and NHS England to firstly address the issue of fair funding for our area and to ensure the general election promise of an extra £8 billion of funding for the NHS is taken into account when assessing the claimed deficit for Devon NHS services.

Until funding issues are addressed it is not possible to decide whether or not there is a local NHS budget deficit to be addressed. Unnecessary cuts to local NHS budgets must be avoided!

Devon MPs to be asked to support this approach to protecting Devon NHS services."

Passed by Health & Well-being Scrutiny Committee 10 votes in favour, 4 abstentions 8 November; passed by DCC Cabinet, 10 November.

The sham of NHS consultation on service provision

A few thoughts from Anne about NHS Consultation

The paper to read is called "The sham of NHS consultation on service provision" *www.radstats.org.uk/no096/BoyleSteer96.pdf*

This document is about consultation. Considering the CCG/Trust failed to consult prior to closing the hospital beds in Torrington I would say what happened next in the Test of Change was a complete sham. Our MP, who is also a barrister, stated it was illegal not to consult prior to the healthcare change. The four requirements for lawful NHS consultation that are in this paper are listed below. That this model of care "*care closer to home*", a model that is failing, is to be rolled out across Devon, unethically, is really worrying. Personally I wouldn't want anyone to suffer the way our community has suffered and continues to do so.

Yesterday we heard that Staples ward in NDDH is closed. Was there any prior notice of this? I believe this is preparatory for the Trust to be in readiness for the Sustainability and Transformation Plans to be implemented. If so then the consultation is a sham. To be legal I would say that the consultation must come before any implementation (we probably need a lawyer to confirm this assertion). This is equally true of Holsworthy running at only 16 beds when the public (and the outcome of the consultation last year) was led to believe that 20 beds would remain in place: and yes I do remember Dr Womersley at the EGM saying that they would not reduce the beds without a consultation. That the beds remain "*flexed down*" is unlawful. That should be on record. What I would ask of all of you is this: should we challenge this closure of a ward and the reduction of another; and do we do it loudly? Secondly how can we support the staff who had no idea this was coming? I have added my comments. Please discuss and tell me your thoughts. .

Here is an excerpt from the Boyle Steer Report about lawful consultation. Something that has been missing throughout this whole process. (I would say the CCG/Trust and Success regime have failed on most of these lawful requirements.)

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"The Local Government and Public Involvement in Health Act 2007 (TSO, 2007) which places a duty on NHS Trusts, Primary Care Trusts and Strategic Health Authorities to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for change. (John's comment: In theory – though not often in effect – this should mean consulting and involving not just when a major change is proposed, but in ongoing service planning; not just in the consideration of a proposal, but in the development of that proposal; and, in decisions about general service delivery, not just major changes.)

The duty to involve and consult commenced on 1 January 2003 and guidance was issued in February 2003 – *Strengthening accountability - involving patients and the public: practice guidance* (Department of Health, 2003a). Further guidance was issued in *Substantial variations and developments of health services: a guide* (Centre for Public Scrutiny, 2005).

There are four requirements for lawful consultation:

1. at the formative stage the consulting body must have an open mind on the outcome;

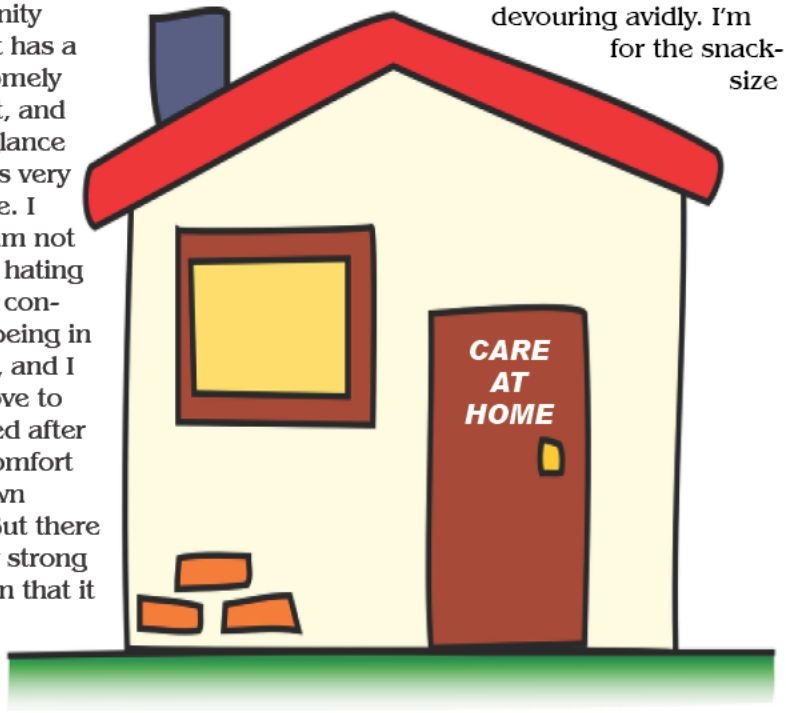
2. there must be sufficient reasons for the proposals and requests for further information should be supported;

3. adequate time should be allowed for consultation with all key stakeholders ie NHS bodies should not delay consultation until a situation is urgent; and,

4. there should be evidence of 'conscientious consideration' of responses by the consulting body."

Care in the Community

With a name that changes almost weekly, Care in the Community, Hospital at Home, Community Care, call it what you will, this concept is a pivotal part of the STP report, and at the very heart of the changes to our health service that are proposed. So it was with interest I turned to a report produced by Rand Europe. Before I go on to that let me just point out that I have many times asked whether there is any proof Care in the Community works. It has a great homely ring to it, and at first glance it sounds very attractive. I know I am not alone in hating the very concept of being in hospital, and I would love to be looked after in the comfort of my own home. But there is a very strong suspicion that it will not work. After all, it takes about three visits for a plumber to fix the radiators, so we would have to hope that a health care team would manage to deal with matters of life and death more efficiently. I don't want to be left in limbo during treatment while the technician pops back to base to see if they have any spares in the store.



So then we turn to Rand, a company that has some answers to the question. They describe themselves as a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. They produced a report back in 2006, which they have now updated. They call it a Scoping Review, which may not be the most snappy title, but, hey, it's streets ahead of Sustainability and Transformation Plan.

The review takes some time to read through, and for those who like all the details, there is a link given to an even more comprehensive version, which I am sure some of our SOHS people will be downloading and devouring avidly. I'm for the snack-size version myself. So to get down to the important detail, did the Rand team (some very impressive people put their name to the report) say it worked? Cutting down to the minimum, the answer is no. To be fair, it was possibly more a case of "not proven" because it had not been tested and there was no available data. But that is the very point. If someone were to come to you and say let's jump off this ledge, your first question would be, is it safe? If the answer came back that there was no data, nobody knew, because it had not been done before, then I am sure that, assuming you are sane, you

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would turn back. Who but a fool would suggest a plan that has never been tested, if there is a safer, proven alternative?

There are four assumptions investigated. Let's look at them:

> Care can safely be transferred from specialists to primary care practitioners

Not true of minor surgery and not necessarily true of GPSI[1] services

> Care in the community is cheaper than care in hospitals

Often not the case. Cost evaluation should not focus purely on NHS costs but also on prices charged by providers

> Transferring care into the community will not increase overall demand

There is a serious risk that increasing provision may increase demand either because of increased demand from patients or increased referral from GPs

> Care in the community is popular with patients and should therefore be encouraged

The general popularity of this policy would not necessarily survive loss of quality and efficiency

There's not exactly a lot that's positive there then. Basically the conclusion is that some parts of Care in the Community might work, but they might not be cheaper than the current model of care.

This is how Rand puts it:

- For many conditions, high-quality care in the community can be provided and is popular with patients. However, there is little conclusive evidence on the cost-effectiveness of the provision of more care in the community.
- Evidence from this study suggests that further shifts of care into the community can be justified only if (a) high value is given to patient convenience in relation to NHS costs or (b) community care can be provided in a way that reduces overall health-care costs.
- The reconfiguration of services can often be introduced without adequate evaluations, so it is important that new NHS initiatives collect data to show whether or not they have added value, and improved quality and patient and staff experience.

You can read it all for yourself at the following URL:

www.rand.org/randeurope/research/projects/moving-care-into-community.html

There are a couple of things that are not considered in the review, as they were outside the scope (pun not intended). They seem to this writer to be part of the same issue. Even if Care in the Community was possible, how is it going to be staffed and operated? Who would provide the care, and how would it be done? Presumably all the necessary machines and test equipment will have to be transported around, as well as the medical personnel. Not a problem, if all that is required is an injection, but rather more difficult if some sort of diagnostic tests need carrying out. In any case, surely the simple stuff can be carried out in the doctor's surgeries, if that is not already done. The STP does not give any detail of what their plan involves, which leads me to one of two conclusions: they don't know or they do know but don't want us to know. Either conclusion is undesirable.

I have already reached my own conclusion: the community should treat Care in the Community with care.

Stephen

[1] GPSI GP with Special Interest

Torrington News

Dave Clinch, has produced a good and informative press release that covers latest developments on the campaign in Torrington. You can view and download the document on our website.