Ashby de la Zouch Civic Society

Shaping the future and preserving the heritage of our town

Ashby District Hospital : A Valued Community Asset

Prof. Dr Barbara Kneale, MBChB, MRCGP, MFOM
on behalf of the Ashby de La Zouch Civic Society

We call upon you to be bold !

1. Do your duty and exert your power to stop this misguided strategy .

-Call for the re-opening the inpatient beds

-Call for a halt to removal of remaining services

-Call for proper innovative utilisation of the ADH Community Hospital

2. Refer this matter to the Full Council and demand a in-depth review
3. Refer this matter to the Secretary of State for Health to review the decision which we feel is not in the best interests of the Ashby and District Health Services

WE HAVE NO CONFIDENCE IN THE LPT and WLCCG,
NEITHER SHOULD THE COUNTY COUNCIL –YOU CAN'T AFFORD IT!

Contents

1. Clinical Evidence Base for Decision
2. Is the hospital “Fit for Purpose” or just not wanted ?
3. Lack of Proper Consultation and Engagement
4. Lack of Proper Planning and Long term Financial Planning
5. A Disregard for Equal access to healthcare

1. WE BELIEVE THAT THERE IS NO CLINICAL EVIDENCE BASE TO JUSTIFY CLOSING ASHBY DISTRICT HOSPITAL .

- Virtual Ward – *Nuffield Trust study 2013 no evidence in reducing emergency admissions .(LPT paper agrees)*
- Better Care Together Programme – no evidence in reducing long term hospital admissions and difficult to deliver due to staffing difficulties.(MD of CCG even agrees)
- End of Life Care- Already assessed as inadequate by the Care Quality Commission in January 2015
- Local A/E Targets – Only recently DCE UHL warned of higher level of admissions this winter which in his words "is clearly is worrying for us and our commissioners" This will lead to an increase in delayed transfer of care
- National Targets - Nationally 12% increase in delayed transfer of care-
- 5 Large Care Private sector providers - 2 weeks ago announced "continued supply of state-funded homecare will become unviable"

IN OUR VIEW THIS ONLY SIGNPOSTS IMPENDING PATIENT SAFETY ISSUES

WE BELIEVE THAT THERE IS NO CLINICAL EVIDENCE BASE TO JUSTIFY CLOSING ASHBY DISTRICT HOSPITAL .

Modern Ward Bathroom

2. WE BELIEVE THAT WITH MINIMAL INVESTMENT ASHBY DISTRICT HOSPITAL COULD PROVIDE QUALITY HEALTH SERVICES FOR THE LONG TERM FUTURE

- FIT FOR PURPOSE - Quality Care Commission report (Accredited Hospital Inspectorate) v Ernst and Young report (Accountants)
- ADH has **NOT** been classed as a category D! (DOH classification for unfit.)
- Repair and Maintenance Backlog – LPT unable to explain adequately
- No Estates Strategy or 5 year full property appraisal with the annual update as per DOH guidance.
- Complies with Fire Safety Regulations and Health and Safety regulations . No improvement notices.
- Hospital Tour with our own builder disputes the list of works by Intaserve.(which includes a £120,000 management fee!)
- Even so, any works (at a cost of £900K or not)would ensure that (it) will remain in Category B for at least the next 5 Years.

2. WE BELIEVE THAT WITH MINIMAL INVESTMENT ASHBY DISTRICT HOSPITAL COULD PROVIDE QUALITY HEALTH SERVICES FOR THE LONG TERM FUTURE

Ward Area

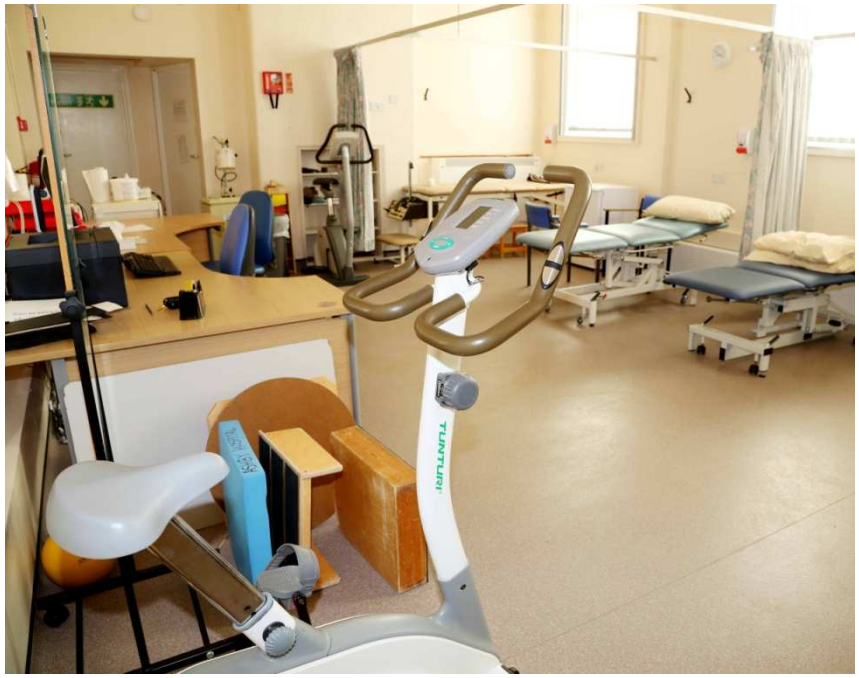
All the images in this presentation were taken in Autumn 2014

3.WE BELIEVE THE VIEWS OF ASHBY AND DISTRICT PEOPLE HAVE BEEN IGNORED

- LPT/WLCCG have **MISLED** this committee they have **NOT** actively engaged . All meetings that have been at the request of the ACS and been granted reluctantly . We have **ALWAYS** been told the decision is made and that is that!
- We have not received specific answers to our specific questions rather provided with voluminous documents or diverted to another body .
- Contrary to Jeremy Hunt's expectation of transparency ,after 10 months of difficult communication we have had to resort to FOI requests and it seems our next step is the Data Commissioner.
- We still not had our survey of 3,000 Ashby residents acknowledged given that The LPT/WLCCG consultation figures are woefully small < 400!
- LPT/WLCCG rebuffed our 200 strong public meeting all of who opposed to closing the hospital.
- Chief Exec NWLDC asked for consideration of 2 additional options involving the use of the ADH site which appear to have been discarded
- Ashby Town Council have opposed the closure of the hospital and a letter of support has been sent to this committee.

WE BELIEVE THAT THE VIEWS OF ASHBY AND DISTRICT PEOPLE HAVE BEEN IGNORED

Physiotherapy Department



4. WE BELIEVE THAT THERE IS NO VALID BUSINESS PLAN TO JUSTIFY THE CLOSURE OF ASHBY DISTRICT HOSPITAL.

- The Business Implementation plan (27-11-14) post dates the closure decision
- No Bed Modelling – planned on assumptions!
- "The State of the Art Facility" or "one stop shop" Where is it ? We have NEVER seen a viable plan .
- Hood Park facility -estimated cost £ 500 ,000 min with no budget approval and apparent wrangling between the NWLDC and LPT to relocate physiotherapy!
- All options have not been equally assessed
- The WLCCG has been awarded £ 200 million pounds to invest in primary care facilities.- why could some of this not be used on an innovative Ashby Community Health Hub?
- SHORT- TERM SOLUTION -Even the WLCCG Finance Director has expressed his concerns about the short term nature of this strategy based on their previous experiences

The Business Plan has achieved an empty hospital , an empty GP surgery ,a half empty GP surgery and a contentious extension to HoodPark or **was** that the plan all along?

WE BELIEVE THAT THERE IS NO VALID BUSINESS PLAN TO JUSTIFY THE CLOSURE OF ASHBY DISTRICT

Common Room

Ward Area

5.WE BELIEVE THAT THE LPT/WLCCG STRATEGY IS AGE DISCRIMINATORY

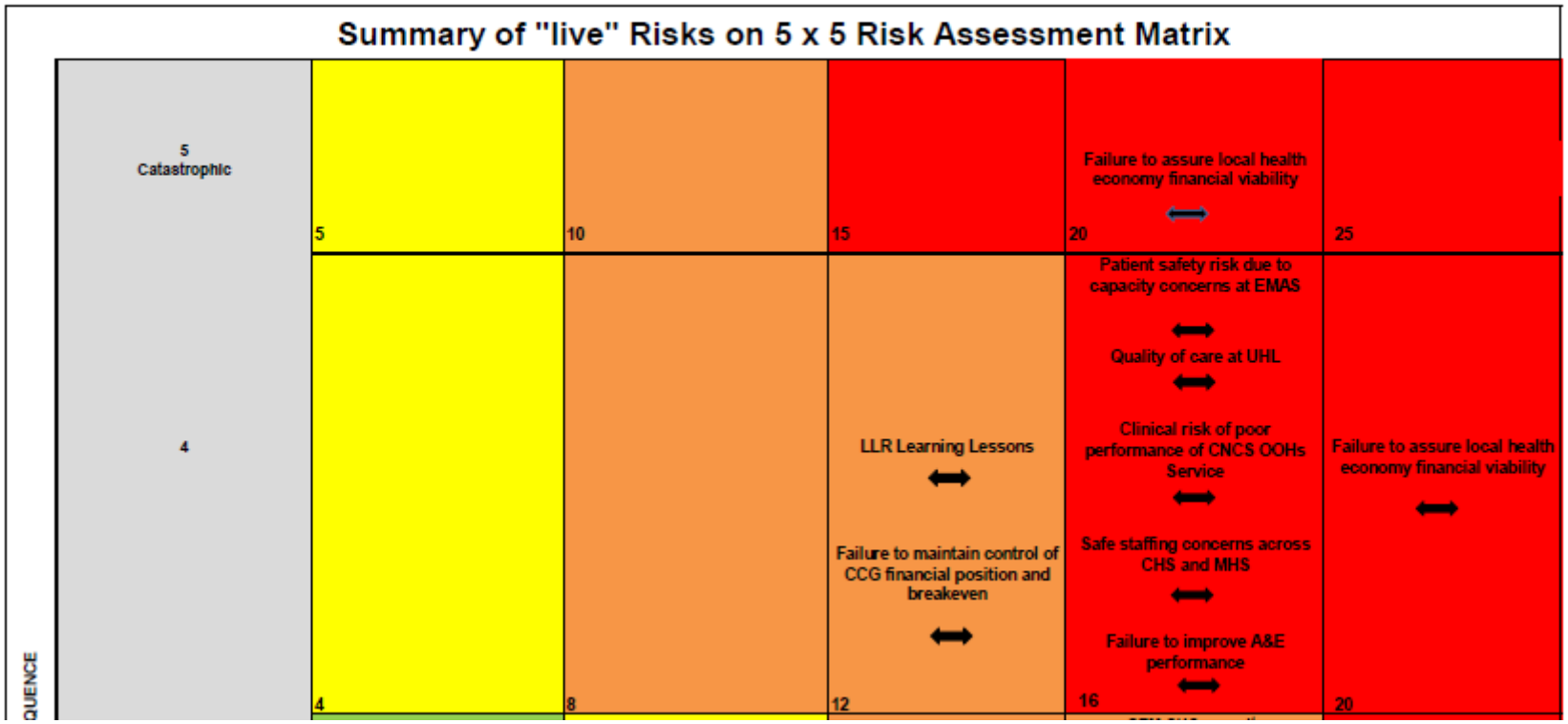
- UNIVERSAL ACCESS TO HEALTHCARE . The legal duty to reduce inequalities in the ability to access health services
- AGEING POPULATION -Majority of patients admitted to hospital are over 65 . This population is increasing and is above average in the Ashby region.
- Disproportionate funding of Community Health Services- Community Health services are being sacrificed to Acute Services and Primary Care .This has its main impact on the elderly
- In our opinion this misguided policy of closing community hospitals and underfunding community services is an example of INDIRECT DISCRIMINATION as it particularly effects the ageing population.
- In our opinion the lack of availability of local facilities means more travel and as such is an example of DIRECT AGE DISCRIMINATION . Not withstanding the comments of the Adult and Communities Overview Scrutiny Committee 1-9-15 ....

EXECUTIVE SUMMARY:
RISK REGISTER WLCCG 8-9-15

HIGH LIKLIHOOD OF CATASTROPHIC IMPACT

- Failure to assure local health economy financial viability over the next five years
- Patient safety risk due to capacity of East Midlands Ambulance Service
- Clinical risk associated with poor performance of CNCS Out Of Hours service
- Safe staffing concerns across Community Health Services and at the Mental Health Services Divisions
- Failure to improve A&E performance
- Failure to improve 18 week RTT (referral to treatment) performance

RISK REGISTER WLCCG 8-9-15



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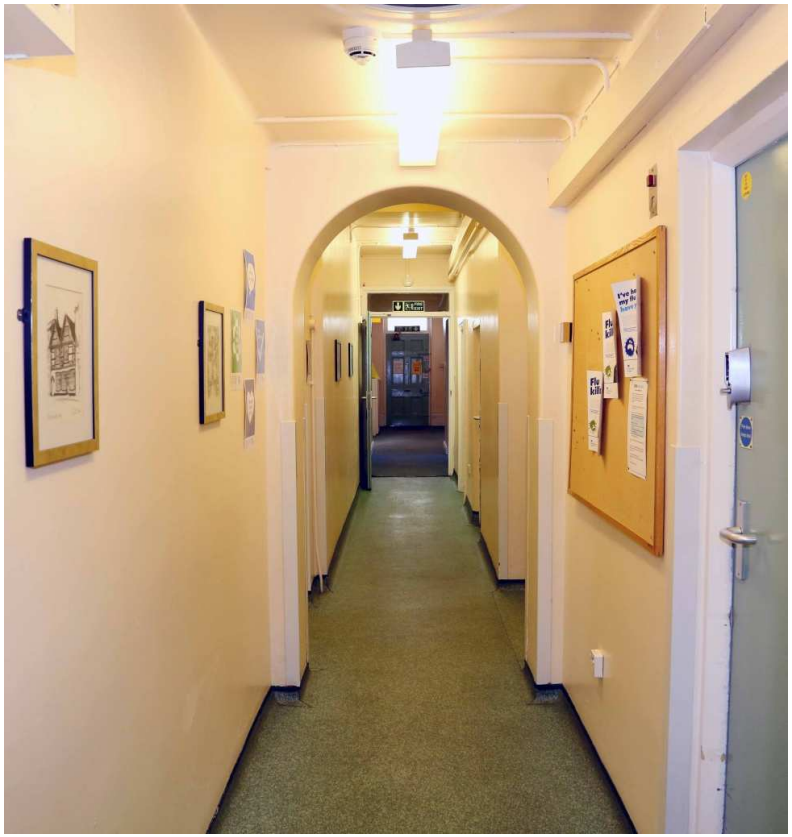
Corridor

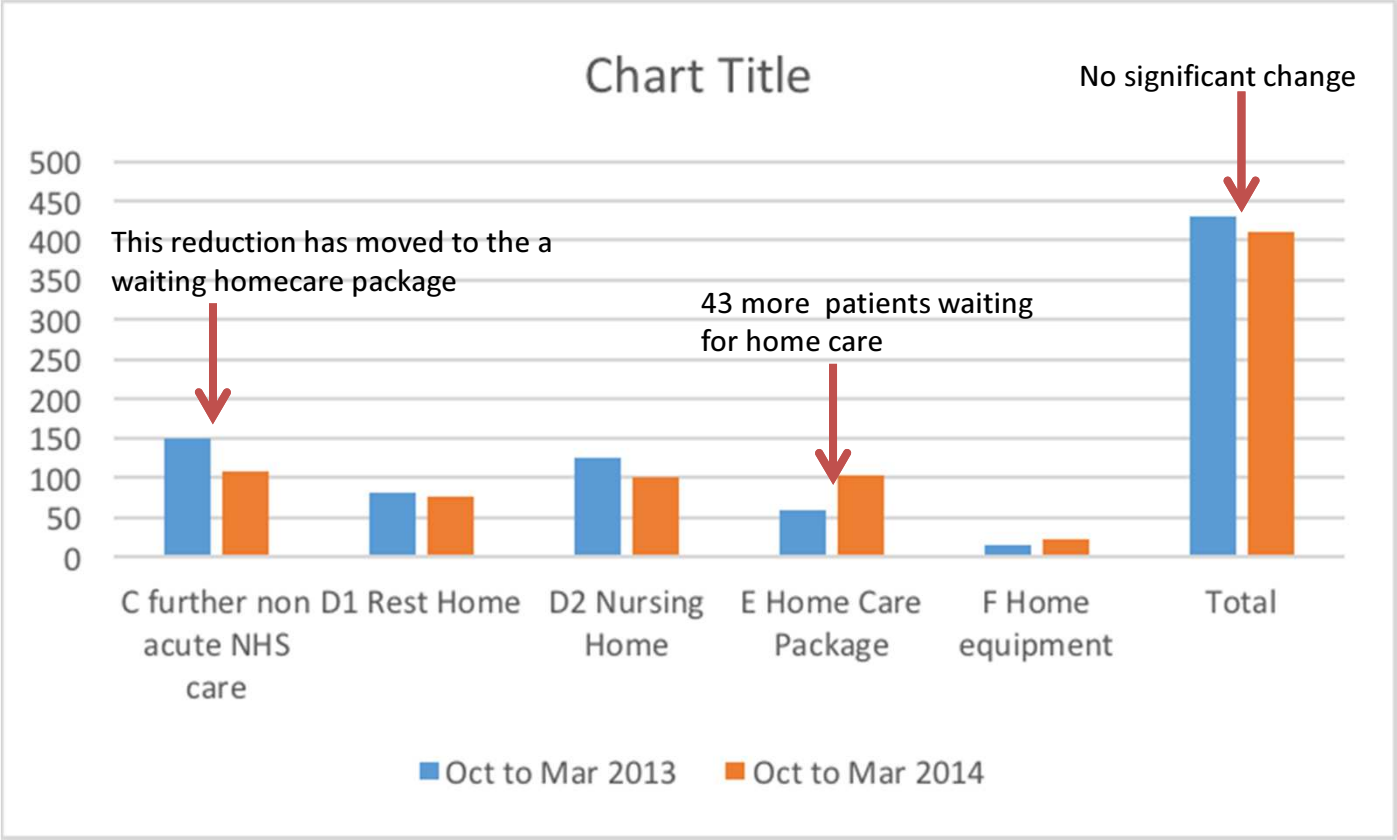


Waiting Area

Broken Promises!

In HOSC March 2014 , the LPT/CCG said;	18 months later actual situation;
Quicker transfer from hospital to home or NH	1.Ashby patients admitted to hospitals out of area . 2.Ashby patients awaiting home care package in Acute Hospitals causing delay of transfer issue for the acute sector. (see graph)
End of Life Care would be unchanged	Is that unchanged from already inadequate? (ref CQC report 2015)
Patient Choice	There is no choice you go where there is availability due to excessive occupancy rates !
More modern setting and alternative facilities to be arranged before closure	Dispersal of services with no concrete plan of where they will be!
Healthwatch expressed concern re UHL statement that the CCG's have decided to reduce community capacity which "reduces our ability to discharge patients"	They were right ! The demand and pressures in the acute sector continue.

Comparison of the Reasons Patients are awaiting discharge from hospital.



We call upon you to be bold !

WE HAVE NO CONFIDENCE IN THE LPT and WLCCG!

1. We ask you to do your duty and exert your power to stop this misguided strategy which is not in the best interests of the Ashby and District health services

-*Call for re-opening of the inpatient beds*

-*Call for a halt to removal of remaining services*

-*Call for proper innovative utilisation of the ADH Community Hospital*

2. Refer this matter to the Full Council and demand a in-depth review

3. Refer this decision to the Secretary of State for Health .

Finally , remember the words of Robert Francis QC after the Mid- Staffordshire public enquiry;

PEOPLE MUST ALWAYS COME BEFORE NUMBERS

Thank-you for your attention

Appendix 1 Questions

1. Question from Mr. John White to 9 September Health Overview and Scrutiny Committee

Re: Ashby District Hospital Closure

Is the committee aware that LPT/WLCCG have stated that £500,000.00 is needed to bring ADH up to current standards- a sum, and the need for it, long disputed by us , and our builder following a recent visit.

Yet they propose to spend at least this sum and ongoing rentals on a “carbuncle” type addition to the front of Hood Park Leisure Centre, to relocate just 1 of 16 Out Patient Services from ADH.

No planning application has been made to date but a covenant exists from the benefactor of Hood Park, given to Ashby residents “for leisure purposes only”, to protect against the use for and any building for “non-leisure purposes”.

Does the Committee consider this ill-founded approach to relocate just one of sixteen Outpatient services to be a prudent, sensible and wise use of public money at a time for financial prudence?

2. Question for the Health Overview and Scrutiny Committee – 9th September, 2015

The Agenda item 8 sets out the plans for implementing aspects of the Better Care Together Programme.

This is a huge sea change in the delivery of acute and community services in Leicestershire.

I note many issues indicating **the unpreparedness** of supporting services and **unproven status** of many initiatives, e.g.:

Mary Barber's paper at Appendix 1: "Community Services Offer-Summary of proposed improvements"says:

"Evidence to support the impact of large scale reconfigurations of hospital services on finance is almost entirely lacking"

"Even with successful implementation, there is little evidence to suggest that community based models of care will generate significant savings"

"There is mixed evidence on the capacity of community and primary care –based initiatives to reduce unplanned hospital admissions and help keep people at home"

As far as clinical effectiveness is concerned she shows in Tables 2 and 3 that the impact of community based initiatives on unplanned admissions is variable, and even increases emergency cases in some cases. Likewise the impact of primary care factors on planned hospital admissions has inconclusive evidence.

Bed modelling still has to be done, despite the closure of one community hospital's beds already

Workforce is one of the greatest areas of risk implementation with basic data about the "actual nursing numbers available to the CCG lacking "transparency.

So will Members please challenge why services are to be dismantled before effective planning and preparation has been completed and before clinical and financial benefits have been proven;

Ensure that effective performance and outcome indicators are in place

Consider what the financial implications of failure might be

And, most importantly, for the sake of patients who will either live or die as a result of any service inadequacies, demand to see what contingency plans are in place in the event of breakdown of any of the services?