

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE



Report subject	Independent Reconfiguration Panel - Dorset CCG Clinical Services Review
Meeting date	22 July 2019
Status	Public Report
Executive summary	This Report provides an update for the Committee on the referral of proposed changes to the delivery of health services in Dorset to the Secretary of State made by Dorset County Council and supported by the Borough of Poole. The Report outlines the current position and relevant procedure.
Recommendations	<p>It is RECOMMENDED that:</p> <p>(a) The Committee notes the current position, and</p> <p>(b) Requests a further report be provided to the Committee when additional information is available</p>
Reason for recommendations	To ensure that the Committee is kept up to date about the progress of the referral

Portfolio Holder(s):	Councillor Lesley Dedman, Portfolio Holder for Adults & Health
Corporate Director	Jan Thurgood, Corporate Director, Adult Social Care
Contributors	Tanya Coulter, Director, Law & Governance
Wards	All wards
Classification	For Update and Information

Background

1. Councils have the power in certain circumstances to refer proposed changes to health services within their area to the Secretary of State for Health and Social Care.
2. This power sits with the relevant Overview and Scrutiny Committee of the local authority.
3. Changes proposed to health services in Dorset have been the subject of debate and consideration by the Councils in Dorset over a lengthy period. This debate culminated in a referral made by the former Dorset County Council to the Secretary of State. This referral was formally supported by the former Borough of Poole following a meeting of its Overview and Scrutiny Committee in December 2018. The letter of referral and letter of support are attached at Appendix 1 and 2.
4. The Secretary of State manages such referrals by seeking the views and recommendations of an Independent Reconfiguration Panel.

Update on Current Position

5. The Council received notification in June 2019 that the referral had been forwarded by the Secretary of State for consideration by the Independent Reconfiguration Panel. The letter was addressed to the former Chair of the relevant Committee at Dorset County Council. It was circulated to all Councillors for information, and is attached at Appendix 3.
6. To ensure that the Independent Reconfiguration Panel is aware of the status of the new BCP Council, and to seek further clarification of its approach and timescales, a letter was sent by the Director, Law & Governance in consultation with the Corporate Director, Adult Social Care; Portfolio Holder for Adults & Health and the Chair of the Health and Adult Social Care Overview & Scrutiny Committee. This letter is attached at Appendix 4.
7. The Committee will note that one of the key issues raised is the status of BCP Council in the matter. As the formal statutory referral was made by Dorset County Council, both Dorset Council and BCP Council as successor Councils are parties to the statutory referral further to the statutory orders which apply to the local government re-organisation.

8. The Independent Reconfiguration Panel has responded by stating that the status of the Council is noted and attaching a letter it has sent to the Secretary of State by way of update on the likely timescales involved. This response is attached at Appendix 5. Councillors will note that due to other matters requiring completion it is unlikely the Independent Reconfiguration Panel will be able to consider the Dorset position until later in the summer. It is also currently awaiting information it requires as part of its standard process. This information will be provided by the health service on a standard template which is completed to enable the review to progress.
9. Information about the Independent Reconfiguration Panel is available on its website, which can be accessed by the following link:
<https://www.gov.uk/government/organisations/independent-reconfiguration-panel>
10. This Committee has the power and responsibility to scrutinise proposed changes to health care in the area, and accordingly is the Committee which will need to be updated as to the progress of this referral and consider any implications and outcomes as the review progresses.

Summary of financial implications

11. There are no financial implications arising from this report.

Summary of legal implications

12. The referral was made pursuant to the relevant Regulations and statutory process. The Secretary of State has to consider the referral and will do so taking account of the independent advice of the Independent Reconfiguration Panel. The Council may be asked to provide further information pursuant to the referral and the Committee will be advised should this be the case.

Summary of human resources implications

13. There are no human resources implications arising from this report.

Summary of environmental impact

14. There are no environmental implications arising from this report.

Summary of public health implications

15. There are no public health implications arising from this report.

Summary of equality implications

16. There are no equality implications arising from this report.

Summary of risk assessment

17. The referral has been made by a predecessor Council and the Council is obliged to engage and provide information in line with the statutory process which applies. There is a potential risk of delay in the process which could cause uncertainty in regard to future arrangements, however the Council is not in a

position to mitigate this risk other than to ensure that it provides information if requested to do so in a timely manner.

Background papers

None

Appendices

Appendix 1: letter from Dorset County Council to Secretary of State

Appendix 2: letter from Borough of Poole to Secretary of State

Appendix 3: letter from Secretary of State to former Chair of Dorset County Council
Overview & Scrutiny Committee

Appendix 4: letter from Director of Law & Governance to Independent
Reconfiguration Panel

Appendix 5: response from Independent Reconfiguration Panel to Director of Law &
Governance



Dorset County Council

Unclassified

Dorset Health Scrutiny Committee
Dorset County Council
County Hall, Colliton Park
Dorchester, DT1 1XJ

The Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care,
39 Victoria Street
LONDON
SW1H 0EU

Telephone: 01305 224388 / 224878

We welcome calls via text Relay

Email: a.p.harris@dorsetcc.gov.uk
Website: www.dorsetforyou.gov.uk

Date: 5 November 2018
My ref: Ref-SofS-Let
Your ref:

Dear Secretary of State

Referral to the Secretary of State for Health and Social Care by Dorset Health Scrutiny Committee with regard to two elements of the Clinical Services Review undertaken by NHS Dorset Clinical Commissioning Group

Please find attached a copy of a referral for your consideration from Dorset Health Scrutiny Committee with regard to two elements of the Clinical Services Review undertaken by NHS Dorset Clinical Commissioning Group:

- Concern that the travel times by the South West Ambulance Service NHS Foundation Trust have not been satisfactorily scrutinised and that the evidence needs further investigation to the current claim that these travel times will not cause loss of life.
- No local alternative to the loss of community hospitals given Dorset's demographic with its ageing population and how that service will be delivered.

The decision to make a referral was made on 17 October 2018 in respect of Section 23 of the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013, Section (9) (c) – that Dorset considers “that the proposal would not be in the interests of the health service in its area”.

As per the legislation, the Committee believes that every effort has been made to reach local resolution, before submitting this referral. However, it has not been possible to reassure the Committee or key sections of the public of Dorset that the agreed changes will deliver universally safe and accessible services going forwards. We therefore urge you to consider this referral in full and request an independent assessment of the matters of concern.

Yours sincerely

Cllr Bill Pipe
Chair, Dorset Health Scrutiny
Committee

Cllr Peter Shorland
Vice-Chair, Dorset Health Scrutiny
Committee

Enclosures:

- Referral to Secretary of State from Dorset Health Scrutiny Committee
- Appendices 1 to 5 for Referral to Secretary of State from Dorset Health Scrutiny Committee
- Appendix 6 for Referral to Secretary of State from Dorset Health Scrutiny Committee (CCG Responses to T&FG)
- Appendix 7 for Referral to Secretary of State from Dorset Health Scrutiny Committee (Letter to Tim Goodson, NHS Dorset CCG)

CC:

- Tim Goodson, Chief Officer, NHS Dorset Clinical Commissioning Group
- Cllr Rebecca Knox, Leader, Dorset County Council
- Debbie Ward, Chief Executive, Dorset County Council
- Helen Coombes, Transformation Programme Lead for the Adult and Community Services Forward Together Programme, Dorset County Council

**Referral to the Secretary of State for Health and Social Care by
Dorset Health Scrutiny Committee, November 2018**

1 Background

- 1.1 In October 2014, NHS Dorset Clinical Commissioning Group (CCG) announced that a Clinical Services Review was to be undertaken to consider how health and care organisations in Dorset could work better in the face of a number of significant challenges. Following a needs and demand analysis, the CCG set out their case for change, which included demographic pressures, variations in the quality of care across Dorset, workforce shortages across sectors and specialisms, and financial pressures which were expected to reach unsustainable levels within a few years.
- 1.2 To address the challenges the CCG drew up a range of proposals around the following themes:
- Care closer to home – with locality hubs with or without community hospital beds;
 - Maternity and paediatric services – creating a pan-Dorset service (potentially linked to services in Somerset for individuals living in the west of Dorset);
 - Acute care – with a networked service incorporating a Major Emergency Hospital and Major Planned Hospital in the east of Dorset, along with a single emergency and planned hospital in the west of Dorset;
 - Mental health services – looking in particular at the acute care pathway.
- 1.3 The CCG undertook clinical design and engagement with a range of stakeholders throughout this time and launched a formal three-month public consultation on a range of options in December 2016. The outcome of that consultation was used to modify some of the proposals and to inform the Business Case for change, which was ultimately presented to the CCG's Governing Body on 20 September 2017 following the achievement of assurance from NHS England.
- 1.4 In total 23 decisions were put to and agreed by the Governing Body. In summary, this would result in:
- Changes to community hospitals, with an overall increase in the number of beds but the loss of beds in some areas of the County of Dorset (excluding Bournemouth and Poole);
 - The establishment of community hubs, which would host integrated community teams;
 - The development of distinct roles for Poole and Bournemouth Hospitals, with Poole becoming a Major Planned Hospital and Bournemouth becoming a Major Emergency Hospital. This would result in the relocation of trauma and maternity and paediatric services (amongst others) from Poole to Bournemouth;
 - The continuation of Dorset County Hospital's role as a planned and emergency hospital for the western area;
 - The delivery of consultant-led maternity and paediatric services in west and east locations, including a new unit within the Major Emergency Hospital to be sited at Bournemouth Hospital and the closure of the existing maternity unit at Poole Hospital.
- 1.5 From the outset the CCG has been clear that implementation will take place over a number of years.

- 1.6 Sections 2 and 3 below set out the format and chronology of the scrutiny that has been undertaken by Dorset Health Scrutiny Committee, since September 2014, and a Joint Health Scrutiny Committee, since July 2015. *Links to all agenda papers and minutes can be found at Appendix 1.*

2 The role of Dorset Health Scrutiny Committee in scrutinising the Clinical Services Review

- 2.1 Dorset Health Scrutiny Committee (DHSC) is comprised of six County Councillors and six District and Borough Councillors, representing each of the localities within the County of Dorset (excluding the unitary authorities of Bournemouth and Poole). It should be noted that, under the terms of a Joint Health Scrutiny Protocol with Bournemouth Borough Council and the Borough of Poole, the power to make a referral to the Secretary of State for Health and Social Care remains with the individual Committees and has not been delegated to any Joint Committees that are convened.
- 2.2 DHSC were first made aware of the Clinical Services Review (CSR) via a briefing paper from the CCG to Committee on 10 September 2014. The briefing paper informed DHSC that the CCG were about to embark on the Review, on the basis that it was not an option to do nothing or assume that significant increases in NHS funding would be forthcoming. The CCG outlined the case for change (demographic pressures, variations in quality of care, workforce and financial shortfalls), the principles underlying the CSR, the expected outcomes, the delivery partners and timescales.
- 2.3 The CCG also presented two briefing papers regarding mental health services: the first outlined an independent evaluation of Urgent (mental health) Care Services that was to be undertaken by the University of the West of England; the second highlighted the Acute Care Pathway and Organic (Dementia) Specialist Pathway reviews, both of which were being led by the CCG. The outcomes of all these reviews have subsequently been incorporated into the work of the Mental Health Acute Care Pathway Review (MH ACP).
- 2.4 In November 2014 a further briefing paper was presented, updating Members re the CSR, following its official launch in October 2014. The paper clarified the three main stages of the Review, which would include design, consultation and implementation. The first two stages were to be supported by an external delivery partner, McKinsey. A public launch event was held on 22 October 2014.
- 2.5 On 22 May 2015 a report was presented by Dorset County Council officers, regarding the outcome of a meeting arranged by the CCG and attended by the Chairs of the Scrutiny Committees in Bournemouth, Dorset and Poole, at which the progress of the CSR was presented, along with outline plans for the consultation process. At this stage Dorset's HSC Members were asked to nominate Members for a Joint Committee, to be convened with Bournemouth Borough Council and Borough of Poole, to scrutinise the CSR and ultimately respond to the consultation on behalf of the Councils, in line with Regulations.
- 2.6 On 8 September 2015 Members received a copy of the minutes of the Joint Health Scrutiny Committee (JHSC) meeting which had been held on 20 July 2015. Delays to the timescale for consultation were noted, as was the commitment from the CCG to engage with District and Borough Councils. Models for service delivery were

discussed, with particular reference to the need for consideration of rurality and the value of community hospitals.

- 2.7 On 16 November 2015 a briefing paper from the CCG updated DHSC as to current activity within the CSR, including a review being carried out by the Royal College of Paediatrics and Child Health. The paper also noted the links between the CSR and Dorset's 'Better Together' programme (a forerunner to the STP – Sustainability and Transformation Plan), which supported and promoted integrated working between health and social care.
- 2.8 On 7 June 2016 there were no direct reports regarding the CSR but Members expressed concern as to their low level of involvement in discussions and requested that the Committee receive more information in future. Formal reports became a standing item from this point.
- 2.9 On 6 September 2016 a report to DHSC highlighted the minutes of a Joint Health Scrutiny Committee which had taken place on 2 June 2016 and discussions which had taken place at informal (non-public) meetings on 14 July 2016 and 10 August 2016. The purpose of the informal meeting on 14 July, to which JHSC Members were invited, was to outline the pre-consultation engagement that had taken place in connection with the proposals for Integrated Community Services, and to outline the proposals for public consultation that were to be presented to the CCG Governing Body on 20 July 2016.
- 2.10 The informal meeting on 10 August 2016 was arranged to enable DHSC Members to hear directly and in more detail about the implications of the proposals for acute and community services for Dorset residents. Members had the opportunity to explore particular aspects of the proposals, including: the acute hospital proposals and what this might mean for Dorset County Hospital in particular; the community services proposals and the changes to community hospitals that may go forward for consultation; the rationale behind the proposals and the issues that have influenced them (such as workforce and financial challenges); Mental health services and how these were being reviewed alongside the wider acute and community services.
- 2.11 On 14 November 2016 a report to DHSC, outlined the discussions and outcome of the JHSC which had taken place on 27 October 2016. The focus of this report was the outcome of the MH ACP Review and proposals, but in addition Dorset Members considered how their JHSC Members could feed into the upcoming CSR consultation process at the next JHSC meeting. Members were subsequently invited to a workshop on 20 February 2017, at which they would have the opportunity to submit their views on the proposals under consultation.
- 2.12 The purpose of the workshop on 20 February for DHSC Members was to enable them to consider each of the questions contained within the CCG's formal consultation regarding the Clinical Services Review. Dorset Members' views would then be taken forward to the formal Joint Committee meeting on 23 February 2017. With regard to Community Services, Dorset Members expressed concerns about how the proposals would be financed, workforce capacity, the proposed loss of beds in a number of Community Hospitals and the use of beds within care homes. With regard to Acute Services, Dorset Members expressed concerns about ambulance response and transfer times if the eastern emergency centre were to move to Bournemouth (particularly with respect to West Dorset and Swanage), the validity of the travel time analysis which had been undertaken and the proportion of people who could be treated in the community. With regard to Maternity and Paediatric Services, Dorset Members were opposed to the potential loss of services in West Dorset but

supported an integrated service between Yeovil and DCH. It was however noted that if the consultant-led facility were to be based at Yeovil transport would be an issue for many parents, which would be further compounded if Bournemouth were to become the major emergency (and maternity and paediatric) centre for the east.

- 2.13 On 1 August 2017 another informal meeting of DHSC was held, to enable the CCG to present the findings from the consultations into the two reviews carried out by the CCG (CSR and MH ACP) and to identify areas of public concern that DHSC would like to highlight at the formal Joint Committee meeting on 3 August. These concerns would then be raised with the CCG, for their consideration prior to any final decision making regarding the proposals set out within the two reviews, at their Governing Body meeting on 20 September.
- 2.14 Members were shown a short film which provided the perspective of the Ambulance Services. The film set out the view that the CSR proposals would be of benefit, in that they would facilitate the transport of patients to the most appropriate hospital setting in the first instance, thereby improving the speed at which specialist care can be provided. Members then reviewed the consultation outcomes and noted the concerns that had been raised by respondents including: travel times, workforce capacity, differences of opinion as to the future role of Poole and Bournemouth Hospitals, mixed views about integrated community hospitals, concerns regarding the loss of some community beds and lack of clarity about the future of maternity and paediatric services. With regard to the Mental Health ACP Review, members noted respondents' concerns about: changes to inpatient mental health beds (and transport to access them), the proposed location of some services and the potential reduction of services in west and north Dorset.
- 2.15 On 4 September 2017 a report to DHSC outlined the outcome of the Joint Committee meeting held on 3 August 2017, at which presentations had been delivered by ORS (Opinion Research Services), supported by the CCG, regarding the findings of the consultations on proposals relating to the CSR and MH ACP Review. Dorset's Members received copies of letters with recommendations that had been sent to the CCG by the Joint Committee, following the meeting on 3 August. Members were reminded of the special Governing Body meeting to be held by the CCG on 20 September, at which the decisions would be made regarding the proposed changes to services.
- 2.16 On 13 November 2017 a report to DHSC provided: an update to Members as to the response from the CCG to the recommendations made by the Joint Committee following their meeting on 3 August; and the outcome of the CCG's Governing Body meeting held on 20 September. Copies of correspondence were provided, along with links to relevant papers. In addition to the update report, three questions and three statements concerning the Clinical Services Review (specifically the reduction in acute hospital bed numbers and the implications for travel and transport, particularly for residents in the Purbeck area) had been submitted to DHSC by members of the public. The representations requested that, in light of the issues raised, DHSC refer the matters to the Secretary of State for Health and Social Care. Following discussion about the concerns, it was agreed that DHSC would in fact make a referral, pending a meeting of the Joint Health Scrutiny Committee which should be arranged as soon as possible.
- 2.17 On 20 December 2017 an urgent meeting of the DHSC was held, in response to the decision to make a referral to the Secretary of State and the subsequent convening of a meeting of the JHSC to consider that decision (and whether they supported it). Members heard evidence from NHS Dorset CCG outlining the rationale behind the

decisions that had been made and emphasising their view that the changes would benefit all Dorset's residents. Support for the changes was also expressed by a range of representatives from the local acute hospitals, community health services and general practice.

- 2.18 Members discussed whether to proceed with a referral at this point, based on the additional information that had been provided and on the advice that a referral was unlikely to succeed, given that engagement with the CCG was ongoing. By a majority vote, Members resolved NOT to proceed, but to support the proposed further scrutiny of ambulance services and emergency transport, in relation to the changes to be implemented under the CSR. An existing Joint Committee convened to scrutinise NHS 111 services provided by SWAST (hosted by the Borough of Poole) would be expanded to accommodate this. Despite a number of requests from Dorset County Council, this particular Joint Committee has yet to be reconvened some ten months after the decision was made.
- 2.19 On 8 March 2018 an update report to DHSC set out the outcomes of the Joint Committee meeting on 12 December and the subsequent DHSC meeting on 20 December, at which Members had resolved not to proceed with a referral to the Secretary of State for Health and Social Care, but to support further scrutiny of emergency transport by a Joint Committee to be hosted by the Borough of Poole.
- 2.20 However, reflecting the views of public participants at the meeting, some Members still felt that the Committee had failed to fully scrutinise the CSR proposals and whether they were 'in the interests of the health service' in the area, and suggested that the decision to make a referral should be reviewed. Following discussions, it was agreed that a task and finish group of five Members would be established to review the evidence and determine whether the criteria for a referral would be met. The group would report back to DHSC at the next Committee meeting.
- 2.21 The Task and Finish Group subsequently met on 1 May 2018 with a view to establishing the scope and context of their work and the process involved in making a referral to the Secretary of State. At this stage though, the Group needed to consider the impact and implications arising from the progress of a Judicial Review which had meanwhile been lodged by a Purbeck resident, and would come before the courts on 17/18 July 2018. On balance, it was agreed that it would be prudent for the work of the Task and Finish Group to be adjourned until the outcome of the Judicial Review was known. This decision was made on the basis that the grounds on which the Judicial Review had been brought mirrored the concerns that the Task and Finish Group were expected to investigate.
- 2.22 An update report to DHSC on 15 June 2018 outlined the rationale behind the decision that had been made by the Task and Finish Group to adjourn their deliberations, and it was recommended that the Committee support that decision. However, the majority of Members felt that the focus of the proposed referral to the Secretary of State would be that the CCG's decisions were 'not in the interests of the health service', whereas the Judicial Review would focus on whether correct legal process had been followed in making the decisions. It was agreed that the work of the Task and Finish Group would recommence urgently, prior to the outcome of the Judicial Review.
- 2.23 The Task and Finish Group subsequently met on 4 July 2018 to scope the remit of their review and to determine which organisations should be invited to speak to the Group at their next meeting on 22 August 2018. It was agreed that the scope would include: including emergency travel times, the proposed future location of health

services, future acute and community hospital bed numbers, community services and the impact of changes on Adult Social Care provision. It was also agreed that four specific members of the public (including three representing Defend Dorset NHS) and a representative from Healthwatch Dorset would be invited to meet with the Task and Finish Group as soon as possible. A District Councillor from Purbeck was subsequently also invited to attend.

- 2.24 On 22 August 2018 the Task and Finish Group met with six individuals, three of whom were representatives of the campaign group Defend Dorset NHS. The individuals detailed their concerns including: the transfer of services of services from Poole Hospital to Bournemouth Hospital, the proposed future number of inpatient beds, capacity and workforce requirements in community services, the perceived risk to people living in the Purbeck area as a result of longer journeys to A&E and maternity services, the loss of beds in community hospitals and the way in which the CSR had been conducted and consulted upon. Evidence which had been collated by the individuals was shared with the Group, including feedback from doctors working in A&E.
- 2.25 Following the meeting, a list of 19 specific questions was drawn up, which would be submitted to NHS Dorset CCG, South Western Ambulance Service NHS Foundation Trust, Dorset County Hospital NHS Foundation Trust, Dorset HealthCare University NHS Foundation Trust and Poole Hospital NHS Foundation Trust. The commissioners and providers were invited to meet with the Task and Finish Group on 18 September 2018 to respond to the questions.
- 2.26 On 18 September 2018 the Task and Finish Group met with the NHS representatives. Prior to the meeting, responses had been provided to the set of 19 questions which had been collated following the Task and Finish Group's meeting on 22 August. Members of the Group had the opportunity to explore particular concerns, including:
- Future A&E and Urgent Care provision, particularly in Poole and Bournemouth;
 - Future ambulance service provision and the impact of any increase in travel times for some residents of Dorset;
 - Wider CSR changes and the impact on community services.
- 2.27 Members heard about the ongoing development and evolution of the original CSR proposals and of the benefits which the commissioners stated would arise, including:
- New investment in buildings and facilities, services and workforce;
 - Improved safety and quality of services;
 - Improved outcomes for patients.
- 2.28 Members and the Commissioners agreed that there was still room for improvement in the communication of the benefits that would arise, and that it would be helpful for the local authorities to support the CCG in getting certain messages across. On balance and by a majority, the Task and Finish Group resolved to recommend to the full Committee that "the CSR proposals are NOT referred to the Secretary of State for Health and Social Care" and that the Joint Committees set up to scrutinise the CSR and ambulance performance and capacity should both be reconvened as soon as possible.

2.29 On 17 October 2018 DHSC received a report, detailing the work and the conclusions of the Task and Finish Group. At the meeting a large number of representations and formal statements were presented to Members, reiterating the concerns of residents around the future location of trauma and maternity and paediatric services and the capacity of community services to accommodate an increase in demand. Following discussion Members voted on the recommendation that “the CSR proposals are not referred to the Secretary of State for Health and Social Care” and, by a majority of 6 to 4 votes, decided to reject the recommendation and therefore to submit a referral. It was agreed that the referral would be on two specific grounds and not on the entirety of the 23 decisions agreed by the CCG on 20 September 2017. Those two grounds were:

- *Concern that the travel times by the South West Ambulance Service NHS Foundation Trust have not been satisfactorily scrutinised and that the evidence needs further investigation to the current claim that these travel times will not cause loss of life.*
- *Concern that there is no local alternative to the loss of community hospitals given Dorset's demographic with its ageing population and how that service will be delivered.*

3 The role of the Joint Health Scrutiny Committee

- 3.1 As required by Regulations, a Joint Health Scrutiny Committee was convened in July 2015 in response to the CSR which officially commenced in October 2014. The remit of the Committee was subsequently expanded to cover the MH ACP Review, running separately but in parallel to the CSR. Membership includes three Councillors from Dorset County Council, Bournemouth Borough Council, Borough of Poole and Hampshire County Council, plus observers from Somerset County Council.
- 3.2 At the first meeting of the Joint Health Scrutiny Committee on 20 July 2015 the context behind the Review was reinforced and the broad proposals at that stage were set out. The report and presentation confirmed that formal public consultation had been delayed, with a view to undertaking further work on out of hospital / community services.
- 3.3 Members were also told that a review of the Mental Health Acute Care Pathway had commenced and would be running in parallel with, but separate to, the CSR. Members emphasised the value of engaging with Councillors at all levels and the CCG confirmed that there would be wide-ranging engagement. Key issues raised by Members included staffing shortages, transport and the need for mental health to be fully integrated into the Review.
- 3.4 On 2 December 2015 a report informed Joint Committee Members of the revised timetable for the CSR which meant that public consultation would not commence before summer 2016. Again Members noted concerns about workforce and transport.
- 3.5 On 2 June 2016 the JHSC received presentations from the CCG covering three aspects: the Vision for the Future of Health and Care in Dorset, the Vision for Community Services in Dorset and the Mental Health Acute Care Pathway Review. Members were reminded of the need for the CSR and were informed of the progress of the Review, including the engagement process. The resultant two options for acute hospital provision, which would be the subject of public consultation, were

explained, including the need to make changes to paediatric and maternity services. The implications for travel were queried by Members, including the availability of ambulances; the CCG emphasised the work which had gone into this aspect of the Review and the need to provide high quality care, with a 24/7 network of services.

- 3.6 Members were informed that the Vision for Community Services was also based on extensive engagement, and that the focus would be on the delivery of care closer to home, with improved quality and access. Further engagement and 'roadshows' were planned and it was the intention of the CCG to provide the public with explicit information regarding any planned changes, for example to Community Hospitals.
- 3.7 On 14 July 2016 an informal (non-public facing) meeting was arranged for JHSC Members, for the CCG to outline the pre-consultation engagement that had taken place in connection with the proposals for Integrated Community Services, and to outline the proposals for public consultation that were to be presented to the CCG Governing Body on 20 July 2016. Members heard about options for the localities across Dorset, the extensive modelling which had been undertaken with regard to community beds, travel time analysis, the use of operating theatres in community hospitals and the evaluation of sites. This had led to the identification of potential sites for community 'hubs', with and without in-patient beds.
- 3.8 The JHSC met again on 27 October 2016 to enable the CCG to share the outcome of the Mental Health Acute Pathway Review and the proposals, which had been approved by the CCG Governing Body and would now go forward for NHS England assurance and public consultation. The Committee heard about the reasons for the review, the work which has supported it (including needs analysis, view seeking and modelling), the subsequent shortlisting of options and the criteria on which the recommended option was based. The Review had a 'co-production' focus, with the intention that all stakeholders would feel engaged and able to contribute to the proposals.
- 3.9 On 23 February 2017 the JHSC met to provide the opportunity for Members to submit their views on the proposals within the formal consultation documents published by the CCG in December 2016. The proposals were considered in turn and all views collated to form a collective response from the Committee. This was submitted to the CCG on 3 March 2017. *A copy of that detailed submission is attached as Appendix 2*, but in addition the Joint Committee sought reassurance on two key issues:
- That full and detailed financial modelling will be undertaken with all key partner agencies, particularly the Local Authorities, to ensure that the cost of proposals has been adequately established and that they are affordable and achievable for all partners;
 - That maternity and paediatric services will be maintained to serve the west Dorset area, in recognition of the genuine concerns that some Members have regarding travel times, should consultant-led maternity and paediatric services be based in Bournemouth in future.
- 3.10 Following the announcement that consultation on the proposals relating to the Mental Health Acute Pathway Review would run from 1 February 2017 to 31 March 2017, a further Joint Health Scrutiny Committee meeting was held on 23 March 2017. This enabled full consideration of the proposals relating to mental health services and the formulation of a formal response for submission to the CCG on 31 March 2017. Again the Joint Committee sought reassurance on two key issues:

- That work will be undertaken with the Local Authorities, to ensure that transport and access concerns are fully explored and that mutually beneficial solutions can be put in place;
 - That demand for inpatient beds will be reviewed on an on-going basis, to ensure that the re-location of provision from west to east Dorset is not detrimental to some residents.
- 3.11 On 3 August 2017 the JHSC met to review the outcomes of the consultations into the CSR and MH ACP Reviews. Members viewed a short film produced by the Ambulance Trust (SWASFT) and the CCG, which was a joint response to public concerns about travel and response times. This was followed by presentations led by ORS (Opinion Research Services) and the CCG regarding the findings from the two consultations.
- 3.12 The minutes of the meeting reflect the discussions that followed and were used to collate a formal response from the Joint Committee to the CCG. The response included a series of recommendations centred around service provision, the consultation process and implementation of any agreed proposals. *The text of that letter is attached as Appendix 3, and the detailed response from the CCG is attached as Appendix 4.*
- 3.13 An urgent meeting of the JHSC was convened on 12 December 2017 to respond to concerns raised at a meeting of Dorset Health Scrutiny Committee on 13 November 2017. Those concerns particularly related to the impact of changes on residents living in the Purbeck area, with access to emergency treatment foremost. The Joint Committee met to consider its position (in accordance with governance) in relation to a decision by the DHSC to make a referral to the Secretary of State for Health and Social Care. The Joint Committee received presentations and evidence from NHS Dorset CCG and a range of providers, including the acute hospitals, community health services and general practice. Members recognised the concerns raised, in particular noting the difficulties in relation to emergency access to acute and maternity services for some individuals. However, a majority of Members voted NOT to support the decision by Dorset's Members to make a referral to the Secretary of State, proposing instead that detailed scrutiny of emergency ambulance services would be more appropriate and beneficial.
- 3.14 The Joint Committee resolved:
- 1 *That the referral by the Dorset Health Scrutiny Committee to the Secretary of State for Health regarding the outcome of the Clinical Services Review is not supported by the Joint Health Scrutiny Committee; and*
 - 2 *That the Joint Health Scrutiny Committee undertakes some detailed scrutiny work around the capacity and performance of the ambulance service.*
- 3.15 It was further agreed that this detailed scrutiny work would be undertaken by the Joint Committee which had originally been established to look at the NHS 111 service provided by South Western Ambulance Service NHS Foundation Trust (SWAST). This Joint Committee last met in January 2017 and DHSC Members are awaiting notification of the date of the next meeting.

4 Dorset Health Scrutiny Committee's position

4.1 Dorset Health Scrutiny Committee has always acknowledged the CCG's case for change and recognised the need for improved outcomes for all Dorset's residents. However, this referral to the Secretary of State is focussed on the following specific concerns:

- *Concern that the travel times by the South West Ambulance Service NHS Foundation Trust have not been satisfactorily scrutinised and that the evidence needs further investigation to the current claim that these travel times will not cause loss of life.*
- *Concern that there is no local alternative to the loss of community hospitals given Dorset's demographic with its ageing population and how that service will be delivered.*

It should be noted that the referral is in respect of concerns relating only to the Clinical Services Review and NOT in respect of the Mental Health Acute Care Pathway Review, which the CCG carried out within a similar timeframe and has been referenced for context in sections of this submission.

4.2 As a result of the CCG's decisions to relocate some services from Poole to Bournemouth, it is beyond dispute that some residents will incur longer journeys to access A&E, maternity and paediatric services. It is also beyond dispute that the proposals for 'care closer to home' will result in the need for increased resources to support that service area.

4.3 Following their initial consultation, engagement and modelling phases, Dorset CCG went out to consultation with a detailed set of proposals in December 2016. At this point Dorset Health Scrutiny Committee members expressed concern at the proposed transfer of trauma, maternity and paediatric services from Poole to Bournemouth Hospital, and whether ambulance response and transfer times would be safe for residents in certain areas of Dorset in future. The validity of travel time analysis which had been commissioned by the CCG was also queried, along with the assertion that more individuals could be treated and supported in the community, thereby reducing the need for journeys to hospitals.

4.4 Concerns about community services form the basis of the Committee's second core reason for referring the matter to the Secretary of State, in that Members cannot be reassured that the planned redistribution of beds, with the associated closure of a number of community hospitals, particularly affecting Dorset residents, will provide sufficient capacity for the ageing population. In Dorset 28% of our population is aged 65+ (119,700) compared with 18% in England and Wales. Over the next ten years, the percentage of Dorset residents aged 65+ is expected to grow by 0.9% per annum, and almost a fifth of those individuals will be aged 85+. Whilst 'care closer to home' is recognised as delivering positive outcomes, the ability for health and social care services to provide sufficient workforce and resources to do this effectively is in doubt.

4.5 The Committee disputes: whether the CCG have adequately addressed and mitigated the risks to (some) patients, the equity of future access to services and the stability and sustainability of community services.

5 Evidence in support of the reasons for referral

5.1 Despite the numerous reports and presentations which the CCG has provided to both DHSC and the JHSC over the last four years in relation to the CSR, Members cannot be confident that the concerns increasingly being raised are unfounded. In particular:

- There is doubt as to whether the level of risk to residents living in certain areas of Dorset as a result of the relocation of trauma, maternity and paediatric services from Poole to Bournemouth Hospital has been accurately and transparently evaluated;
- There is scepticism as to the validity of travel data which has been provided or commissioned by the CCG and SWAST in terms of ambulance response and transfer times and whether, in future, patients will be able to reach urgent and emergency treatment within an acceptable time limit;
- There is doubt that, having closed in-patient community hospital beds in certain locations (particularly in Dorset County), services provided in the community will be able to cope with and afford the increased demand. This includes social care services;
- There is a lack of confidence in the workforce planning which is being done, with regard to capacity and urgency, sustainability and accuracy.

6 The evidence considered

6.1 Although some reports have only been presented formally to the JHSC, the minutes of every meeting have been presented to DHSC via Committee papers.

6.2 With regard to the concerns about travel times, the CCG have shared a number of specific reports and presentations with DHSC as follows:

- **Travel Time Analysis:** A document produced in March 2015 by the CCG setting out analysis of travel time modelling for acute hospitals in Dorset, including data provided by Steer, Davis, Gleeve Transport Consultancy. This analysis includes blue light, private car and public transport travel under various acute hospital configurations;
- **SWAST Report:** A document produced in July 2017 by South Western Ambulance Service NHS Foundation Trust, presenting the outcome of a modelling project commissioned by the CCG to establish the potential impact of the proposed CSR reconfiguration on the emergency ambulance service. The project included analysis of 21,944 SWAST patient records to estimate whether the relocation of trauma, maternity and paediatric services would create any increased risk to patient outcomes;
- **Dorset County Council Transport Review Report:** A document produced by Dorset County Council in July 2017 at the request of the CCG to review transport concerns raised during the public consultation and to provide assurance regarding the approach taken by the CCG, and to identify issues to be addressed by a Transport Reference Group. The report does not deal with 'blue light' emergency transport as this is a matter for the SWAST report;

- SWAST short animation: Shown to members in August 2017 to illustrate the perspective of the Ambulance Service with regard to the benefit of having specialised hospitals to transport patients too, thereby reducing inter-hospital transfers and delays and freeing up capacity;
- 6.3 In addition to the above local reports and evidence, the CCG have been invited to meet with DHSC Members at workshops, to enable discussions outside the public arena where appropriate. These have included:
- A workshop was held for DHSC on 10 August 2016, which included exploration of the future of acute services and the proposals that were under development around the need to reduce duplication. The roles of Poole and Bournemouth Hospitals were discussed, including the reasons for the CCG's preference for the site of the major emergency hospital. Members queried the adequacy of access to the Bournemouth site and it was noted that a new link road would improve matters;
 - An informal meeting of DHSC was held on 1 August 2017 to enable Members to consider the results from the CCG's formal consultation, prior to a meeting of the JHSC on 3 August. Members heard that travel and transport had been the most frequently raised concerns. The CCG highlighted the additional work that was being undertaken as a result, including the analysis of data by SWAST and collaborative work with the Local Authorities.
- 6.4 With regard to concerns about community services and whether the loss of inpatient beds in community hospitals can be accommodated, the CCG shared reports and information with DHSC on the following occasions:
- A workshop held for DHSC on 10 August 2016, which included exploration of the community services proposals and the changes to community services that might go forward for consultation. Members heard detail around the issues faced by commissioners and providers and of the need to redistribute in-patient community beds. Members expressed concerns about the proposed use of beds in care homes in some areas, due to the variable quality. They also noted that care at home still relies on adequate staffing;
 - An informal meeting of DHSC held on 1 August 2017 to enable Members to consider the results from the CCG's formal consultation. At this meeting the CCG presented the findings in relation to community services, including mixed views about integrated community hospitals and concerns about the loss of some community beds. Members again queried the proposals in a number of areas and whether it was appropriate to remove in-patient beds, given the expected demographic pressures in future.
- 6.5 As a result of the on-going concerns raised with DHSC and outlined within the chronology of meetings in section 3, a Task and Finish Group of five Members was appointed in March 2018 to look in more detail at specific evidence and report back to the full Committee. *Links to all agenda papers and minutes from the Task and Finish Group can be found at Appendix 1.*
- 6.6 The Group first met on 1 May 2018 and agreed that evidence would be gathered firstly from those individuals who had consistently raised concerns with DHSC, particularly since November 2017. Some of those individuals were part of a campaign group (Defend Dorset NHS) but others were acting independently. In

addition, a representative from Healthwatch Dorset was invited to the meeting, which was held on 22 August 2018.

6.7 Evidence presented on 22 August 2018 to the Task and Finish Group can be found at *Appendix 5* but in summary included:

- A paper from Defend Dorset NHS highlighting the range of concerns which Defend Dorset NHS felt that the Task and Finish Group should consider, including: misleading claims by the CCG around the benefits of the proposals; misleading claims regarding the level of clinical risk for individuals who would face longer journeys to reach trauma, maternity and paediatric services; flaws in the CCG's plans, specifically around travel times, insufficient hospital beds in future, insufficient staff to provide community services; and a lack of a coherent plan to replace community hospital provision. The paper also suggests alternative proposals, including the retention of A&E services etc. at both Poole and Bournemouth, with capital investment attached, or the retention of those services at Poole, on the basis that this site offers greater, safer accessibility;
- A paper from Defend Dorset NHS addressing their particular concern that the CCG has failed to properly assess the risk of harm to residents as a result of the proposals to relocate A&E, maternity and paediatric services from Poole to Bournemouth. This paper highlights: time critical conditions; actual travel times; the number of patients estimated to be at clinical risk; the services that would and would not be available in future at Poole Hospital; concerns about the analysis of travel data presented in the report published by SWAST in August 2017, with particular regard to the assessment of risk and/or potential fatality if patients have to travel further;
- A paper from Defend Dorset NHS outlining evidence with regard to the need for community hospital beds to be retained, given their role in providing accessible, high quality care and facilities for assessment, rehabilitation and end of life care. The capacity for the CCG's plans to effectively and sustainably provide care closer to home in future was also challenged, citing concerns about readmissions to acute hospitals, the current considerable shortage in community staff and the impact on social care staff, which had not been properly assessed;
- A paper from Defend Dorset NHS detailing concerns gathered from A&E doctors. Those concerns centre on: the specialist functions that would also have to relocate, should services be moved to Bournemouth; the impact on other hospitals, particularly Dorset County Hospital; the accuracy of the financial case made by the CCG; risks to patient safety as a result of increased travel times from some locations; workload impacts and the modelling which the CCG used to predict that 25% of the current emergency workload could be managed in the community; the disruption and fragmentation to departments that will be caused by relocation; the lack of a planned Level 3 Intensive Care facility at Poole if it becomes the planned hospital; the impacts on staff with regard to travel, parking, recruitment and retention;
- Papers from a Dorset resident with a long history of interest in health services and the CSR, outlining his concerns about the way in which the CSR had been conducted from the outset. In particular, the papers suggest a lack of

planning, underestimation of the timescales required and inadequate assessment and consideration of equality matters such as accessibility of services due to rurality and deprivation.

- 6.8 On 22 August 2018 the Task and Finish Group also heard the views of Healthwatch Dorset. Their representative reflected on the different types of evidence and how it may be used on both sides. In addition, he noted that only a small percentage of residents had responded to the CCG's consultation and that more could have been done to engage with people. The issues of accessibility and equality were recognised as difficult to resolve and the representative questioned whether there was real evidence that the proposals would improve outcomes or reduce inequalities. In addition, he questioned whether there would be sufficient resources, both financial and in terms of workforce, to deliver the changes and he challenged the apparent lack of response from the CCG to serious questions raised at the end of the SWAST travel report of August 2017.
- 6.9 As a result of the matters raised on 22 August, a set of 19 questions was collated and submitted to the CCG and provider Trusts, along with an invitation to meet with the Task and Finish Group on 18 September 2018. At that meeting attendees included: NHS Dorset CCG, South Western Ambulance Service NHS Foundation Trust, Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, Dorset HealthCare University NHS Foundation Trust and Poole Hospital NHS Foundation Trust.
- 6.10 The CCG and the NHS Provider Trusts submitted written responses to the 19 questions which had been put to them. Those responses can be found at *Appendix 6*, but in summary on 18 September the evidence covered and areas of discussion included:
- The future level of A&E / Urgent Care provision at Poole Hospital and the lack of clarity for the public around this. SWAST representatives outlined details of a modelling exercise and comparisons that had been carried out with Tiverton UCC and emphasised that patients would always be taken to the most appropriate centre for treatment based on clinical need. Members felt that there was a need for better communications around the use of A&E services and the CCG's plans for the future;
 - The significant concerns raised by the public regarding ambulance response times and ability to transport people to hospital within safe timescales. The CCG outlined the capital investment that is planned for both Bournemouth and Poole Hospitals and the way in which demand would be managed. In addition, the impact and therefore reduction in the need for inter-hospital transfers under the proposed model was emphasised, thereby releasing ambulance capacity. National investment in vehicles was noted, which would hopefully result in an additional 4 to 5 ambulances for Dorset. In addition, it was confirmed that there are no plans to close the ambulance station at Swanage, which supports the Purbeck locality (the area which has raised the most concerns about the relocation of services from Poole to Bournemouth). SWAST representatives emphasised that it was problematic to use end-to-end call out to arrival at hospital times to judge ambulance performance, given that a great deal of time may be spent on scene assessing and stabilising patients before a decision is made to transport to the most appropriate hospital;

- The wider CSR proposals were discussed, particularly in relation to community services, the opportunities to provide more care closer to home and the increased collaboration with primary care services. The need to 'divert' patients from A&E services was noted, as was the statistic that 90% of care is already delivered in the community. The need for greater emphasis on collaborative working with the local authorities and better communications with the public was again emphasised;
- Funding matters were queried and the CCG noted the £147m government funding which has been awarded to Dorset's health services, of which £62m would be spent on improving facilities at Poole Hospital. The investment in community and primary care services was also outlined, along with other investment in a range of programmes around transformation. The CCG reiterated the case for change and the need to address variations in the quality of services;
- The rationale behind transferring maternity (and associated paediatric) services from Poole to Bournemouth was explored, including the fact that the Bournemouth area has a larger antenatal population. The inadequacy of the current site at Poole was noted, as was the intention to retain services at Dorset County Hospital within a Maternity Transformation Plan.

7 Steps taken to try reach agreement with NHS Dorset CCG

- 7.1 Dorset County Council continues to be a part of the local system planning network with health partners and is actively involved in the development of an Integrated Care System. DHSC receives regular feedback on this activity, including input from the Cabinet Lead for Health and Social Care.
- 7.2 The Joint Committee and Dorset's own Health Scrutiny Committee have met with the CCG and NHS providers many times over the last four years and have considered the proposals and challenges faced in relation to the CSR in detail. Evidence has been gathered from a range of stakeholders, including:
 - The Chair, Chief Officer and Lead Officers including Transformation Leads, Finance Leads, Clinical Chairs, Primary Care and Locality Leads for NHS Dorset CCG;
 - Deputy Chief Executive, Clinical Director and Lead Officers for South Western Ambulance Service NHS Foundation Trust;
 - Chief Executive and Medical Director for Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust;
 - Chief Executive and Lead Officers for Dorset County Hospital NHS Foundation Trust;
 - Chief Executive, Director of Strategy and Lead Officers for Poole Hospital NHS Foundation Trust;
 - Chief Executive and Lead Officers for Dorset HealthCare University NHS Foundation Trust;
 - Dorset County Council Cabinet Lead for Health and Social Care;
 - Healthwatch Dorset;
 - Defend Dorset NHS campaign representatives and other public representatives.

- 7.3 Whilst acknowledging the case for change made by the CCG and the challenges around finances and workforce in particular, Members have consistently raised concerns about future equitable access to services and the need to ensure that community services are fully resourced. The establishment of the Task and Finish Group earlier this year was in recognition of the need to look in more detail at issues being raised, with increasing strength of feeling. The format of a Task and Finish Group enabled campaigners and NHS organisations to present their evidence and views without the limitations of a formal Committee meeting.
- 7.4 Despite the efforts to resolve these matters since requests for a referral to the Secretary of State were first put to DHSC in November 2017, Members have still not been adequately reassured around the future safety of all Dorset's residents or that there are plans to mitigate risks. In addition, DHSC believes that despite all attempts to explain the proposals and engage with the wider community, there are specific sections of the community with on-going concerns who do not believe that their fears have been addressed.
- 7.5 The Committee have found themselves in a difficult position as a result of such strong representation from the public over the last year; this has been exacerbated by the outcome of the recent Judicial Review brought against the CCG on this matter. DHSC would appeal to the Secretary of State for Health and Social Care that, in order to fully discharge the duty to scrutinise substantial variations to health services, an independent review of the evidence is wholly appropriate. We acknowledge that the Judicial Review has, in some respects, already considered concerns that are broadly similar to those raised within this referral. However, a Judicial Review seeks to establish whether legal process has been followed, whereas this referral seeks to establish whether the CCG's proposed changes are truly 'in the interests of health services' with regard to ALL Dorset's residents.
- 7.6 The Committee has found the CCG willing to engage throughout this process and is aware that a referral is a matter of 'last resort'. Unfortunately we no longer feel that the concerns can be resolved locally and, in light of the evidence presented here, would urge the Secretary of State in the first instance to request a review by the Independent Reconfiguration Panel.

8 Compliance with the requirements which apply where a recommendation has not been made, or where no comments have been provided on the proposal

- 8.1 In view of the fact that it was the JHSC which formally responded to the CCG's consultation in March 2017 and made recommendations following the outcome of the consultation in August 2017, DHSC submitted a letter to the CCG on Tuesday 23 October 2018 notifying them of their intention to make a referral to the Secretary of State. (See Appendix 7)

**Appendices: Referral to the Secretary of State for Health and Social Care by
Dorset Health Scrutiny Committee, November 2018**

Appendix 1	Links to agenda papers and minutes for Dorset Health Scrutiny Committee, Joint Health Scrutiny Committee and Task and Finish Group
Appendix 2	Response on behalf of the Joint Health Scrutiny Committee to the consultation being undertaken by NHS Dorset Clinical Commissioning Group on their Clinical Services Review (March 3 2017)
Appendix 3	Text of letter from the Joint Health Scrutiny Committee in response to the outcomes of the consultations by NHS Dorset CCG with regard to the Clinical Services Review and Mental Health Acute Care Pathway Review
Appendix 4	Text of Letter from NHS Dorset CCG in response to the letter from the Joint Health Scrutiny Committee dated 29 August 2017
Appendix 5	Evidence provided to Dorset Health Scrutiny Committee Task and Finish Group by invited representatives on 22 August 2018
Appendix 6	Responses to 19 questions provided to DHSC Task and Finish Group by NHS Commissioners and Provider Trusts on 22 August 2018
Appendix 7	Letter of notification re intention to refer sent to NHS Dorset CCG on 23 October 2018

Appendix 1

Links to agenda papers and minutes

Dorset Health Scrutiny Committee meetings

Dorset Health Scrutiny Committee has received reports and briefings regarding the progress of the CCG's Clinical Services Review on regular basis since the Review was first announced. All Committee papers can be accessed via this link:

<http://dorset.moderngov.co.uk/mgCommitteeDetails.aspx?ID=142>

Dorset Health Scrutiny Committee Task and Finish Group meetings

A Task and Finish Group was established in March 2018 and met four times between May and September 2018. The minutes and agenda papers can be accessed via this link:

<https://dorset.moderngov.co.uk/mgCommitteeDetails.aspx?ID=347>

Joint Health Scrutiny Committee Meetings

A Joint Health Scrutiny Committee (JHSC) was established in 2015, comprising 3 Councillors (plus reserves) from each of Bournemouth, Dorset and Poole Councils, plus Councillors representing Hampshire and later (in June 2016) Somerset, in recognition of the impact changes may have to individuals in those areas. Somerset's Members chose not to be full voting members of the Joint Committee.

Joint Committee papers can be accessed via this link:

<http://dorset.moderngov.co.uk/mgCommitteeDetails.aspx?ID=268>

Response on behalf of the Joint Health Scrutiny Committee to the consultation being undertaken by NHS Dorset Clinical Commissioning Group on their Clinical Services Review (March 3 2017)

The Joint Health Scrutiny Committee includes elected Councillors representing Bournemouth Borough Council, Dorset County Council, Borough of Poole, Hampshire County Council and (on an informal basis) Somerset County Council. The Joint Committee was convened specifically to consider the NHS Dorset Clinical Commissioning Group's Clinical Services Review, its proposals and the consultation process. The Joint Committee has met five times since July 2015, most recently on 23 February 2017 to consider its response to the consultation.

That response is set out below, reflecting the points raised by Members:

Acute Hospitals (and preferences for Options A or B)

The Joint Committee made the following comments with regard to the proposals relating to the reconfiguration of acute hospitals:

- The Bournemouth representatives noted that they had initially been of the opinion that Poole Hospital would be the better location for the major emergency centre, but now felt that Bournemouth Hospital [Option B] offered greater opportunities to achieve future aspirations and build capacity;
- The Poole representatives noted concerns regarding the potential loss of some A&E facilities at Poole [if Option B were to be implemented], but felt that the public did not understand the full picture with regard to the possible impact of the proposals. Better education and examples of such impacts, including the clinical benefits, would have been helpful. Strong views had been expressed by the Poole Committee when they met to consider the matter: there had been some support for the CCG's preferred option [B], but it was felt that more detail was needed to support the decision making process;
- Overall, the Dorset representatives were minded to choose Option A as their preference (with Poole as the location for the major emergency centre), because they felt that Bournemouth Hospital was much more difficult for many residents in the County of Dorset to access;
- The Hampshire representatives were clear that, having analysed the impacts and benefits of the proposals for West Hampshire, Option B would offer an enhanced level of care for their residents;
- There were questions from some Members as to the accuracy of some of the travel time estimates provided by the CCG to reach the acute hospitals, particularly Bournemouth Hospital from the west of Dorset and Purbeck;
- Members from west and south Dorset reiterated their view (and that of local people) that the difficulties of rural transport had not been fully considered, and that Poole Hospital was easier to access [and would therefore be a better option for the major emergency centre];
- The possibility that individuals could be more likely to request 999 transfers, for fear of not being able to reach Bournemouth Hospital within a reasonable time, was raised. In addition it was felt that ambulance response times are generally worse in west than east Dorset, and that consideration should be given to the increased return journey times, if vehicles had to travel further to and from Bournemouth.

Maternity and Paediatric Services

The Joint Committee made the following comments with regard to the proposals relating to the reconfiguration of maternity and paediatric services:

- The direct inter-dependency between the future location of the major emergency centre and the consultant-led maternity service was recognised, and concerns were voiced as to the implications for mothers in labour and families with seriously ill children (who may well be travelling via private car rather than under 'blue light' conditions). The fact that discussions with Yeovil Hospital regarding combined arrangements with Dorset County Hospital were on-going made it difficult for Members to fully consider the proposals set out for consultation;
- The Poole representatives highlighted concerns as to exactly what services would be available and where, should the major emergency centre [and therefore consultant-led maternity service] be based at Bournemouth Hospital;
- The Bournemouth representatives felt that quality of care was the most important factor to consider, and also noted that the cost of locating the major emergency centre (and maternity and paediatric services) at Bournemouth Hospital has been estimated at £40 million less than locating it at Poole;
- The Dorset representatives queried the extent to which the transfer of high-risk maternity and paediatric services to Bournemouth would impact on the viability of Poole Hospital. In addition they noted that the loss of consultant-led maternity and overnight paediatric services at Dorchester Hospital would result in mothers and children (and their families) having to travel to Bournemouth or Yeovil for services, which would be difficult for many people.

Integrated Community Services

The Joint Committee made the following comments with regard to the proposals relating to the reconfiguration of integrated community services:

- Members acknowledged that early intervention and care closer to home were to be welcomed, but needed adequate finance and workforce;
- The Bournemouth representatives recognised that the challenges and opportunities presented by the integrated community services review were very different for the rural and urban areas. They were very supportive of the potential improvements, but sought some confirmation as to the purpose of community hubs and the provision of community beds within an acute (major planned care) hospital;
- The Dorset representatives expressed particular concern as to the planning of the proposals outlined for integrated community services and the ability to finance them. Assumptions regarding the availability of the workforce necessary to support the proposals were also queried, as was the assumption that public transport would be able to serve the locations identified, given recent reductions in provision;
- The expectation that beds in nursing and residential care homes would be available to accommodate patients in areas where community hospital beds would not be provided was questioned: Members asked how this could be guaranteed;
- The Dorset representatives expressed further concern relating to some proposals relating to integrated community services and in particular felt that the loss of community beds at the Westminster Memorial Hospital (Shaftesbury) would be problematic, given the expected growth in population, the lack of alternative options and the very poor public transport links in the area. The potential loss of beds in community hospitals at other locations, including Bridport, Christchurch, Weymouth and Portland, were also a matter of concern, particularly if none were to be provided

at Dorset County Hospital. It was felt that if patients were placed instead in nursing homes, these types of facility would be less able to cope with a medical crisis than a community hospital;

- The Poole representatives welcomed the proposals for a community hub in Wimborne and noted that it would be easy to access;
- However, the Poole representatives felt that it was difficult to comment on the situation regarding Alderney Hospital, given that its future was dependent on the outcome of a separate review of dementia services. If dementia and/or mental health services were to be lost from Alderney Hospital this would be a cause for great concern.

The consultation process

The Joint Committee made the following comments with regard to the way in which the consultation by the Clinical Commissioning Group has been undertaken:

- There were mixed views amongst the Joint Committee Members as to whether the consultation had been carried out well: whilst Hampshire's representatives reported that their area had been well served and their CCG had been fully involved, some of Poole's representatives felt that the consultation exercise had been inconclusive and poorly researched and Dorset's representatives expressed a number of specific concerns;
- The particular issues raised by Dorset were:
 - A query as to the validity of the telephone survey that had been undertaken (were the questions the same as the paper copy of the questionnaire, were they 'leading' questions and did the respondents have access to the full context on which to base their responses);
 - The documentation, which was felt to be confusing and lacking in clarity as to the implications of the proposals;
 - A query as to whether the views of people who attended the drop-in and stakeholder events had been fully recorded;
 - A query as to why changes to primary care commissioning had been separated from the clinical services review, given the links.

Conclusion

In summary, the Joint Committee understands the rationale behind the case for change but urges the CCG and NHS England to take account of the concerns raised in this document as it develops the proposals. In particular, the Committee seeks reassurance on two key issues:

- That full and detailed financial modelling will be undertaken with all key partner agencies, particularly the Local Authorities, to ensure that the cost of proposals has been adequately established and that they are affordable and achievable for all partners;
- That maternity and paediatric services will be maintained to serve the west Dorset area, in recognition of the genuine concerns that some Members have regarding travel times, should consultant-led maternity and paediatric services be based in Bournemouth in future.

The Committee recognises and appreciates the degree to which engagement has been carried out with a wide range of stakeholders over the last two years by the CCG. However,

there are concerns as to the degree to which people are able to comment on some proposals, given the lack of detailed information and/or key decisions, at this stage. The Committee would expect continued engagement and consultation with the CCG as the outcome of the current public consultation is considered, and any changes that are subsequently agreed by the CCG Board and NHS England are taken forward for implementation.

Joint Health Scrutiny Committee
3 March 2017

Text of letter from the Joint Health Scrutiny Committee in response to the outcomes of the consultations by NHS Dorset CCG with regard to the Clinical Services Review and Mental Health Acute Care Pathway Review

29 August 2017

Dear Sirs

Joint Health Scrutiny Committee – comments and recommendations regarding the findings of the Clinical Services Review and Mental Health Acute Care Pathway Review consultations

Many thanks to Tim and other colleagues for attending the Joint Health Scrutiny Committee meeting held on 3 August, to present the findings of the public consultations carried out in connection with the Clinical Services Review (CSR) and the Mental Health Acute Care Pathway Review (MH ACP).

The draft minutes of that meeting are attached to this letter, but we would like to highlight the following areas for consideration raised by the public and/or noted by the Joint Health Scrutiny Committee within the results of consultation exercises. We recommend that the Governing Body of the Clinical Commissioning Group should take these concerns into consideration when making its decisions about proposed changes on 20 September 2017.

Service provision

The Committee recognises the overall need for change, which has been clearly articulated by the CCG. However, a number of important issues relating to specific aspects of service provision must be considered:

- With regard to the proposals relating to **the establishment of distinct roles for Bournemouth and Poole Hospitals**, Members acknowledge that the consultation results for the open questionnaire showed a slight majority in favour of Option B (Bournemouth as the location of the MEC (Major Emergency Centre)), but the residents' survey showed a majority in favour of Option A (Poole as the MEC site). However, Poole Councillors do query whether respondents were aware of the full implications of the options, namely that cancer and maternity services would move from Poole to Bournemouth if Option B is agreed. Whilst recognising that perspectives will differ, Members noted that it is not possible for service provision to continue as it is currently. **The Committee acknowledges the rationale behind the proposals to establish distinct roles for Bournemouth and Poole's Hospitals but recommends that the CCG ensures that the views of all affected residents are taken into consideration and that any adverse consequences are mitigated to benefit the whole system.**
- With regard to **Integrated Community Services and the establishment of Community hubs with and without beds**, the Committee recognises that divided views were expressed during the consultation exercise, with many individuals voicing concerns about the potential loss of much-valued facilities in their localities. The suggested use of beds within care homes as an alternative in some areas was also questioned by respondents, and Members echoed this concern. **The Committee recommends that careful consideration is given to the concerns raised by those who responded to the consultation regarding the potential loss of community**

beds in localities across Dorset and Poole, and the use of care home beds to provide capacity.

- One locality where there was very **strong opposition to the potential loss of community beds** was **Shaftesbury**. The Committee feels that due regard must be given to that strength of feeling, acknowledging the particular isolation of the area, both geographically and with regard to the availability of public transport. **The Committee recommends that the CCG takes full account of the views of the North Dorset population and commits to all necessary access to services.**
- With regard to proposals for **maternity and paediatric services**, the Committee noted that Option A (a consultant-led service in the east of Dorset and a partnership service between Dorset County Hospital and Yeovil Hospital in the west) had received the most support during the consultation. However, Members were concerned as to whether it had been made clear to respondents that Option A might result in Dorset mothers and children having to travel to Yeovil for services, should the consultant-led unit (and overnight paediatric services) be based there. The CCG advised that further consultation on site-specific decisions, in conjunction with Somerset CCG, would be necessary if Option A is taken forward. Members also doubted whether there had been clarity during the consultation process regarding consultant-led maternity services in the east of Dorset, and the fact that those services would move from Poole to Bournemouth, if maternity services were to be co-located at the CCG's preferred site for the Major Emergency Centre. **The Committee supports the suggestion from the CCG that further consultation would be undertaken to consider site-specific options for maternity and paediatric services, should Option A be agreed.**
- With regard to the **Mental Health Acute Care Pathway consultation**, the Committee noted that respondents were generally supportive of the proposed changes to service provision, but had particular concerns about the **potential lack of facilities** in West and North Dorset and the proposed moving of beds from west to east Dorset (including the closure of the Linden Unit in Weymouth). **The Committee recommends that the CCG ensure that residents across West and North Dorset have sufficient access to mental health acute care services, whilst recognising the need for increased facilities in the eastern localities to meet the needs of that population.**

The consultation process

The Committee recognises that the CCG have undertaken extensive engagement and consultation in connection with both the Clinical Services Review and the Mental Health Acute Care Pathway Review. This is to be commended, but there are some caveats to that commendation:

- With regard to the consultation process for the Clinical Services Review, Members expressed concern (which had also been raised with them by members of the public) about **the validity of the 'residents' survey'**, which had been carried out via telephone. It was felt that individuals who completed the questionnaire under this method had done so without the benefit of access to the full consultation document, and were therefore not acquainted with all the context and data necessary for an informed view. The CCG has been able to provide some assurance that those who took part in telephone interviews were given the opportunity to access the full set of documents prior to the interview. However, **the Committee recommends that the CCG treats the responses from the residents' survey with a degree of caution, given that many of those responding via this method will not have read the full**

consultation document available to those responding via the open questionnaire.

- With regard to the consultation responses to the proposals put forward under both the Clinical Services Review and the Mental Health Acute Care Pathway Review, the Committee noted that people living in West and North Dorset were particularly concerned about access to facilities in their locality. Whilst acknowledging that the **organised campaigns** in that area (for both the CSR and MH ACP) had influenced the overall results of the consultations, Members felt that this demonstrated the strength of feeling in North Dorset in particular, which should not be dismissed. The CCG stated that this would not be the case and that work was on-going to ensure that resources were best-placed and as accessible as possible. **The Committee recommends that due recognition is given to the views of individuals who responded to the consultations under the auspices of campaign groups, recognising the particular strength of concerns highlighted.**
- In further reference to the consultation process, Members noted the **views of Healthwatch Dorset**, which had been submitted to the CCG in April 2017. Healthwatch had received feedback from the public, suggesting that the consultation process had not been as accessible as they would wish, along with reservations as to the extent to which views would be taken notice of. The CCG reported that they had considered and responded to the report and that they are working with Healthwatch. **The Committee acknowledges the concerns raised and recommends that the CCG continues to work with Healthwatch Dorset to ensure meaningful consultation and the full involvement of the public.**

Implementation of any agreed proposals

As the two Reviews move towards implementation, the Committee welcomes the news that NHS Dorset CCG has been awarded in excess of £100 million investment monies towards major improvements to services. Members would urge the CCG to be mindful of the following concerns however, within the next phase of the programme:

- The Committee welcomes the additional work that has been undertaken by the CCG in connection with **concerns raised during the consultation processes about transport and access to services**. The review carried out by the Ambulance Service and the partnership work being led by Dorset County Council is reassuring, but the Committee would urge the CCG to take full consideration of all issues raised in relation to transport and travel. In particular, it is clear that travel times for private transport continue to cause concern, compounded by cuts to public transport funding, rurality and congestion. **The Committee recommends that work continues with the Local Authorities and Ambulance Service, to ensure that transport and access concerns are fully explored and that mutually beneficial solutions can be put in place.**
- When reviewing the outcome of the Clinical Services Review consultation in relation to Option B for the delivery of a Major Emergency Centre, Members noted the **reliance on the building of a new spur road to improve access to Bournemouth Hospital**. This was felt to be a risk, should the building of the road not progress (it is understood that the planning application is yet to be submitted) and in addition it was noted that if the road is built it would be more beneficial to residents living in east Dorset, in terms of reducing travel times, and not necessarily beneficial to those coming from west Dorset. **The Committee recommends that the CCG ensure that plans to increase**

the level of service delivery at Royal Bournemouth Hospital would still be appropriate and achievable, should the new spur road not progress.

- With regard to the specific proposals relating to future specialist roles for Bournemouth and Poole Hospitals, the Committee noted that these proposals bore **similarity to a planned merger between the Hospitals, which was refused by the Competition Commission** (now the Competition and Markets Authority – CMA) in 2013. Members were concerned that money might be wasted, should the CMA be minded to refuse the current proposals on the same grounds (a reduction in competition). The CCG were able to provide reassurance that discussions had taken place with the CMA and that their position on these matters had changed since 2013. The CCG felt that a clear patient benefit case had now been made. **The Committee recommends that detailed discussions with the CMA take place as soon as any decisions are made, to prevent the waste of public money which had resulted under the previous proposals.**
- The Committee questioned the nature of the Equality Impact Assessment (EqIA) process, given the potential impact of proposals, particularly on individuals living in areas of high deprivation. The CCG's website seemed to indicate that parts of the EqIA had been undertaken as a 'desk-top' exercise only, which Members felt was not sufficient. **The Committee recommends that detailed and thorough EqIAs should be carried out in relation to all proposals, to ensure that individuals are not disadvantaged as a result of income, age, rurality or any other characteristic.**
- The Committee noted that, to successfully implement the proposals within both the Clinical Services Review and the Mental Health Acute Care Pathway Review, there would have to be **a sufficient workforce** in place. Whilst recognising the CCG's intentions to create networks to support and develop the workforce, it remains to be seen whether recruitment and retention can meet the demands of the services. **The Committee recommends that the CCG continues to focus on workforce development, alongside partner organisations, to ensure that planned changes can be properly supported and recognises that this is the role of the STP partnership.**

The Committee acknowledges the extensive engagement and involvement which has been undertaken with respect to both the Clinical Services Review and the Mental Health Acute Care Pathway Review. In particular, the co-production approach which was adopted during the course of the Mental Health Review seems to have been well-received, and a good example of enabling stakeholders to feel that their views are valued, even when difficult or contentious matters are being explored.

We thank the CCG for their willingness to work with the Joint Committee and look forward to meeting again, once the proposals have been before the CCG Board, which we understand is scheduled for 20 September 2017.

Yours sincerely

Cllr Bill Pipe

Chair, Dorset Health Scrutiny Committee and Joint Health Scrutiny Committee

Text of Letter from NHS Dorset CCG in response to the letter from the Joint Health Scrutiny Committee dated 29 August 2017

15 September 2017

Dear Cllr Pipe,

Re: Joint Health Scrutiny Committee – comments and recommendations regarding the findings of the Clinical Services Review and Mental Health Acute Care Pathway Review consultations.

Thank you for your letter dated 29th August 2017.

We acknowledge and appreciate the time the Joint Health Scrutiny Committee has taken to meet with the CCG on 3rd August and in providing us with a detailed response.

Please be assured that the letter has been passed to the Governing Body of NHS Dorset CCG for their consideration and has formed part of their deliberation on the proposals. The Governing Body will make its decision on the proposals at their Governing Body meeting on 20th September 2017.

As no decisions have been made by the Governing Body, we are unable at this time to comment on the final outcomes of some of the recommendations made by the Committee. We will provide the Committee with a further detailed response following the Governing Body's decision meeting.

The Governing Body papers are now available online –
<http://www.dorsetccg.nhs.uk/aboutus/20-september-special.htm>

Since the formal public consultation ended, the Governing Body has reviewed the information gathered. The final recommendations contain amendments to the previous proposals. This includes 5 revised proposals which we trust demonstrate that due consideration has been given to the responses made during our consultation. This has now been awarded 'Best Practice' status by the Consultation Institute which is their top status and is an upgrade to their previous 'Good Practice' award.

In North Dorset, we now propose:

- to commission a community hub with beds at Sherborne Hospital;
- to commission a community hub with beds at Blandford Hospital;
- **new** - to maintain a community hub with beds in Shaftesbury Hospital whilst working with the local community until a sustainable model for future services based on the health and care needs of this locality is established, possibly at a different site to the existing hospital.

In Weymouth and Portland, we now propose:

- **new** - to maintain services including beds at Westhaven Hospital until the community hub with beds at Weymouth Hospital is established and staff and services have been appropriately transferred;
- a local community hub without beds in Portland, possibly on a different site.

In Bournemouth and Christchurch, we now propose:

- to commission a community hub without beds at Christchurch Hospital. [This will not affect the palliative care beds];
- **new** - to commission a community hub with beds on the Major Emergency Hospital site. (This is in addition to the proposed community hub with beds on the Major Planned Hospital site).

Maternity and Paediatrics revised recommendation:

- To commission option A;
- to commission the delivery of consultant-led maternity and paediatric services from the Major Emergency Hospital;
- **new** - to seek to commission the delivery of consultant-led maternity and paediatric services integrated across Dorset County Hospital (DCH) and Yeovil District Hospital (YDH) for the Dorset population. The implications for this will be considered by DCH and YDH and any proposed changes to services in either hospital would be subject to further local public consultation by both Dorset and Somerset CCGs as appropriate.

Mental health ACP:

- **new** - Travel time analysis was reviewed and the recommendation changed the Sturminster location to either Shaftesbury or Gillingham.

Where possible we have responded to the comments and recommendations as attached to this letter. We are also holding time for a possible Joint Health Scrutiny Committee on 19 October. If this date is confirmed, we will update the Committee further on the decisions.
Yours sincerely,

Tim Goodson

Chief Officer, NHS Dorset Clinical Commissioning Group

SERVICE PROVISION

The Committee acknowledges the rationale behind the proposals to establish distinct roles for Bournemouth and Poole's Hospitals but recommends that the CCG ensures that the views of all affected residents are taken into consideration and that any adverse consequences are mitigated to benefit the whole system.

CCG response

NHS Dorset CCG acknowledges the recommendation made and will take this under advisement during their decision making deliberations.

The Committee recommends that careful consideration is given to the concerns raised by those who responded to the consultation regarding the potential loss of community beds in localities across Dorset and Poole, and the use of care home beds to provide capacity.

CCG response

NHS Dorset CCG acknowledges the recommendation made and will take this under advisement during their decision making deliberations. Please note the revised recommendations relating to beds at Shaftesbury, introducing new community beds at the

Major Emergency Hospital, and ensuring beds continue to be provided at Westhaven Hospital until such point when the Weymouth Hub has been fully established.

The Committee recommends that the CCG takes full account of the views of the North Dorset population and commits to all necessary access to services.

CCG response

NHS Dorset CCG acknowledges the recommendation made and will take this under advisement during their decision making deliberations. Please note the revised recommendations relating to beds at Shaftsbury and the revised location of the Community front Room.

The Committee supports the suggestion from the CCG that further consultation would be undertaken to consider site-specific options for maternity and paediatric services, should Option A be agreed.

CCG response

NHS Dorset CCG acknowledges the recommendation made and will take this under advisement during their decision making deliberations. Please note the revised recommendation where option A was recommended and a further public consultation, in conjunction with Somerset CCG, would take place.

The Committee recommends that the CCG ensure that residents across West and North Dorset have sufficient access to mental health acute care services, whilst recognising the need for increased facilities in the eastern localities to meet the needs of that population.

CCG response

NHS Dorset CCG acknowledges the recommendation made and will take this under advisement during their decision making deliberations. Please note the revised recommendation relating to the revised location of the Community Front Room.

THE CONSULTATION PROCESS

The Committee recommends that the CCG treats the responses from the residents' survey with a degree of caution, given that many of those responding via this method will not have read the full consultation document available to those responding via the open questionnaire.

CCG response

We recognise that although not all residents contacted via telephone would have read the consultation document, they were all offered the opportunity to do so before responding. Some people chose to take this option and were called back.

The residents' survey was undertaken in order to ensure a representative profile of opinions across Dorset. To capture the views of the general population, 1,004 residents across Dorset and neighbouring affected areas in West Hampshire, Somerset and Wiltshire took part in a structured telephone interview with an ORS interviewer during February 2017.

This survey, conducted using a quota based sampling approach, ensured that residents who were less likely to engage with the wider consultation were included and encouraged to give their views about the proposals. A survey approach was used because, with a population of

around 750,000 residents, it would have been neither practical nor cost-effective to do a census of all households or residents.

The residents' survey data, once weighted, is broadly representative of the entire population of Dorset and the results provide a statistically reliable estimate of the views of the county's residents. The sample of 1,004 responses yields overall findings for the general population of the whole of Dorset and surrounding affected areas that are accurate to within about ± 3 percentage points.

Taking into account the sample sizes, the opinion splits, and the degrees of statistical weightings used (to compensate for different response rates from different demographic groups), the survey findings are sufficiently accurate to allow confident conclusions to be drawn about opinions on the CCG's proposals. As such, the residents' telephone survey provided a statistically robust guide to overall public opinion across Dorset (including areas bordering Dorset where residents use some Dorset NHS services).

The Committee recommends that due recognition is given to the views of individuals who responded to the consultations under the auspices of campaign groups, recognising the particular strength of concerns highlighted.

CCG response

Petitions are important expressions of public feeling. The CCG received and noted the petitions submitted and the petitions have been included in ORS's report. In interpreting and reporting them, ORS took account of the 'petition statements', the numbers of people signing, and the ways in which they were compiled. NHS Dorset CCG Governing Body will consider the consultation report and its findings, including the petitions, in full.

ORS's guidance regarding petitions notes that petitions can exaggerate general public sentiments if organised by motivated opponents. Petitions should never be disregarded, for they show local feelings; these observations do not discredit the petitions, but provide a context within which they should be interpreted. A consultation is not a vote; and influencing public policy through consultation is not simply a numbers game in which the loudest voices or the greatest numbers automatically determine the outcome. Interpreting the overall meaning and implications of consultations is neither straightforward nor just numerical, all the various consultation methods have to be assessed.

Accountability means that public authorities should give an account of their plans and take into account public views: they should conduct fair and accessible consultation while reporting the outcomes openly and considering them fully. This does not mean that the majority views should automatically decide public policy; and the popularity or unpopularity of draft proposals should not displace professional and political judgement about what is the right or best decision in the circumstances. The levels of, and reasons for public support or opposition are very important, and are considerations to be taken into account, not as factors that necessarily determine authorities' decisions. For the public bodies considering the outcomes of consultation, the key question is not 'Which proposal has most support?' but, 'are the reasons for the popularity or unpopularity of the proposals cogent?' In this context, we encouraged people who signed a petition to also complete the open questionnaire.

Please also note the 5 revised proposals which we trust demonstrates that due consideration has been given to the responses made during our consultation, which has now been awarded 'Best Practice' status by the Consultation Institute which is their top status and an upgrade on their previous 'Good Practice' award.

The Committee acknowledges the concerns raised and recommends that the CCG continues to work with Healthwatch Dorset to ensure meaningful consultation and the full involvement of the public.

CCG response

The CCG works closely with Healthwatch Dorset, especially with regards to the CSR consultation. Throughout the CSR the CCG had regular meetings with Healthwatch Dorset. This helped us to review and develop our approaches, to help ensure effective, timely and accessible opportunities for local people to be informed and get involved.

Our Patient and Public Engagement Group designed a series of consultation principles which emphasised the need to reach out across Dorset's geography, demography and diversity – offering opportunity for information and involvement for all. This core principle was strongly supported by Healthwatch Dorset.

Our regular meetings with Healthwatch Dorset enabled us to collectively explore challenges. We were able to take a step back and reflect on their advice, ideas and suggestions and to combine this with our own knowledge and experience to develop approaches and actions to address these challenges.

Across the CSR engagement and consultation Healthwatch Dorset encouraged local people to take part. We worked closely on social media – receiving and answering people's queries and concerns – and regularly updating our FAQs. They also forwarded the feedback they received from the public onto the CCG. This included views and comments on the consultation and events which helped us to learn and evolve.

In addition to the formal consultation document, we produced and widely published:

- A new consultation website - <https://www.dorsetsvision.nhs.uk/> which included an interactive map that explained the CSR proposals in the local areas of population
- two simplified animations (specifically requested by organisations working with people with learning disabilities)
- three films aimed specifically at young people
- an Easy Read questionnaire
- a summary 'z-card' - which was initially produced for all grades of staff but was enthusiastically and well received by many, many members of the public
- frequently asked questions and answers – developed with Healthwatch Dorset
- a social media campaign 'it's mine, it's yours, it's ours' which encouraged people to take part in the consultation regardless of their views
- two invited audience events, 20 drop-in events and 25 more local pop-up events
- leaflet drops to 85,600 homes in Weymouth, Portland, Bridport, Bournemouth, Poole and South Wiltshire, also to encourage people to have their say
- shared 50 + CSR on social media
- 370+ media interactions
- Reached 125,000 people through Facebook advertising.

The independent advice Healthwatch provider is of huge value and we look forward to working closely with Healthwatch Dorset through the next steps of CSR and across Dorset's Sustainability and Transformation Plan (STP).

IMPLEMENTATION OF ANY AGREED PROPOSALS

The Committee recommends that work continues with the Local Authorities and Ambulance Service, to ensure that transport and access concerns are fully explored and that mutually beneficial solutions can be put in place.

CCG response

We appreciate that people have been particularly concerned about both emergency and non-emergency transport and we have received and responded to a number of queries regarding transport.

In response to these concerns in August we published an independent report by South Western Ambulance Service NHS Foundation Trust (SWASFT) - 'Dorset Clinical Services Review: Modelling the Potential Impact on the Emergency Ambulance Service.'
<http://www.dorsetccg.nhs.uk/Downloads/news/Dorset%20CSR%20Modelling%20Final%20v1-0.pdf>

The report examined how the proposals and subsequent decisions detailed in the CSR could impact on emergency transport in Dorset. The report analysed nearly 22,000 patient records, detailing what the impact on services could be across three areas: maternity services, emergency transfers (adults) and emergency transfers (children).

The report concluded that if the CSR proposals are implemented then the average emergency journey times will remain similar to those undertaken at present and for many patients, journey times will be shorter. In addition, there will be a large reduction in patient transfers between hospitals in East Dorset and this will improve journey times and patient safety. Numbers of hospital transfers in East Dorset are currently the highest in the South West.

We hope that this report reassures people that these proposals are designed to ensure that people get the best possible care and that we are focusing on getting the best outcomes for people in Dorset using these services in future. This report demonstrates that, through public consultation, we have listened to those people who expressed their concerns about having to travel further or for longer to get emergency care.

NHS Dorset CCG, Dorset County Council, Bournemouth Borough Council and Borough of Poole have set up a new Transport Reference Group to develop an integrated transport system for non-emergency health and social care across Dorset. This is the first time, agencies and organisations across Dorset are joining together to collaboratively and holistically consider transport. This includes health, local authority, community and voluntary services.

The group, which comprises councillors and transport leads from the four partner organisations, will start by considering the transport infrastructure across Dorset, Bournemouth and Poole before looking at how specific ways of joint working and could be introduced next year.

The group will identify gaps in transport connections to health services across the county and consider what can be done to address them. They will also work alongside local healthcare transport schemes, such as e-Zec, which is contracted to provide transport for non-urgent NHS patients.

As a first step, the group has published a report that looks at concerns about transport that people raised during consultation on the CCG's Clinical Services Review (CSR) which ran between December 2016 and the end of February 2017 and what could be done to address them.

Led by DCC, they conducted a thorough and independent analysis of the travel times presented in the CSR. This has been undertaken by transport planning officers and has involved comparing the CSR source data with local authority routing software, digital maps and other routing software. The resulting analysis indicates that that CSR travel times are within similar and acceptable parameters to the routing software and analytical tools used in local authority transport planning activities. The results were found to be consistent across all travel comparators for acute and community based healthcare services. Sense checks on the results using digital mapping confirm that the travel times used are a reasonable approximation from which to draw conclusions for travel associated with the CSR proposals.

The full report is available online -

<http://www.dorsetccg.nhs.uk/Downloads/2017%2007%2014%20-%20DCC%20CSR%20Transport%20Review%20Report%20-%20FINAL.PDF>

All partners will be working to better integrate and co-ordinate services and approaches to travel, and to consider how our combined resources and capabilities could be best utilised for people in Dorset.

We will continue to work closely with SWASFT and the local authorities to ensure we address the implementation requirements and needs of the CSR.

The Committee recommends that the CCG ensure that plans to increase the level of service delivery at Royal Bournemouth Hospital would still be appropriate and achievable, should the new spur road not progress.

CCG response

NHS Dorset CCG acknowledges the recommendation made and will take this under advisement during their decision making deliberations.

The Committee recommends that detailed discussions with the CMA take place as soon as any decisions are made, to prevent the waste of public money which had resulted under the previous proposals.

CCG response

Until final decisions have been made regarding the configuration of acute hospitals the CMA is unable to formally comment. We have kept the CMA informed of the proposals as the CSR has progressed. We are in a different position now compared to the one we were in when the application to merge Poole and Bournemouth Hospital was blocked. A clear patient benefit case has been made and NHS Dorset CCG has been earmarked for £147 million of capital funding by NHS England to support the preferred recommendation to allow for major improvements to health services across Dorset. These are key requirements to achieve CMA approval.

It will be possible for formal discussions with the CMA to take place after the Governing Body has made its final decision.

The Committee recommends that detailed and thorough EqlAs should be carried out in relation to all proposals, to ensure that individuals are not disadvantaged as a result of income, age, rurality or any other characteristic.

CCG response

Throughout the design and consultation phase, we have continually tested our models of care against Equality Impact Assessments. Following consultation these were reviewed and updated to reflect some of the feedback provided during consultation and in line with best practice. In doing this, we followed a robust process which involved review by the CCG's leads for service delivery; independent review by the Equality and Diversity Lead for Dorset HealthCare NHS Trust; and a workshop for service leads in the provider organisations.

We arranged a second facilitated workshop for our Patient and Public Engagement Group and additionally invited members of the public/staff who collectively represented the nine protected characteristics. This was to ensure that the process was inclusive and realistic. The revised and updated EIA was then sent for legal review before being scrutinised by the Quality Assurance Group and publication in July 2017. The EIA can be found at: <http://www.dorsetccg.nhs.uk/Downloads/aboutus/equality/EIA/CSR%20EQIA%20Site%20Specific%20FINAL%20190717.pdf>

The Committee recommends that the CCG continues to focus on workforce development, alongside partner organisations, to ensure that planned changes can be properly supported and recognises that this is the role of the STP partnership.

CCG response

We continue to work closely with our colleagues in partner organisations to ensure the proposals are deliverable from a workforce perspective.

As you are aware the STP has been jointly developed between the Borough of Poole, Bournemouth Borough Council, Dorset County Council, NHS Dorset Clinical Commissioning Group and the five main health care provider organisations within Dorset.

One of the five enabling portfolios within the STP is 'Leading and Working Differently'. The work streams within this portfolio include:

- developing our leaders: the vision is to develop leadership behaviours and their impact, resulting in improved organisational and staff performance and staff morale;
- recruitment and retention of staff: the vision is to develop a system-wide approach to attract new staff and retain existing staff within the health and social care sector in Dorset;
- developing our staff: the vision is to improve the development opportunities for staff, to ensure the future workforce supply, to improve retention and morale within health and social care organisations in Dorset, and to work in greater partnership with education providers to ensure future workforce supply is available;
- supporting our staff through change: the vision is to improve the working environment for staff by ensuring they are engaged and involved in changes that affect them;
- workforce planning: the vision is to ensure that a workforce with the required skills and competencies to deliver new models of care is available.

Evidence provided to Dorset Health Scrutiny Committee Task and Finish Group by invited representatives on 22 August 2018

Appendix 5.1 – Overview Report, Defend Dorset NHS

Dorset Health Scrutiny Committee: Task and Finish Group 22 August 2018

“Should Dorset HSC now refer the CCG STP to the Secretary of State?”

Paper by Steve Clarke Defend Dorset NHS Group

We are aware that Health Scrutiny Councillors have a weighty responsibility in terms of protecting resident's lives, health and NHS services. We appreciate the opportunity to share, and clarify, the information that we have gathered during our campaign, and for the Judicial Review.

1-We attended the consultations by the CCG on the Clinical Services Review, the Governing Body meeting in September 2017, the Councillor briefings by the CCG, the several HSC meetings where there was very long presentations by the CCG and decisions to refer/not to refer to the S of S. Subsequently we worked on the case for the Judicial Review and hearing drawing on national and international research.

2-After all these hearings should Dorset elected members still refer the plan to the Secretary of State on the basis that the proposed CCG plan will not improve health services in Dorset? We believe that the evidence gathered in these meetings and the Judicial Review **strengthens the case** for referral for the reasons set out below.

3-Positive aspects of the CCG plan

We welcome the creation of community hubs if they are well equipped and staffed to provide more diagnosis and treatment locally. We welcome the *aspiration* to provide better community health services with the aim of reducing the need to use A and E services (but alas the aspiration is not a plan). All of us would love to see a NHS so well resourced that no planned operations have to be cancelled because of emergency pressures but such a resourcing plan does not exist.

We welcome the provisional allocation of £147 million capital investment for Dorset. This was never dependent on the closure of Poole A and E, in fact the money was allocated in July 2017, prior to the CCG making the decision about where to locate the Major Emergency Hospital. However, the securing of this capital meant that the CCG did not want to engage on the flaws of their plan in case it put the allocation at risk. The JHSC was told last December that any delay would mean risk to the capital allocation, but it has not been withdrawn.

4-There were however numerous issues with the Consultation process being neither accessible nor transparent, and there were also some **highly misleading presentations by the CCG** to the JHSC. The CCG plans “would save 60 lives” but in correspondence and at the High Court this claim was not backed up. The closure of Poole A and E would contribute to the need to “save £229m” but in fact the creation of separate planned and emergency hospitals will cost **more** as the emergency hospital has to staff for a larger margin of unused beds for unplanned emergencies. Properly funded ‘Care Closer to Home’ would also be very costly. We were told that all the staff were behind the changes, yet senior staff, who are very unhappy with the proposals, but concerned about the consequences if they speak out publicly, have contacted us to express their concerns about risk to residents in some areas due to unacceptably long travel times, and about the capacity of the two remaining A&Es to

cope. Please see their concerns in our Appendix "Dorset A&E Drs - Questions and Comments".

4 (b) The **biggest misleading claim** was that there was "no clinical risk" in their proposals which, as the High Court came to understand, is unfortunately not the case. There is significant risk of harm, including of fatality, to a substantial number of residents who will face longer journeys to services if the plans to downgrade Poole A&E and close Poole Maternity go ahead. My colleague Debby Monkhouse will present to you separately on this.

5- At the Judicial Review Hearing held in the High Court on 17th and 18th July, our Barrister Jason Coppel QC evidenced that the decision makers were not told about risk, were misled that there would be 24/7 Consultant Delivered A&E in Bournemouth, were not told that 2/3 of Poole's Hospital beds would close, and did not know whether or not enough social care staff would be available, given budget constraints, to deliver the proposed new integrated care services. Requirements to have new services in place, before acute and Community Hospital beds are closed, were not addressed.

6- The 4 Fundamental Flaws in Dorset CCG's plans

A-The decision to close Poole A and E and Maternity would lead to unacceptable travelling times for parts of Dorset with the increased risk of mortality or poorer recovery. (Debby Monkhouse will present on this point). Moving the Neo Natal Intensive Care unit to RBH would mean that it is too far to travel in maternity emergency for the majority of Dorset residents.

7-B-There will not be sufficient hospital beds to cope with anticipated demand. The CCG forecast that 2467 beds would be required in 2021 but their plan only provided for 1632 beds, 835 less than forecast and 245 less than we have now. 245 would be the net acute bed loss across Dorset, however as there will be additional beds at Bournemouth Hospital, the brunt of the acute bed closures would be faced by all areas West of Bournemouth - Poole and Dorset County will lose 481 beds between them. The CCG say the reduction would be achieved "by reduced demand, by fewer operations, better community care and faster discharges from hospital".

The 835 bed shortfall was set out in p104/5 of the Decision Making Business case (DMBC) but the charts were never presented together to the JHSC/ DHSC, only the chart on p105, which showed the 245 bed reduction and which was presented as a modest change. The CCG misleadingly claimed that the Clinical Services Review had nothing to do with beds, only services. They did not make clear that the anticipated need was for 2467 acute beds, nor that they are proposing to close 136 physical healthcare beds across 5 Community Hospitals, to reduce Dorset County beds by 74 (a loss of 1/5 of their current beds) and Poole by 407 (a loss of 2/3 of their current beds).

8-The CCG did not share their own statement with the JHSC, which was that the large 835 bed shortfall relied on a transformation of community health services. In the submission to the NHS the CCG stated, "All acute hospital savings are based on a 25% reduction in acute admissions so acceleration of acute hospital revenue savings will require an acceleration of community transformation otherwise the system will be extremely challenged because of the assumed acute bed reductions." Very rarely do public bodies use the term extremely challenged as it signals complete failure. In plain language if the NHS cannot reduce admissions by having more GPs, community nurses etc A and E services will be overloaded with Dorset patients in ambulances, corridors and having to be shipped elsewhere with risk to life.

9-Nothing since last year suggests Dorset can survive with fewer beds. The winter flu epidemic caused all planned operations to be cancelled at Poole/RBH in January and this

summer the heat wave overloaded A and E with waiting lists continuing to grow. If there were signs that there was a community transformation plan we would be less worried but ...

10-C-There is no viable plan to provide for sufficient staff in the community, or for integrated work with social services.

11-This was a particularly weak part of the CCG case when they made their decision with vague references to staff being transferred from hospitals? The current community services already had a 14% shortfall, which meant 900 staff needed to be recruited. Again the CCG did not wish to discuss at JHSC/DHSC their own statement that *“There is a major challenge around the capacity of the existing workforce and the ability to attract and retain additional workforce to implement the planned changes, whilst carrying out business as usual. There is also a dependence on a shift in the number of staff from the acute to the community to deliver the Integrated Community proposals”*. Dr Haines for the CCG said that the existing service was “on its knees” because of staffing shortages without realising the illogicality of basing the whole plan on recruiting several hundred more staff in the areas of greatest shortfall.

12-District and community nursing relies on staff being able to afford accommodation in the County and there no plans to make the situation better.

13-Reducing delayed discharges from hospital relies on close working with Social Services whose financial problems are worsening and whose levels of support are becoming ever more restricted. The CCG sought to argue that their plans did not rely on social services, yet plans rely on integrated working.

14-We have no evidence in Dorset that the situation has improved in the last year and that a viable plan now exists. All the national evidence is that GP turnover is rising and district/community nursing numbers are falling. At no time in the Judicial Review process did the CCG produce evidence that they had filled all the vacancies and were increasing numbers. This suggests to us that Dorset still has a serious and difficult to solve recruitment problem.

15D-There is no coherent plan to replace the Community Hospitals

The CCG has argued that most community hospitals are unviable as 24 beds is the minimum for staffing and economic viability. Some community hospitals, which have been “saved”, such as Shaftesbury, Wimborne and Swanage, have 16 beds, raising concerns about their futures under this policy. Community hospitals play an intermediate role in caring, particularly for the elderly: for example those who have had falls and are disorientated but are not yet ready to return home. They work best when they are close to where people live. We have not seen the full plan to replace these Community beds but the suggestion is these ‘community beds’ will be at Poole and RBH - just the large-scale environment, at a distance, which is unsuitable for the patients. My colleague Giovanna Lewis will speak more on this point.

So how did we get to this position?

16- Reduction in the national NHS annual budget uplift from 4% on average 1948-2010 to 1.2% 2010-2018 has pushed Trusts into deficit. The Keogh Report recommended specialist A and E centres but did not prescribe how this would be achieved, as it recognised that everywhere was different.

In London (but not in Manchester) the creation of specialist stroke and heart centres led to increased survival rates, however the reconfigured centres are still only a maximum of 30 minutes blue light travel time from the population. In rural areas such as Shropshire where

some local stroke services have been closed in favour of fewer 'Hyper Acute Stroke Units' a significant percentage of patients do not arrive at the new stroke centres within the maximum time allowed between stroke and treatment, and the mortality rate is significantly above the national average. Many CCGs are creating specialist A&E services, but are not closing smaller A&Es, with patients transferring to the specialist services if necessary, once they have been stabilised.

17-Dorset already has specialist centres with Poole leading on Trauma and Maternity, and RBH on cardiology, although Poole treated more cardiac arrests than RBH last year, as SWAST take patients to the nearest A&E if it would put their life at risk to travel further. However the concept of specialist centres cannot be fundamental as Dorset CCG propose to retain Dorchester as an A and E and planned hospital, with presumably the same level of outcomes. What does the plan mean for the future of Dorchester CH?

18-In Dorset the CCG decided early on to create one emergency hospital and one planned hospital which would centralise A and E expertise. However the plan is flawed on travelling times, on the number of beds required and on access. The "facts" have been made to fit but they don't.

19-Should the DHSC refer in the light of the Judicial Review?

20-The Judicial Review is about the legality of how the CCG made its decision not the decision itself. A terrible plan can be agreed if the right processes were followed. If the JR is upheld the CCG will have to review its plans and consult again.

21-If the JR is not upheld this does not mean the Judge thought the plan was a good one. By law it is for Dorset HSC to give a view on that.

22-As we have argued the plan has fundamental flaws, which have not been rectified in the last year. Referral to the Secretary of State would force a review of these issues.

23-Do we have an alternative?

Defend Dorset NHS view is that to make the best use of the hospital stock the A and Es at both hospitals should be retained under joint Trust governance and integrated A and E management. The capital allocation would refurbish the whole stock and enable continued investment in Poole Maternity Unit. This would enable the specialist skills to be developed across both hospitals, building on the specialist skills now available. There has been a new £20 billion central Government allocation for the NHS in England. In Dorset, does this mean that the CCG still need to save £229 million per annum against expected expenditure?

24-If the CCG do believe that in order to save money, they have to close one of our 3 Dorset A&E and Maternity Services, we believe the Major Emergency Hospital should be at Poole. The population of West Hampshire can access Southampton within safe guideline times. Poole is the Regional Trauma Unit, it delivers 2/3 of the County's babies born in Hospital, and its geographical location means that all of the Dorset population would be able to access A&E and Maternity, including Neo Natal High Dependency and Intensive Care, within safe guideline times.

Steve Clarke

Appendix 5.2 – The risk to residents, Defend Dorset NHS

The risk to residents due to loss of A&E and Maternity at Poole (Debby Monkhouse)

The CCG has failed to properly assess the risk to residents as a result of the proposed loss of A&E and Maternity services at Poole. There is significant risk to at least 400 patients per year, and there are at least 180 patients per year at risk of fatality.

CONTEXT

Safe Travel Time Guidelines

CCG Consultants Steer, Davies, Gleave said in their Travel Times Analysis that safe travel times for maternity emergency, major trauma and acute stroke are just 30-45 minutes.

The 'Golden Hour' is often used as a guideline. It is measured from incident to treatment, includes the time it takes for the ambulance to come, and the time to unload the patient on arrival at Hospital.

Time critical conditions that can't be treated in the ambulance It's important to remember there are a range of conditions, such as heart attack, stroke, sepsis and meningitis that cannot be treated in the ambulance, and where increased journey time could mean fatality, or living with disability. In respiratory arrest, treatment in the ambulance relies on there being a Paramedic on staff. Not all cardiac arrests can be treated by defibrillation, and out of hospital survival rates are just 8%. Ambulances do not carry blood, so can not treat haemorrhage in trauma, or in maternity emergency.

Actual Travel Times

Purbeck: South West Ambulance Services Trust (SWAST) say that blue light time alone from Swanage to Poole is 38 minutes, to Dorset County Hospital is 47 minutes, and its 57 minutes to RBH. Swanage residents would always be outside safe guidelines of 30-45 minutes for major trauma, maternity emergency & acute stroke.

Swanage has 10,000 residents, and a million visitors per year.

In response to a Freedom of Information Act request by Langton Parish, SWAST said that the average time for all BH19 postcodes (Swanage, Langton, Worth & Studland) from category 1 (imminent danger of death) call to SWAST, to arrival at Poole A&E, over the thirteen month period Nov 16 – Dec 17, was 1 hour 43 minutes.

North Dorset: We have not seen SWAST times for journeys from North Dorset to RBH and DCH under the plans, but in evidence to the High Court the CCG said that some North Dorset residents would have to go out of County to access A&E and Maternity.

If Poole were the Major Emergency Hospital: All Dorset and West Hampshire residents could get to A&E and Maternity within safe times. Purbeck, North Dorset, Bournemouth and Christchurch residents can get to Poole, while West Hampshire residents can access Southampton. Poole is better located if we have only one Dorset newborn Intensive and High Dependency care service.

Calculating the number of residents put at clinical risk by the plans to close Poole Maternity and downgrade Poole A&E

A) Patients currently treated at Poole

Poole Hospital: Current A&E Volume and Specialisms

Poole A&E saw 68,000 people last year, and 37,500 were unwell enough to be admitted. If Poole A&E is replaced by an Urgent Care Centre, and Poole loses 2/3 of its beds, what will happen to the 37,500?

Time critical conditions that can't be treated in the ambulance Among the 37,500 admitted through Poole A&E last year, are a significant number of patients with time critical emergencies that can't be treated in the ambulance. Some of these will face journeys of an hour or more to access Hospital care, increasing fatalities and lives lived in disability. A Freedom of Information Act response shows 1784 patients arriving in Poole A&E in 2017 with the time critical conditions of heart attack, cardiac arrest, stroke, sepsis, meningitis, maternity emergency and trauma.

Poole specialisms: Trauma and Maternity & Paediatrics

Poole specialises in Trauma. The SWAST Report names Poole as the Regional Trauma Unit. Poole treats or stabilises 2/3 of Dorset Trauma cases, 507 patients in 2017.

Poole also specialises in Maternity & Paediatrics. Poole Specialist Maternity delivers 2/3 of all Dorset babies born in Hospital, over 4,500 babies last year. Poole is the only Dorset Hospital offering high dependency and intensive care for newborn babies.

A Freedom of Information Act response from Poole regarding newborns needing additional care in 2017, shows that over 1,000 babies needed additional care. This includes 80 newborns that needed Intensive Care, and 171 newborns that needed High Dependency Care. The mothers of these 251 babies have come from all over Dorset, as Poole is the only Dorset Hospital offering this level of care. These maternity emergency Mums would all have to get to RBH under the plans.

Cardiac: Although RBH is the specialist cardiac centre, the Ambulance Trust's triage tool guidance is to take cardiac cases to the nearest A&E if the further journey to RBH would endanger life. More cardiac arrest cases were treated at Poole than at RBH last year. 127 heart attack cases were also taken to Poole.

Statements made to Dorset Health Scrutiny Committee that 'all Trauma cases go to Southampton now'; 'all cardiac cases go to Bournemouth'; '85% of those attending Poole A&E would be able to be treated in the proposed Poole Urgent Care Centre' were, therefore, **highly misleading**. It is also of concern that Poole's role as the leading Dorset Maternity Hospital has not been discussed at DHSC, nor have the implications of moving Neo Natal Intensive and High Dependency Care Services to RBH been addressed.

B) South West Ambulance Services Trust (SWAST) Report, August 2017: "Dorset Clinical Services Review: Modelling the Potential Impact on the Emergency Ambulance Service."

This Report considered the risk of harm to patients, if Poole A&E were downgraded and Poole Maternity closed, and they had to travel further to access these services elsewhere. The Report covered a 4 month period, January – April 2017, and it looked at those arriving at Poole A&E by ambulance over that time.

The Report did not consider the risk to those who did not arrive at Poole A&E by ambulance over the 4 months, so the Report can only underestimate the number at risk.

Dorset Specialist Clinicians asked to look at the Report stated that it could not be used to quantify the risk to Maternity and Paediatric emergencies as the majority do not come to A&E by ambulance.

Freedom of Information Act responses from Poole show 80% of maternity emergencies do not arrive by ambulance and a significant minority of adult time critical emergencies self present.

The Clinicians were also concerned about the representativeness of the adult sample as there were no respiratory emergencies. There were also only two trauma cases in the sample identified.

The Report did not consider the risk to rural residents facing the longest total travel times on to alternative A&E and Maternity services. It did not consider total travel times at all, so did not address whether these journey times were within safe guidelines, or what the risk to those residents, as a group, would be.

The Report Executive Summary relies on 'average' journey times for its conclusions. 'Outliers' have been removed. As more people live in Bournemouth than in rural areas, using an 'average' time will favour RBH as a location, and the impact upon rural residents of loss of services at Poole will be concealed.

However the Report provides a starting point for assessing risk.

Based on the cases in the SWAST Report, the CCG calculated during the Judicial Review High Court case in July that **132 of the patients** arriving at Poole A&E by ambulance over the 4 month period of the Report, **would face potential harm had they had to travel further.**

This scales up to 396 patients at potential harm over a year.

Despite knowing in August 2017 that almost 400 per year of those arriving at A&E by ambulance alone were at risk of potential harm, the CCG claimed in September 2017 that the Clinical Risk of the plans to downgrade Poole A&E and close Poole Maternity was 'minimal' and in fact went on to claim that '60 lives would be saved'. When pressed in Court for evidence, the CCG relied on the Keogh Report, which was based on centralisation of services in urban areas where access to A&E was never more than 30 minutes away. Keogh specifically warned against using the blueprint of centralising services in rural areas due to longer travel times to reconfigured services cancelling out any benefits.

SWAST Report: Calculating actual harm: likely fatalities

The SWAST Report called for further review by a wider range of Clinicians to confirm the overall clinical impact of the changes (page 2, 1.6). This work was started in August 2017. Evidence to the High Court showed that the Clinicians asked for more time to carry out the risk assessment, and for access to the patients Hospital records.

The CCG rely on the fact that they have not done the work to assess how many of those at 'potential harm' would have faced actual harm.

However, an A&E Dr has looked at the sample cases listed in the Ambulance Trust Report, in terms of the danger posed by additional travel time to Hospital and says that a significant number of the cases listed are in imminent danger of dying.

Maternity Cases at risk of fatality

2 of the 3 Maternity cases listed (p10, 4.5.3) are in imminent danger of dying. They urgently need blood, which the Ambulance does not carry. These are:

Case 1: Post-Partum haemorrhage with absent radial pulse, which indicates extensive bleeding, where the Mum's life is at risk, facing a 9 minute longer journey.

Case 3: Ectopic Pregnancy with extreme hypotension, systolic BP 66mmHg (extremely low) and pain score 10/10. There would be bleeding into abdominal cavity putting the Mum's life at risk.

Adult Cases at risk of fatality

12 of the 27 Adult cases listed (pp 15-16, 5.4.5) are in imminent danger of dying.

These include 9 of the 10 cases where SWAST has put 'Yes' in the Potential Harm column (the A&E Dr excluded case 27 as improving) plus:

Case 6: 91 year old with large PR bleed, hypotensive and becoming shocked, facing a 20 minute longer journey.

Case 9: 42 year old overdose with fluctuating Glasgow Coma Scale and requiring Airway intervention, facing an 18 minute longer journey.

Case 26: 76 year old with cardiac arrest, where the Ambulance staff are trying to give CPR in a moving ambulance. Although the onward journey is only 4 minutes longer, in cardiac arrest a minute can be the difference between life and death.

The 27 adult cases are taken from a sample pool of 150 cases, where the actual pool at risk is 696 cases. 12 of the 150 are at imminent risk of dying. This scales up to 56 cases out of the 696.

Child Cases at risk of fatality

3 of the 4 Paediatric cases listed (p24, 6.5.3) are in imminent danger of dying. These are:

Case 1: Multiple Convulsion (status epilepticus). Patient remained Glasgow Coma Scale 3 (unresponsive) throughout ambulance attendance. Facing a 9 minute longer journey.

Case 3: Post cardiac arrest facing a 4 minute longer journey

Case 4: "Very sick child" – more details would aid assessment

Therefore we believe that those at risk of fatality over the 4 month period due to loss of A&E and Maternity at Poole are: 3 Children, 2 Mums in labour & 56 Adults = 61

Over a year, this scales up to 183 patients at risk of fatality due to longer journey time caused by loss of A&E and Maternity at Poole: 9 Children, 6 Mums-to-be and 168 Adults.

This is **183 patients per year who arrive by ambulance** at risk of fatality due to loss of A&E and Maternity services at Poole.

This figure does not include the risk to those who do not arrive at A&E by ambulance, the majority of Maternity & Paediatric emergencies, and a significant minority of adults with time critical conditions. Longer journeys affect those who are not travelling with blue lights much more, as the traffic will not move aside for them.

Appendix 5.3 – The case for community hospitals, Defend Dorset NHS

DCC DHSC Task and Finish Group – 22 Aug 18

Save Portland Beds and Defend Dorset NHS - Giovanna Lewis

1 What exactly are Dorset CCG's plans for our Community Hospitals and beds?

According to their Decision Making Business Case, Dorset CCG plan to close Community Hospitals and/or beds in 5 of 13 Dorset locations: Portland, Westhaven (Weymouth), Wareham, Alderney (Poole), and St Leonards (Ferndown). There will be no local replacement services at Ferndown, and possibly in other areas, and 136 Community Hospital beds will be closed over these five localities.

We were invited to a Meeting with Ron Shields, Chief Executive DHUFT, on 15 May 2018, to clarify the plans and timeframes. At the Meeting we were told many variables of future plans, but expressly that:

- a) Portland beds would not close for a few years yet
- b) Seven beds from Wareham would be relocated to Swanage Cottage Hospital
- c) There was the possibility of a new site in Weymouth with 50 beds in the future

These positive statements were recorded in our notes, but it seems that we were misled, as they have either not been mentioned since, or have proved not to be true. In the case of Portland beds, we were then very surprised to hear in June that they would be closing in August. We said that we had been told in May that the beds would not close for a few years yet. This was then denied.

People in Portland were very upset to hear, at very short notice, that their Community Hospital beds were closing. There was a Public Meeting on Portland on the 5th of July. At the Meeting Ron Shields claimed that Portland beds were closing because, although he had enough money for staff, he could not get staff to work on Portland. However this is misleading because:

- a) The CCG decision to close Portland beds was made in September 2017. This has deterred staff from applying to work there. Staff do not generally apply to work in places that are due to close.
- b) We have since been told that, for many months before bed closures, Portland Hospital was not listed as a location that staff could choose to work at on the staff rota. So staff could not have chosen to work there, even if they wanted to.
- c) After the Public Meeting we sent an open letter to Ron Shields, signed by many Councillors and significant people, asking for further discussion around the staffing issue, before Portland beds were closed. This request has been ignored, and, sadly, the beds were closed on 7th August.

We also wonder about the legality of the closure of Portland Beds, given that we are awaiting the JR decision. No extra provision has been made to replace the beds at Portland Community Hospital.

2 We need our Dorset Community Hospitals and beds – why are they being closed?

Community Beds are vital in the provision of accessible, high quality health care, close to home and close to family and friends. They are also key in alleviating pressure on our major/acute hospitals. They provide a vital 'step-down' service from expensive major hospital beds for patients who no longer need acute care, but are not well enough to go home. They provide environments for patient assessment, rehabilitation and end of life care, as endorsed by the following statements:

29 May 2014 Simon Stevens, NHS CE -

<https://www.telegraph.co.uk/news/health/news/10864015/NHS-chief-Simon-Stevens-We-need-cottage-hospitals.html>

"The NHS must stop closing cottage-style hospitals and return to treating more patients in their local communities." "British hospitals have become among the worst in western Europe at caring for local populations, because too many services have been stripped out and centralised". "A number of other countries have found it possible to run viable local hospitals serving smaller communities than sometimes we think are sustainable in the NHS"

17 May 2018 Theresa May -

<http://www.southhamtoday.co.uk/article.cfm?id=111809&headline=Prime%20Minister%20backs%20cottage%20hospitals§ionls=news&searchyear=2018>

Prime Minister Theresa May has backed retaining cottage hospital beds: "I wholeheartedly agree that community hospitals are a vital part of the range of services we want to see in our NHS."

Also containing a quote from Jeremy Hunt - June 2014 – "I agree with the new chief executive of NHS England. There is an incredibly important role for community hospitals and, indeed, for smaller hospitals". He was making the point that it is not always the largest hospitals that have the highest standards. "One reason why the public like smaller hospitals is that they are more personal, and very often the doctors and nurses know people's names, which makes a difference. They are also closer to people's homes and easier to get to for relatives wishing to visit people in hospital."

3 Will the alternative 'Care Closer to home' be as good as our Community Hospital Care?

a) What does 'Care closer to home' actually mean, and do residents want it?

Respondents to the CCG Questionnaire did not understand that agreeing to 'Care closer to home' would mean that local Community Hospitals and beds would close – in fact they assumed the opposite. Respondents were unhappy with the proposals in the areas that are losing Community Hospitals and/or beds, as acknowledged by the CCG: "negative opinion was strongest where it was proposed that beds or hospitals are closed: North Dorset (Shaftesbury), East Dorset (St Leonards), Purbeck (loss of beds at Wareham) and Weymouth and Portland (loss of beds at Portland and proposed closure of Westhaven)."

b) Where 'Care closer to home' is in place, is it working?

With regard to the replacement of Community Hospital beds with 'care closer to home' here's what is reported from Devon, where 71% of Community Hospital beds have been closed.

9 Jan 2018 - Devon Save our Hospital Services video "Care closer to Home – it's not working" https://www.youtube.com/watch?v=NQ3ddkEW_C8&t=202s

Community Hospitals have been replaced by a DIY system with the patient in their own home largely responsible for their own care. It's called "Care Closer to Home", and it's not working.

Unlike Community Hospitals, Care closer to Home provides:

No or limited

Medical care in any 24 hour period

Supervision of medication

Physiotherapy

Nutritious meals

Personal care

Bed linen washed and changed

End of life care, and

Nowhere safe to discharge to free up of beds in the acute hospital

On 1 June 2018 Dr Chaand Nagpaul, Chair of the BMA, and others, expressed concern about the steep increase in readmissions to acute care due to too early discharges, which are caused by bed shortages, and concerns about 'Care closer to home'

<https://www.theguardian.com/society/2018/jun/01/number-of-patients-readmitted-to-hospital-rises-to-138m-in-a-year>

Dr Chaand Nagpaul, chair of the council of the British Medical Association, said: "Bed occupancy across the country is still staggeringly high and way above levels considered safe. A chronic lack of resourcing is entirely to blame and with so few beds available, patients could end up being discharged before they're fully ready to leave. A lack of district nurses and social care means that patients are also being discharged without enough support in home settings."

This is particularly worrying given that the CCG envisage treating 110,000 patients a year under 'Care closer to home'. My colleague Steve Clarke has already made the point that this would require 900 additional community staff, who need to be recruited against a backdrop of the CCG saying that they will save £229 million per annum against expected expenditure. Also of concern is that Dorset CCG has made no workforce impact assessment of social care staff to ascertain how many social care staff would be needed for the 'integrated care closer to home', or whether that number of staff would be available.

4 Summary and conclusion

We are extremely concerned about the loss of valued, high quality, Community Hospital Care close to home, in favour of a model that does not seem to be working in other areas. There is intense pressure on Dorset acute beds now, yet the CCG plan to cut these further, despite the forecast increase in need. At the same time, the local Community Hospital beds that the patients would have been discharged to, are being closed. These beds would have offered rehabilitation or palliative care in a more peaceful and conducive setting, close to home, enabling visits and support from friends and family. The acute bed cuts will mean increased pressure to discharge patients back to their homes as soon as possible, and, as the increase in readmissions shows, often before they are ready. It will not be possible to provide comparable high quality care at home without substantial additional funding and staffing, and there is no evidence that either the funding, or the staff, will be available to deliver the services. This will leave many vulnerable and unwell Dorset residents isolated and at risk. As Dorset Health Scrutiny Councillors, you can not allow this to happen. Please refer these plans to the Secretary of State for Independent Review.

Appendix 5.4 – Concerns raised by Dorset A&E Doctors, Defend Dorset NHS

Dorset A&E Dr's Concerns

The data used by the CCG to look at the future of Poole and RBH A&E seems to be incorrect and inaccurate. The large proportion of patients who go to Poole A&E have tests and investigations done whereas the CCG stated that they were mostly minor injury patients. Also, around half of the patients need to be seen by a doctor so could not be seen in an Urgent Care Centre/MIU. All of these patients would have to go to RBH instead.

Poole A&E is currently the trauma unit (Bournemouth does not take trauma, head injuries and paediatrics, and only does elective orthopaedics) and sees a similar number of patients to Bournemouth. I'm not sure that it was obvious to the public in the consultation documents that all these departments would be moving. All the specialist nurses for paediatrics, maxillofacial, obstetrics and gynaecology, acute orthopaedics, ENT and A&E trauma nurses would need to move or those in Bournemouth would need specialist training.

Poole A&E is staffed to see around 180 patients/day but currently sees around 240. RBH A&E are experiencing the same increase. I'm not convinced that creating one A&E, which will be nearly the size of Portsmouth, where patients routinely wait 8-10 hours to see a Dr, is going to make anyone safer. The Portsmouth data is horrific, colleagues working there describe it as a 'war zone', and say they are overwhelmed by the volume of patients. This is not a model that Dorset should be considering following. Can the CCG assure the public that Portsmouth failures will not happen in Dorset?

All of the acute admissions are meant to be going to RBH but there is no funding for more CT's and MRI's to cope with the increased demand. Even if there is no medical take on the Poole site, what anaesthetic or critical care support will there be for the patients on this site?

The predicted size of the new A&E in Bournemouth looks like it is at least half the size it needs to be. I understand that this is same for paediatrics and Intensive Care. If the planned size of each department on the new site is incorrect, then the affordability calculations are then incorrect.

The CCG suggest RBH is more accessible for East Dorset and West Hampshire residents. Shouldn't the residents of West Hampshire be going to Southampton? Has the growth of the population of each area, the morbidity of the population, and the new housing developments taking place been taken into account? I am not reassured that the planned site in Bournemouth is fair or safe for patients from the Purbecks and North Dorset. Assuming a proportion of Purbeck patients decide to go to Dorchester, has any money has been allocated to increase the size of Dorchester? Dorchester is already seeing almost twice as many patients as it was originally built to see, and there do not seem to be any plans or funding to improve the A&E facilities or staffing there. There is concern about the lack of Senior Consultants and theatre time being allocated there.

Is there any evidence elsewhere in the country that care in the community reduces A&E/hospital attendances? If community services are going to be improved to this extent, where is the funding for this coming from?

If there is a planned reduction in the number of acute beds, how can this be a sensible idea when both A&Es have been unable to offload ambulances due to the inability to move patients to a ward as there are no beds available? There is no evidence whatsoever for patient flow into A&E reducing. According to the Royal College of Emergency Medicine A&E attendance has been increasing by 7% per year. Flow out of the A&E departments on both sites is already poor when the hospitals are full. Is there any evidence that the care in the

community can reduce attendances by the amount the CCG is predicting? We cannot *assume* that there will be a reduction in admissions of 25%. Also, with regards to the size of the future A&E, several new A&E's in England have said that they wished they had *added* 25% to their numbers when they were rebuilt.

I am not reassured that there will be enough acute beds on the planned site.

Unless the planning permission is given to build a flyover to improve access to RBH, it would be a nightmare to get into and out of the hospital.

I am not reassured that the current road network will cope with the increased demand from staff, patients, relatives and ambulances. Nor am I reassured that there will be enough space for staff and patient parking. At the moment, it takes staff over 1.5hrs just to get out of the car park at around 5pm. Imagine the situation if the hospital is doubled in size! There would be *no* ambulances going to Poole. How will the volume of ambulances at the Major Emergency Hospital manage to get in and offload their patients?

The CCG say there is a £42m (28%) price difference between option A and option B, based on the Capita calculations, *although the actual cost could be around 20%-30% lower*. Were the theoretical sizes of each new department in Bournemouth correct and if not, would this change the costings?

I am not reassured that the new site is going to be big enough, as each department on the current plan is too small. Also, the Portsmouth experience shows that bigger has so far not been proved to be better. While there may be benefits to the concept of a single Emergency Hospital, the concerns relate to whether it is going to be the correct size, fit for purpose and is in the correct location. If the CCG cannot guarantee that the new Major Emergency Hospital will be adequately sized, in the correct location, and fit for purpose, it will be unsafe.

Patient safety

The CCG has looked at the issue of patient safety with 'rose tinted glasses', which has led to a biased view towards their desired outcome and distracted them from the realities of the difficulty of providing safe, effective care for major treatment patients if, as is proposed, Poole A&E was replaced by an Urgent Care Centre.

Questions are not being asked appropriately, because the CCG are so fixed on their ultimate destination. The CCG needs to listen to the concerns of A&E clinicians, SWAST and patients group to address these issues.

If Poole A&E becomes an Urgent Care Centre, the CCG suggest that 19 minutes will be added onto the journey time for major treatment for Purbeck patients to get to at RBH, and it will be 8 minutes longer to Dorset County, which will not have Major Emergency Hospital services. Even 8 minutes is a long time for a critically ill patient and, quite simply, means the difference between life and death.

There are a range of conditions that cannot be treated in the ambulance where time to hospital treatment is critical, as the patient could die at any moment. It cannot, therefore, be argued with any honesty that longer journey time to access treatment is irrelevant in these cases. The SWAST report corroborates this and identifies many patients whereby longer transfer time could have led to patient deaths or disability.

It may be true that those arriving at a better resourced centre are likely to do better, however this does not address the issue of those who die en route, or for whom treatment has come too late to avoid permanent disability. While it would not be surprising if better resourced departments produced better outcomes, this is an argument for improving services at existing hospitals, not for closing A&E and Maternity Departments.

Looking in more detail at the risk in several time critical conditions:

Strokes require an urgent CT scan to find out if it is appropriate to treat the patient with blood thinning drugs within the 4 hour time frame. An ambulance cannot treat, as they do not know what type of stroke it is. If relatives don't recognise initially that the patient is having a stroke the ambulance call is already delayed. Once a patient arrives in hospital clinicians have 60 minutes for tests to be completed and analysed and treatment given- 'door to needle time'.

In a heart attack, every minute delay to treatment will result in loss of heart muscle. In all heart attacks, the sooner the patient receives treatment, the better, as the heart muscle dies with each passing minute. Hence the saying "minutes mean myocardium".

Sepsis is a time critical condition administration of antibiotics in a timely manner is crucial, every hour delay in receiving antibiotics results in a 7.6% increase in the risk of mortality. Ambulance crews cannot give antibiotics for sepsis.

Respiratory emergencies need to be sorted out within 3 minutes to improve oxygenation and prevent hypoxic brain injury. In order to effectively ventilate a patient you need to get oxygen in and remove carbon dioxide. If a patient is unconscious or has a breathing problem they can't ventilate and will require the skills of a paramedic, anaesthetist or A&E doctor. SWAST cannot always provide paramedics to these emergencies and ambulance crews would need to get the patient to the nearest A&E as quickly as possible to save life.

In cardiac arrest the patient may not be susceptible to defibrillation. Out of hospital survival rates for cardiac arrest are very poor – around 8.6%, while in-hospital rates about 20% depending on the many factors that influence outcome. The sooner these patients arrive in A&E the better for their chances of survival.

In major trauma, SWAST may decide the patient needs to go to the Major Trauma Centre at Southampton Hospital. However, the guidance recommends that the patient needs to arrive at the Trauma Centre within 45-60 minutes, which cannot be achieved from most of Dorset. In this instance the patient would then need to be stabilised at Poole Trauma Unit within 45 minutes, before onward travel to Southampton Trauma Centre.

Unless measures are taken to consider how these time critical conditions would be affected by the CSR plans at this stage, lives will be lost.

<https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/ors-final-report.pdf>

Emergency Consultants and Consultants in Acute Medicine, Poole Hospital

The Consultants are concerned that a single-site model for emergency care 'will create an emergency workload of patients that cannot be managed safely or efficiently'. They strongly believe that there should be two emergency departments in east Dorset *until such time as community services and primary care are able to reduce admissions by 25% as proposed* (a figure that is considered somewhat unrealistic given demand pressures).

The Consultants are concerned about the proposed model of a single major emergency hospital in east Dorset. They are very worried that by continuing to support a single site model 'we will create *an emergency workload of patients that cannot be managed safely or efficiently*' - and that 'we may [thus] create a single emergency hospital that will also fail to deliver on the quality of care we currently provide'.

The Consultants say their concerns are upheld by the Royal College of Emergency Medicine. The Consultants strongly feel that the assumptions made within the CSR are not achievable, especially that 25% of the current emergency workload can be managed in the community and that there can be a commensurate reduction in the total number of inpatient emergency beds. They believe that primary care and community services are currently under equal pressure to deliver unscheduled care and are struggling to cope with their own demand in the face of recruitment and retention problems - and they cannot see how they will reduce the current Emergency Department workload by 25% in future.

The Consultants say that models of emergency care that have made similar assumptions as Dorset have had to be completely revised - and that concerns are accentuated by the fact that the three Acute Trusts in Dorset are performing relatively well (particularly against the four-hour target), which 'makes it more difficult for clinicians to perceive a clinical benefit for the majority of patients in reconfiguration'.

The consultants are very concerned that having a reduced bed base and relatively small designated floor space at the emergency site will create huge delays in being seen at the front door and dangerous overcrowding within the department and assessment areas. Furthermore, they say that many clinicians and physicians feel that a single medical take of at least 100 patients per day would be unmanageable. In summary, the Consultants strongly believe that there should be two Emergency Departments in east Dorset until such time as community services and primary care are able to reduce admissions by 25% as proposed. If this reduction were achieved, they would then have some reassurance that a single emergency hospital might be a viable option.

Consultant Gastroenterology Body, Poole Hospital

The Consultant Gastroenterologists firmly oppose the proposal for one major emergency and one major planned hospital site due to: the negative effect it will have on the delivery and provision of local cancer services; and the change of provision of the Acute Medical and DME take that would occur. They suggest that the way forward lies in developing major changes to the provision of community social care, rather than reconfiguring secondary care facilities.

Community and Neurodevelopmental Paediatricians, Poole Hospital

The Paediatricians suggest that: the CCG should not dilute the paediatric service by separating its component parts; a modern, purpose-built children's unit should be developed to include all services currently provided by Poole Hospital NHS Foundation Trust; and that if any services are to be provided within community hubs, adequate and appropriate space - as well as clinic support staff and a robust IT infrastructure - must be provided.

Poole Hospital NHS Foundation Trust Joint Staff Side Representatives

Staff Side understands the need for change but disagrees with the CCG's preferred option B for the reconfiguration of acute services as it 'will cause major disruption and fragmentation of many of the quality services that PHFT has become synonymous with'. It also expresses concern about: the long journey times between the two hospitals and from west Dorset to the RBH; the recruitment and retention of Poole Hospital staff; service quality at the RBH; and the potential cost of implementing the changes. Staff Side understands the pressures on services and the need to make savings, and that certain services may need remodelling. Nevertheless, they are disappointed that the CCG has recommended option B for the reconfiguration of acute services as it 'will cause major disruption and fragmentation of many of the quality services that PHFT has become synonymous with'. Emergency department and intensive care Staff Side are particularly concerned about plans to close an 'extremely busy and active' Emergency Department at Poole Hospital. They believe this decision would put many patients at risk, especially those in the west and north of Dorset who will have further to travel for emergency care.

Staff Side are also concerned that if PHFT becomes the planned care site, there are no plans to include a level 3 intensive care service, meaning patients who become unstable whilst receiving treatment or care would need transferring to RBH for treatment. This, it is said, would also mean staff and other resources transferring with the patient via ambulance when they could be treated safely and successfully at PHFT. **There is also some worry about the implications of DCH not being named as a 'major' hospital for either A&E or planned care and about the lack of Senior Consultants and theatre time being allocated there.**

Maternity and paediatric services Staff at Poole Hospital are extremely concerned about the potential loss of their maternity department as the distance travelled for patients from the west and north of Dorset would significantly increase. It is said that the most vulnerable mothers and babies would be placed at 'enormous risk'. There is further worry that the proposed shared service between DCH and Yeovil could lead to a midwife-only service in Dorchester and that travelling further to Bournemouth or Yeovil to give birth will again increase risks and create problems for families with other children to care for.

Paediatric staff at Poole Hospital enjoy excellent multi-disciplinary links with other teams within the organisation which, it is said, would be severely disrupted should paediatric services move to RBH. There is also concern that unwell children would have to travel between sites for services currently available on one site - or that the service may move to RBH in its entirety, which would be detrimental to children in the west and north of Dorset.

Oncology Staff Side say that option B could mean a loss of inpatient cancer wards from Poole, which would compromise the treatment of patients. Many cancer patients need a complete package of care from a multi-disciplinary team, which should be delivered on the same hospital site to avoid the need for daily transfers. Having to bring a patient for radiotherapy at Poole from a ward at RBH would 'cause an unnecessary strain on resources and on patient quality of life'.

Travel and parking: Staff Side would like the CCG to consider the travel time between Poole and Bournemouth Hospitals, which can be up to an hour at peak times. Also, it is said that if option B is chosen, patients from the west of Dorset will suffer extremely long journey times (in excess of an hour) to receive care at RBH, while travelling past Poole Hospital to get there. It is said that option A would ensure patients across Dorset enjoy more equitable transfer times because Poole Hospital is centrally-located. The roads around RBCH are apparently very congested and it is said that this will worsen under option B, even if the A338 is improved. Furthermore, the car park at RBH is not considered capable of accommodating the traffic generated by RBH becoming the main emergency hospital. Note, it can take up to 1.5 hours for staff to get out of the hospital site!

Recruitment and retention Staff side are concerned that staff working within departments that may close in light of the CCG's recommendations will leave the Trust prematurely, which 'will be detrimental to the organisation and to the quality of services we provide'. There is also worry that the decision to make PHFT the planned care hospital may dissuade potential new staff from applying for positions within the Trust. Staff Side would like the CCG to note that, in the most recent CQC inspections that took place at RBCH, significant issues were found within a range of specialties and a number of improvement measures were recommended. It would also like the CCG to benchmark the RBCH result against the recent CQC inspection at PGFT, which performed exceptionally well.

Cost of implementation Staff Side dispute that the cost of implementing option B will be £42 million cheaper than option A as Poole Hospital already has successful, established major emergency services and travel infrastructures - and a new road will have to be built to accommodate the extra traffic around RBH. The representatives also question whether the

CCG has taken into account: the number of patients travelling via ambulance between sites on a daily basis for certain treatments should option B be chosen; and that many patients from the west of Dorset will not be able to travel by car to RBH due to the distance, placing 'extra strain on an already struggling transport service'.

Consultation format Staff, patients and members of the public have apparently told Staff Side representatives that they found the questionnaire format very difficult to understand and longwinded. Staff Side also feel the acute care services proposals should have featured more prominently. Staff Side believe residents in the west of Dorset have been marginalised by the CCG's own justifications for preferring option B. The CCG says that there are more patients in the east and so option B would mean more Dorset patients would be closer to RBCH - but east of Dorset patients are also closer to Southampton Hospital and so already have a major emergency department within easy access. West Dorset patients are nearest to Poole Hospital and would be severely affected by option B.

In summary The Staff Side representatives believe that the correct and fair decision for the patients of Dorset is to choose option A.

Appendix 5.5 – Concerns regarding process and equality impacts, Dorset Resident

QUESTION FOR 20 SEP 17 NHS DORSET CCG BOARD SPECIAL MTG RE CSR DECISIONS

Having not inconsiderable Services Review, Design & Transformation experience, & noting the unresolved strategic & detail issues across the proposals: I write to request DCCG Governing Body to both:

- 1) Postpone it's 20 Sep 17 CSR Decisions & instead
- 2) Give Officers till Summer 2018 to resolve the issues necessarily incumbent in work @ such scales & e.g. as in the attached or the following:

Ref 13 Sep 2017's issued AGENDA for 20 Sep 2017's SPECIAL GOVERNING BODY MEETING Item 4.1

Clinical Services Review - Commissioning Decisions

Decision Making Business Case

Decision Making Business Case Appendices

Though the Decision Making Business Case & Decision Making Case Appendices has much information, there doesn't seem to be the ¹¹Appendix Z¹¹ cited in the CSR Commissioning Decisions Point 1.5 which says:

*"The report lists out the recommended decisions to read alongside the Decision Making Business Case be considered by the Governing Body & should be **¹¹Appendix Z that describes the decisions evidence and rationale for the recommended**"*

(my emboldening!)

& not having clarity, on such an integral part of this MEETING'S Agenda Introduction to key CSR decisions, can mean the Meeting itself will be at best flawed as e.g.

Any reader - member of CCG, public or staff - could, at the very least, question subsequent recommendations! &, though one Board Member's recently wrote that

¹¹after the extensive process"

"over the last few years, it is time that the CCG now made some decisions".

The above apparent omission &/or related issues justify delay on these decision/s

- as do unresolved strategic detail issues across proposals such as e.g.
- flaws in proposals analysis & communication
- danger of individual un-coordinated decisions
- current lack of clarity on proven practicable community services integration & no evidence of equitable accessibility o/a &/or strategic or particular detail:
 - to/from the very local to strategic &/or major, &/or
 - in proposals re Hubs & GPs, along with
 - Pharmacies &/or in proposals re Conurbation
 - &/or Rural Acute Care e.g.

coordinated pathways to/from community Hospitals (why some without beds?) & one major Eastern Planned & Emergency Hospital + one Western Planned & Emergency Hospital i.e. DCH (minimisation of DCH (&YDH) M&P consultation impacts?) &/or Mental Health short & long term care integration in all the above too!

& when few could disagree that

"there is more work to be done on certain issues"

With reference to the above & attached:

it must be clear that it's a self defeating, impracticable & denial of NHS principles to assume equitably based NHS service provision decisions can be done piecemeal, as seemingly de-facto proposed in 20 Sep 17's Agenda Commissioning Decisions

TOWARDS HELPING DORSET NHS CCG BOARD'S KEY 20 SEPTEMBER 2017 DECISIONS RE THE CSR (& STP! PRIMARY CARE ETC)

Please can you note that, this 30 Aug 17 CSR related communication has the following aim:

To help the CCG Board's key 20 Sep 17 CSR (& STP! Primary Care etc) decisions get the current CSR proposals reconsidered

The reason for this above aim is that the Clinical Services Review proposals that went out to Consultation in Dec 16 remain flawed:

-despite huge efforts on the CSR (& STP! Primary Care etc) to respond to stakeholder & professional feedback, since the CCG's Aug 15 decision to stand-down from the Public Consultation that had been due for full launch then i.e. in Aug 15!

In particular, the following are some reasons why the CCG's CSR Dec 16 Consultation proposals remain flawed:

- 1) Their complicated Language, lacks numbers & graphics help & obscures rather than clarify it's un-maturated proposals.
- 2) a) They lack the thoroughly researched equitable, accessible Planning & Integrated Design needed by an NHS CSR (/STP etc) e.g.
- b) They're Access & Accessibility deficient- despite Jan 2015 CCG Board Questions & the Answers- please see attached
 - i) They actually increase current In-equitable Access & Accessibility to Acute Care across Dorset;
 - ii) So-called "independent" existing data reviews don't look at situations where High Grade treatment is to be further away*
- c) They're contrary to HMG & Local Plan Review requirements for housing provision & related population growth
 - i) They lack an SEA as part of a wider Sustainability Appraisal social & economic factors, as well as environmental
 - ii) They're devoid of anything re 2015 NHS Report www.sduhealth.org.uk/areas-of-focus/community-resilience/adaptation-report.aspx

3) a) Though required by all HMG departments since 2002, rural proofing is at best insufficient in these proposals, that are but a post rationalisation of MacKinsey's Autumn 14-Spring 15 "at pace" CSR run-up aimed at Aug 15 Public Consultation & e.g.

- i) Attention to Dorset's west/northern borders has not been equivalent to that given to its eastern (west Hampshire) one & it seems west Hants residents get more attention than those of west Dorset, Weymouth & Portland etc- for whom:
- ii) They lengthen distance to high quality Health Care like Trauma/Premature-Birth-Complications/24/7 Paediatric Care e.g.
- iii) April 16's sudden Yeovil M&P Option, combined with continuing conurbation bias doesn't necessarily help in the west, where proposals like Weymouth community health & (now former) dementia beds seem set on Jevelling down provision &

iv) They're seemingly furthering post WW2 demeaning of the greater W&P (Weymouth/Portland) area especially, such that:

-Even though the NHS doesn't always seem to work in unison with local/national government, big events &/or buildings (like hospitals) have long been recognised as more significant & impactful than just accountancy bean-counting exercises

-The 2012 Olympics water sports/associated road access upgrading, largely failed to reverse the loss of Navy base etc combined as it was with a de-facto downgrade of Weymouth's NHS Hospital (due to DCH's late 20th rebuilding) & now

- CSR proposals can seem to further attack the greater W&P area (like women in a certain age losing out on pensions 2X?)

& are short-sighted given projected population rise the current W&P/WDDC/INDC Local Plan Review must accommodate

4) a) Similarly, CSR proposals don't settle e.g. the longstanding unresolved duality of the conurbations 2 Acute Care Hospitals

- i) They don't analyse western Hants access to Southampton v a single conurbation Major Acute & Planned Care Hospital
- ii) They don't include the option to sell much of existing 2 conurbation sites, to help fund 1 new major state of the art facility

-located immediately to the west of & accessed via the Holes Bay Rd + very close to Poole Rail & Bus Stations!

- with patients in western Hants &/or Christchurch & eastern Bournemouth choosing between Soton & this +

-much better placed for western Dorset (than the current "Bournemouth" Hospital) for Major Acute & Planned Care

OS) a) Whatever the realities of the above, as in Aug 15, there are other fundamental flaws across Dec 16's Dorset CSR proposals. e.g.

i) Clarity lack re Acute Care & other Care - community services & joint working between health & care providers proposals lack clarity re existing facilities & professionals like GPs & proposed Hubs, let alone Integrated Community Services?

d) Though benefiting from £100M HMG payback (apparently= to 40% of the total

shortfall in HMG funding over recent years):

- i) What is the CSR implementation budget &/or budget/s?
- ii) What are the related the programme &/or programme/s?
- iii) Where's the related 5WH GANT timetable/s for who achieving what, where & by when?
- iv) How & in what way, will who co-ordinate all the complex moves where & when e.g.
- v) Across & between Localities, Hubs &/or GPs, Acute Care Hospital/s, Care Homes, & private homes?

*This 9 Aug 17 information http://www.dorsetccg.nhs.uk/news/Report_on_emergency_transport_published.htm from the Dorset NHS only came to this writer's attention 28 Aug 17 & from a prelim read through the following must be noted** as well as this quote
"We hope that this report reassures people that these proposals are designed to ensure that people get the best possible care and that we are focus-ing on getting the best outcomes for people in Dorset who will be using these services in future. This report demonstrates that, through public consultation, we have listened to those people who expressed their concerns about having to travel further or for longer to get emergency care."

**Though the CCG may well have: *"listened to those people who expressed their concerns"*, despite much much alphanumeric, graphic, statistical & other information, at best it's unclear if this Report exactly answers (or understands) *"their concerns"*- & such can also be said ref this recent link too <http://www.dorsetccg.nhs.uk/news/Report-into-transport-published.htm> which also needs reading with e.g. above Item 2) a) & this piece's related attachment from Jan 2015's CCG Board's Public Questions & Answers

Appendix 6

Responses to 19 questions provided to DHSC Task and Finish Group by NHS Commissioners and Provider Trusts on 22 August 2018

See PDF

Appendix 7

Letter of notification re intention to refer sent to NHS Dorset CCG on 23 October 2018

See PDF

DCC Task and Finish Group re Clinical Service Review, 18 September 2018

	Area of concern	Question	Response
1	Assertion that 60 lives would be saved per year	The CCG's documentation suggests that 60 lives per year will be saved via the proposed new model for services. What was the source of evidence for this assertion and is the CCG confident that this benefit would be realised in rural Dorset?	<p>On January 18 2013, NHS Medical Director Professor Sir Bruce Keogh announced a comprehensive review of the NHS urgent and emergency care system in England.</p> <p>The review drew on the experience of patients and all professionals in the NHS and across social care. The 60 additional lives saved is our considered estimate based on the recommendations in Sir Bruce Keogh's* report at the time it was published. The Clinical Services Review documentation set out many benefits in terms of outcomes for patients, workforce and finance. Further work being done on the patient benefits of the proposed merger between Royal Bournemouth and Poole hospitals and the creation of the major emergency and planned hospitals is now providing more details. For example, the patient benefits case estimates that 750 patients per year will have shorter waits for treatment with a reduced length of stay for the 400 of these who will require interventional treatment. This alone will save an estimated 11 to 21 lives per year for patients with heart conditions.</p> <p>Consolidation of acute stroke services at Bournemouth Hospital would lead to quicker access to the review of strokes by consultant doctors, higher nurse to patient ratios and improved specialist staffing levels, which would save more lives. There will be improved quality care for A&E patients because they will receive consultant-delivered care for more hours of the day. There will be significantly improved facilities for maternity services. All these factors mean that there would be many lives saved in our opinion.</p> <p><i>Please see draft summary patient benefits case report.</i></p>

			<p>We would also like to draw your attention to the recent High Court approved judgement, in which Sir Stephen Silber concluded: 'I am not satisfied that that it was unreasonable for the CCG, who after all had the expert knowledge which I do not have, to predict that 60 lives would be saved each year '. (<i>para 146</i>)</p> <p>The benefits described will be realised by the people who use the hospital whether they live in rural or urban areas, as both groups will use the facilities as they do now.</p> <p><i>* NHS England, Transforming urgent and emergency care services in England: Urgent and Emergency Care Review End of Phase 1 Report, Appendix 1 – Revised Evidence Base from the Urgent and Emergency Care Review, November 2013, pp.8-9 at Appendix 5.2.2.</i></p>
2	Future demand for beds	<p>The Business Case suggests that in future there will be 800 fewer in-patient beds than expected demand. What reliable local evidence does the CCG have that demand for non-elective beds can be reduced by 25%? And would the CCG be willing to maintain two Emergency Departments until such time as community services and primary care services are able to achieve that reduction?</p>	<p>These figures are based on estimates of what might be needed if we did nothing. The CSR clearly articulated why we need to change and that doing nothing is not an option.</p> <p>It is important to clarify that the model is based on avoiding future growth of urgent care by 25%, as opposed to a reduction of 25% in urgent care demand. Several commentators on the CSR have misunderstood this key difference.</p> <p>It is not appropriate to focus on only one element of the bed modelling in isolation, without considering the whole model, including the assumptions for decreases in beds.</p> <p>The 800 beds would equate to more than the number of beds currently at either the Royal Bournemouth or Poole Hospitals. If you just focus on bed numbers, you would need to build an additional hospital, which would be the same size as RBH or Poole. This is totally unrealistic in terms of cost and timescale.</p> <p>The number of beds at each acute hospital change flexibly to meet changes in demand throughout the year.</p> <p>The movement between A and E departments is likely to take five years to complete, as we have said throughout the CSR. Community services are being</p>

			<p>developed already and changes will be implemented before the movement in A&E departments. Both A&E departments will remain in the interim period.</p> <p>It is important to be clear that for people needing urgent and emergency care, there will be considerable local options available.</p> <p>There will be 24/7 A and E at Dorset County Hospital, the Royal Bournemouth Hospital, Salisbury, Yeovil, Southampton and the Royal Devon and Exeter Hospitals with a 24/7 urgent care centre at Poole Hospital and a 12/7 urgent care centre at Weymouth.</p>
3	Future of Dorset County Hospital	<p>If DCH only has 341 beds in future, how will it compete and compare with the hospitals in the east, if elite/specialist hospitals are created there? Will DCH be able to provide the same quality outcomes and attract the right staff?</p>	<p>The bed numbers are indicative only. The hospitals open and close beds throughout the year in response to changing demand. Therefore, this number should not be seen as an absolute.</p> <p>A central part of the CSR plans is about creating networks of acute care services (for example, stroke, cardiac and cancer and other services) to allow rotations of staff across Dorset. This means that people will have access to the same high quality of services across the county and it will help attract staff. A good example of this is the renal (kidney care) network which is run across Dorset by Dorset County Hospital.</p> <p>DCH already performs well in many national performance standards and there no reason why this should change.</p>
4	Ambulance response times	<p>Information provided to Langton Parish Council by SWAST indicated that the average time from call out to arrival at hospital for a Category 1 call in the BH19 area was 1 hr 43 mins (between Nov 2016 and Dec 2017). Does this timeframe pose an unacceptable level of risk?</p>	<p>This information was provided through a Freedom of Information request, and was not included in the SWAST report commission by Dorset CCG.</p> <p>SWAST data shows a steady improvement in category 1 response times (ie most urgent) to the BH19 area from January 2018 onwards. In a potentially life-threatening emergency, the most important factor is getting skilled clinicians quickly to the scene. For the period November 2016 to December 2017, the average time from a call being received to the response arriving on scene was 8:34 minutes.</p>

			<p>A key factor is the time that the paramedics are on the scene with the patient. At each incident, paramedics make a clinical judgement on whether the patient should be taken to hospital rapidly by ambulance, or whether it is in the patient's interest to receive immediate treatment on-scene first. This may include giving life-saving medicines. Many of the most urgent category 1 calls will be a cardiac arrest (heart attack), where paramedics spend significant time on-scene. Evidence shows that patients have the best chance, if resuscitation is provided for as long as necessary on-scene. Such patients will generally only be taken to hospital when their heart starts beating again.</p> <p>The average time to take a patient to a hospital was 37:29 minutes. This is the time we would expect it to take given the rurality of the area. Please note that 41.3% of patients in this category are managed on-scene, without the need to go to hospital.</p> <p>Please refer to the Sir Bruce Keogh report and the recent study by Queen Mary and Sheffield universities that, after studying changes to A and E departments in five areas, concluded: 'Overall, across the five areas studied, there was no statistically reliable evidence that the reorganisation of emergency care was associated with an increase in population mortality (death rates)'. https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr06270#/abstract</p> <p>There is evidence in the patient benefits case that shows that onward transfers from the nearest to a more specialised hospital is not in the best interest of the patient. This creates delays in getting the patient to the right clinical team at the right time. The CSR focus on getting the person to the right hospital first time (benefits case). Under CSR, there will be a significant reduction (at least 90 per cent) in the 3500 patients transferred from one hospital to another.</p>
5	Ambulance response times	In light of lengthy delays in recent ambulance response times, what reassurance can be given that the transfer of the MEC to Bournemouth will improve the availability of emergency	<p>The location of emergency ambulances is not related to the changes to Bournemouth and Poole hospitals. SWAST plans and locates emergency ambulances to where they are needed most.</p> <p>As explained in the previous response, travel time is less important than going directly to the right place for optimum treatment.</p>

		response vehicles, rather than having a detrimental effect?	<p>It is important to remember that if you live in say Purbeck and have a heart attack, currently, you will be taken to the Royal Bournemouth Hospital. This has been the case for many years. If you suffer a major trauma, you will be taken to Southampton, which is also what happens now.</p> <p>Since the CSR decisions were taken, Dorset and other CCGs in the South West have been awarded £6m national money to increase in the number of ambulances in the area by 63 from February 2019. The CCGs have agreed to invest additional funds to boost the number of crews to staff the increased fleet. The major share of this investment will be in Dorset, Devon and Gloucestershire. The exact split of the increased fleet has yet to be determined.</p> <p>This additional resource will vastly outstrip the original estimate of 0.5 of an ambulance which SWAST calculated was required to meet the CSR changes.</p>
6	Southampton trauma centre	How many trauma patients were taken from BH19 to Poole trauma centre last year? And what percentage / number of patients from BH19 were taken straight to Southampton trauma centre last year?	<p>Of all BH19 patients who attended an A and E department, only 1.8 per cent were in the most serious category. Of these, 0.1 per cent (2 patients) were taken to Southampton and the majority were taken to Poole Hospital.</p> <p>If you add up the number of patients suffering either medical conditions or trauma, 26 adults and 1 child were transported directly from scene to Southampton General Hospital during the sample period. Following the CSR reconfiguration, it is predicted that this will remain unchanged.</p>
7	High risk cases travelling by private car (maternity in particular)	What research has been undertaken to look at the risk to maternity patients who do not travel to the maternity and paediatric centre by ambulance, given that data suggests that only 22% of maternity emergencies arrive by ambulance? (This concern would also apply to other patients, but the	<p>Yes, we have looked at the travel times for all patients travelling by bus/car/ambulance going to Dorset County, Poole and Bournemouth Hospitals.</p> <p>The recommendations were checked with experts at the Royal College of Paediatrics and Child Health who were satisfied with our proposal.</p> <p>We are aware that this concern has come from people living in Purbeck, but there is little difference in the travel times from Purbeck to Poole and Purbeck to Dorset County Hospitals.</p>

		percentages are particularly high in respect of maternity)	<p>For example:</p> <ul style="list-style-type: none"> • The time by car from Swanage to Poole Hospital is 37mins (20 miles) and • from Swanage to Dorset County Hospital it is 45mins (29 miles). • Therefore, the difference in travel time by car is 8 minutes and by blue light ambulance 5 ½ mins. <p>The majority of women from Purbeck already go to Dorset County Hospital to have their babies. Last year, 52.8% (133) of mums registered with GPs in Purbeck had their babies at DCH compared with 47.2% (119) at Poole Hospital.</p> <p>Many mothers are already travelling from Bournemouth to Poole as the biggest group of women giving birth at Poole Hospital live in the Bournemouth area.</p> <p>The CSR decision will avoid some 170 mothers a year who arrive at RBH at the start of their labour and then for clinical risk factors as the labour progresses are transferred from RBH to Poole during the later stages of labour.</p> <p>It should also be considered that there will be greater support for women who choose to have their babies in the community or at home.</p>
8	Total journey times to hospital	Does the CCG acknowledge that the inclusion of data relating to travel time by Bournemouth residents skewed the average journey times, to the detriment of residents of places like Purbeck and North Dorset? Why was there so much focus on additional journey time, rather than total journey time?	<p>We looked at travel times at all levels – from the largest geographical ward to the smallest - and the travel time to each acute hospital depending on the scenario.</p> <p>Any focus on additional travel times has been in response to information circulated by the claimant in the judicial review and other commentators. The CCG's focus was primarily on total travel times.</p> <p>Please refer to the JR judgement in which Sir Stephen Silber states: ' Mr Coppel (claimant's QC) contends that the CCG did not consider "outliers" which were said to be "namely those patients who would be most seriously affected by increased journey times". I do not accept that criticism as the SWAST report refers to the maximum travel times for adult patients and children and that would include outliers. Nothing has been put forward to show that "outliers" were not considered in the SWAST report (par 140)</p>

			<p>The CCG needed to consider all people who use services when it carried out the CSR. This includes people who live on or over the borders of our neighbouring local authority boundaries. That is why five local authorities sat on the Joint Overview and Scrutiny Committee (JOSC) that was set up specifically for the CSR. This is a reflection of how the CSR affects the whole population that uses the services provided within Dorset.</p> <p>Many of the total journey times from Purbeck and other rural areas to hospital has not changed in the respect that Purbeck and other rural area residents already go to RBH for cardiac and other services.</p> <p>It also needs to be considered that journey times for all planned treatment will be shorter for Purbeck and a lot of other rural areas and that most people will have more planned treatment in their lifetimes than urgent and emergency care.</p> <p>The majority of people who currently attend Poole A and E will continue to receive care and treatment at the Poole urgent care centre.</p> <p>In addition to this, 90% of patient contact with the NHS will still be delivered in a community/primary care setting, not in an acute hospital.</p> <p>The CSR vision was to create and make use of community hubs by moving services closer to or in people's homes. The most serious emergencies account for a relatively small percentage of patients and they will be taken by ambulance or helicopter directly to the most appropriate specialist hospital. One of the deciding factors in the preferred location for the major emergency hospital was that RBH has an on-site helicopter landing pad (as does Dorset County Hospital), Poole Hospital does not have this or the capacity to create a helipad.</p> <p>The major focus of the clinically-led CSR was not on additional journey times, it was about getting the patient to the right team in the right place first time for the best clinical outcome and patient experience. It is commentators and others who are focussing on additional journey times.</p>
--	--	--	---

9	Recommendations in SWAST modelling report (August 2017)	The SWAST modelling report published in August 2017 made five recommendations. What actions have been taken in relation to those recommendations, and in particular, what was the outcome of the expert review of cases (where extended journey time may have increased clinical risk)?	<p>Recommendation 1:</p> <p>Utilise the findings of the model and the additional information within the SWAST CSR preliminary report to support the CSR process.</p> <p>Response:</p> <p>Yes; - please see the response to question 2 below</p> <p>Recommendation 2:</p> <p>Support the expert review of cases identified where extended journey times may increase the clinical risk.</p> <p>Response:</p> <p>A separate panel was established to look at this but could not determine the point at which clinical risk might be increased due to any additional travelling time rather than the total time. It needs to be remembered that the total time incurred includes; time before calling an ambulance, time for an ambulance to arrive on scene, treatment time on scene, travel time to hospital, handover at hospital. Neither of the two reviews were able to pinpoint for 100% of cases the level of any increased clinical risk that may be associated just with an increased travel time element.</p> <p>Please refer to the judicial review judgement (para 136) in which Sir Stephen Silber states that ‘the CCG was entitled to conclude that SWAST’s statistics and analysis indicated that the additional clinical risk caused by the increased travel times as a result of implementing the proposed reconfiguration of medical services was “minimal”.’</p> <p>During the JR hearing it was agreed by all parties that there was only 0.6% of cases where there <u>may</u> (judge’s emphasis) have been an increased risk (para 137) and that any additional work by an expert review panel may well have lowered the percentage of potential risk even further (para 140).</p>

			<p>The judgement further emphasised that the CCG needed to progress with its plans as there was a 'need for the CCG to take urgent action' (para 141).</p> <p>It should also be born in mind that the CSR has been through a considerable amount of assurance by the Clinical Senate, NHS England and the Royal Colleges. We have commissioned additional work on emergency and non-emergency travel times with SWAST and Dorset County Council and set up a clinical panel following consultation.</p> <p>Recommendation 3:</p> <p>Support additional modelling of the DCH/YDH consolidation of paediatric and maternity services.</p> <p>Response:</p> <p>Yes. Both Dorset County and Yeovil District Hospitals have done considerable work on this;</p> <p>Recommendation 4:</p> <p>Identify a national example of a change from an ED to UCC to provide information to enable the increased activity due to patients continuing to self-present at PGH with conditions which require an ED.</p> <p>Response:</p> <p>Yes. Dorset Consultants visited Northumbria to see how emergency services run when you centralise on one site, along with visits to Frimley and Portsmouth;</p> <p>Recommendation 5:</p> <p>Consider the potential impact of the CSR on the emergency ambulance service, utilising the model to ensure that any changes are appropriately commissioned, and patients across Dorset continue to receive a timely response to 999 calls.</p> <p>Response:</p>
--	--	--	--

			Yes, the additional investment in the ambulance service is already covered in the response to question five.
10	Reduction in the number of community hospital beds	What assessment of the amount of additional social care capacity has been undertaken to compensate for the reduction in community beds?	<p>Firstly, we would clarify that we are not reducing community beds; there will be an increase of up to 69 community beds.</p> <p>The local authorities have been involved in the whole process. Please refer to the comments in the judicial review judgement – paragraphs 77/78 onwards.</p> <p>The NHS and local authorities will continue to work in partnership and there are already innovative programmes under way, for example, in North Dorset and the Piddle Valley to provide local support for social care packages.</p> <p>We have already stated that the CSR is not dependent on an increase in social care provision. People go into hospital when they need acute care. They are then discharged into the community where they live and if they need social care, they will receive it anyway. So we don't accept that there is any correlation between the CSR plans and increased dependence on social care due to hospital admissions. There will be multi-disciplinary teams of health and social care professionals working around the needs of people in the community. The longer people stay in hospital has a detrimental effect on their health. For example, older people can lose mobility very quickly if they do not keep active. A national review highlighted a study which showed that, for healthy older adults, 10 days of bed rest led to a 14% reduction in leg and hip muscle strength and a 12% reduction in aerobic capacity: the equivalent of 10 years of life. (7 Monitor (formerly NHS Improvement), <i>Moving healthcare closer to home: Literature review of clinical impacts</i>, September 2015.</p> <p>If we can avoid or reduce the length of any acute hospital admission this could actually result in a lower package of social care and its related costs.</p>
11	Reduction in the number of	How much additional resource will be put into community nursing services to provide adequate nursing support when	We are not reducing overall numbers in community beds, we are increasing them by up to 69.

	community hospital beds	community beds close? (Including support for end of life care for example, when individuals have little or no family around them)	<p>All partners in the Our Dorset Integrated Care System, which includes Dorset County Council, have agreed to a multi-million-pound investment which the CCG will fund to enable people across Dorset get more care closer to home. The agreement will see £3m being invested this financial year (2018/19) with £6.5m full year effect in 19/20 and an additional £6.5m in 20/21.</p> <p>The money will be invested in a number of areas from September 2018, including</p> <ul style="list-style-type: none"> • More healthcare professionals working in primary and community teams (to support people with complex needs; • Supporting people with diabetes or respiratory conditions; • Employing more community based pharmacists; • End of life care and support to people in local residential and nursing homes. <p>As part of this, there will be an increase of approximately 140 community and primary care staff because of this investment. Dorset Healthcare will be employing over half of these staff.</p> <p>This investment is as a direct result of the CSR decision and is part of the implementation roll out.</p>
12	Community staff	Everyone agrees on the need for better community services, but the staff do not currently exist. How will the required staff be recruited and retained?	There is a comprehensive staff recruitment and retention programme under the Our Dorset Workforce Delivery Plan. Recruiting additional staff to work in community and primary services is the priority under this programme and will include the 140 staff mentioned in the previous response to question 11.
13	Closure programme for community beds	What confidence can be placed in the statements that facilities will not be closed before alternative provision is in place, in light of the recent closures at St Leonards Hospital and Portland?	<p>In terms of the examples provided alternative provision is in place as follows:</p> <p>Beds have been opened and staffed at Westhaven Community Hospital in Weymouth to allow for the closure of those on Portland.</p> <p>22 beds from Fayrewood ward at St Leonards Hospital are being transferred to ward 9 at the Royal Bournemouth Hospital at the end of October.</p>

			<p>The number of beds will be the same as before but moved to different locations.</p> <p>Please refer to the response to question 11 regarding additional investment in integrated community and primary care services and note that this is a five-year plan so movements will be phased in.</p>
14	Future of Poole A&E / UCC	Given the large percentage of patients who present at Poole A&E currently who require clinical tests, how would an Urgent Care Centre cope with this?	<p>Diagnostics and other tests will still be available at Poole Hospital. As the major planned care site, Poole Hospital will see over 42,000 people who, at present, go to Royal Bournemouth Hospital for procedures. The footfall through Poole Hospital will be considerable and it will receive up to £62m to improve facilities. Commentators are underestimating the future role of Poole Hospital, it will very much remain a major acute hospital.</p>
15	A&E consultant cover	Given that Poole and Bournemouth A&E staff already have a networking staffing system to cover on-call etc, why couldn't this continue and enable both hospitals to retain a full A&E service?	<p>The essence of the CSR is that patients get better outcomes if they are seen by a consultant doctor delivering care on-site. This is based on the recommendations in the Keogh report referred to in the response to question one.</p> <p>At present, there are 10.6 whole time equivalent (WTE) consultants in the A and E at Bournemouth and 8.6 WTE at Poole. This is not enough to deliver a 24-7 on site consultant delivered service at each site. Between 18 and 22 consultants are required depending on the rota system used, therefore by combining the A and E consultants on the one site the ambition to have 24/7 on site consultant delivered services can be achieved. This will be a major patient benefit and will improve patient outcomes.</p> <p>At present approximately 33,000 patients are seen at either Poole or Bournemouth hospitals where there is no A and E consultant on site. See PBC appendix.</p> <p>A similar patient benefit will apply for the consultant anaesthetists who support the high dependency units as part of the emergency care service. Again this will be a major patient benefit and will improve patient outcomes.</p>

16	Future maternity provision at Poole	Could the CCG explain the reason for the removal of all maternity delivery services from PGH rather than the reversal of the existing PGH/RBH arrangement so that routine deliveries (within a midwife-led unit) could continue at Poole?	<p>The proposal came from the clinical teams who didn't favour the stand alone midwife unit (see patient benefit case).</p> <p>The Royal College of Paediatrics and Child Health also recommended having a single maternity service across Dorset.</p> <p>While the delivery of babies in East Dorset will be provided through a single team based at the at Royal Bournemouth Hospital, antenatal care will still be provided at Poole Hospital and in the community.</p>
17	Other concerns about implications for Poole Hospital	What reassurance can be provided that implementation of the changes will not have a negative effect on other services at PGH, for example, the fragmentation of Paediatric Services, the potential loss of in-patient cancer wards, a lack of Level 3 intensive care?	<p>Please refer to the response to question 14&16 above.</p> <p>The aim is for the future is to have a single organisation to manage delivery of services on both the Poole and Bournemouth hospital sites. They will be two busy, vibrant hospitals delivering the best care locally, under the management of single clinical teams working across both sites. Both hospitals have very positive futures and we expect this will attract additional staff and improve care on both sites.</p>
18	Building costs at Poole and Bournemouth	There is concern that the planned new departments at Bournemouth Hospital will not be big enough to cope with the number of patients. If it transpires that bigger facilities need to be built, would this change the relative costings (and decrease the advantage of locating the MEC at Bournemouth)?	No. This would increase the advantage of locating the major emergency centre at Royal Bournemouth Hospital as the site has greater potential for further large-scale expansion, and the site is a more cost-effective site to build upon and operationally run. This was explained in the CSR consultation document as some of the reasons as to why RBH was the preferred site for the larger Major Emergency Hospital (pages 35 to 36).
19	Lack of understanding about inequality issues	What measures have the CCG taken to understand and mitigate against the inequality impacts of the proposed changes, given that individuals from rural areas and those from more	<p>Throughout the design and consultation phase we continually tested the models of care against Equality Impact Assessments. Following consultation these were reviewed and updated to reflect some of the feedback provided and in line with best practice.</p> <p>In doing this, we followed a robust process which involved review by the CCG's leads for service delivery; independent review by the Equality and Diversity Lead for Dorset</p>

		<p>disadvantaged backgrounds will be more adversely affected?</p>	<p>HealthCare NHS Trust; and a workshop for service leads in the provider organisations. We then arranged a second facilitated workshop for our Public and Patient (Carer) Engagement Group (PPEG) and additional invited members of the public/staff who collectively represented the nine protected characteristics. This was to ensure that the process was inclusive and realistic. The revised and updated EIA was then sent for legal review before being scrutinised by the Quality Assurance Group and publication in July 2017. The EIA can be found at; https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/11/CSR-EIA.pdf</p> <p>EIAs will continue to be reviewed as new services are implemented.</p> <p>In addition, we have set up an Integrated Transport Programme, which, for the first time, brings together the NHS, local authorities, community transport providers and voluntary organisations. One of the objectives is to look at how access to health and care services can be improved in both rural and urban areas.</p> <p>We don't recognise the statement being made as the CSR was clear that the development of community hubs would reduce the need for people to travel to services. This includes rural areas.</p> <p>DCH will remain largely the same and people from across all areas are already travelling to Poole and Bournemouth for treatment.</p> <p>Please refer to the response to question 8 regarding the proportion of care that is provided in the community compared to acute hospitals.</p> <p>The judicial review did not challenge the equality impact assessment work at all.</p>
--	--	---	--



Dorset County Council

Official

Tim Goodson
Chief Operating Officer,
NHS Dorset Clinical Commissioning Group
Vespasian House, Barrack Road
Dorchester
Dorset
DT1 1TG

Chief Executive's Department

County Hall
Colliton Park
Dorchester
DT1 1XJ

Telephone: 01305 224181

Minicom: 01305 267933

We welcome calls via text Relay

Email: j.e.mair@dorsetcc.gov.uk

Website: www.dorsetforyou.com

Date: 23 October 2018

Ask for: Jonathan Mair

My ref: ReferralLet

Your ref:

Dear Tim

Notification of intention to make a referral to the Secretary of State for Health and Social Care by Dorset Health Scrutiny Committee

As you are aware, Dorset Health Scrutiny Committee met on 17 October 2018 and considered whether to make a referral to the Secretary of State for Health and Social Care, in relation to the impact of some proposals within the Clinical Services Review (CSR). Following discussion and a vote by Members, it was agreed that a referral should be made, with regard to the following two matters:

- Concern that the travel times by the South West Ambulance Service NHS Foundation Trust have not been satisfactorily scrutinised and that the evidence needs further investigation to the current claim that these travel times will not cause loss of life.
- No local alternative to the loss of community hospitals given Dorset's demographic with its ageing population and how that service will be delivered.

With regard to both these matters the referral to the Secretary of State will be submitted under Section 23 of the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013, Section (9) (c) – that Dorset considers “that the proposal would not be in the interests of the health service in its area”.

Officers are currently collating the required evidence to submit a referral and it is our intention to make the submission as soon as possible, and by the first week of November at the latest. We will notify you again when this has been done.

Yours sincerely

Jonathan Mair
Service Director – Organisational Development

Debbie Ward, Chief Executive

Working together for a strong and successful Dorset



Department
of Health &
Social Care

Stephen Hammond MP
Minister of State for Health

39 Victoria Street
London
SW1H 0EU

020 7210 4850

The Lord Bernard Ribeiro
6th Floor
157-197 Buckingham Palace Road
London
SW1W 9SP

05 JUN 2019

Dear Lord Ribeiro

Referral to the Secretary of State under Regulation 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 of changes to healthcare services in Dorset proposed by Dorset CCG

I am writing to request the initial advice of the Independent Reconfiguration Panel (IRP) in relation to the above referral.

In particular, I would like the panel to look into the following aspects of this case:

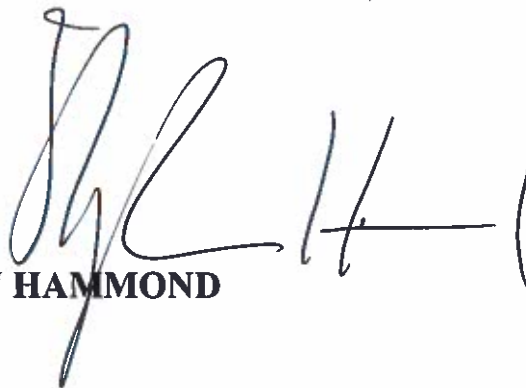
- Whether proposals are in the interests of local health services, with reference to:
 - South Western Ambulance Service NHS Foundation Trust (SWAST) response and transfer times and clinical risk, in relation to the acute hospital reconfiguration and changes to maternity and paediatric provision;
 - the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area of the authority in relation to community services; and
 - The equity of future access to services;
- Whether the proposals meet the five reconfiguration tests;
- Whether implementation has progressed to the degree that halting changes at this stage would not be in the best interests of local health services; and
- What could have been done differently by local organisations to avoid a referral more than one year after services changes were approved by the CCG
- As you will be aware, the NHS Long Term Plan includes a reference to the development of an 'A&E Local' model. This work is being led by NHS

England and NHS Improvement at present. It is possible that this model could be of use in this case, and I would therefore be grateful if you could liaise with NHS England and Improvement to consider the potential relevance of the developing model in this case.

The advice would normally be provided in 20 working days from receipt of all relevant information in line with the agreed protocol between the Department of Health and Social Care and the IRP. However, I am aware of an ongoing Judicial Review and recognise that the IRP may need to commence its work following the Court's judgement later in the year.

I would be grateful if you could contact Fabiola Boccuti in Provider Policy here at the Department of Health on 0207 2103833 if you require any additional information at this stage.

I enclose copies of my letters to the OSCs and CCGs informing them of my decision. I look forward to hearing from you.



STEPHEN HAMMOND



Department
of Health &
Social Care

Stephen Hammond MP
Minister of State for Health

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Councillor Bill Pipe
Chair, Dorset Health Scrutiny Committee
Dorset County Council
County Hall, Colliton Park
Dorchester
DT1 1XJ

05 JUN 2019


Dear Cllr Pipe

**Referral to the Secretary of State under Regulation 23(9) of the Local Authority
(Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations
2013 of changes to healthcare services in Dorset proposed by Dorset CCG**

Thank you for your letter of 5 November 2018 referring to me the above proposals resulting from the Clinical Services Review undertaken by NHS Dorset Clinical Commissioning Group. I am today writing to the Independent Reconfiguration Panel (IRP) asking them to undertake an initial assessment of this case. Should the IRP advise me that a full review is necessary, you will have the chance to present your case to them in full. Your letters of 5 November and 10 December 2018 have been passed to the IRP.

I am copying this letter to The Lord Ribeiro, Chair of the IRP.

I have written in similar terms to Councillor Peter Shorland and Tim Goodson, Accountable Officer of Dorset CCG.

Yours sincerely

STEPHEN HAMMOND



Department
of Health &
Social Care

Stephen Hammond MP
Minister of State for Health

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Councillor Peter Shorland
Vice Chair, Dorset Health Scrutiny Committee
Dorset County Council
County Hall, Colliton Park
Dorchester
DT1 1XJ

05 JUN 2019

Dear Mr Shorland


**Referral to the Secretary of State under Regulation 23(9) of the Local Authority
(Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations
2013 of changes to healthcare services in Dorset proposed by Dorset CCG**

Thank you for your letter of 5 November 2018 referring to me the above proposals resulting from the Clinical Services Review undertaken by NHS Dorset Clinical Commissioning Group. I am today writing to the Independent Reconfiguration Panel (IRP) asking them to undertake an initial assessment of this case.

Should the IRP advise me that a full review is necessary, you will have the chance to present your case to them in full. Your letters of 5 November and 10 December 2018 have been passed to the IRP.

I am copying this letter to The Lord Ribeiro, Chair of the IRP.

I have written in similar terms to Councillor Bill Pipe and Tim Goodson, Accountable Officer of Dorset CCG.

Yours sincerely


STEPHEN HAMMOND



Department
of Health &
Social Care

Stephen Hammond MP
Minister of State for Health

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Tim Goodson,
Accountable Officer Dorset CCG,
Vespasian House,
Barrack Road,
Dorchester
DT1 1TG

05 JAN 2019

Dear Mr Goodson

Referral to the Secretary of State under Regulation 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 of changes to healthcare services in Dorset proposed by Dorset CCG

Following a referral received from Dorset Health Scrutiny Committee on 5 November 2018, I am today writing to the Independent Reconfiguration Panel (IRP) asking them to undertake an initial assessment of this case. Your letter of 8 November has been passed to the IRP.

I am copying this letter to The Lord Ribeiro, Chair of the IRP.

I have written in similar terms to Councillors Bill Pipe and Peter Shorland.

Yours sincerely

STEPHEN HAMMOND



Councillor Jane Newell

Ward Councillor for Merley and Bearwood
Chair of People Overview and Scrutiny Committee (Health and Social Care)

Borough of Poole,
Civic Centre, Poole BH15 2RU
Tel: 01202 633043
Mobile: 07866 187725
Email: J.Newell@poole.gov.uk



The Rt Hon Matt Hancock, MP
Secretary of State
39 Victoria Street
LONDON
SW1H 0EU

Date: 4th January 2019

Dear Secretary of State,

Re: Referral to Secretary of State Health and Social Care by Dorset Health Scrutiny Committee with regard to two elements of the Clinical Services Review undertaken by NHS Dorset Clinical Commissioning Group

We write on behalf of the Borough of Poole Health and Social Care Overview and Scrutiny Committee to support the referral made to you by Dorset Health Scrutiny Committee. The details of the referral are set out in a letter to you dated 5th November 2018, which was sent by Cllr Bill Pipe and Cllr Peter Shorland and in the attached Referral document and supporting appendices.

A decision was taken by the Borough of Poole People Overview and Scrutiny Committee (Health and Social Care) on 17th December 2018 to support the Referral made to you by Dorset County Council's Committee. This is not a separate referral to the Secretary of State by the Borough of Poole.

The key concern for Poole Committee is increased travel times for the South West Ambulance Service NHS Foundation Trust. The concerns are set out comprehensively in the Dorset Referral documentation. This is in a context where the Dorset Clinical Commissioning Group has decided that a future Major Emergency Hospital for the Dorset, Bournemouth and Poole area should be located at the Royal Bournemouth Hospital and not at Poole Hospital. At present, Accident and Emergency, Trauma, Maternity and Paediatric Services are all provided at Poole Hospital and Royal Bournemouth Hospital provides Accident and Emergency and Maternity Services.

The Borough of Poole Full Council in July 2017 made formal representations to the Dorset Clinical Commissioning Group that Poole Hospital should be the location of the future Major Emergency Hospital. A key consideration in this decision by the Council was that Poole Hospital affords safer and better access to local people both in Poole and in the Dorset area to essential services including Accident and Emergency, Maternity and Paediatric Services.

In September 2017, the Dorset Clinical Commissioning Group decided that Bournemouth Hospital should be the Major Emergency Hospital and Poole, a Major Planned Hospital.

On 17th December 2018, the Borough of Poole Committee Members considered the referral made to you by the Dorset Health Scrutiny Committee. Senior Leaders from the NHS in Dorset presented evidence to the Committee with a key focus on travel times by the South West Ambulance Service NHS Foundation Trust.

Members of the public were also able to ask questions. The majority of these relate to safety and ambulance travel times.

The Dorset Clinical Commissioning Group presented evidence of a further and recent study undertaken into travel times and any potential risk in those travel times which would be lengthened by the relocation of Accident and Emergency, Trauma and Maternity Services to Royal Bournemouth Hospital.

The Borough of Poole Elected Members decided that it was imperative to support the Dorset's Health Scrutiny Committee Referral to the Secretary of State on the following key grounds:

- 1) Committee and Public are seriously concerned regarding the increase in ambulance conveyance time for some residents if the plans go ahead to locate the major emergency hospital at Royal Bournemouth. Concerns centre on whether the increased travel time could put patients lives at risk. The Dorset Clinical Commissioning and its NHS partners have undertaken further work to examine the risks to life of extended travel times. This study and its outcomes have not been evaluated independently by experts beyond Dorset NHS partners. A Referral by you of these issues and all available evidence to the Independent Reconfiguration Panel would afford an entirely independent scrutiny on a matter of very significant concern to members of the committee and the public in Poole and surrounding area. At the meeting on 17th December 2018, the Committee was advised by the Ambulance service representative that national standards for the timescales for ambulance conveyances have changed since the Dorset Clinical Commissioning Group's business case was developed. This is another reason why the Committee would strongly recommend independent examination of the current and all available studies and their conclusions around patient safety and travel times.
- 2) The Committee members considered that work undertaken by Dorset Clinical Commissioning Group on travel times and travel planning in relation to the proposed future configuration of hospitals in the Poole/Bournemouth area had not taken into sufficient account major current and planned regeneration and development plans in Poole. Therefore, analysis of travel times and related issues, such as congestion, does not take into account key aspects of Poole's Local Plan, adopted by Full Council in November 2018. As a consequence, there is concern that the analysis and its outcomes are not valid in the longer term.
- 3) The Borough of Poole Health Scrutiny Committee would strongly underline the serious impact of moving Maternity Services from Poole to Bournemouth in relation to travel times for Poole and many Dorset residents.

When the Dorset Clinical Commissioning Group made the decision in September 2017 to relocate Maternity Services to the Royal Bournemouth Hospital, NHS leaders informed Poole Councillors that serious and detailed consideration would be given to locating a midwife led maternity provision at Poole Hospital. At the meeting on 17th December, the chair particularly asked for further information regarding Maternity Service provision at Poole Hospital. No facility or provision was offered by the CCG. NHS Leaders confirmed that all Maternity Services will be located at Royal Bournemouth Hospital. This decision means that Poole parents' choice and access to maternity services will be detrimentally impacted by the Dorset Clinical Commissioning Group's decisions.

Councillors welcome the commitment of substantial national capital funds to build new Maternity facilities but strongly take the view that work carried out by the Dorset Clinical Commissioning Group on travel times evidences that Poole Hospital should be the preferred site for Maternity Services as part of a Major Emergency Hospital.

The Committee believes every effort has been made to reach local resolution, before submitting this letter of support of Dorset's Referral to you, and is grateful to local NHS leaders in Dorset for attending the lengthy Committee Meeting on 17th December 2018 to present information and fully answer questions from the public, Committee and other elected Members.

We urge you to consider the Dorset Referral in full and the concerns set out in this letter. The Committee requests an independent assessment of the matters of concern and particularly of all available and the most recent studies of the impact on patient safety of increased travel times for the South West Ambulance Services NHS Foundation Trust, if the Major Emergency Hospital is located at the Royal Bournemouth Hospital.

Yours sincerely



Councillor Jane Newell
Chair

People Overview and Scrutiny Committee (Health and Social Care)

CC: Councillor Vishal Gupta (Vice-Chair)
Councillor Malcolm Farrell (Committee Member)
Councillor Jennie Hodges (Committee Member)
Councillor Drew Mellor (Committee Member)
Councillor Marion Pope (Committee Member)
Councillor Louise Russell (Committee Member)
Councillor Ann Stribley (Substitute Committee Member)
Councillor Russell Trent (Committee Member)
Councillor Karen Rampton (Portfolio Holder for Health and Wellbeing)
Councillor Janet Walton (Leader of the Council)

www.poole.gov.uk



Poole2020
acting responsibly, preparing for the future

Appendix 4

Law & Governance
BCP Council Offices
Town Hall
Bournemouth BH2 6DY



Independent Reconfiguration Panel
6th Floor
157-197 Buckingham Palace Road
London
SW1W 9SP

Date: 27th June 2019

Our Ref: TC/IRP Referral

irpinfo@dhsc.gov.uk

Contact: Tanya Coulter
Email: tanya.coulter@bcpcouncil.gov.uk
Tel: 01202 451172

Dear Sir/Madam,

Re: Referral to the Secretary of State under Regulation 23(9) of the Local Authority (Public Health, Health & Wellbeing Boards, and Health Scrutiny) Regulations 2013 of changes to healthcare services in Dorset proposed by Dorset CCG

I write on behalf of Bournemouth, Christchurch & Poole Council in respect of the above matter.

The Council has been provided with a copy of the letter sent by the Secretary of State addressed to the Chair of Dorset County Council's Overview and Scrutiny Committee.

As you will be aware following local government re-organisation on the 1st April 2019 the nine Councils which formally existed in Dorset were abolished, and the two new unitary Councils of Dorset Council and Bournemouth, Christchurch & Poole (BCP) Council were created.

The Regulations provide for continuity provisions, which ensure that matters relating to the predecessor Councils automatically transfer to the two successor Councils. In this case therefore both Dorset Council and BCP Council are "parties" to, and have an interest in, the referral made by the former Dorset County Council as each Council contains areas which formed part of Dorset County Council.

I should be grateful therefore if you would kindly acknowledge this position, and that any correspondence about this referral is sent to each Council. Correspondence for BCP Council can be sent to me at the above email address.

In addition to the formal referral made by Dorset County Council, the former Borough of Poole sent a letter in support of the referral. This letter highlighted the support for all issues raised within the formal referral and made specific reference to some. In light of the wording of the letter to you from the Secretary of State, I should be grateful if you could confirm that the following issues will be considered in your assessment:

1. The impact of congestion within the conurbation on travel times for people conveyed both by the ambulance service and those attending A&E and Maternity Services by other means.
2. The matter of local access and choice in respect of Maternity Services when considering the impact of the proposed changes.
3. The impact of local housing developments on the current and future needs for and access to local health services.

I should be grateful if you would advise as to the process and timescale that you intend to apply to this assessment. There is reference within the letter from the Secretary of State to an "A&E Local" model. It would assist the Council if you could advise as to your approach to this matter, and whether further information will be sought in regard to this and the other issues.

The Council is keen to provide any assistance required to enable you to progress the assessment process, and if you would like any additional information in regard to the above, or any other issue, please let me know.

I look forward to hearing from you.

Yours faithfully,



Tanya Coulter
Director, Law & Governance

Appendix 5

From: Houghton, Martin <martin.houghton@dhsc.gov.uk> on behalf of IRPINFO <irpinfo@dhsc.gov.uk>
Sent: 04 July 2019 10:58
To: Tanya Coulter
Cc: Jeavons, Richard
Subject: RE: Proposed changes to healthcare in Dorset - referral by Secretary of State
Attachments: BR Essex-Dorset letter to SH 13.06.19.doc

Ms Coulter

Thank you for your letter of 27 June 2019 received here on 2 July.

The local government re-organisations described in your letter are duly noted. You may wish to note Lord Ribeiro's response to Stephen Hammond of 13 June 2019 attached.

Martin Houghton
Secretary to IRP

From: Tanya Coulter <tanya.coulter@bcpcouncil.gov.uk>
Sent: 02 July 2019 15:59
To: IRPINFO <irpinfo@dhsc.gov.uk>
Cc: Jan Thurgood <jan.thurgood@bcpcouncil.gov.uk>
Subject: Proposed changes to healthcare in Dorset - referral by Secretary of State

Please see attached letter in respect of the above.

Regards,

Tanya Coulter
Director, Law & Governance
Law & Governance
T. 01202 451172 M. 07786 635 247
tanya.coulter@bcpcouncil.gov.uk
bcpcouncil.gov.uk

Sign up to BCP Council's email news service

DISCLAIMER: This email and any files transmitted with it may be confidential, legally privileged and protected in law and are intended solely for the use of the individual to whom it is addressed. The copyright in all documentation is the property of BCP Council (Bournemouth, Christchurch and Poole Council) and this email and any documentation must not be copied or used other than as strictly necessary for the purpose of this email, without prior written consent which may be subject to conditions. Any view or opinions presented are solely those of the author and do not necessarily

represent those of BCP Council. BCP Council reserves the right to inspect incoming and outgoing emails. If you have received this email in error please contact the sender by return and confirm that its contents have been destroyed.

***** This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you have received this email in error please notify the system manager. This footnote also confirms that this email message has been checked for the presence of computer viruses.

This e-mail and any attachments is intended only for the attention of the addressee(s). Its unauthorised use, disclosure, storage or copying is not permitted. If you are not the intended recipient, please destroy all copies and inform the sender by return e-mail. Any views expressed in this message are not necessarily those of the Department of Health and Social Care or its Executive Agencies. For information about how we use your personal data, please see our Privacy Notices by selecting the relevant links: Department of Health and Social Care privacy notice

Please note: Incoming and outgoing email messages are routinely monitored for compliance with our policy on the use of electronic communications.

This email was scanned by the Sophos anti-virus service. **DISCLAIMER:** This email and any files transmitted with it may be confidential, legally privileged and protected in law and are intended solely for the use of the individual to whom it is addressed. The copyright in all documentation is the property of BCP Council (Bournemouth, Christchurch and Poole Council) and this email and any documentation must not be copied or used other than as strictly necessary for the purpose of this email, without prior written consent which may be subject to conditions. Any view or opinions presented are solely those of the author and do not necessarily represent those of BCP Council. BCP Council reserves the right to inspect incoming and outgoing emails. If you have received this email in error please contact the sender by return and confirm that its contents have been destroyed.

***** This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you have received this email in error please notify the system manager. This footnote also confirms that this email message has been checked for the presence of computer viruses.

6th Floor
157-197 Buckingham Palace Road
London
SW1W 9SP

Stephen Hammond MP
Minister of State for Health
39 Victoria Street
London
SW1H 0EU

13 June 2019

Dear Minister

Commissions for advice on referrals by Southend-on-Sea Council and Thurrock (Mid and South Essex STP) and Dorset Council (Dorset Clinical Services Review)

Thank you for your letters of 5 and 6 June 2019 about the above.

As you will know, our advice of 31 May 2019 about the *Future Fit* proposals in Shropshire exercised the option contained in the Secretary of State's commissioning letter of 22 March 2019 to take additional time to consider further the evidence before finalising our advice. We expect to complete this substantial piece of work by the end of July.

The Panel's available resources, both in terms of membership and administrative support, do not allow us to undertake more than two commissions for advice at any one time – a fact acknowledged by the Secretary of State who recognises that our members have their own work commitments in addition to offering expert advice as part of the Panel.

Since we have today received the required documentation in relation to the Mid and South Essex STP referrals, we intend to start work on this commission first alongside completion of the Shropshire advice. Having submitted these pieces of advice, we will then turn our attention to the Dorset Clinical Services Review for which documentation is at present still awaited. I trust this is acceptable to you.

I should also mention that, as a former consultant surgeon at Basildon University NHS Trust, to avoid any possible suggestion of a conflict of interest I will not be taking part in the Panel's deliberations on the Mid and South Essex STP. I will, instead, appoint a very able deputy from the Panel membership to lead on this work.

Yours sincerely



Lord Ribeiro CBE
IRP Chairman