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Agenda
Supplement

Dorset County Council

Meeting: Dorset Health Scrutiny Committee

Time: 9.30 am

Date: 20 December 2017

Venue: Committee Room 1, County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ

Debbie Ward
Chief Executive

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Tuesday, 12 December 2017

5. **Joint Health Scrutiny Committee re Clinical Services Review and Mental Health Acute Care Pathway Review - Update** 3 - 26

To consider a report by the Transformation Programme Lead for the Adult and Community Services Forward Together Programme (attached).

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Dorset County Council

Joint Health Scrutiny Committee - Clinical Services Review

Minutes of the meeting held at County Hall,
Colliton Park, Dorchester, Dorset, DT1 1XJ on
Tuesday, 12 December 2017

Present:

Bill Pipe, Bill Batty-Smith, Ros Kayes, Vishal Gupta, Jane Newell, David Brown, David d'Orton-Gibson, Rae Stollard, David Harrison and David Keast

Other Members Attending
Jon Orrell and Katharine Garcia attended the meeting as observers.

Officers Attending: Helen Coombes (Transformation Programme Lead for the Adult and Community Forward Together Programme), Ann Harris (Health Partnerships Officer), Jonathan Mair (Head of Organisational Development - Monitoring Officer) and Matthew Piles (Service Director - Economy).

For certain items, as appropriate
Debbie Fleming (Chief Executive, Poole Hospital NHS Foundation Trust), Tim Goodson (Chief Officer), David Haines (Locality Chair for Purbeck), Stuart Hunter (Chief Finance Officer, Dorset Clinical Commissioning Group), Patricia Miller (Dorset County Hospital NHS Foundation Trust Chief Executive), Sally O'Donnell (Locality Director Dorset Healthcare University NHS Foundation Trust), Tony Spotswood (Chief Executive, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust) and Forbes Watson (Clinical Commissioning Group Chairman).

(Notes:(1) These minutes have been prepared by officers as a record of the meeting and of any decisions reached. They are to be considered and confirmed at the next meeting).

Apologies for Absence

19 Apologies for absence received from Roger Huxstep (Hampshire) and Hazel Prior-Sankey (Somerset).

Code of Conduct

20 A general interest was declared by Cllr Ros Kayes added that she was employed in the mental health profession outside of Dorset and on occasion, her employer received funding from Dorset HealthCare University NHS Foundation Trust.

Minutes

21 The minutes of the meeting held on 3 August 2017 were confirmed and signed.

Public Participation

22 Public Speaking
Nine public questions and three public statements were received at the meeting in accordance with Standing Order 21(1) and 21(2). All public participation at the meeting related to minute 23 in respect of the Clinical Services Review (CSR). The questions, answers and statements are attached as an annexure to these minutes.

Cllr Jon Orrell, as County Councillor for Weymouth Town, addressed the Joint Committee as a Borough and County Councillor, local GP and former CCG Locality Chairman, describing the way in which local hospitals and community beds had been eroded despite assurances that public money could be reinvested in community

services. He stated that beds in NHS hospitals could be defended and he anticipated the loss of further beds if the CSR proposals were implemented. He also highlighted weaknesses in the consultation process that had been outlined in a report by Healthwatch. He asked the Joint Committee to support the Referral to the Secretary of State for Health on the basis that the proposals would not be in the interests of the health service in the area.

Petitions
There were no petitions received at the meeting in accordance with the County Council's Petition Scheme.

NHS Dorset Clinical Commissioning Group: Clinical Services Review

23 The Joint Committee received presentations by the CCG and the NHS partner organisations, with the opportunity for questions by members of the Joint Committee following each presentation.

Members were given a brief outline of the need for change by the Chairman of the CCG, and a reminder of the proposals in respect of the acute hospitals that included:-

- a major emergency hospital (MEH) at Bournemouth with 24/7 consultant led Accident & Emergency (A&E) Department;
- a major planned hospital at Poole including an Urgent Care Centre 24/7;
- Emergency and planned hospital at Dorchester with retention of A&E services.

The Chairman emphasised that this was a 5 year phased plan, which had received majority support.

Poole Hospital – Robert Talbot, Medical Director and Consultant Surgeon
Dr Talbot described the need to address the financial problems, variations in the quality of care across different specialities and hospital trusts and workforce issues. Poole Hospital supported option B and would continue to be a busy local facility that would be enhanced by the £62m investment in order to deliver high quality elective surgery.

Dorset County Hospital (DCH) – Patricia Miller, Chief Executive
DCH would remain a planned and emergency hospital with 24/7 A&E services. The provision of services closer to where people lived would reduce the need for travel to hospital which was particularly important for frail elderly patients to retain independence at home and prevent long term care. The creation of a hub on the DCH site was therefore supported, ensuring the same level of service as other localities. The CCG decision to work with Yeovil Hospital with regard to paediatric services was also supported and work would continue to pursue this option.

Royal Bournemouth Hospital (RBH) – Tony Spotswood, Chief Executive, Alison O.Donnell, Medical Director and Mark Sopher, Clinical Director of Cardiology
The Trust was acutely sensitive to travel concerns and already admitted 2,500 residents a year from Purbeck for emergency care. As an MEH, the hospital could provide better outcomes for those who were acutely unwell and emergency services were already provided for particular types of heart attack and out of hours service for Dorset.

The Chief Officer (CCG) highlighted the award of £147M capital funds to improve facilities (at RBH and other units), which was over a third of the total NHS money that had been available across the country. A full business case was required to draw down this money and he expressed concern that a referral to the Secretary of State might give the wrong message to the Department of Health.

Following the presentation, Cllr Kayes highlighted that the national population centred model of care did not take into account travel times from rural areas and she asked

how the proposals protected against inequalities and a two tier healthcare system and allow travel to a specialist centre within the “golden hour”.

In response, members were informed that services provided at DCH would remain largely unchanged and that the community hubs would prevent hospital admissions which was already being seen in Bridport and Weymouth. DCH would be working closely with RBH to ensure that the final delivery model met the needs of patients and be capable of repatriating patients to local hospitals as soon as possible.

Cllr Jane Newell asked whether some maternity services could remain in Poole due to increased population arising from homes being built in Poole and East Dorset.

CCG representatives explained that replacement of maternity services in Poole had been suggested 30 years ago and there was an opportunity to have a bespoke facility that was fit for purpose. A significant amount of care would continue within the community hub at Poole. A further benefit would be fewer women travelling from Bournemouth, where there were greater levels of antenatal activity.

Cllr David D’orton-Gibson noted that concerns were mainly around transport and not reaching hospital within the “golden hour” and asked about plans to address rural ambulance issues and the rationale behind the choices made in relation to the acute hospitals.

In response, members were informed that the delivery of outcomes was the key factor and that a patient could be transported beyond the nearest hospital to reach a centre that would deliver the best care. Furthermore, there were insufficient numbers of doctors and nurses to support the current pattern of provision and the proposed changes would support 24/7 care in specialist centres.

Siting of an MEH in Bournemouth had been the preferred option as RBH was a newer hospital on a larger footprint, making it cheaper to build on and expand in future. Location had also been a factor with quicker access for patients in East Dorset and West Hampshire. Poole Hospital was an older building on a constrained site and could not support the 1000 beds necessary for an MEH and, due to its public transport links, had been considered a more suitable location for planned treatments. Option B had therefore represented the best use of both sites with the cancer centre and urgent care centre remaining at Poole. The net result of patient flow between the two hospitals had shown no overall loss in footfall.

Cllr Brown asked about the reduction in bed numbers at Poole Hospital.

Members were reminded that the CCG commissioned services rather than beds. It was confirmed that Poole currently had 654 beds and that the estimate for a planned hospital was 247 beds, the reduction being due to the many treatments that were now provided as day cases. In terms of the overall position, there would be a reduction from 1800 to just over 1600 acute beds which was compensated by more beds in the community, giving a net reduction of around 100 beds.

Cllr Kayes asked when a decision would be taken regarding maternity and paediatric services at DCH and was informed that it had been decided to defer the decision to enable Somerset CCG to undertake more work and that any alternative proposal would be subject to a separate public consultation and scrutiny process.

South Western Ambulance NHS Foundation Trust – Adrian South, Clinical Director
Members received a presentation regarding the work carried out around travel times and containing performance information, with particular regard to the Purbeck area. Travel time is critical to patient outcome in only a small percentage of cases. Additional ambulance resource of 3 ½ hours per day would be required as a result of

the CSR proposals (although it was noted that not all the issues raised relate to the CSR) and further modelling would be undertaken once the decision on maternity and paediatric services had been announced.

Cllr Kayes remained concerned that residents in rural Dorset would experience increased journey times and suggested further investigation to inform the CCG of the additional financial support required.

Cllr D'orton-Gibson requested further detail concerning the additional 3 ½ hours ambulance provision to support the CSR, the way in which ambulances were deployed following a long journey to hospital and whether patients would be discharged more quickly from an ambulances in future.

It was explained that there would be a significant reduction in the number of inter-hospital transfers as a result of the proposals, particularly in relation to Bournemouth and Poole. It had also been evidenced that travelling to a centre of excellence and receiving the best quality of care superseded travel time. Improvements were already being seen in discharging patients from ambulances which were subsequently dynamically deployed to the most appropriate job. Non-emergencies represented a different challenge that could be met in rural communities by the hubs.

The Service Director, Economy (Dorset County Council) outlined the work being undertaken between the CCG and the Local Authorities regarding transport for health care. The focus is on offering a range of options and reducing the overall need for travel.

It was confirmed that CCG funded patient transport for those with clinical need and investment had been doubled in recent years. Rural transport would continue to be subject to wider discussion with local authority colleagues in relation to the Local Transport Plan and should not be subsidised by the NHS. Part of the transport solution lay in the CSR plans to provide care closer to home so that there would be less need to travel.

Community Services
Members were informed by the Locality Chair of the integration of services within community hubs, with specific references to the Purbeck area. The range of multi-agency work was emphasised, along with the need to be bold about the changes and the shift in resources from the acute to community sector.

Financial Plan
Members heard that the Finance Plan had been through an NHS England assurance process and would continue to be developed as the changes were implemented.

Equality Impact Assessment (EqIA)
An EqIA had been undertaken and copies were available at the meeting. The CCG noted that this was a 'live' document.

Elements of the EqIA were questioned, in particular, that it did not take account areas or rural deprivation and isolation and that transport had not been recognised as having a major impact.

The Chief Officer (CCG) responded that the CSR was a 5 year commissioning plan that had been backed by a financial plan and assurance process. The detail and feasibility would form part of the implementation phase and the travel impact lessened if care was moved closer to where people lived. The CCG noted that they are happy to receive more input to the EqIA.

Following the presentations, members asked about the extent of powers of the Joint Committee and were advised that the ability to refer the CSR to the Secretary of State for Health remained with the individual local authorities and had not been delegated to the Joint Committee. The Dorset Health Scrutiny Committee (DHSC) had already agreed to make this referral and therefore the Joint Committee could support the DHSC in its referral or express a view back to its respective committees.

The Chairman and Chief Officer (CCG) summed up, recognising that there are major changes planned but that they believe it is the right thing to do for the people of Dorset. They stated that the CSR had been through a high level scrutiny and assurance process to reach this point and the Secretary of State for Health had expressed his support through the capital bid, which represented a third of the total national fund.

On conclusion of the debate, the Chairman stated that it had been made clear from all the public interest and questions and statements that the Joint Health Scrutiny Committee had received, that many individuals had concerns over the CCG's plans for the future of Health Services in Dorset. In particular, it was clear that confidence was needed with regard to timely access to services, whether by ambulance or other forms of transport.

With regard to ambulance services, although the Joint Committee had been assured that increased capacity would be released for SWAST and that modelling had been undertaken to assess the future capacity needed, it was difficult to make a genuine determination as to whether the performance of SWAST would improve sufficiently to cope with the changes to the locations for delivery of services.

The Chairman proposed that the Dorset Health Scrutiny Committee commit to undertaking some detailed scrutiny work around the capacity and performance of the ambulance service.

The proposal was seconded by Cllr Bill Batty-Smith and subsequently amended that the Joint Health Scrutiny Committee undertake this review. The proposal was supported as amended. It was suggested that the review could be linked to the existing Joint Committee which is scrutinising the NHS 111 Service provided by SWAST.

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.

<u>Reason for Decision</u>

The role of the Joint Committee was to scrutinise the Clinical Services Review and Mental Health Acute Care Pathway Review, to ensure the best outcomes for health and wellbeing for all citizens.

Meeting Duration: 9.30 am - 1.20 pm

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Public Questions and Statements for the Joint Health Scrutiny Committee on 12 December 2017

Agenda Item 5 – NHS Dorset Clinical Commissioning Group: Clinical Services Review

<u>Questions</u>

1. Thelma Deacon, resident of Purbeck
2. David Holman, resident of Swanage
3. Stephen Bendle, resident of Weymouth
4. Chris Bradey, resident of Wareham
5. Steve Clark, Corfe Castle Parish Council
6. Deborah Monkhouse, resident of Swanage
7. Margaret O'Neill, resident of Purbeck
8. Emily Bosher, resident of Bridport
9. Professor Rick Stafford

<u>Statements</u>

10. Terry Stewart, Keep Our NHS Public Dorset
11. Damien Stone, Keep Our NHS Public Dorset
12. Philip Jordan

Questions

1 Question from Mrs Thelma Deacon

Every Minute Counts

Under the CCG plans, Poole A&E would be downgraded and Poole Maternity would close. SW Ambulance mapping shows the blue light travel time from Purbeck to Royal Bournemouth is 19 minutes longer than the same journey to Poole, and that the total journey time from Purbeck to RBH is 57 minutes.

We will not be able to access emergency treatment at RBH within the 'golden hour', from incident to treatment in hospital, which includes the time it takes for the ambulance to come. This will be more than 3 minutes. For 7 of the last 8 months SWAST have missed their target of responding to category 1 calls – imminent danger of loss of life - within 8 minutes, at least 75% of the time.

Nor will residents be able to access treatment in maternity emergency, acute stroke and major trauma within the 'safe' times of 30-45 minutes noted by Steer Davie Gleave, Consultants commissioned by the CCG.

The emergency medicine input into the CCG's plans seems, at best, limited.
A Dorset A&E Dr has made it clear that there are grave concerns about the plans to downgrade Poole A&E as, in a number of critical conditions, "Every Minute Counts". Even a few minutes delay in receiving treatment can be a matter of life and death in stroke, heart attack, cardiac arrest, meningitis and septicaemia.

None of these critical conditions can be treated in the ambulance, with the exception of those types of cardiac arrest that are susceptible to defibrillation.
Furthermore ambulances do not carry blood, and so can not cope with haemorrhage, a risk in both major trauma and maternity emergency.

The CCG's own records show that 64% of those admitted to Dorset Hospitals, ie the majority of people, do not arrive by ambulance, and many of these people will face journeys in excess of 57 minutes, through Bournemouth, the 'most congested Town in the UK'. A Member of Dorset County Council Health Scrutiny Committee has said that in the Summer it took him over an hour to get from Bournemouth Town Centre to Royal Bournemouth Hospital.

While residents would welcome any genuine improvement in the ambulance service, this will not move Royal Bournemouth Hospital any closer to Purbeck or address concerns about the loss of A&E and Maternity at Poole. No one, rich or poor, can opt out of the need for prompt access to A&E and Maternity.

As a result of the CCG plans, many Dorset residents face unsafe journey times in an emergency. Over 8,000 people in Purbeck signed, by hand, a petition to Save Poole A&E and Maternity over last Winter. A total of 36,910 people across Dorset signed petitions to Save A&E and Maternity at Poole.

Please would the Joint Health Scrutiny Committee support Dorset residents to continue to access A&E and Maternity Services within safe times by referring the CCG plans to downgrade Poole A&E and close Poole Maternity to the Secretary of State for review by the Independent Reconfiguration panel?

2. Question from David Holman, a Swanage Resident

Longer travel times in an emergency for many Dorset residents

The downgrading of Poole A&E and the closure of Poole Maternity, against which 37,000 local voters petitioned, will result in significantly longer travel times and increased risk of mortality in an emergency for most Dorset residents.

Steer, Davies Gleave, who looked into travel times for the CCG in March 2015, cite 30-45 minutes as the maximum acceptable travel time in acute stroke, major trauma or maternity emergency.

From parts of Dorset, including Purbeck, we will no longer be able to access services, even by blue light ambulance, within recommended 'safe' times.

Please would you consider referring these serious deficiencies in the CCG plans to the Secretary of State for Independent Review?

3. Question from Stephen Bendle, a Weymouth Resident

In view of the needs of Portland residents, the travel time from Portland to Dorchester especially when traffic is busy and the impact on the already over-loaded facilities in Weymouth and Dorchester, will you refer to the Secretary of State, for independent review, the CCGs plan to close Portland Community Hospital and replace it with a hub with no beds?

4. <u>Question from Chris Bradey, a Wareham Resident</u>

I am concerned about Dorset CCG's plan to cut 245 beds across the three acute Hospitals, in the absence of fully staffed replacement services, and ahead of evidence that such staffed services would indeed result in reduced demand for acute beds.

The core of the CCG's plan is to cut the demand for acute beds by an arbitrary one third - that is a cut of over 800 beds against the forecast need. The CCG state that they plan to achieve this reduction by strengthening local delivery in the community. However there is already a 14% vacancy rate (230 staff) in community and primary care services, and a further 670 FTE staff are required for the 'replacement' community services, making a shortfall of 900 community staff in all.
The CCG business plan states that the challenges are:
"- A significant gap; in terms of current versus future workforce numbers
- A shortage of staff in key roles
- An ageing workforce in a number of professions"

The plan goes on to state:

"To address the gap in workforce capacity it ASSUMES (my capitals) there will be a:

-Transfer of staff from the hospital to the community
-Redeployment of staff from the community hospitals
-Redeployment of staff following the reduction in outpatient appointments"

In addition the Councillors were told on 29 November that some community hospitals had recently closed at short notice because of staff shortages.

There are also vacancies in the main hospitals. I am very concerned about the word 'assumes', which suggests that there is no **evidence** or **experience** of significant staff redeployment. ***Where is the comprehensive plan with significant resources, which would ensure Dorset recruits 670 extra staff in addition to filling the existing 230 vacancies?***

If the JHSC is not confident that the reduction in forecast bed needs of one third can be achieved by the current plans for community and primary care services, please will you refer the plans to the Secretary of State for review by the Independent Reconfiguration Panel?

5 Question from Steve Clarke, Corfe Castle Parish Council

The CCG business plan agreed on 20 September included an Implementation Risks section, which gave a positive tick to all the 11 major risks identified.

Councillors will know of professional risk management tools, which assess the impact and likelihood of risks. On any measure most of the risks in the CSR are high risk or would be labelled Red at this stage.

There are huge risks in this radical plan including:

-The huge staffing challenge in recruiting to the community and primary care service

-The risk that Dorset will be seriously short of acute beds if the community-based strategy does not deliver the outcomes

-The lack of approval to the capital bid for the Integrated Community and Primary Care Services programme

-The risk of a serious decline in the quality of A and E services at Poole as on the CCG's plans it will have to provide A and E for five years although planned for closure.

-The lack of an integrated Trust structure as integration requires the approval of the Competition and Markets Authority, which had previously refused merger

Parliament's Health Select Committee is calling for evidence early next year as it is concerned that the Sustainability and Transformation Plans are not deliverable.

If the JHSC is not confident that this plan can be delivered within the timescales and budget available without significant risk to patients in Dorset, please would you refer the plan to the Secretary of State for review by the Independent Reconfiguration Panel?

6 Question from Deborah Monkhouse, a Swanage Resident

The Major Emergency Hospital should be at Poole

There has been considerable opposition to the loss of A & E and Maternity Services at Poole, with many residents, councils and organisations opposing closure. 36,910 residents signed petitions to Save Poole A&E and Maternity.

Poole is uniquely located to enable residents in Bournemouth, Poole and in Dorset County Council areas such as Purbeck and North Dorset to access emergency and maternity services within safe travel times. Steer, Davies Gleave, commissioned by the CCG to look into travel times, reported:

"Option evaluation for access to major emergency hospital (MEH) services rates MEH services provided at Poole General Hospital higher than where MEH services are provided at Bournemouth hospital. This is because a higher proportion of the whole Dorset's population is able to reach MEH services within 30 minutes and that the maximum travel time is 10 minutes less than where the MEH services are provided at Royal Bournemouth Hospital"

The CCG have made it clear that the MEH could be sited at either location. While building up at Poole makes the costs there higher, once the additional costs of the new road needed if the MEH is at Bournemouth are included, the difference in costs is relatively small, particularly when compared to the CCG's commitment to save £229 million pa against expected running costs.

The real cost of closing Poole A&E and Maternity will be paid in increased fatalities and lives lived in disability for Dorset residents who can no longer access treatment at RBH within the 'golden hour', let alone within the 'safe' times of 30-45 minutes for maternity emergency, acute stroke & major trauma.

Poole A&E saw 66,000 people in 2015/16, 36,000 of whom were admitted. These 36,000 people, more than half of whom made their own way to Poole A&E, and a large number of whom were seriously ill, would go to the 'wrong place' if they sought treatment in the proposed Poole Urgent Care Centre.

Poole Hospital was built in 1907 and has been a central feature of Poole for over 100 years. The closure of A&E and Maternity services, together with the plan to cut 407 of Poole's 654 beds, a cut of 2/3, can only have a negative impact on recruitment, and calls the Hospital's financial viability into question.

Through-flow of A&E and Maternity patients into hospital beds is essential for services to work: it will not be possible to move more people safely through less A&E locations into less acute beds. Last Winter's OPEL alerts show that we do not have enough acute beds now, and the CCG plan to meet only 2/3 of forecast need.

We need to site the MEH at Poole, and to keep the 407 beds that are being cut at Poole.

If the JHSC members agree that residents deserve the best access to emergency and maternity services within safe times, and access to acute beds when needed, please would you consider referring these serious deficiencies in the CCG's plans to the Secretary of State for review by the Independent Reconfiguration Panel?

7 Question from Margaret O'Neill

Ambulance waiting times

The CCG's plans to reduce A&E and Maternity locations relied on the claim that residents could access Royal Bournemouth Hospital within 30 minutes. However, it was acknowledged in the CCG Meeting on 29th November that blue light travel time from Purbeck to Royal Bournemouth is 57 minutes, ferry and traffic permitting.

The 'golden hour' in trauma is from incident to hospital treatment. It includes the time it takes the ambulance to come. Therefore, we will be unable to access emergency treatment at RBH from Purbeck within the 'golden hour'.

Ambulance response times are also, in themselves, a matter of serious concern. Three examples that I know of are:

DD.12.16 was diagnosed with a life threatening/life limiting in Poole A&E.

At 7.50pm Poole A&E called to say that an ambulance would come within 8 minutes to take to the Wessex Neurological Centre at Southampton. was in a lot of pain due to the pressure on brain. The ambulance did not arrive at Poole until 10.15pm, two and a half hours later. Poole reported an Opel alert on DD.12.16: shortage of acute beds.

DD.6.17 fell in Swanage, fracturing , was in a lot of pain and could not move. The ambulance was called at 10pm. was categorised '3T', which meant the ambulance should come within 40 minutes. The ambulance came 3 hours 20 minutes later. died on of a pulmonary embolism. GP told the Coroner he believed that having to lie still for three and a half hours the previous Friday was a contributory factor. The Coroner told daughter that her was the third case in two weeks of elderly people falling, have very long ambulance waits, and subsequently dying.
The ambulance service said there wasn't an ambulance to send.

DD.7.17 and DD.8.17 aged , who lives in , and who has , was categorised as red 2 – blue light – but waited 2 hours on both occasions for an ambulance to come. is admitted on average times per year to Poole. says ambulances picking up mainly come from Poole having dropped off patients; they will be having to come from Bournemouth once Poole A&E goes. is very concerned the longer wait and longer journey to Bournemouth that will regularly face at times when life is at risk.

As your residents, we rely on Joint Health Scrutiny Committee to ensure that health plans meet our needs. The plans to close Poole A&E and Maternity will increase fatalities, and lives lived in disability.

Are Joint Health Scrutiny Committee Members confident that all residents will be able to access services at Royal Bournemouth within the 'golden hour'?

If not, would committee Members please stand up for residents by referring these dangerous plans to the Secretary of State for independent review?

8 Question from Emily Bosher, a Bridport Resident

Are Councillors confident that the CCG have fully considered SWAST operating problems in closing A&E and Maternity services at Poole?

While residents would welcome genuine improvement in the ambulance service, is there any real prospect of this happening in the current climate?

SWAST's Integrated Corporate Performance Report for October* shows on page 13 that SWAST have missed the target, of attending 75% of Dorset category 1 (imminent danger of loss of life) calls within 8 minutes, in 7 of the last 8 months. There are no plans to increase funding and they cannot recruit staff. It is not clear that the CCG is engaging with the reality of this situation.

SWAST's Chief Executive's letter of 6th October does not acknowledge that there is any problem. There are many specific examples known to Councillors of dangerously long ambulance waits, and further examples are being given to this Committee today. Some examples beg the question as to whether calls are being downgraded in an effort to mask SWAST inability to meet targets.

A recent Coroners report found that a category 1 call had been 'downgraded' twice for this very reason, and a young Poole student had died as a result.

The Head of the Ambulance Service said that there is 'no clinical risk' in the CCG's plans to close Poole A&E and Maternity. Common sense says that this can not be true, and South West Ambulance Trust's own August 2017 report into Travel Times, commissioned by the CCG, makes clear on page 2, no. 1.6, that a clinical assessment would be needed on the most acute cases to assess risk. This work has not been done. Therefore the Head of the Ambulance Service can not in reality give any assurance. South West Ambulance Trust Staff seem to have lost confidence in their Head of Service, and have been calling for his resignation in the Bournemouth Echo.

The CCG have stated that SWAST problems 'are nothing to do with the CSR'. This seems an incredible statement for those responsible for residents' health to make. The CCG's plans to have less acute beds in less A&E and Maternity locations will make SWAST's job more difficult, while ignoring SWAST's problems provides further evidence of the unreality of the CCG's plans.
75,570 people across Dorset have signed petitions against the CCG's plans.

Please could the Joint Health Scrutiny Committee stand up for Dorset residents health by considering referral of the CCG plans to the Secretary of State for review by the Independent Reconfiguration Panel?

https://www.swast.nhs.uk/Downloads/SWASFT%20downloads/SWASFT%20Corporate%20Performance%20Reports/ICPR%20October%202017.pdf

9 Questions from Professor Rick Stafford

I am aware that the issues of bias in questions used in the CCG in their consultation has been raised previously, I would like to add my support to these claims. There are statistically significant differences in the responses from written and telephone surveys, which are not addressed, and which I would conclude as strong evidence that neither telephone nor consultation process was fit for purpose. I am writing in an independent context, but I am a Fellow of the Royal Statistical Society and Professor at Bournemouth University, with considerable research and teaching experience in statistical methods and survey design.

Overview of the ORS report into the CCG consultation – Professor Rick Stafford

Personal background and expertise: I am a Professor at Bournemouth University in the Department of Life and Environmental Sciences. I have a PhD in Ecology and Ecological Modelling and considerable experience in teaching statistics to PhD level. I am a fellow of the Royal Statistical Scociety. I was formally (2014-2016) the lead for the British Ecological Society's Quantitative Ecology Group and have published research and supervised PhD completions involving survey data and subsequent analysis. I have also been awarded fund by NERC (a UK research council) for delivering training methods in statistics and data synthesis to PhD, post-doc and other professional workers. I do not claim to have a clinical background or in depth knowledge of this area.

My comments are based largely on reading the executive summary – but with more in depth reading in some specific places. Overall, the report presents a fair account of the data collected and the executive summary gives a clear indication of the figures and opinions from different feedback methods.

- it is especially worth emphasising the large number of petition signatures which were obtained against specific aspects of the CCG plans. For example, 36,146 signatures were obtained objecting to the closure of Poole Hospital A+E and Maternity. While it is acknowledged that these signatures would come from a wider geographical areas than just the Borough of Poole itself, this number of signitures constitute 24.5% of the population of Poole based on 2011 census data. As such, **there is clearly overwhelming opposition to this closure based on survey data.**

Again, I have no doubt that the tables on pages 13 and 14 of the main report's executive summary are factually correct. However, there are two areas for concern here in terms of misleading data. Firstly, the 'agree' and 'disagree' figures do not add up to 100%. While I am sure this is correct, it is misleading. The consultation frequently had a response of 'another option' and in many cases, given the lack of transparency in the questions asked (see below for details of this) this 'other option' would be against the CCG proposals. Indeed, section 3.4 (page 47 – 48) details how a document produced by Keep Our NHS Public frequently suggested selecting 'another option' or disagreeing strongly with the proposals. As such, it is important to be transparent about how many 'other options' were selected as opposed to questions just left blank. **In conclusion, the responses to the CCG consultation documentation are likely to be more negative than indicated in the table.**

It is worth noting that ORS completed the analysis of the data. It is not clear until page 34 of the report that ORS also designed the initial questionnaire used for the consultation. As such, while the data analysis conducted is fair and robust, **the**

company must also be aware they are analysing data from questions deliberately set up to contain bias and reflect the results wanted by the CCG.

For example, the questions for Poole and Bournemouth/Christchurch respectively were:
Our proposal for the POOLE LOCALITIES includes a community hub with beds at Poole (only if this is the major planned care hospital). Alderney Hospital would not be used as a community hub and proposals for its future would form part of a separate review of dementia services. To what extent do you agree or disagree with our proposal for the POOLE LOCALITIES?

Our proposal for the BOURNEMOUTH and CHRISTCHURCH LOCALITIES includes a community hub with short term care home beds at Bournemouth (only if this is the major planned care hospital) and a hub without beds at Christchurch. To what extent do you agree or disagree with our proposal for the BOURNEMOUTH and CHRISTCHURCH LOCALITIES?

Firstly, it is not clear what 'only if this is the major planned care hospital' means – what are the proposals if it is not? These would be hidden within a lot of detail in the consultation document.

Secondly, there is not a clear overview of the overall situation in these statements. For example – where is the clear wording regarding the proposals for closure of Poole A+E?

The bias in the questions is verified within the difference in response to the written responses to the CCG questionnaire and resident surveys. The proposals for Poole (p 13) show a net agreement figure of -6 for the questionnaire response but +36 for the resident survey, Bournemouth shows figures of -10 and + 55 and North Dorset -32 and +45 respectively. **These differences in figures need to be questioned carefully.** My explanation of these facts are that many (but far from all) people filling in a written response to the questionnaires had time to research, or had been informed of real implications of the proposals. Those contacted by telephone did not, and responded positively to the positive spin put on the questions asked.

Overall conclusions
1. The petition data clearly demonstrates that a VERY LARGE proportion of Dorset are unhappy with these proposals. This must not be ignored.
2. It would be useful to see 'other options' in the CCG questionnaire classified as positive or negative, along with other responses.
3. The discrepancy in data between two different collection methods clearly indicates that the questions asked in the consultation were bias. It should be concluded that public opinion is much more negative than presented in the report.

As Questions:

Dear Sir or Madam,

I am writing to question the data analysis produced in the ORS report on the consultation process. While the majority of the report appears fair, there are some major and important discrepancies and omissions in the report. I feel these important discrepancies and omissions bias the results presented in favour of the CCG proposals and against true public opinion. As an academic with considerable statistical knowledge and expertise, in addition to knowledge of questionnaire design

and survey techniques, I wish to raise the following questions (in bold). The context and evidence for the questions is detailed below each question.

1. **The petition data clearly demonstrates that a VERY LARGE proportion of Dorset is unhappy with these proposals. How is this going to be accounted for in any decisions made?**

Context: A very large number of petition signatures were obtained against specific aspects of the CCG plans. For example, 36,146 signatures were obtained objecting to the downgrading of Poole Hospital A+E and Maternity. While it is acknowledged that these signatures would come from a wider geographical area than just the Borough of Poole itself, this number of signatures would constitute 24.5% of the population of Poole based on 2011 census data. As such, there is clearly overwhelming opposition to this closure based on petition data.

2. **Why were 'another option' responses not included in the data analysis in the executive summary on pages 13 and 14 of the report?**

Context: On page 13 and 14 of the report the 'agree' and 'disagree' figures do not add up to 100%. While I am sure this is correct, it is also misleading. The consultation frequently had a response of 'another option' and in many cases, especially given the lack of transparency in the questions asked (see below for details of this), this 'other option' would be against the CCG proposals. Indeed, section 3.4 (page 47 – 48) details how a document produced by Keep Our NHS Public frequently suggested selecting 'another option' or disagreeing strongly with the proposals. As such, it is important to be transparent about how many 'other options' were selected as opposed to questions just left blank. In conclusion, the responses to the CCG consultation documentation are likely to be more negative than indicated in the table.

3. **There is considerable (statistically significant) discrepancy in the data collected between two different collection methods (CCG consultation documents and resident telephone surveys). Why is this not addressed, and given the context detailed below, do the CCG acknowledge that the questions asked in the consultation were bias, misleading and designed to provide support for the answers they wanted, rather than gauging public opinion?**

Context: While it is clear that ORS completed the analysis of the data, it is not clear until page 34 of the report that ORS also designed the initial questionnaire used for the consultation. As such, while the data analysis conducted is largely fair and robust, the company must also be aware they are analysing data from questions deliberately set up to contain bias and reflect the results wanted by the CCG – hence the conclusions of the report are not a fair representation of public opinion.

As evidence of this, the questions for Poole and Bournemouth/Christchurch respectively were:
Our proposal for the POOLE LOCALITIES includes a community hub with beds at Poole (only if this is the major planned care hospital). Alderney Hospital would not be used as a community hub and proposals for its future would form part of a separate review of dementia services. To what extent do you agree or disagree with our proposal for the POOLE LOCALITIES?

Our proposal for the BOURNEMOUTH and CHRISTCHURCH LOCALITIES includes a community hub with short term care home beds at Bournemouth (only if this is the

major planned care hospital) and a hub without beds at Christchurch. To what extent do you agree or disagree with our proposal for the BOURNEMOUTH and CHRISTCHURCH LOCALITIES?

Firstly, it is not clear what ‘only if this is the major planned care hospital’ means – what are the proposals if it is not the case? The answers to these questions would be hidden within a lot of detail in the consultation document.

Secondly, there is not a clear overview of the overall situation in these statements. For example – where is the clear wording regarding the proposals for downgrading of Poole A+E?

The bias in the questions is verified within the difference in response to the written responses to the CCG questionnaire and resident surveys. The proposals for Poole (p 13) show a net agreement figure of -6 for the questionnaire response but +36 for the resident survey, Bournemouth shows figures of -10 and + 55 and North Dorset -32 and +45 respectively. All of these responses show very high levels of statistical significant difference between data collection methods ($p \ll 0.001$ from Fisher’s exact tests), yet these discrepancies are mentioned in the report. These differences in figures need to be questioned carefully. My explanation of these facts are that many (but far from all) people filling in a written response to the questionnaires had time to research, or had been informed of real implications of the proposals. Those contacted by telephone did not, and responded positively to the positive spin put on the questions asked. As such, the significantly different results from the different questions are direct evidence of the inbuilt bias in the questions asked.
I would be grateful for the following to be considered carefully in forming any final decisions, and in particular, in presenting evidence of public opinion to the options provided.

Statements

10 Statement from Terry Stewart, Keep Our NHS Public Dorset

Introduction
On behalf of Keep Our NHS Public Dorset we would like to welcome the democratic decision of Dorset County Council's Health Scrutiny Committee in calling this meeting today, so as to voice their concerns over the far reaching and sweeping proposals of the Clinical Services Review by Dorset CCG. We cannot underestimate the role that democratically elected members have in overseeing and scrutinising the work of the CCG because of the impact of their decisions upon constituents lives and wellbeing.

In this statement I want to confine myself to comments about the CSR even though the CCG believes, as stated at their last Board meeting, that the CSR is a finished matter. What I would urge elected members to focus their attention on today, is on the full extent of the CCG's proposed bed closure that will have a damaging impact upon LA's in planning their social care programmes and budgets.

Bed Losses
Members of Keep Our NHS Public Dorset would like to bring to the JHCS attention some key concerns that ought to inform the discussion today. These concerns are in relation to the loss of beds across Dorset County, Poole General Hospital and the increased beds at Royal Bournemouth Hospital. Additionally, there are also 67 'other' beds appearing in plans where it is not clear where these beds are to be commissioned such as in private nursing homes. Overall, our concern is that of acute bed losses and the impact they will have upon local authority social care planning and funding as well the safeguarding and wellbeing of vulnerable groups.

Impact upon Social Care Planning and the abandonment of sharing risk between the NHS and the Local Authorities
The burden of these bed losses if left unchallenged will fall directly on the older people and their carers as well as the LA's. The CCG pays lip-service to equalities assessment in their plan where a disproportionate burden falls upon one part of the constituent members. Within the CSR there is no proper statement of collective responsibility for health and risk pooling. At the moment joint commissioning/health and social care planning is rightly focused on integration and joint planning yet LA's budgets have been cut by over 20% by central government. At the same time across Dorset a CQC report has revealed that one in five care home beds are not up to standard and some 21 per cent of beds in homes are rated as needing improvement. In the same report it states that in neighbouring Hampshire, 23 per cent of beds need improvement or are inadequate (reported in the Bournemouth Echo 30/11/17). In other words, the burden of risk for social care unduly falls upon the LA's, who have to monitor private care and where there is already increased neglect and safeguarding issues. Yet when the Secretary of State for Health announced £155 million to underpin the Dorset CSR/STP no additional funds were given to the LA's who have to burden these bed losses.

Keep Our NHS Public Dorset urges the JHSC to refer the CSR to the Secretary of State for Health for further scrutiny to the Independent Reconfiguration Panel. Elsewhere in the country LA Health Scrutiny Committees and Well Being Boards have also taken similar actions and in doing so expressed real concerns that cuts, closures and downgrading made by their respective CCGs have been passed onto LAs without the appropriate funds being reallocated.

11 Statement from Damien Stone, Keep Our NHS Public Dorset

Our group have maintained that the whole process has been confusing and not transparent. I sent a question to the CCG asking if any money for new buildings in Bournemouth would be PFI money & was given the following non answer. They wrote: .. ***"This question was answered in either the content of the presentation, the presenter's script or in the questions asked by the Governing Body".*** I could have been given a YES or NO. Is the CCG worried that some answers won't please the public? PFI has implications with regards to value and profits going to tax havens.

12 Statement from Philip Jordan

What value's Care, if people can't access it?

Modern local democracy's vital in publically funded public services =

Scrutinising CSR (Accountable Care*/Locality Plans, Quality, Equitable Accessibility etc) Decisions let alone implementation by pressured Professional officers/boards:

Whatever DCC/DCH/a CCG Boss's current "Leadership training" @ Yale etc

Understandably, Clinicians etc = CCG Board haven't resolved clashing pressures like

HMG under funding, distance v time, lack of transport, or work v care "in the home" e.g.

- for disabled v other children &/or old relatives – often, if not always:

- lacking full H&S Training like Manual Handling, Lone Worker/Stress/other Management etc

Please can Dorset JHSC reject Dorset NHS CSR flawed decisions

e.g. for A&E/M&P:

- Major A&E/M&P @ RBH = Dorset's inaccessible extreme east

- subjecting to consultation DCH (v YDH) ref having M&P 24/7 Consultant care!

- whilst un-consulted, moving DCH's higher grade baby unit to Poole

(similarly Weymouth's Chalbury (Dementia) unit went to Poole without consultation)

*https://www.england.nhs.uk/blog/dorsets-journey-to-becoming-an-accountable-care-system/

Responses to Questions 1, 2, 6, 7 and 8 related to A&E and Maternity Services and ambulance performance and response times

Thank you for your questions regarding the proposed changes to A&E and Maternity services at Poole Hospital. We acknowledge your concerns about future access to these services in a timely way (particularly for Purbeck residents) and your concerns about the ability of the Ambulance Service to provide an adequate response in emergency situations. Please be assured that the Joint Committee has raised these issues with the CCG throughout its scrutiny of the Clinical Services Review, which began in July 2015. The Joint Committee responded to the formal consultation in March 2017 and made recommendations to the CCG in August 2017, on both occasions making specific reference to the need for on-going work around both emergency and non-emergency transport. The CCG provided a positive response to those recommendations and has committed to continue to work with the Local Authorities and South Western Ambulance Service to ensure safe and timely access to all services.

With reference to your specific request that the Joint Health Scrutiny Committee makes a referral to the Secretary of State for Health, under the terms of the agreed pan-Dorset protocol for joint health scrutiny, the Local Authorities involved decided that they would not defer the power to refer to the Joint Committee, but would retain that power locally. The Joint Committee carries out the scrutiny and makes recommendations, but does not have the power to make a referral in its own right.

Response to Question 3 related to changes to Portland Community Hospital

Thank you for your question regarding the proposed changes to Community Hospital services at Portland Hospital. We acknowledge your concerns about future access to services and your concerns about travel times.

Please be assured that the Joint Committee has raised issues such as this with the CCG throughout its scrutiny of the Clinical Services Review, which began in July 2015. The Joint Committee responded to the formal consultation in March 2017 and made recommendations to the CCG in August 2017, on both occasions making specific reference to the need for on-going work around both emergency and non-emergency transport. The CCG provided a positive response to those recommendations and has committed to continue to work with the Local Authorities and South Western Ambulance Service to ensure safe and timely access to all services.

With reference to your specific request that the Joint Health Scrutiny Committee makes a referral to the Secretary of State for Health, under the terms of the agreed pan-Dorset protocol for joint health scrutiny, the Local Authorities involved decided that they would not defer the power to refer to the Joint Committee, but would retain that power locally. The Joint Committee carries out the scrutiny and makes recommendations, but does not have the power to make a referral in its own right.

Response to Questions 4 & 5, and Statements 1 & 3 related to the ability to deliver changes and shift resources to the community and potential impacts

Thank you for your questions and statement regarding the implementation of the Clinical Services Review and the confidence that the Joint Committee has that this can be done successfully. Please be assured that the Joint Committee has raised issues such as this with the CCG throughout its scrutiny of the Clinical Services Review, which began in July 2015. The Joint Committee responded to the formal

consultation in March 2017 and made recommendations to the CCG in August 2017, on both occasions making specific reference to the need for detailed work with partner organisations to ensure that implementation plans were realistic and achievable. The CCG provided a positive response to those recommendations and has committed to continue to work with the Local Authorities and other organisations to provide integrated services across the health and social care system.

With reference to the specific requests that the Joint Health Scrutiny Committee makes a referral to the Secretary of State for Health, under the terms of the agreed pan-Dorset protocol for joint health scrutiny, the Local Authorities involved decided that they would not defer the power to refer to the Joint Committee, but would retain that power locally. The Joint Committee carries out the scrutiny and makes recommendations, but does not have the power to make a referral in its own right.

Response to Question 9 related to the consultation process and interpretation of the results

Thank you for your question and overview regarding the consultation process undertaken for the Clinical Services Review. The Joint Committee questioned the robustness of consultation and engagement with the CCG throughout its scrutiny of the Clinical Services Review, which began in July 2015. The Joint Committee responded to the formal consultation in March 2017 and made recommendations to the CCG in August 2017, on both occasions making specific reference to the consultation process and the way in which responses (including petitions) had been dealt with. The CCG provided a detailed response to the concerns raised and were able to evidence that the consultation and engagement approach had been assured by the Consultation Institute. The Joint Committee felt that overall there had been extensive engagement and involvement by the CCG, going back over a two year period.

The CCG advise that they spent several months considering the consultation response and other factors before making a final decision. The decision was not purely based on the consultation (it was not a referendum), hence the CCG accepts that different people will have different views on the consultation results

The company which undertook the consultation and wrote the Report of Findings (ORS) attended a meeting of the Joint Health Scrutiny Committee on 3 August 2017. At that meeting Members had the opportunity to challenge both the methodology of the consultation and the reporting of results. The minutes of that meeting have been circulated today and hopefully demonstrate that the Joint Committee is aware of concerns and has raised them with the CCG.

Response to Statement 2 regarding the funding of the new buildings in Bournemouth

Dorset has been earmarked for £147m of capital from the NHS England allocation (a third of all national capital available for such schemes). The CCG still has to undertake a full business case to gain final Department of Health andTreasury approval, but this is the source of funding for the Poole and Bournemouth Hospital schemes, not PFI.