Dorset County Council

Dorset Health Scrutiny Committee

Minutes of the meeting held at County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ on Wednesday, 20 December 2017

Present:
Bill Pipe (Chairman)
Ros Kayes, Ray Bryan, Nick Ireland, Peter Oggelsby, Bill Batty-Smith, Tim Morris and Peter Shorland

Officers Attending: Helen Coombes (Transformation Programme Lead for the Adult and Community Forward Together Programme), Ann Harris (Health Partnerships Officer) and Lee Gallagher (Democratic Services Manager).

For certain items as appropriate: Tim Goodson (Chief Officer, Dorset Clinical Commissioning Group), Dr David Haines (Clinical Chair, Purbeck Locality), Stuart Hunter (Chief Finance Officer, Dorset Clinical Commissioning Group), Jennie Kingston (Deputy Chief Executive, South Western Ambulance Service NHS Foundation Trust), Dr Karen Kirkham (Clinical Chair, Weymouth and Portland Locality), Patricia Miller (Chief Executive, Dorset County Hospital NHS Foundation Trust), Paul Miller (Director of Strategy, Poole Hospital), Sally O'Donnell (Locality Director, Dorset Healthcare University NHS Foundation Trust), Dr Phil Richardson (Director, Design and Transformation, Dorset Clinical Commissioning Group), Adrian South (Deputy Clinical Director, South Western Ambulance Service NHS Foundation Trust), Dr Forbes Watson (Clinical Commissioning Group Chairman) and Dr Simone Yule (Clinical Chair, North Dorset Locality).

(Notes: 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 of the Cabinet to be held on **Thursday, 8 March 2018**.)

Apologies for Absence

47 Apologies for absence were received from Cllrs David Jones, Graham Carr-Jones, Steven Lugg and Alison Reed.

(Note: Cllr David Jones did not attend the meeting as he was a governor of Poole Hospital.)

Code of Conduct

48 There were no declarations by members of disclosable pecuniary interests under the Code of Conduct.

Cllr Bill Batty-Smith declared a general interest as his granddaughter was employed by the NHS.

Cllr Peter Shorland declared a general interest as a Governor of Yeovil Hospital.

Minutes

49 The minutes of the meeting held on 13 November 2017 were confirmed and signed.

Note: Maternity and Overnight Children’s Service in Dorchester
At this point in the meeting, Tim Goodson, Chief Officer of the Dorset Clinical Commissioning Group (CCG), announced that the CCG intended to work to maintain a consultant-led maternity and overnight children’s service in Dorchester as part of a single maternity and paediatrics service for Dorset. The retention of services was identified as a result of the conclusion of the Clinical Services Review public

consultation. The delivery of consultant-led maternity services would also seek to be integrated across Dorset County Hospital and Yeovil District Hospital for the Dorset population.

In addition, it was reported that Somerset CCG would also be undertaking a review of clinical services which would include maternity and paediatrics. The future possible configuration across Dorchester and Yeovil would continue to be discussed by both CCGs.

Dorset CCG's Governing Body would agree a way forward in the new year, and if a sustainable model was possible then public consultation would be undertaken on the proposals before making any decision.

Patricia Miller, Chief Executive of Dorset County Hospital NHS Foundation Trust welcomed the retention of the services at Dorset County Hospital as good news for patients and staff.

Noted

Public Participation

50 Public Speaking

Three public questions and two 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 51 in respect of the Clinical Services Review (CSR). The questions, answers and statements are attached as an annexure to these minutes.

Petitions

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

Joint Health Scrutiny Committee re Clinical Services Review and Mental Health Acute Care Pathway Review - Update

51 The Committee received presentations by the Clinical Commissioning Group (CCG) and the NHS partners in response to the Dorset Health Scrutiny Committee's request to make a referral to the Secretary of State (SoS) for Health in respect of the concerns about the Clinical Services Review at its meeting on 13 November 2017, and subsequent consideration of further information at the Joint Health Scrutiny Committee meeting on 12 December 2017. The remit of the referral was about the proposed reduction in the number of acute hospital beds, the reduction in Accident and Emergency services at Poole Hospital, concerns about travel times, confidence in the ambulance service data, and the lack of a clear Equality Impact Assessment or financial plan.

All concerns raised as part of the referral request related to the proposals in respect of the acute hospitals which 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; and,
- Emergency and planned hospital at Dorchester with retention of A&E services.

Tim Goodson, Chief Officer for the Dorset CCG, also drew attention to his announcement earlier in the meeting on the intention to work to maintain a consultant-led maternity and overnight children's service in Dorchester as part of a single maternity and paediatrics service for Dorset.

Three public questions and two public statements were received at the meeting under public participation. The questions, answers and statements are attached as an annexure to these minutes.

Detailed presentations were received in relation to:

Ambulance Travel Times
The presentation focused on the assessment of the proposed changes in the CSR, which included population growth and service demand, and had taken into account the impact on travel times as a result. The changes would see a transformation of service provision as a whole system plan, and would look to ensure people were taken to the right hospital at the right time which would save lives through the right care being provided at the right place, in addition to reducing the number of transfers between hospitals by ambulance. Fewer patients who call 999 were taken to hospital these days (over half were treated on-scene) and, of those who were taken, only 1% were deemed to be life threatening cases. 85% of future ambulance journeys could be made in the same or less time than the existing arrangements. From the remaining 15%, with particular reference to Purbeck, there was a spread of admissions to Dorchester, Bournemouth and further afield to other hospitals depending on the circumstances of the emergency which would see an increase in travel time, but these would be to the most appropriate hospital setting for the patient rather than the closest hospital.

In terms of ambulance waiting times to transfer patients to A&E, the pressure on services was a major concern of the NHS and proposed changes to Royal Bournemouth Hospital would include mitigation through the physical extension of the A&E service in a revised hospital design over the next 5 years. New road access to the Hospital from the A338 was raised, but it was clarified that the new road would be needed with or without the hospital changes. The plan would also evolve over time and would continually change and adapt moving forward.

The 'golden hour' concept was discussed by members, and challenged by NHS professionals as the reality of population, dispersity and transport in Dorset did not make the concept realistic, and it also did not take account of the care provided in the ambulance and the start time of the hour being from the point of injury or trauma, where it was often not possible to arrive at hospital within an hour.

The Chairman drew attention to the recommendation of the Joint Health Scrutiny Committee on 12 December 2017 to jointly scrutinise the capacity and performance of the ambulance service. Further views were expressed by members which included the lack of funding available to resource the Ambulance Trust; concern over the funding of transport to rural-proof Dorset, including travel times without ambulance; and support for community based transport initiatives.

Integrated Transport
Following the concern raised above, clarification was given by the CCG that it was not their statutory responsibility to provide funding for integrated transport, but it was willing to be part of identifying solutions. The CCG was already embedded in a process of joint working with the County Council to address rural isolation through a Pan-Dorset Transport Reference Group with health identified as a priority. Investment in the non-emergency Patient Transport Scheme had also been increased from £3m to £5m through an integrated transport programme.

Matthew Piles, Service Director – Economy from Dorset County Council, provided an overview of the joint working to identify and use assets and knowledge to effectively facilitate travel planning and deploy community and local transport initiatives, including schemes which included opening school bus routes to the public.

Community Based Services
An extensive summary on the steps being taken to move community care closer to

the home for patients was provided, which would lead to less patients needing to access acute care. Support was voiced by a range of GPs from across the whole of Dorset in respect of primary care provision, which explained the background input of over 600 clinicians to the CSR, the history of integrated health and social care services. A number of initiatives were outlined which included providing appropriate and timely care to enable people to stay at home; to avoid stays in hospital of more than 2 days; encouragement of school leavers and graduates to enter caring professions to support community care; relocation of diabetic support in Purbeck out of hospital setting; a Community Hub in Wareham as a template for other areas moving forward; a Community Services Reference Group in North Dorset; work with the Local Authority to improve domiciliary care; providing a focus on the wider determinants of public health; an Urgent Care Centre in Weymouth which prevented 30k of admissions to Dorset County Hospital (DCH); development of a frailty team including support for end of life care plans; development of GP access 7 days per week; enhanced intermediate care solutions (including a Community, Physical and Mental Health Hub in Bridport); and work beyond social care with recognition through local planning for key worker housing. Sally O'Donnell, Locality Director Dorset HealthCare, reiterated the value of the integrated work which had already started, which is building the infra-structure ahead of the planned changes associated with the CSR.

The benefits of the CSR to the wider population were felt by the CCG, hospitals, the South West Ambulance Trust and GPs to far outweigh the increase in time taken to get to hospital in emergency situations. It was also felt that any delay in the progression of the CSR would create a real risk to patient care and to funding.

Members highlighted that the question of a referral to the SoS for Health was not a criticism of the professionalism of people working in health services.

<u>Acute Hospital Services</u>
Patricia Miller, Chief Executive Dorset County Hospital (DCH), emphasised the support from her Trust for the proposals and noted that there would not be enough money in the system without the changes. DCH saw the retention of A&E and trauma services and the development of integrated community and primary care hubs as critical, and welcomed the announcement made by the CCG regarding the retention of maternity and paediatric services. The Chief Executive committed to making sure that any changes would deliver the best outcomes for Dorset residents.

Paul Miller, Director of Strategy Poole Hospital, also noted that the proposed changes to Poole Hospital were fully supported by the Hospital itself. He noted that it had taken 5 years to reach this point and implementation of the changes would take another 4-5 years. In addition to other views expressed, Poole Hospital also felt that the review could not afford a delay from a referral to the SoS for Health. There was still lots of opportunity for further detailed discussion on changes, but the national funding was not available indefinitely and progress needed to be made to enable an exciting future for Poole Hospital.

<u>Financial Plan</u>
The Financial Plan was part of the wider Sustainability and Transformation Plan and Clinical Services Review decision making process. Assurance had been given by NHS England through the process for securing national funding of £147 for the transformation of services in Dorset. The Plan would continue to be developed through investment into community, primary care and mental health whilst managing the reconfiguration of acute provision.

<u>Reduction in Acute Beds</u>
Bed movements were explained as part of the focus to increase care in people's

homes and in the community through integrated services, and avoid people entering the acute hospital setting. Planned Hospitals would then work to reduce patient time spent in hospital, and result in less need for beds from 1810 to 1632. The situation was more complex for Emergency Hospital settings, but was part of the whole picture of what bed shape would be needed for the future.

Equality Impact Assessment (EqIA)
The CCG had considered the variance of needs across all protected characteristics, and geography of Dorset, through clinical teams and through sense checking through a Patient, Carer and Public Group, which considered the clinical design and data. Other wider groups were also involved in the process for sense checking. Feedback was fed into the formal EqIA through an independent review and workshop with groups. The EqIA would continue to develop and was treated as a live document at the heart of CSR. Moving forward there would be a Patient Group with an independent Chairman to provide an assurance role in addition to the formal scrutiny process.

Concern about the 'minimal impact' conclusions of the EqIA not reflecting the issues within the document was raised, to which the CCG indicated that the document would be further developed to reflect issues about travel times; impact on rural and deprived areas; child poverty; disabled travel arrangements; teenagers access from Weymouth and Portland; and cuts to public transport.

It was explained by the CCG that existing services would have similar impacts to those detailed in the EqIA. There were a difficult set of issues faced and the CSR would seek to improve outcomes through the proposals around acute and community provision, but would not be able to resolve every issue.

Cllr Jon Orrell, County Councillor for Weymouth Town, addressed the Committee as a local councillor and as a GP to express his view that there needed to be sustainable change through Prevention at Scale to ensure community integration of health and social care. He explained that the need for ongoing savings had previously resulted in community services being diminished after a reduction in hospital beds. He also expressed the need for health organisations to recognise and have regard to the democratic process when reviewing services. Dr Forbes Watson, as the Chairman of Dorset CCG, refuted the claims made by Cllr Orrell and attention was drawn to the plan explained in detail at the meeting, which was leading wider influence on NHS systems and would impact on provision beyond Dorset across the Country. He also confirmed that the plan constantly responded to change and could be modified to meet demands and needs.

Recognition was given to the need to ensure the best use of assets through facilities and buildings to best serve Dorset. The focus of the CSR was repeated by the CCG, that it would provide what was best for the general public and what was in the best interests of patients. Original proposals looked at acute provision differently in relation to locations of emergency and planned hospitals, but through the extensive review process the proposals had been changed and refined, through testing and assessment of sites to provide a model which was the most sustainable for Dorset. The £147m funding from the NHS would also allow reconfiguration to take place through the best utilisation of assets.

In relation to the impact across Dorset, and on DCH in particular, if Poole Hospital was to retain A&E and major trauma services, it was explained that although there would not be a downgrading of DCH there would need to be consideration given to the services that had been reserved for DCH as it was not possible to keep all services at all sites.

At the end of the debate the Chairman summarised the areas considered throughout

the meeting including the contributions from professionals and health partners, and that a decision was needed based on service provision for the whole of Dorset, not just Bournemouth and Poole. He explained that in his view the continuation of a referral to the SoS for Health did not meet the necessary criteria for referrals and proposed an additional recommendation, subject to the referral to the SoS for Health not being progressed, to support the JHSC's resolution regarding the joint scrutiny of the capacity and performance of ambulance services. A further request was made to include detailed scrutiny of transport arrangements related to the changes.

On being put to the vote, the Committee voted to not progress the referral to the SoS for Health, and agreed the additional recommendation above.

Resolved
1. That the presentation by NHS Dorset Clinical Commissioning Group be noted;
2. That the outcome of the Joint Health Scrutiny Committee meeting held on 12 December 2017 be noted;
3. That, in light of the further information that has been provided and developments that have taken place, the Committee do not proceed with a formal referral to the Secretary of State for Health; and,
4. That the Joint Committee's resolution that some detailed (joint) scrutiny work around the capacity and performance of the ambulance service be supported, and detailed scrutiny of transport arrangements related to the changes would also be undertaken.

Questions from County Councillors

52 No questions were asked by members under Standing Order 20.

Meeting Duration: 9.30 am - 1.05 pm

Public Questions and Statements for the Dorset Health Scrutiny Committee on 20 December 2017

Questions

1 Question from Deborah Monkhouse, a Swanage Resident

Decision regarding dangerous travel times for many DCC residents

Dorset Health Scrutiny Committee voted unanimously on 13th November to unilaterally refer the CCG plans to the Secretary of State. Much of the discussion that day concerned the dangerously long times that it will take for many DCC residents to access A&E and Maternity if these services are no longer provided at Poole.

The need to make an independent decision was noted on 13th November, as it was not expected that Joint Health Scrutiny Committee could fully represent DCC residents, who, I feel, are the 'losers' in these plans. At JHSC on 12th December, Bournemouth and Hampshire voted against referral. The only voting Poole Councillor supported referral. One of the DCC representatives is the Chair, and did not vote. The decision was lost by just one vote.

Royal Bournemouth Hospital has not got any closer since the 13th of November. The CCG acknowledged, in their presentation on 29th November, that the blue light time from Purbeck to RBH is 57 minutes, and does not include the time it takes for the ambulance to come. It is clear residents will not be able to access A&E and Maternity services at the Major Emergency Hospital within the golden hour, let alone within the 30-45 minutes identified by Steer Davies Gleave as 'safe' travel times in maternity emergency, acute stroke and major trauma. Over 8,000 Purbeck residents were worried enough about this issue to sign a hard copy petition to Save Poole A&E and Maternity.

It is suggested Purbeck residents go to Dorset County. The blue light time is 46 minutes, 8 minutes longer than the current journey to Poole. If the ambulance response target of 8 minutes is added, we are up to 54 minutes. Purbeck residents can not get to DCH within safe times for major trauma, acute stroke or maternity emergency, and have just 6 minutes to call the ambulance and get the patient on board if we are to arrive within the 'golden hour'. Dorset County will not have the range of services available at the Major Emergency Hospital, and an A&E Dr has said they are operating at almost twice capacity and can not cope with any more.

The CCG seemed to assert at JHSC that the time it takes to get to Hospital is irrelevant. If this is true, why have blue light ambulances? There is solid research for the 'golden hour' in trauma, and demonstrating that every minute counts in a number of critical conditions that can not be treated in the ambulance, including stroke, heart attack, the types of cardiac arrest not susceptible to defibrillation, septicaemia and meningitis. Ambulances do not carry blood so can not treat haemorrhage in trauma or maternity emergency.

There is just one Dorset Neo Natal service: if this is moved from Poole, where it is now, to RBH, many Mums with premature deliveries under 32 weeks will face journeys of at least double recommended 'safe' travel times in maternity emergency.

If the Committee is not confident that DCC residents will be able to access life saving and maternity services within a reasonable timescale in an emergency, please could you affirm your decision to refer the plans to downgrade Poole A&E and close Poole Maternity to the Secretary of State for Independent Review?

The answer to questions 1, 2 and 3 is provided after question 3

2 Question from Avril Harris, a Swanage resident and Swanage Town Councillor

The Major Emergency Hospital should be at Poole

There is considerable opposition to the loss of A & E and Maternity Services at Poole from residents, councils and organisations.

36,910 residents signed petitions to Save Poole A&E and Maternity services.

Poole is uniquely located to enable residents across Dorset, including in more remote 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 has 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 a year against expected running costs. At JHSC the CCG implied funding would be lost if the MEH moved to Poole. Yet funding was allocated in June, before the CCG chose the MEH site.

At JHSC the CCG were asked why RBH was chosen. The 50,000 people living in West Hampshire were mentioned, yet they have good access to Southampton Hospital, and are a fraction of the Dorset residents negatively affected by the loss of services at Poole. Hospital 'footprints' were mentioned but lack of detail regarding whether the Poole St Mary's site was included, or how far up it was possible to build there, made genuine scrutiny impossible.

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 and major trauma.

Poole has a long track record in successful A&E and Maternity care whereas the last Care Quality Commission report on Bournemouth was very critical. 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, which is limited to treating the following (CCG definition):
"Sprains and strains, broken bones, wound infections, minor burns and scalds, minor injuries to the head and torso, insect and animal bites".

Poole also faces closure of 407 of its 654 beds, a cut of two thirds.

If Dorset Health Scrutiny Committee thinks residents deserve the best access to emergency and maternity services, and beds, within safe times, please would you confirm your decision to refer deficiencies in the CCG's plans to the Secretary of State for review by the Independent Reconfiguration Panel?

The answer to questions 1, 2 and 3 is provided after question 3

3 Question from Steve Clarke, Corfe Castle Parish Councillor

The proposed CCG strategy for Clinical Services is based on improving support in the community so that less people have to go to hospital in the first place, and patients can leave hospitals more quickly, which we all support.

The lengthy presentations given to members at the recent JHSC gave no hard evidence that plans and finance were in place to achieve this revolution in patient care. Indeed one CCG presenter, Dr Haines, talked of the need for wholesale changes in society, including in the education system, to achieve this revolution: clearly this is a 10-20 year aspiration.

As a reminder Dorset CCG need to recruit at least 900 community staff, as there are 230 current vacancies and 670 staff needed for the new services. The assumed reduction in acute beds is one third of forecast demand: that is 800 beds less than we are expected to need.

Failure at community level would cause a huge shortage in hospital beds for Dorset residents. The CCG finance document submission to NHS England states:

"All acute hospital savings are based on a 25% reduction in acute admissions, so acceleration of acute hospitals revenue savings will require an acceleration of community transformation, otherwise the system will be extremely challenged because of the assumed acute bed reductions."

The words "extremely challenged" are those of the CCG, and are a well known administrator's code word for anticipated failure.

Referral to the Secretary of State would highlight the need for the radical changes that are needed for the Community Services to work: a huge recruitment drive, training programme, proper funding of community services and remuneration of staff: some of these changes require a national response.

While the Secretary of State deliberates the CCG should be asked to work on a coherent and transparent community services plan for Dorset.

Will Dorset County Council Health Scrutiny Committee please uphold its unanimous decision to unilaterally refer these plans to the Secretary of State for review by the Independent Reconfiguration Panel?

The answer to questions 1, 2 and 3 is provided after question 3

Answer to Questions 1, 2 and 3
Provided by the Chairman, Cllr Bill Pipe

Thank you for your questions, all three of which remind the Committee of the concerns which people have about the proposed re-location of major A&E and maternity services from Poole to Bournemouth and the CCG's intention to deliver more health services in the community. The questions specifically request that Dorset Health Scrutiny Committee members confirm the decision taken on 13 November to refer these matters, and other concerns, to the Secretary of State for Health, for review.

At today's meeting we will receive a presentation from the CCG and partner organisations, and will discuss developments since 13 November, before considering how to proceed. As a result of the vote by Dorset's Committee, an additional meeting of the Joint Health Scrutiny Committee was held on 12 December. It was important to seek the views of the Joint Committee Members, respecting governance arrangements, but also acknowledging that the individual Local Authority Committees retain the power to make a referral to the Secretary of State.

At the meeting on 12 December a majority of the Joint Committee Members did not support Dorset's decision, but they recognised the strength of feeling and the concerns that were raised and recommended that additional joint scrutiny of ambulance services should be undertaken to look in detail at capacity and performance.

Today's further meeting of the Dorset Committee provides an opportunity to review the CCGs' response to all the concerns, to hear the evidence that will be presented and to consider whether it is appropriate to continue with a referral to the Secretary of State. Informal advice has been sought from the Independent Reconfiguration Panel to establish their initial view as to whether the Dorset Committee would have a valid case. The IRP's response was that "referral to Secretary of State is a last resort and should only be exercised once all other options have been exhausted." Given the CCG's willingness to continue to engage with both the Dorset and Joint Health Scrutiny Committees, and their particular acknowledgement of the need for on-going work on matters relating to travel and the Equality Impact Assessment, we would need to be absolutely sure that a referral is justifiable and beneficial to all Dorset's residents.

Statements

4 Statement from Philip Jordan

CSR from a Services Review/er, as well as Patient etc, perspective

Good Morning All – particularly Members, who have a vital task today ref

The *"Expectation that efforts have been made to resolve matters*
Locally before a referral is made"

As a retired Professional – with decades of experience including Services Reviews:
I've followed this one from it's public launch & see your just outlined task today as
un-resolvable by you ref e.g. SE Conurbation Hospitals duo after last week's JHSC
&/or DCH* v YDH's 24/7 Access to Consultant led M&P
i.e. whilst welcoming CCG's CEO's statement just prior
to this Mtg's start, I don't know the important detail

CSR DECISIONS = FLAWED RE WHAT VALUE'S CARE, IF ONE CAN'T ACCESS IT?
& LACKS LIKE: WHERE people/patients live? & HOW they get about? &/or
RURAL-PROOFING (Despite inclusion in Consultation Responses)? EQUITABILITY?
LISTENING/LEARNING & RELATED ACTION!

*& going back to DCH where staff & patients have been confronted by unfinished
business ref 24/7 M&P's indeterminate future & continuing deleterious stress levels
for both staff, & patients/families/colleagues etc: Despite this, under capable Leader
-ship (as the link below shows) remarkable advances are happening at DCH like
lung disease patients being treated @ home = better for patients, & NHS budget!
Remember this is happening now in this amazing hospital - despite fears etc above!
http://www.dorsetecho.co.uk/news/15740207.Scheme_where_hospital_lung_disease_patients_are
_treated_at_home_praised_by_national_charity/

5 Statement from Stephen Bendle, resident of Weymouth

The major issues concerning local people are the future of NHS hospital provision in Dorchester, Poole and Southampton.

Community beds may be a more minor issue but have great importance to local people. The loss of 16 beds at Portland Community Hospital would be a major blow to the Island, isolating it further and adding further disadvantage to an already disadvantaged population. We would ask that the Scrutiny Panel reaffirms its decision to refer to the CCG's Plan to the Secretary of State and that the referral makes specific mention of the proposal to close Portland's community beds, a proposal that conflicts with

- the CCG's own statements that "care closer to home gives us the best opportunity to improve services and patient outcomes"
- the decision to retain a 16-bed unit at Swanage, even though Portland's 16 beds are said to be too few for viability
- the Government's rural-proofing policy which while, not strictly applicable to Portland, is relevant given its isolation and limited and time-consuming transport connections
- the CCG's statement that total community beds will *increase* (by 69)
- the CCG's intention that "clarity about the function and purpose of each community hospital will only emerge going forward" which is only possible if the 16-beds remain available during this emergent period.