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.