DCC Task and Finish Group re Clinical Service Review, 18 September 2018			
	Area of concern	**Question**	**Response**
1	Assertion that 60 lives would be saved per year	The CCG's documentation suggests that 60 lives per year will be saved via the proposed new model for services. What was the source of evidence for this assertion and is the CCG confident that this benefit would be realised in rural Dorset?	On January 18 2013, NHS Medical Director Professor Sir Bruce Keogh announced a comprehensive review of the NHS urgent and emergency care system in England. The review drew on the experience of patients and all professionals in the NHS and across social care. The 60 additional lives saved is our considered estimate based on the recommendations in Sir Bruce Keogh's* report at the time it was published. The Clinical Services Review documentation set out many benefits in terms of outcomes for patients, workforce and finance. Further work being done on the patient benefits of the proposed merger between Royal Bournemouth and Poole hospitals and the creation of the major emergency and planned hospitals is now providing more details. For example, the patient benefits case estimates that 750 patients per year will have shorter waits for treatment with a reduced length of stay for the 400 of these who will require interventional treatment. This alone will save an estimated 11 to 21 lives per year for patients with heart conditions. Consolidation of acute stroke services at Bournemouth Hospital would lead to quicker access to the review of strokes by consultant doctors, higher nurse to patient ratios and improved specialist staffing levels, which would save more lives. There will be improved quality care for A&E patients because they will receive consultant-delivered care for more hours of the day. There will be significantly improved facilities for maternity services. All these factors mean that there would be many lives saved in our opinion. *Please see draft summary patient benefits case report.*

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

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

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

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

		percentages are particularly high in respect of maternity)	For example: • The time by car from Swanage to Poole Hospital is 37mins (20 miles) and • from Swanage to Dorset County Hospital it is 45mins (29 miles). • Therefore, the difference in travel time by car is 8 minutes and by blue light ambulance 5 ½ mins. The majority of women from Purbeck already go to Dorset County Hospital to have their babies. Last year, 52.8% (133) of mums registered with GPs in Purbeck had their babies at DCH compared with 47.2% (119) at Poole Hospital. Many mothers are already travelling from Bournemouth to Poole as the biggest group of women giving birth at Poole Hospital live in the Bournemouth area. The CSR decision will avoid some 170 mothers a year who arrive at RBH at the start of their labour and then for clinical risk factors as the labour progresses are transferred from RBH to Poole during the later stages of labour. It should also be considered that there will be greater support for women who choose to have their babies in the community or at home.
8	Total journey times to hospital	Does the CCG acknowledge that the inclusion of data relating to travel time by Bournemouth residents skewed the average journey times, to the detriment of residents of places like Purbeck and North Dorset? Why was there so much focus on additional journey time, rather than total journey time?	We looked at travel times at all levels – from the largest geographical ward to the smallest - and the travel time to each acute hospital depending on the scenario. Any focus on additional travel times has been in response to information circulated by the claimant in the judicial review and other commentators. The CCG's focus was primarily on total travel times. Please refer to the JR judgement in which Sir Stephen Silber states:' Mr Coppel (claimant's QC) contends that the CCG did not consider "outliers" which were said to be "namely those patients who would be most seriously affected by increased journey times". I do not accept that criticism as the SWAST report refers to the maximum travel times for adult patients and children and that would include outliers. Nothing has been put forward to show that "outliers" were not considered in the SWAST report (par 140)

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

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

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

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

	community hospital beds	community beds close? (Including support for end of life care for example, when individuals have little or no family around them)	All partners in the Our Dorset Integrated Care System, which includes Dorset County Council, have agreed to a multi-million-pound investment which the CCG will fund to enable people across Dorset get more care closer to home. The agreement will see £3m being invested this financial year (2018/19) with £6.5m full year effect in 19/20 and an additional £6.5m in 20/21. The money will be invested in a number of areas from September 2018, including • More healthcare professionals working in primary and community teams (to support people with complex needs; • Supporting people with diabetes or respiratory conditions; • Employing more community based pharmacists; • End of life care and support to people in local residential and nursing homes. As part of this, there will be an increase of approximately 140 community and primary care staff because of this investment. Dorset Healthcare will be employing over half of these staff. This investment is as a direct result of the CSR decision and is part of the implementation roll out.
12	Community staff	Everyone agrees on the need for better community services, but the staff do not currently exist. How will the required staff be recruited and retained?	There is a comprehensive staff recruitment and retention programme under the Our Dorset Workforce Delivery Plan. Recruiting additional staff to work in community and primary services is the priority under this programme and will include the 140 staff mentioned in the previous response to question 11.
13	Closure programme for community beds	What confidence can be placed in the statements that facilities will not be closed before alternative provision is in place, in light of the recent closures at St Leonards Hospital and Portland?	In terms of the examples provided alternative provision is in place as follows: Beds have been opened and staffed at Westhaven Community Hospital in Weymouth to allow for the closure of those on Portland. 22 beds from Fayrewood ward at St Leonards Hospital are being transferred to ward 9 at the Royal Bournemouth Hospital at the end of October.

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

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

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