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Agenda

Dorset County Council

Meeting:	Dorset Health Scrutiny Committee
Time:	2.00 pm
Date:	17 October 2018
Venue:	Committee Room 1, County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ

Bill Pipe	Dorset County Council
Kevin Brookes	Dorset County Council
Ray Bryan	Dorset County Council
Beryl Ezzard	Dorset County Council
Nick Ireland	Dorset County Council
David Walsh	Dorset County Council
Alison Reed	Weymouth & Portland Borough Council
David Jones	Christchurch Borough Council
Peter Oggelsby	East Dorset District Council
Bill Batty-Smith	North Dorset District Council
Tim Morris	Purbeck District Council
Peter Shorland (Vice-Chairman)	West Dorset District Council

Notes:

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- **Public Participation**

  Guidance on public participation at County Council meetings is available on request or at http://www.dorsetforyou.com/374629.

  Public Speaking

  Members of the public can ask questions and make statements at the meeting. The closing date for us to receive questions is 10.00am on 12 October 2018, and statements by midday the day before the meeting.

Debbie Ward
Chief Executive

Date of Publication:
Tuesday, 9 October 2018

Contact: Denise Hunt, Senior Democratic Services Officer
County Hall, Dorchester, DT1 1XJ
01305 224878 - d.hunt@dorsetcc.gov.uk

1. **Election of Chairman**

To elect a Chairman of the Committee for the remainder of the year 2018/19.

2. **Apologies for Absence**

To receive any apologies for absence.

3. **Code of Conduct**

Councillors are required to comply with the requirements of the Localism Act 2011 regarding disclosable pecuniary interests.

- Check if there is an item of business on this agenda in which the member or other relevant person has a disclosable pecuniary interest.
- Check that the interest has been notified to the Monitoring Officer (in writing) and entered in the Register (if not this must be done on the form available from the clerk within 28 days).
- Disclose the interest at the meeting (in accordance with the County Council's Code of Conduct) and in the absence of a dispensation to speak and/or vote, withdraw from any consideration of the item.

The Register of Interests is available on Dorsetforyou.com and the list of disclosable pecuniary interests is set out on the reverse of the form.

4. **Minutes** 5 - 10

To confirm and sign the minutes of the meeting held on 15 June 2018.

5. **Public Participation**

(a) Public Speaking

(b) Petitions

6. **Appointments to Committees and Other Bodies** 11 - 14

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

7. **Report regarding the work of the Dorset Health Scrutiny Committee Task and Finish Group Re: Clinical Services Review** 15 - 56

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

8. **Integrated Urgent Care Service** 57 - 58

The Deputy Director of Service Delivery, NHS Dorset Clinical Commissioning Group will provide a verbal update and answer any questions regarding progress with the implementation of a new Integrated Urgent Care Service.

9. **Integrated Care System: Primary Care Transformation Programme Review and Evaluation** 59 - 84

To consider a report by the Head of Primary Care of the NHS Dorset Clinical Commissioning Group (attached).

10. **Glucose Monitoring Device for Individuals with Diabetes** 85 - 92

To consider a report by the NHS Dorset Clinical Commissioning Group (attached).

11. **Forward Work Programme** 93 - 94

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

12. **Briefing for Information - Maternity and Paediatric Services at Dorset County Hospital NHS Foundation Trust** 95 - 102

To consider a report by the Chief Executive of the Dorset County Hospital NHS Foundation Trust (attached).

13. **Briefing for Information - Repatriation of Activity from Bridport Hospital to Dorset County Hospital** 103 - 110

To consider a report by the Chief Operating Officer of the Dorset County Hospital NHS Foundation Trust (attached).

14. **Liaison Member Updates**

To consider any updates from the liaison member for the following;

- Dorset County Hospital NHS Foundation Trust.
- Dorset Healthcare University NHS Foundation Trust
- NHS Dorset Clinical Commissioning Group
- South Western Ambulance Service NHS Foundation Trust

15. **Questions from Councillors**

To answer any questions received in writing by the Chief Executive by not later than 10.00am on 12 October 2018.

16. **Glossary of Abbreviations** 111 - 112

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Dorset County Council

Dorset Health Scrutiny Committee

Minutes of the meeting held at County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ on Friday, 15 June 2018

Present:
Kevin Brookes, Ray Bryan, Beryl Ezzard, Paul Kimber, Nick Ireland, David Jones, Bill Batty-Smith, Tim Morris and Peter Shorland

Other Members: Cheryl Reynolds, reserve member for West Dorset District Council, attended the meeting as an observer.

Officers Attending: Ann Harris (Health Partnerships Officer), Jonathan Mair (Service Director - Organisational Development and Monitoring Officer), Matthew Piles (Service Director - Economy, Natural and Built Environment) and Denise Hunt (Senior Democratic Services Officer).

Others in Attendance:
Diane Bardwell, Dementia Services Review Project Manager, Dorset CCG)
Des Persse (Executive Director, Healthwatch Dorset)
Phil Richardson (Dorset CCG)
Eugine Yafele (Chief Operating Officer, Dorset Healthcare University NHS Foundation Trust)

(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 on **Wednesday, 17 October 2018**.)

Apologies for Absence

14 Apologies for absence were received from Councillors Peter Oggelsby, Bill Pipe, Alison Reed, Steven Lugg and Helen Coombes (Transformation Programme Lead for the Adult and Community Forward Together Programme). Councillor Paul Kimber attended the meeting as a substitute for Councillor Alison Reed.

Election of Chairman

15 **Resolved**
That the election of Chairman be deferred until the next meeting.

Appointment of Vice-Chairman

16 **Resolved**
That Peter Shorland be elected as Vice-Chairman for the 2018/19 year.

Code of Conduct

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

Peter Shorland declared a general interest as a Governor of Yeovil Hospital. As this was not a disclosable pecuniary interest he remained in the meeting and took part in the debate.

David Jones declared a general interest as he was previously a Governor of Poole Hospital NHS Trust, but had now ceased in that role. As this was not a disclosable pecuniary interest he remained in the meeting and took part in the debate.

Kevin Brookes declared a general interest as a Governor of Dorset County Hospital. As this was not a disclosable pecuniary interest he remained in the meeting and took part in the debate.

Ray Bryan declared a general interest as a Governor of the Dorset Healthcare University NHS Foundation Trust. As this was not a disclosable pecuniary interest he remained in the meeting and took part in the debate.

Terms of Reference

18 Members received the Terms of Reference for the Committee.

Noted

Minutes

19 The minutes of the meeting held on 8 March 2018 were confirmed and signed, subject to the following amendment:-

Minute 6 - Joint Health Scrutiny Committee Re: Clinical Services Review and Mental Health Acute Care Pathway Review - Update
That the Task and Finish Group "would ask for submissions, including from the public, *Defend Dorset NHS* and Healthwatch".

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

20 The Committee considered an update following its decision to set up a Task and Finish Group to assess the evidence in respect of a referral to the Secretary of State for Health in relation to the Clinical Service Review (CSR) proposals.

The report was introduced by the Monitoring Officer who advised that the Task and Finish Group had met on 1 May 2018 when it had been reported that the grounds of the Judicial Review (JR) brought against the Dorset Clinical Commissioning Group's (CCG's) decision overlapped with the terms of reference of the Task and Finish Group and could override any outcomes of the Group.

He explained that, if the Judge determined that the CCG's decision making was flawed, the Court would direct the CCG to correct any errors. This would eliminate the need for a referral to the Secretary of State for Health as the CCG would be required to submit new proposals that would be scrutinised by the Committee. If the Court decided that there was no case to answer and that there was no fault in the proposals, then a decision to refer the matter to the Secretary of State may also be rejected in light of the Court's decision. The Task and Finish Ground had accepted this position and, in order to avoid duplication of the work of the Court, agreed to defer its next meeting until the outcome of the JR was known.

Members questioned this rationale in light of the reason for investigation of a referral to the Secretary of State for Health being due to the view that the CSR proposals were not "in the interests of the health service in the area". Members also noted that the JR only concerned whether the process had been carried out correctly rather than any faults in the CSR proposals being directly addressed. It was further suggested that the grounds for the hearing may have been more limited than the 7 grounds put forward by the appellant, and therefore any overlapping with the work of the Task and Finish Group should be looked at again.

The Monitoring Officer confirmed that the Council had been supplied with the grounds for the JR by the CCG and that no further information was available. He emphasised that rather than focus on the JR grounds, this was more about outcomes and the options available to the Judge. If the grounds for the JR were accepted then what came out of the process as a replacement proposal could be markedly different and

there would be an opportunity for the Committee to scrutinise the new proposals and refer any concerns to the Secretary of State at that stage. The hearing would take place over the course of 2 days in mid July and the Judge may give a judgement on the day or come back at a later date to provide a more considered judgement, depending on the Judge and the complexity of the case.

As Chairman of the Task and Finish Group, Councillor Ray Bryan explained that the Task and Finish Group had been adjourned until 1 August when the outcome of the JR would be known and that the Group had not stopped its work.

Councillor David Jones stated that the JR would not focus on whether the CSR was the right decision, but whether the correct process had been followed and that continuation of the work of the Task and Finish Group would allow more time to collect evidence from people. He therefore proposed that the work of the Task and Finish Group continue pending the outcome of the JR and this was seconded by Councillor Paul Kimber.

Resolved
That the work of the Task and Finish Group continues pending the outcome of the Judicial Review.

Public Participation

21 Public Speaking

There were public questions received at the meeting in accordance with Standing Order 21(1). A statement was also received from Councillor Bill Trite, County Councillor for Swanage which was read aloud by the Chairman as he was unable to attend the meeting due to a prior commitment. The questions, answers and statement are attached as an annexure to these minutes.

Councillor Tim Morris read aloud the decision of the Purbeck District Council meeting on 12 December 2017 on behalf of the Councillor Gary Suttle, Leader of Purbeck District Council, when it was resolved that "local residents' concerns over the review be acknowledged and supported and the Dorset Health Scrutiny Committee be asked to continue opposing the Dorset Clinical Commissioning Group's Clinical Services Review."

Arising from the concerns raised about ambulance waiting times, the scrutiny of services provided by the South Western Ambulance Service NHS Trust (SWAST) including the ambulance service was being dealt with by another Joint Health Scrutiny Committee that was being co-ordinated by the Borough of Poole. It was agreed that the concerns of the Dorset Health Scrutiny Committee regarding the delay in arranging a second meeting of the Joint Committee would be conveyed.

Petitions

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

Integrated Care System

22 The Committee received a presentation concerning the Integrated Care Systems by the NHS Dorset Clinical Commissioning Group. The presentation had been published with the agenda. It was emphasised that Dorset was one of the top ten areas in the country for progress with integrated care and that this gave greater freedom to develop the partnership work. There would not be a decision about setting up the system as this was a national mandate and decisions would be around how it would work locally, linked to wider plans such as the Sustainability and Transformation Plan.

Members asked about services in their areas and it was confirmed that the approach used started with the assessment of local need in all of the different areas of Dorset,

starting with the provision of services at a person's home. Progress within the different localities could be reported at a future meeting if requested.

Members asked whether the budget was sufficient to implement an Integrated Care System and were informed that nationally £450m had been set aside to support changes. Additional funding had also been granted to Dorset as the changes that were proposed had been viewed in a positive light and Dorset was one of three areas that had been awarded funding of £7.5m to move forward digital work with Hampshire.

In terms of the CSR, £147m of funding had been allocated for the capital costs associated with Bournemouth and Poole Hospitals, representing almost a half of the entire national funding pot. An offer was made for members of the Committee to visit facilities and talk to staff members on the ground, if this would be of interest.

Councillors were viewed as having a significant role to play in explaining the changes to the public and CCG officers had been liaising with the Leader and Cabinet Member for Health and Care about a collective approach locally.

Noted

Dementia Services Review Update

23 The Committee considered a report by the Dementia Services Review Project Manager of the NHS Dorset Clinical Commissioning Group, that was also the subject of a presentation at the meeting. The CCG had worked with the Dorset Dementia Partnership and the review would focus on supporting people better.

Following the presentation it was confirmed that the strategic outline case would be considered by the committee during the consultation period in the Autumn of 2018.

Members asked about the below average rate of referrals to the Memory Support and Advisory Service from the Weymouth & Portland area and were informed that there was variation across the localities for this and other specialist services and, in this particular instance, could be due to a lack of accurate statistical information.

It was suggested that the relevant helpline numbers were circulated to members of the Committee.

Funding of Admiral Nurses was also discussed and members heard that, although this was an excellent service, it had a specific patented model to upskill professionals and support families and carers, some of which was already provided by the Dementia Service. In addition, Admiral nurses were unable to support people with no family or carers, leaving a gap in care for this vulnerable group. The employment of Admiral Nurses was expensive and this money could be used in a better way to employ dementia co-ordinators that could support people from diagnosis to end of life care.

It was confirmed that representatives of the Dementia Service accepted invitations to speak to groups.

Noted

Integrated Transport Programme - Update Report

24 The Committee considered a report by the Service Director - Economy, Natural and Built Environment providing an update on the Integrated Transport Programme (ITP). He updated members on the recent Inquiry Day and work with communities to inform residents of services, integrated planning of transport services, the implementation of community schemes to allow access to health services and green travel plans to

address parking at the acute hospitals. The vision and challenge would be to have an integrated transport system for the new Dorset Council.

Members commented on the development of a multi-storey car park at Yeovil Hospital to address parking issues and asked about the timeline for implementation of some of the transport proposals.

The Service Director advised that use of the Local Authority's fleet and green transport plans to alleviate parking at acute hospitals were two of the areas currently being investigated. It was anticipated that a review over the next 12 months would put in place an integrated solution followed by pilot projects in some local areas.

There was an overall aim to increase the use of local buses to make them commercially viable and sustainable. The concessionary fare scheme was also being challenged both nationally and regionally as bus companies received a higher payment for urban than rural services.

An update to the Committee would be provided in 6-12 months' time.

Noted

Dorset HealthCare University NHS Foundation Trust Care Quality Commission (CQC) Inspection Outcome Report

25 The Committee considered a report by the Chief Operating Officer of the Dorset Healthcare University NHS Foundation Trust presenting the Care Quality Commission (CQC) 2017 inspection outcome report findings for the Trust. The Trust's overall rating had improved from "required improvement" to "good"

This was the second comprehensive inspection by the CQC and the report had also highlighted the three areas where the regulations had been breached that had contributed to the judgement of requiring improvement in the area of safety.

The issue of numbers of mental health beds was being addressed through the acute care pathway, with additional beds having been made available at Forston Clinic recently and there were more planned for the East of Dorset over coming months.

Noted

Appointments to Committees and Other Bodies

26 The Committee considered a report further to a review of appointments by the Committee on 8 March 2018. Since the last meeting a vacancy for a reserve member had arisen on the Joint Health Scrutiny Committee on the NHS 111 Service provided by the South Western Ambulance Service NHS Foundation Trust (SWAST) as the appointed person was no longer a member of the Dorset Health Scrutiny Committee.

Resolved

That Kevin Brookes be nominated as the reserve member on the Joint Health Scrutiny Committee for the NHS 111 Service provided by SWAST - future remit to include emergency transport provision.

Forward Work Programme

27 The Committee noted its work programme.

A report by the Task and Finish Group (Clinical Services Review) would be included in the regular agenda item on the "Clinical Services Review and Mental Health Acute Care Pathway Review - Update".

Briefings for Information/Noting

28 The Committee considered a report containing briefings for information concerning the responses to Annual Quality Accounts for

- Dorset County Hospital NHS Foundation Trust
- Dorset Healthcare University NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust.

The second briefing contained notes following a visit to the Melstock and Waterston Units at Forston Clinic, Charlton Down by the Quality Account Panel aligned to the Dorset Healthcare University NHS Foundation Trust.

Noted

Liaison Member Updates

29 Nick Ireland had attended a Dorset Healthcare NHS Trust Board meeting at the end of May 2018 and reported on the budget, the appointments of a new Medical Director and Head of Nursing, major issues in recruiting and retaining staff and the closure of the final ward of St Leonards Hospital in September 2018 with staff moving to the Royal Bournemouth Hospital in line with TUPE Regulations. There was a budget underspend for the current financial year, but areas of overspend due to higher out of area placements in mental health and the Trust would therefore struggle to meet its overall savings targets. Although there had been an increase in the number of beds at Forston Clinic and the suggestion of building a new unit at Forston, overall there were less mental health beds in the west of the County and more in the conurbation.

Reports presented by Peter Shorland, Liaison Member for Dorset County Hospital and Beryl Ezzard, Liaison Member for SWAST were based upon the meetings relating to the Quality Accounts Panels and reflected in the item on Briefings for Information.

Glossary of Abbreviations

30 The glossary had been provided for information.

Questions from County Councillors

31 There were no questions submitted under Standing Order 20 (2).

Meeting Duration: 10.00 am - 1.10 pm

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	17 October 2018
Officer	Helen Coombes, Transformation Programme Lead for the Adult and Community Forward Together Programme
Subject of Report	**Appointments to Committees and Other Bodies**
Executive Summary	The Dorset Health Scrutiny Committee appoints members on an annual basis to additional Joint Committees, Task and Finish Groups and Liaison roles. These appointments were reviewed by the Committee on 15 June 2018, but a further vacancy has now arisen. The position to which an appointment needs to be confirmed is: • The Joint Health Scrutiny Committee relating to the NHS 111 service and ambulance services provided by South Western Ambulance Service NHS Foundation Trust;
Impact Assessment:	Equalities Impact Assessment: Not applicable
	Use of Evidence: Not applicable.
	Budget/ Risk Assessment: Not applicable.
Recommendations	The Committee is asked to confirm appointments and/or appoint new members to the bodies as set out in the Appendices to this report.

Reason for Recommendations	The Committee supports the County Council's aim to help Dorset's citizens to remain safe, healthy and independent.
Appendices	1 Current Appointments to Committees and Other Bodies, with vacancies in italics.
Officer Contact	Name: Ann Harris, Health Partnerships Officer Tel: 01305 224388 Email: a.p.harris@dorsetcc.gov.uk

Appendix 1

Appointments to Committees and Other Bodies (as at Sept 2018)

Committee/Panel Name	Members Appointed
Joint Health Scrutiny Committee on the NHS Dorset Clinical Commissioning Group Clinical Services Review	• Bill Pipe • Bill Batty-Smith • Nick Ireland • David Jones (Reserve) • Alison Reed (Reserve)
Joint Health Scrutiny Committee on the NHS 111 Service Provided by South Western Ambulance Service NHS Foundation Trust – Future remit to include emergency transport provision	• Beryl Ezzard • Peter Oggelsby • ***Vacancy*** • Kevin Brookes (Reserve)
Quality Accounts Panel for Dorset County Hospital NHS Foundation Trust	• Bill Pipe • Bill Batty-Smith
Quality Accounts Panel for Dorset Healthcare University NHS Foundation Trust	• Bill Pipe • Bill Batty-Smith
Liaison Member Roles	
Dorset County Hospital NHS Foundation Trust	• Peter Shorland
Dorset Healthcare University NHS Foundation Trust	• Nick Ireland
NHS Dorset Clinical Commissioning Group	• Bill Pipe
South Western Ambulance Service NHS Foundation Trust	• Beryl Ezzard

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	17 October 2018
Officer	Helen Coombes, Transformation Programme Lead for the Adult and Community Services Forward Together Programme
Subject of Report	**Report regarding the work of the Dorset Health Scrutiny Committee Task and Finish Group Re: Clinical Services Review**
Executive Summary	A Joint Health Scrutiny Committee was convened in July 2015 in response to the undertaking of a wide-ranging Clinical Services Review (CSR) by NHS Dorset Clinical Commissioning Group (CCG), which officially commenced in October 2014. The remit of the Committee was subsequently expanded to cover a Mental Health Acute Care Pathway (MHACP) Review, running separately but in parallel to the CSR. Although it is the Joint Committee's role to receive reports from and make recommendations to the CCG, the individual local authority members (Bournemouth, Dorset, Hampshire and Poole) retained the power to make referrals to the Secretary of State for Health and Social Care locally. This report provides an update following the decision made by Dorset Health Scrutiny Committee on 8 March 2018 to set up a Task and Finish Group to review whether there is a case to make a referral to the Secretary of State for Health and Social Care, with regard to some of the changes agreed by the CCG within the CSR.
Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Reports and summaries prepared for the Task and Finish Group; minutes of Task and Finish Group meetings.

	Approved Judgement from Sir Stephen Silber, High Court of Justice, 5 September 2018
	Budget: Not applicable.
	Risk Assessment: Current Risk: LOW Residual Risk: LOW
	Other Implications: None.
Recommendations	1 That the CSR proposals are not referred to the Secretary of State for Health and Social Care. 2 That the Joint Health Scrutiny Committee hosted by the Borough of Poole to undertake the work requested in relation to the ambulance service be convened as soon as possible. 3 That the Joint Health Scrutiny Committee hosted by Dorset County Council to scrutinise the implementation of the Clinical Services Review decisions be reconvened as soon as possible.
Reason for Recommendation	Dorset Health Scrutiny Committee has the power to make referrals to the Secretary of State for Health and Social Care. In the light of the answers received from NHS Commissioners and Providers to questions and concerns, the Task and Finish Group has recommended that there should be no referral. In addition, since the decision was made in March 2018 by Dorset Health Scrutiny Committee to review the possibility of making a referral, there has been an outcome to the Judicial Review launched by a Purbeck resident. Firstly, all the claims brought were rejected and secondly, references by the Judge to the actions of the local authorities and scrutiny committees are highly likely to influence the view of the Secretary of State and the Independent Reconfiguration Panel, were they to be asked to review a referral. Going forwards, dialogue with the CCG must continue and there must be full engagement in the work of the two Joint Health Scrutiny Committees. This should enable Dorset Health Scrutiny Committee members to oversee and influence the future planning, commissioning and operation of Health Services across Dorset.
Appendices	1 Minutes of Task and Finish Group, 4 July 2018 2 Minutes of Task and Finish Group, 22 August 2018

	3 Minutes of Task and Finish Group, 18 September 2018 4 Questions to and responses from NHS Commissioners and Providers, to questions arising from Task and Finish Group meeting on 22 August 2018 5 Summary of the Judgement of Sir Stephen Silber handed down on 5 September 2018 in relation to the Queen on the Application of Anna Hinsull v NHS Dorset Clinical Commissioning Group
Background Papers	Committee papers – Joint Health Scrutiny Committee: http://dorset.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=268 Committee papers – Dorset Health Scrutiny Committee: http://dorset.moderngov.co.uk/mgCommitteeDetails.aspx?ID=142 Judgement: Hinsull v NHS Dorset Clinical Commissioning Group: https://www.judiciary.uk/judgments/hinsull-v-nhs-dorset-clinical-commissioning-group/
Officer Contact	Name: Ann Harris, Health Partnerships Officer, Dorset County Council Tel: 01305 224388 Email: a.p.harris@dorsetcc.gov.uk

Joint Health Scrutiny Committee re Clinical Services Review and Mental Health Acute Care Pathway Review – Update Report regarding the work of the Dorset Health Scrutiny Committee Task and Finish Group

1 Background

1.1 As required by Regulations when a Health body undertakes consultation which involves more than one local authority, a Joint Health Scrutiny Committee was convened in July 2015 in response to the undertaking of a wide-ranging Clinical Services Review (CSR) by NHS Dorset Clinical Commissioning Group (CCG). The Review officially commenced in October 2014. The remit of the Joint Committee was subsequently expanded to cover a Mental Health Acute Care Pathway (MHACP) Review, running separately but in parallel to the CSR.

1.2 The Dorset Health Scrutiny Committee (DHSC) have been provided with updates regarding the progress of the CSR and the work of the Joint Committee at each of their own Committee meetings, and in relation to an update provided on 13 November 2017 a number of questions and statements were submitted under the Public Participation section. These questions and statements expressed concerns about the decisions that had been made by the CCG at their Governing Body meeting on 20 September 2017 and the impact on people who would have to travel further to access A&E and maternity services. The concerns also questioned the planned reduction in hospital bed numbers, the robustness of the EqIA and financial plan and the consultation which had been undertaken. The individuals who had submitted the questions specifically asked DHSC to refer the matter to the Secretary of State for Health and Social Care and, after some discussion, the Committee voted in agreement, pending consideration by the Joint Committee.

1.3 An additional meeting of the Joint Committee was urgently arranged on 12 December 2017, at which the CCG had the opportunity to respond to the concerns (they did not get the opportunity to do so at the DHSC meeting on 13 November). In addition, Members heard support for the CCG's proposals from a range of providers, including the acute hospitals, community health services and general practice. The Joint Committee Members then voted as to whether they wished to support the decision of DHSC: the majority did not support Dorset's decision.

1.4 A further meeting of the Dorset Health Scrutiny Committee was subsequently held on 20 December 2017, at which the CCG again presented their response to the concerns, alongside NHS Provider Trusts and representatives from General Practice. Members discussed the concerns at length before voting against proceeding with the referral, by a majority. They also voted to support a resolution by the Joint Committee that scrutiny of the performance and capacity of local ambulance services should be undertaken through a second Joint Committee, to be hosted by the Borough of Poole.

1.5 On 8 March 2018 an update report to DHSC reiterated the outcome of the Joint Committee meeting on 12 December and the subsequent DHSC meeting on 20 December, at which Members had resolved not to proceed with a referral to the Secretary of State, but to support further scrutiny of emergency transport. However, reflecting the views of public participants at the meeting, some Members felt that the Committee had failed to fully scrutinise the CSR proposals and whether they were 'in the interests of the health service' in the area, and suggested that the decision not to make a referral to the Secretary of State should be revoked. Following discussions, it was agreed that a task and finish group of five Members would be established to

review the evidence on both sides and determine whether the criteria for a referral would be met.

1.6 This report provides an update on the work of the Task and Finish Group to review whether there is a case to make a referral to the Secretary of State for Health and Social Care with regard to some of the proposals for changes agreed by the CCG at their Governing Body meeting on 20 September 2017.

2 Dorset Health Scrutiny Committee Task and Finish Group

2.1 The Task and Finish Group held their first meeting on 1 May 2018, with a view to establishing the scope and context of their work and the process involved in making a referral. In addition, the Group needed to consider the impact and implications arising from the progress of a Judicial Review (JR) which had recently been lodged by a Purbeck resident, and would come before the courts on 17/18 July 2018.

2.2 Following consideration, it was agreed that it would be prudent for the work of the Task and Finish Group to be adjourned until the outcome of the JR was known, given that there were common concerns. However, when the minutes of the meeting of 1 May were presented at full Committee on 15 June 2018, some Members felt that the work should still continue, and that the focus should be on whether the proposals within the CSR were 'in the interests of health services' in Dorset (whereas the JR would focus on the processes underpinning the decision-making undertaken by the CCG). A majority of Members voted for the continuation of the work, and the Task and Finish Group therefore reconvened on 4 July 2018.

3 Task and Finish Group meeting: 4 July 2018

3.1 On 4 July 2018, the Task and Finish Group members reviewed the position of Dorset Health Scrutiny Committee in relation to the JR and noted that it was proceeding on 6 out of 7 Grounds, the exception being the assertion that the 'consultation was so misleading as to be unlawful'[1]. Members considered the context of the CSR and the Sustainability and Transformation Plan, with which it is closely aligned, and noted that the process of implementation for any changes would take many years.

3.2 Members considered the scope of the key concerns which they might wish to review, including emergency travel times, the proposed future location of health services, future acute and community hospital bed numbers, community services and the impact of changes on Adult Social Care provision. It was agreed that key members of the public (including those representing Defend Dorset NHS) and a representative from Healthwatch Dorset would be invited to meet with the Task and Finish Group as soon as possible. (Minutes for 4 July attached at Appendix 1).

4 Task and Finish Group meeting: 22 August 2018

4.1 The Task and Finish Group met with six individuals on 22 August 2018, three of whom were representatives of the campaign group Defend Dorset NHS. The individuals detailed their concerns including: the transfer of services of services from Poole Hospital to Bournemouth Hospital, the proposed future number of inpatient

[1] NB – Following a re-application by the Claimant, the matter of the fairness of the consultation was in fact subsequently dealt with under a 'rolled-up hearing', and judgement on all matters was handed down on 5 September 2018.

beds, capacity and workforce requirements in community services, the perceived risk to people living in the Purbeck area as a result of longer journeys to A&E and maternity services, the loss of beds in community hospitals and the way in which the CSR had been conducted and consulted upon. Evidence which had been collated by the individuals was shared with the Group, including feedback from doctors working in A&E.

4.2 Following the meeting, a list of 19 specific questions was drawn up, which would be submitted to NHS Dorset CCG, South Western Ambulance Service NHS Foundation Trust, Dorset County Hospital NHS Foundation Trust, Dorset HealthCare University NHS Foundation Trust and Poole Hospital NHS Foundation Trust. The commissioners and providers were invited to meet with the Task and Finish Group on 18 September 2018 to respond to the questions. (Minutes for 22 August attached at Appendix 2).

5 Outcome of the Judicial Review: 5 September 2018

5.1 A Judgement regarding the Judicial Review brought against the CCG and the decisions made by their Governing Body on 20 September 2017 was handed down on 5 September 2018[2]. The summary judgement is attached as Appendix 5 to this report but in brief, the Judge rejected all the challenges which had been raised, citing: appropriate actions by the CCG, adequate consideration of options, assurance from NHS England, evidence that an improvement in services would be secured and assurance that the consultation was not unlawful. Application by the claimant for permission to appeal was refused (but has since been appealed itself and is awaiting a decision).

5.2 In addition to setting out in detail the above reasons for rejecting the challenges, the full Judgement also made reference to the actions taken by the Joint Health Scrutiny Committee and Dorset Health Scrutiny Committee throughout the lead up to the CCG's decision making process and subsequently. The Judge quoted directly from the list of recommendations made to the CCG within the letter sent to them by the Joint Health Scrutiny Committee in August 2017, and noted the willingness of the CCG to continue to work on resolving the concerns raised. It is clear that the Judge has inferred from the original actions of the Joint Health Scrutiny Committee and Dorset Health Scrutiny Committee that they did not feel that the decisions being made by the CCG were not *"in the interests of health services in its area"*. The Judge also notes that:

"the Claimants have said that the Dorset Health Scrutiny Committee is currently considering whether to make a referral almost one year after the Decisions were made. The critical time for determining the legality of the Decisions was when they were made in September 2017 and not one year later."

6 Task and Finish Group meeting: 18 September 2018

6.1 On 18 September the Task and Finish Group met with representatives from NHS Dorset Clinical Commissioning Group and the Provider Trusts: South Western Ambulance Service NHS Foundation Trust, Dorset County Hospital NHS Foundation Trust, Dorset HealthCare University NHS Foundation Trust, Poole Hospital NHS

[2] https://www.judiciary.uk/judgments/hinsull-v-nhs-dorset-clinical-commissioning-group/

Foundation Trust and Royal Bournemouth and Christchurch NHS Foundation Trust. (Minutes for 18 September attached at Appendix 3).

6.2 Prior to the meeting, the Commissioners and Providers had submitted responses to a set of 19 questions which had been collated following the Task and Finish Group's meeting on 22 August (attached at Appendix 4). Members of the Group had the opportunity to explore particular concerns, including:

- Future A&E and Urgent Care provision, particularly in Poole and Bournemouth;
- Future ambulance service provision and the impact of any increase in travel times for some residents of Dorset;
- Wider CSR changes and the impact on community service.

6.3 Members heard about the ongoing development and evolution of the original CSR proposals and of the benefits which would arise, including:

- New investment in buildings and facilities, services and workforce;
- Improved safety and quality of services;
- Improved outcomes for patients.

6.4 Members and the Commissioners agreed that there was still room for improvement in the communication of the benefits that would arise, and that it would be helpful for the local authorities to support the CCG in getting messages across.

7 Recommendations

7.1 After the Commissioners and Providers had left the meeting on 18 September, the members of the Task and Finish Group concluded that, having listened to the evidence from the members of the public (primarily Defend Dorset NHS) and the NHS bodies, they would make the following recommendation to Dorset Health Scrutiny Committee on 17 October 2018:

1 That the CSR proposals are not referred to the Secretary of State for Health and Social Care.

7.2 In addition, the following recommendations are made:

2 That the Joint Health Scrutiny Committee hosted by the Borough of Poole to undertake the work requested in relation to the ambulance service be convened as soon as possible.

3 That the Joint Health Scrutiny Committee hosted by Dorset County Council to scrutinise the implementation of the Clinical Services Review decisions be reconvened as soon as possible.

Task and Finish Group - Clinical Services Review

Minutes of the meeting held at County Hall, Colliton Park,
Dorchester on Wednesday, 4 July 2018

Present:

Bill Batty-Smith, Ray Bryan, Nick Ireland, Tim Morris and Peter Shorland

Other Members Attending
Bill Pipe attended the meeting as an observer
Jill Haynes, Cabinet Member for Health and Care, attended the meeting as an observer.

Officer Attending: Martin Elliott (Assistant Director Adult Care Operations), (Ann Harris (Health Partnerships Officer), Jo House (Senior Solicitor) and Denise Hunt (Senior Democratic Services Officer).

(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 Task and Finish Group to be held on **Wednesday, 22 August 2018**.)

Apologies for Absence

12 There were no apologies for absence.

Code of Conduct

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

Minutes of Previous Meeting

14 The minutes of the meeting held on 1 May 2018 were confirmed.

Dorset Health Scrutiny Committee involvement with scrutiny of the Clinical Services Review and Mental Health Acute Care Pathway Review, and links with the current Judicial Review

15 The Chairman referred to the decision of the Dorset Health Scrutiny Committee (DHSC) on 15 June 2018 to reconvene the Task and Finish Group as soon as possible and before the outcome of the Judicial Review (JR) was known. Contrary to incorrect information imparted by a committee member, the JR was proceeding on the basis of 6 out of the 7 grounds, with ground 7 being discounted and it was felt that this would have been an important factor in the discussions at the meeting.

The Group was advised that it was likely that a judgement would be handed down immediately following the JR due to the "end of term" on 31 July 2018. The latest legal position with regard to the JR was unknown and the Dorset Clinical Commissioning Group (CCG) had not responded to requests for further information.

The Chairman read aloud the 6 grounds of the JR and the following points were noted:-

- All of the grounds reflected the areas of concern to the Committee, but that grounds 5 and 6 were of greatest interest to the public.
- The outcome of the JR would influence any actions that could be taken by the Task and Finish Group.

- The JR would focus on whether the correct process had been followed, whereas a referral to the Secretary of State (SoS) would look at whether the proposals and decision making had been correct.
- In the event the JR was successful then the CCG would have to develop new plans and ensure that the correct process was followed.

Cllr Haynes, as the Cabinet Member for Health and Social Care, explained that the CSR had had been superseded by the STP and the Systems Partnership Board that was currently looking at elements of the CSR in order to work in a different way. The overall aim of the CSR was to have a greater level of support in the community and to avoid hospital admissions. There would continue to be some flexibility in the arrangements as this was a long term process lasting until 2023-2024 and significant changes could occur in that timeframe.

There remained an issue with new beds in Royal Bournemouth Hospital (RBH) and ambulance travel times that were now being reconsidered. She also advised that the model of funding and governance of the CCG meant that GPs would be keen for the CCG to resolve issues in their localities and keep a close eye on developments.

Members drew attention to the ambulance travel times and poor road network from Purbeck, the lack of highways infrastructure and delays in discharging patients from the ambulance at RBH and the provision of maternity and paediatric services.

Cllr Haynes informed the Group that a series of communications would be released by the Systems Partnership Board in October 2018 that would clearly explain how the system would change to deliver a single vision (currently awaiting sign off by all of the partners) of the health system in future. One of the key messages was the avoidance of unnecessary hospital admissions and accessing care closer to or at home.

Cllr Ireland highlighted one of the areas of public concern related to numbers of beds and the proposal to reduce hospital admissions by caring for patients in the community when it was still unknown how this care would be paid for.

Cllr Haynes explained that this concerned how the care was provided in future by the provision of hubs with GP services available from 8am to 8pm 7 days a week. It had already been demonstrated in the New Forest that this could be covered by implementing 4 hour shift patterns which was attractive to GPs with young families or those who were semi-retired. Hubs that were co-located with a Minor Injuries Unit could also prevent hospital admissions.

She acknowledged the impact on the costs of social care of increased health care in the community and this would be discussed by the Systems Partnership Board in July 18. In addition, the way in which hospitals were funded would also be investigated as this was currently dependent on the number of hospital admissions.

Cllr Haynes advised that £146m capital plan remained in place for the changes to the Poole General Hospital (PGH) and RBH with business plans dependent on whether the 2 hospital trusts were able to merge. The progression of the hubs would allow savings to be made elsewhere in the system.

Considerations with respect to making a Referral to the Secretary of State for Health and Social Care

16 The Group discussed the involvement of the public in an informal meeting of the Task and Finish Group in order to listen to the concerns and provide clarification on some of the issues that had not been adequately communicated so far to provide a degree of reassurance.

Scope of the review to be undertaken by the Task and Finish Group: Key areas of concern

17 The Group considered the key areas of concern that had been circulated with the agenda. Members noted that some of the concerns of the public were shared by Councillors.

Next Steps

18
- The next meeting on 1 August 2018 is deferred due to member availability.
- That the questions that have been asked at recent meetings of DHSC are circulated to the Group for information.
- The next meeting to be held on Wednesday 22 August 2018 at 10am at the Dorset History Centre, Bridport Road, Dorchester.
- Invitations to be sent to Debby Monkhouse, Giovanna Lewis (Defend NHS Dorset), Stephen Bendle and a representative from HealthWatch Dorset

Meeting Duration: 2.00 pm - 3.30 pm

Task and Finish Group - Clinical Services Review

Minutes of the meeting held at the Dorset History Centre, Bridport Road, Dorchester, Dorset, DT1 1RP on Wednesday, 22 August 2018

Present:

Bill Batty-Smith, Ray Bryan, Nick Ireland, Tim Morris and Peter Shorland

Other Members Attending
Councillors Bill Pipe, Katharine Garcia and Jill Haynes (Cabinet Member for Health and Care) attended the meeting as observers.

Officer Attending: Helen Coombes (Transformation Programme Lead for the Adult and Community Forward Together Programme), Ann Harris (Health Partnerships Officer) and Denise Hunt (Senior Democratic Services Officer).

(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 Task and Finish Group to be held on **Tuesday, 18 September 2018**.)

Apologies for Absence

19 Apologies were received from Anna Hinsull, a member of the public, who had been unable to attend the meeting. The Chairman stated that he would offer to arrange to meet Ms Hinsull separately.

Minutes of Previous Meeting

20 The notes of the meeting held on 4 July 2018 were confirmed.

Informal Discussion on Clinical Services Review

21 The Group received evidence from the following representatives as part of the process of gathering information in order to help inform whether a referral of the CSR proposals to the Secretary of State would be necessary.

Steve Clarke, Chairman of Corfe Parish Council and member of Defend Dorset NHS

Mr Clarke circulated a paper outlining his comments that included 2 Clinical Commissioning Group (CCG) documents.

He stated that the Clinical Services Review (CSR) had been well thought out in terms of its principles, but had failed in certain key respects. Positive aspects of the plan included the creation of community hubs to provide local treatment closer to home. However, this aspiration relied upon adequate resources in terms of staff and equipment in the absence of any resourcing plan. Quick access to A&E services would always be necessary, particularly for people with terminal illnesses that required stabilisation at short notice during courses of treatment.

He considered that there were issues with the accessibility and transparency of the consultation and the way in which it was designed to gain support for a Major Emergency Hospital (MEH) at Bournemouth. The CCG had claimed that the proposals would save 60 lives in a number of presentations, but had subsequently

confirmed that this had been an extrapolation of national data and local evidence had never been produced to support this claim.

He outlined that part of the proposal to save money was the £229m saving resulting from the closure of Poole General Hospital (PGH) A&E, however, the proposal to create separate planned and emergency hospitals had been made on the basis that no operations would be cancelled. He stated that the MEH would need an exceptional level of staffing in order to support surges in unplanned emergencies as there would be none of the back-up staff to call on that would be available in a hospital where planned operations took place. The provision of care closer to home would also be very costly. He therefore concluded that this would result in significantly greater costs and that saving money had therefore focussed on the closure of community beds.

The claim by the Head of SWAST that there was no clinical risk by these changes despite travelling further to hospital had been examined in some detail by the High Court within the Judicial Review and could not be substantiated.

Mr Clarke outlined some of the fundamental flaws including:-

- The decision to close Poole A&E and Maternity would lead to unacceptable travelling times for parts of Dorset with an increased risk of mortality or poorer recovery (presented by Debby Monkhouse later on the agenda)

- Insufficient hospital beds to cope with anticipated demand

  The 1810 acute beds used in 2014 were expected to rise during the next 5 years including an increase of 147 beds for elderly people and an additional 365 beds as a result of clinical demand. However, the CSR proposals sought to reduce the number of acute beds to 1632. The CCG recognised the significant work needed to solve this issue which was based on having better community services provided by community nurses, district nurses and GPs as well as the use of technology.

- the lack of a viable resourcing plan to provide sufficient numbers of staff in the community / integrated work with social services

This would be very staff intensive at a time when some staff that would be needed could not afford to live in Dorset. This was therefore a structural and long term issue that required a programme beyond 2021 with the uncertainty surrounding Brexit also having an effect. The CCG had not been able to produce any evidence on how this issue could be addressed.

- the lack of a plan to replace community hospitals

A plan to identify replacement beds resulting from the closure of community hospitals had never been published. The proposal to have 100 community beds at the acute hospital at Poole missed the central ethos of having a community hospital as an intermediary measure closer to home.

His final point concerned the existing specialist teams at PGH and RBH and the idea of having an MEH at Bournemouth before other issues had been addressed. The MEH did not fit the reality of the existing hospitals and it could be pragmatic to retain both as joint working hospitals in the dense urban area, particularly in light of the congestion of the road network at RBH and that PGH supported South Dorset much better. A 341 bed hospital at DCH would be very small and he questioned whether it could continue to offer the levels of care and quality of outcomes that the other hospitals would provide, particularly with the loss of resources and no investment proposed.

Debby Monkhouse, Defend Dorset NHS

A copy of Ms Monkhouse's evidence paper was circulated to the Task & Finish Group. The presentation focussed upon the failure of the CCG to properly assess the risk to residents due to the loss of A&E and Maternity services at Poole. It also included a report by the South Western Ambulance Service NHS Foundation Trust (SWAST) entitled "Clinical Services Review: Modelling the Potential Impact on the Emergency Ambulance Service" and further analytical information resulting from FOI requests that were referred to during her presentation.

CCG consultants Steer, Davies and Gleave noted the 'Golden Hour', used as a guideline for safe travel times, included the time taken for the ambulance to arrive and to unload the patient on arrival at hospital. The safe travel time for maternity emergency, major trauma and acute stroke was 30-45 minutes. The journey times mattered as there were some time critical conditions that could not be treated in the ambulance such as heart attack, stroke, sepsis and meningitis, resulting in either fatality or disability. Haemorrhage in trauma or maternity emergency could not be treated en route, as ambulances did not carry blood.

Ms Monkhouse outlined travel times, all of which had been clearly outlined in her written submission. This included information provided by the NHS on the additional travel times to RBH from the Purbeck BH19 and BH20 areas under the existing and new proposals that demonstrated an extra journey time of 18 - 19 mins that was outside of the 'Golden Hour'. An FOI request from Langton Parish Council found that from receipt of a category 1 call to SWAST to arrival at Poole A&E took an average time of 1 hour 43 minutes, and a transfer to Bournemouth would therefore add a further 19 minutes.

She also provided statistical information to determine the number of residents put at clinical risk by the plan to downgrade Poole A&E and close its maternity unit as follows:-

- 68,000 people visited Poole A&E in 2017, 37,500 of which were admitted. If Poole A&E was replaced by an Urgent Care Centre, with the subsequent loss of two thirds of its beds, how would the 37,500 patients be accommodated?
- Of the 37,500 patients that were admitted in 2017, there were 1784 people with time critical conditions that could not be treated in the ambulance and these people would face a longer journey time to RBH under the proposals.
- Poole Hospital currently specialised in Trauma and Maternity & Paediatrics. The hospital treated or stabilised 507 trauma patients and delivered over 4,500 babies in 2017. It offered the only high dependency and intensive care for newborn babies in Dorset and over 1000 babies needed additional care in 2017 with parents living across Dorset.
- The SWAST triage tool guidance indicated that cardiac arrests should be taken to the nearest A&E to be stabilised if the journey to the existing specialist cardiac centre at RBH would endanger life. It was the case that more cardiac arrest patients were treated at Poole than at RBH in 2017.

Ms Monkhouse referred to the SWAST Report in August 17: "Dorset Clinical Services Review: Modelling the Potential Impact on the Emergency Ambulance Service" which considered the risk of harm to patients due to further travelling distances if Poole A&E was downgraded and the maternity service closed. The report covered the 4 month period from January to April 2017 looking at those arriving at Poole A&E by ambulance during that time. She explained that there were certain flaws in the report outlined below:-

- It did not consider the risk to people who had not arrived by ambulance which included 78% of maternity and paediatric emergencies and 22% of adult

emergencies from 2012 to 2017. No respiratory emergencies were contained in the sample and only 2 trauma cases.

- The report did not consider the risk to rural residents facing the longest travel times under the proposals or whether these were within safe guidelines.

- The Executive Summary relied upon average journey times which was skewed in favour of RBH as there were greater numbers of people in the Poole and Bournemouth areas with shorter journey times, and less people with long and dangerous journey times. The CCG had addressed the additional journey times rather than total travel times and whether these were within safe guidelines.

- The report had called for a further review by a wide range of clinicians to confirm the overall clinical impact of the changes which was started in August 2017, however, this work had not yet been completed.

- In order to assess the clinical risk, just over 3000 cases with a potential increase in travel time were reviewed. Those with higher clinical risk were 1,636 which were further cleansed to remove certain conditions with low risk such as a non-injury fall, bringing this number down to 696 patients.

The Chairman was particularly interested in the data cleansing and potential restriction on information involving informative e-mails between clinicians and calculations provided to the court by the CCG during the Judicial Review.

Cllr Gary Suttle, Swanage Town Councillor and Leader of Purbeck District Council

Councillor Suttle considered that presentations given by the CCG had been very impressive, however, it was well known by local people that travel to Bournemouth from Swanage would not be possible within the specified time of 45 minutes.

Residents in Swanage relied upon PGH for both trauma and maternity services and moving these services to RBH would increase the risk. There were solutions that could mitigate this risk such as ambulances stationed in Swanage. All of the BH19 postcodes were outside of the safe recommended time. Local people were therefore in fear of these proposals as they recognised that this would result in higher numbers of deaths.

He did not consider that information provided by the CCG was substantiated by facts and Defend Dorset NHS had provided contrary evidence that, rather than saving 60 lives, 396 lives could be put at risk.

Purbeck District Council therefore believed that the evidence was flawed and that a referral to the Secretary of State for Health should be considered as the journey times were unsafe for some residents who would be at an increased risk from the proposals.

Giovanna Lewis, Defend Dorset NHS

Ms Lewis outlined her evidence in respect of community hospital beds that was circulated to the Task & Finish Group and explained that she had been involved in trying to save hospital beds on Portland.

Within the Business Case for the CSR proposals, 136 community beds would be closed over 5 localities, however, this was already being achieved in different ways. She explained that Defend Dorset NHS had been invited to a meeting with Ron

Shields on 15 May 18 when the group was informed of the future plans. The group's notes had reflected that Portland Hospital would not close for some years and so they had been surprised by the announcement that the Portland beds would be closing in August 2018, the reason being due to lack of staff.

Following the announcement in June, a public meeting was held in July 18 when it was explained that although there was money allocated for staffing Portland beds, that staff did not wish to work on Portland.

However, Defend Dorset NHS had been informed by some NHS staff, that no one would apply for posts at particular community hospitals due to the closures and that Portland Hospital had not been given as an option on the staffing rota many months before its closure.

She found it difficult to know why community beds were being closed as they were highly valued and provided close friendly care near to people's homes where they could be visited by family and friends. These hospitals also served as a "step down" function from the main hospitals in a less intensive setting and were sometimes a place for people to receive vital end of life care when no other option was available. The implications of care that was closer to home was not clearly understood by the public who were unhappy with the closure of community hospitals. The reality was to close hospitals and replace these with well trained staff, however, this was being suggested in a climate when it was difficult to recruit and retain staff.

Ms Lewis referred to the replacement of community hospital beds with care closer to home in Devon where 71% of hospital beds had been closed and where community hospitals had been replaced with a system of discharging patients to their own home with very limited levels of care.

The lack of support for people leaving hospital had led to multiple readmissions due to inadequate levels of care and early discharges. This was a concerning factor as the CCG envisaged treating 110,000 patients closer to home under the CSR proposals. During the Judicial Review hearing, the court heard that no assessment was carried out on what was required in terms of social care staff which would be of interest to Councillors should the burden fall on council budgets.

Philip Jordan, a Dorchester Resident

Information provided by Mr Jordan had been circulated to members of the Task & Finish Group in advance of the meeting.

As a Dorchester resident he had attended most of the CCG and Dorset County Hospital Board meetings and many CSR related meetings. He considered that the CCG had underestimated the CSR business case and consultation timeframe from the very beginning and relayed what had occurred at the early stage Board meetings of the CCG and DCH Governing bodies in 2015.

As a former project manager in an NHS teaching hospital, he questioned why the project had jumped to the solution and design phase before all the relevant facts had been gathered, including travel times that was a critical factor for so many people. He also drew attention to the difficulties in involving clinicians in the practicalities due to the nature of their work and also to the significant issues around equitability and rurality.

Martyn Webster, HealthWatch Dorset

Mr Webster stated that the challenge for the NHS would be the way in which it responded to concerns.

There were many different sorts of evidence and change needed to rely on both data and experience, as sometimes these two elements were in conflict. Research by Sheffield University on the effect of the closure of A&E Departments, 2 years before and 2 years following the closures, had found no reliable evidence that closures led to more deaths, but also found that the closures and reorganising of services had not improved outcomes for patients either.

The general public were the silent majority and only 2% of the population had completed the consultation questionnaire. The vast majority of residents would not be aware of the CSR and he felt that the CCG could have done much more to engage with local people.

The controversy was around the issues of access and quality, however, there was no clear evidence in the CSR in respect of reducing inequalities. Whatever the final proposal, there would be winners and losers and this had always been the case as there had never been a level playing field. In spite of this the NHS should not stop striving for equality for all and mitigate against those who were worse off as a result of the proposals.

He questioned where the financial and staffing resources would come from to support the CSR as the public was concerned about closing beds without creating capacity elsewhere in the system.

It was unfortunate that the CSR had not directly included mental health and GP services as the variety of programme names were of little interest to the general public. The number of GP practices had reduced dramatically since 2013 and would receive only 11% of the NHS budget leading to further issues of GP practices being lost due to business viability. This was a real concern for rural villages that were already disadvantaged by the CSR proposals. If appointments were inaccessible then people would not attend.

The SWAST report was also of interest to HealthWatch as there were serious questions raised at the end of the report for the CCG to look at going forward. HealthWatch had pressed CCG for a statement on how they were dealing with these questions, but the response had not been enlightening.

Dorset A&E Doctors

A document was circulated to the Task & Finish Group that outlined the concerns expressed by Dorset A&E Doctors that was outlined by Debby Monkhouse. She stated that under the CSR proposals, some residents would have to travel further to access worse services and this was a reason to refer the matter to the Secretary of State. The 4% uplift in NHS budgets that experts agreed was needed had been 1.2% since 2010 and this underfunding had pushed every NHS Trust into deficit. Although the UK had the 5th largest economy, it was 17th in terms of cost per head on healthcare services.

On conclusion of the evidence submissions, the Chairman asked the representatives to contact him with any further information and expressed his appreciation for taking the time to come along to speak to the Task & Finish Group.

Ms Monkhouse stated that she had a lot of information in relation to the consultation should the Group require this.

The Chairman thanked the invited representatives for their submissions and explained that the Task & Finish Group would decide which information to focus on and have a further closed session meeting with the CCG to raise questions.

Judicial Review of the Clinical Services Review - Update

22 No update was available as a decision on the Judicial Review was expected in September 2018.

Next Steps / Date of Next Meeting

23 The Chairman asked the Group to consider questions to put to the CCG and SWAST at the next meeting of the Task & Finish Group arranged on 18 September 2018.

A press release and joint briefing note from the Chairman and Cllr Pipe would be circulated to all Councillors following today's meeting to keep people informed.

It was agreed that the next meeting of the Dorset Health Scrutiny Committee on 18 September 2018 would be postponed until October 2018 to allow the Task & Finish Group to fully consider the evidence.

Meeting Duration: 10.00 am - 1.00 pm

Task and Finish Group - Clinical Services Review

Minutes of the meeting held at County Hall, Colliton Park,
Dorchester on Tuesday, 18 September 2018

Present:
Ray Bryan (Chairman)
Bill Batty-Smith, Tim Morris and Peter Shorland

Other Members Attending
Councillors Bill Pipe and Jill Haynes (Cabinet Member for Health and Care) 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), Denise Hunt (Senior Democratic Services Officer) and Jonathan Mair (Service Director - Organisational Development (Monitoring Officer)).

Other Officers in attendance:
NHS Dorset Clinical Commissioning Group: Forbes Watson, Tim Goodson, Phil Richardson, Sally Sandcraft, Vanessa Read, Alan Betts, Sue Sutton and Sara Bonfanti.
Steve Tomkins - Dorset Healthcare University NHS Foundation Trust:
Debbie Fleming and Matt Thomas - Poole Hospital NHS Foundation Trust
Adrian South and Nick Reynolds - South Western Ambulance Service NHS Foundation Trust
Alison O'Donnell - Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Apologies for Absence

24 An apology for absence was received from Cllr Nick Ireland.

Code of Conduct

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

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

Minutes of Previous Meeting

26 The minutes of the previous meeting were approved.

Discussion with NHS Commissioners and Service Providers on the Clinical Services Review (CSR)

27 Following the previous meeting with public representatives, the Task and Finish Group had submitted a series of questions to the NHS Dorset Clinical Commissioning Group (CCG). Both the questions and the responses are attached as an annexure to these minutes.

Referring to the questions and responses, the following matters were discussed.

A&E Provision

The Group drew attention to the great deal of public concern around the closure of the A&E Department at Poole Hospital, asking whether this would be a total closure or whether there would continue to be an A&E element at Poole.

It was confirmed that the A&E Department at Poole would become a 24 hour Urgent Care Centre (UCC) dealing with minor injuries, although the exact range of injuries and conditions was yet to be clarified. Some patients who arrived at Poole Hospital who required a higher level of care in future would be transferred if necessary, but it was noted that Bournemouth and Poole A&E Departments already specialised with trauma patients being treated at Poole and cardiac and vascular patients taken to Bournemouth. It would not be possible to have full A&E Departments at both Royal Bournemouth Hospital (RBH) and Poole Hospital as there would not be sufficient resources, nor the ability to recruit staff to meet that need.

The Group felt that this remained an area of public misconception and that a message needed to be conveyed in a very clear way to the public that this element of the Clinical Services Review (CSR) would not have a detrimental effect on patients.

The SWAST representatives provided details of a modelling exercise and comparison with Tiverton UCC, which had concluded that a similar UCC facility at Poole would be adequate. The ambulance service always ensured that patients were taken to the most appropriate hospital depending on the clinical need and only around 1% of patients being transported had immediately life-threatening conditions. Most people did not understand that ambulances did not always travel to the nearest hospital and the new system would provide clearer pathways and remove ambiguities.

The Chairman relayed his recent experience observing at an A&E Department when he had noted that many patients could have sought treatment elsewhere. He understood that the CSR was trying to address this, however, clearer messages were needed to provide greater public understanding.

<u>Ambulance Services</u>

The Group highlighted the significant public concern with the long delay between phoning for an ambulance and getting to hospital, which sometimes took several hours. Whilst understanding the need to prioritise patients in most need, ambulances were queuing outside hospitals for long periods to unload patients. Members asked how RBH would deal with this in light of the increased number of patients from Poole.

The CCG Chief Officer explained that part of the £147m government funding already awarded to Dorset would be used to create a larger A&E Department and UCC at RBH to deal with the additional patient numbers, in addition to a UCC at Poole. If the UCCs worked as expected, the demand from patients requiring Emergency Department category services could be halved as patients were diverted to the UCC.

Staff working in Poole and Bournemouth A&E and UCCs would be working collaboratively to the same protocols and rotating across sites. Consolidating the workforces would mean that patients were managed much more proactively without unnecessary investigations and having 24/7 consultant led care would be a huge patient benefit. This would be an improvement on the existing consultant cover as patients are not always seen by a senior clinician out of hours currently.

Ambulance transfers between RBH and Poole Hospital represented the highest transfer number in the south west region by a long way and swallowed up ambulance resources. Each transfer that was prevented would save 1 hour journey time and have a positive impact on the service overall and vehicle availability.

The Group was informed of the phone call triage system used when despatching ambulances. Category 1 ambulance performance had been achieved by SWAST for the past 3 months, with further work to be achieved in respect of the lower categories (2-4). Response and dispatch times were a separate issue that must be tackled regardless of the CSR.

SWAST was asked whether any additional priority was given to a category 4 patient due to a person's age and it was acknowledged that it was important that elderly people who had fallen were not left on the floor for too long.

The CCG noted that additional national investment in vehicles for ambulance trusts had recently been announced and would help to improve response times for lower category patients. Volunteers were also being trained to lift people from the floor prior to the arrival of an ambulance. The response level would be increased if a person was unable to answer the triage questions and a patient would be reassessed each time a repeat 999 call was made, with call backs to check for any deterioration as a result of waiting. Once the ambulance arrived there was a clear set of criteria to determine where the patient went.

SWAST had received an allocation of the national investment, which was not linked to the CSR, to provide a mixture of 63 vehicles (not necessarily ambulances), to be phased in from February 2019. Modelling would determine where vehicles were placed, but 4-5 vehicles were likely to be allocated to this area. This would be a substantial increase and significantly more than the 3.5 hours of additional capacity per day that SWAST had previously estimated would be needed.

Members asked whether one of the new ambulance vehicles could be based in Swanage and whether the existing ambulance station next to Swanage Hospital had been closed.

SWAST confirmed that the Swanage ambulance station was open and there were no plans to close it. The station was manned with a double crew ambulance and car based in Swanage. The ambulance would travel from the area if taking a patient to hospital, and in these instances area cover would be provided by another ambulance. Ambulances were routinely moved around to achieve maximum efficiencies and were rarely seen parked at stations, other than for crew handovers.

In response to a question, it was noted that the cost of a Purbeck specific ambulance would be difficult to determine and would open up complexity in other areas due to the way in which the service was operated. There had been increasing demand for the service in the Purbeck area this year when compared to the previous 12 month period. The average response time for the ambulance to attend a life threatening incident was 8 minutes.

The total travel time pathway included the phone call from the incident, ambulance arrival time, stabilisation on scene (which could be the longest period), travel time to hospital and handover. The additional travel times from Purbeck were therefore minimal when seen in this wider context. In addition, travel to a specialised unit in the first instance would provide a better outcome that would save lives.

<u>Wider CSR proposal</u>

There was little scope for further improvements that could be achieved within the existing healthcare system.

The CSR process had provided a significant opportunity to challenge how healthcare services were provided and confidence in the plans had resulted in the prioritisation of national investment of £147m, which was a significant step.

Although the public focus had been on the acute hospitals, the majority of people's healthcare was not delivered in this setting, and alternatives in the community had been fully explored, with funding to provide those options. This would build on the existing services in the community, providing better access to quality care. Most people preferred to be supported at home and the new models of care were already making a difference and building momentum.

Collaboration was also a key factor and a GP presence at the UCC alongside the A&E Department at RBH would enable GPs to work with the 24/7 consultant to provide better clinical care. Other developments were also progressing, such as district nurse teams using specialist equipment to help people who had fallen at home. It was estimated that around 50% of those who currently attended A&E had 'minor' injuries, however, clinicians were still working on the breakdown of conditions that would be dealt with at the UCCs and those that would require attendance at the A&E Department.

The Chairman commented that there was a degree of flexibility in the CSR process and that the hospitals represented some of the building blocks to develop a new system with funding spent in a way that benefitted patients as the foundation. Apart from the funding that had been set aside for the two hospitals in Bournemouth and Poole, other elements were not set in stone and there could be flexibility as plans were developed. Some proposals had already been revised with respect to Shaftesbury Hospital and Kingfisher Ward at Dorset County Hospital (DCH).

The CCG Chief Officer agreed with this point of view, stating that this was about a vision with the big building blocks being the Major Emergency Hospital at Bournemouth and the Planned Hospital at Poole. The benefits could not be achieved by partially adopting the proposals in respect of these hospitals. However, other elements were being explored and were evolving, including the provision of community hubs that was currently being progressed and constantly reviewed.

Members heard that some elements of the CSR would not see any major changes for 5 or 6 years. During the intervening period there would be some services that did not require building works, but that transformed through teams working differently to achieve better outcomes for patients.

The Chair of the Dorset CCG emphasised that there were other options and complementary services which meant that patients would not necessarily need to go to Poole or RBH. He explained that 90% of care was already delivered in the community and the CSR sought to increase that figure. Intermediate care services could avoid admissions to hospital and increasing the capacity to deliver care closer to home across the whole of Dorset would be happening soon.

The Chief Officer stated that there had been a large degree of social media miscommunication that did not reflect what was happening. He welcomed collaborative working with the local authority communications team as well as assistance from other public sector organisations and health scrutiny members as services were developed.

<u>National Funding</u>
Members asked how much of the funding had already been spent in implementing the CSR proposals and the following was confirmed:-

- There was a process in place to draw down the £147m government funding which remained intact. A large portion of this (up to £62m) would be used at Poole Hospital.
- Spending was already taking place to develop the community hubs using a primary care capital allocation.
- A significant investment of £1.2m was made two years ago by the CCG, with a further £2.2m this year for GP services in Dorset, the latter to enable GP practices to engage in the transformation work.
- Investment in mental health services was ongoing, enabling, for example, expansion of the "Steps to Wellbeing" services supporting people with low level mental health needs.

There would be significant change across the hospital sites at RBH and Poole, resulting in more clearly defined clinical areas. Poole would continue to be a busy diagnostic planned facility. The numbers of inpatient beds would be reduced due to the increase in day cases. The investment of £147m was needed to expand the Major Emergency Hospital at Bournemouth and to make improvements at Poole that would include the redevelopment of theatres and a new building for day cases. Poole would also gain Ophthalmology and Orthopaedic Departments.

Other areas of funding included:-

- £1m operational budget this year for transformational planning (including work on transport).
- £9m contributed by all partners and CCG for the Dorset Care Record.
- £3m transformation funding in 2017/18 and the current year, awarded as a result of confidence in the proposed system.
- £800k from Sport England for Sport in Mind initiatives.
- The Local Enterprise Partnership (LEP) Statement of Intent, looking at business innovation for multi million investment around employment initiatives.

The above represented a substantial amount of transformation money that would not have existed if services were continuing as they did before.

The CCG Chief Officer explained that there were 44 Sustainability and Transformation Plan (STP) footprints across NHS England and that it was now unlikely that investment levels greater than £100m would be given to any individual area. Seen in this context, the investment of £147m in Dorset was hugely significant and, if the plans to form the Major Emergency and Planned hospitals were eroded then that level of investment would not be forthcoming.

The Service Director - Organisational Development asked whether a decision to refer the CSR proposals to the Secretary of State for Health might also put that funding in jeopardy.

The CCG Chief Officer responded that Dorset had been recognised as within the top three organisational systems, with a very good STP. The Government wanted the CSR to be achieved and had shown confidence through the level of funding that had been granted. A referral to the Secretary of State by one of the STP members would therefore not send the right message.

The CSR had started in 2014 and a delay had already been necessary due to the Judicial Review. Any further delays created additional risks, including the rise in building costs associated with the CSR proposals and impact on staff leading to the potential for clinical disengagement through a lack of progress.

There was a strong case for change due to the huge and growing pressures in the system and the funding provided opportunities to make improvements. The previous failed merger of RBH and Poole Hospital had created financial challenges and workforce issues during the past 5 years and a step change was needed to improve quality overall. The variations in services could be evened out by a more defined clinical workforce based around centres of excellence to ensure the same level of quality and safety across the County. Transfers between hospitals were not without risk, hence the need to address unnecessary transfers urgently.

<u>Maternity Services</u>

Plans to develop the maternity service at Poole had been ongoing for 20 years and there was now the opportunity to build a brand new facility. RBH was currently the only acute trust in the UK with a standalone midwifery unit without a co-located Obstetrics Department which was a risk.

It was reported that only around 22% of maternity patients travelled by ambulance to hospital, with a very small number requiring a blue light. The majority of births at Poole Hospital continued to involve patients travelling from Bournemouth, where there was a larger antenatal population. Therefore moving the maternity unit to Bournemouth would mean fewer women transferring between the hospitals and a small overall difference in travel time.

The existing maternity unit in Poole was in a separate building from the main hospital site, which resulted in ambulance transfers across a road for some patients. This was not the best use of the service or good for mothers and babies. A maternity unit at RBH would form part of the main hospital site. The existing units at all three acute hospitals had worked together on a maternity transformation plan to provide better care through pregnancy that had already seen the introduction of a labour advice line.

Further to a question, it was confirmed that once vacated, the Poole maternity site would be considered as part of a joint estates plan, but decisions had not yet been made as part of the CSR.

It was noted that the plans had been revised to retain a maternity service at DCH, reflecting public feedback.

<u>Communication</u>

The Group considered that the proposals had not been adequately conveyed to the public and it was suggested that the communications teams at the CCG and Dorset County Council could work together in future to provide greater public understanding of what was being proposed.

The CCG Chief Officer acknowledged that more could be achieved in this area and welcomed collaborative working. Communication had recently been limited by the Judicial Review process and subsequent social media activity had resulted in further misinformation. He advised members that the 18,500 respondents to the CSR consultation were largely supportive of the proposals and that positive support had been received at public events and throughout the NHS assurance processes. Following the CSR decision, there had been a press conference, an 8 page feature in the local newspaper, a dedicated website and paid advertising through Facebook.

The Chairman thanked the representatives for attending the meeting.

The Dorset CCG and NHS representatives left the meeting at this juncture.

The Task and Finish Group discussed the evidence and agreed that they were reassured by the accounts provided by the CCG and NHS representatives. They considered that better explanations for some of the issues raised by the public had been provided and had also demonstrated that elements of the plan were already being implemented.

Members considered that the programme should continue to involve key representatives from the local authority and that improved communication was required as elements of the CSR proposals were developed, in order to allay public concerns.

They discussed the urgent need for the Joint Health Scrutiny Committee hosted by the Borough of Poole to undertake the work requested in relation to the ambulance service, as agreed in late 2017. In addition, further scrutiny of the implementation of the CSR decisions would benefit from a meeting of the Joint Health Scrutiny Committee hosted by Dorset County Council.

The Group had regard to the evidence presented by the CCG and NHS representatives. They were also mindful of the conclusion of the Judge in relation to the JR, that the local authorities had not made a referral to the Secretary of State in the intervening period of a year since the CSR decision had been made and that to do so at this stage may not be beneficial to either party.

It was concluded that having listened to both sides of the argument, the Group had asked questions to which the majority of answers were satisfactory. An alternative view was expressed that although the arguments were very compelling, these were not sufficient to override the concerns in Purbeck.

RECOMMENDED
That the CSR proposals are not referred to the Secretary of State for Health and Social Care.

Update on Judicial Review of the Clinical Services Review

28 The Judicial Review had not been upheld on any of the Grounds submitted. The full Judgement setting out the reasons for rejection had been circulated to the Group and all members of the Dorset Health Scrutiny Committee.

Informal advice had been sought from the Independent Reconfiguration Panel (IRP) with regard to the implications of comments made within the Judgement to the position of the Dorset Health Scrutiny Committee. The indication from the IRP was that, if the Secretary of State for Health and Social Care were to ask the IRP for a view, whilst all referrals are considered on their merit, the Judgement would be 'an important part of the evidence that the IRP would need to consider'.

Next Steps

29 That the recommendation of the Task & Finish Group is considered by the Dorset Health Scrutiny Committee on 17 October 2018.

Meeting Duration: 3.30 pm - 6.00 pm

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.

THE QUEEN ON THE APPLICATION OF ANNA HINSULL v NHS DORSET CLINICAL COMMISSIONING GROUP

Summary of the judgment of Sir Stephen Silber handed down on 5 September 2018.

NOTE: This summary is provided to help in understanding the Court's decision. It does not form part of the reasons for the decision. The full judgment of the Court is the only authoritative document. Judgments are public documents and are available at: www.bailii.org.uk

The figures in square brackets are the relevant paragraph numbers in the judgment

1. Anna Hinsull seeks to challenge the decision of the Dorset Clinical Commissioning Group ("the CCG") of 20th September 2017 which made significant changes to the configuration of health services in the Dorset area. The CCG is responsible for commissioning and paying for NHS services in that area. [1]

2. Like many similar bodies, it had been facing pressure on its funds to continue providing healthcare in the way that it had been provided previously as it was spending more money than it received, and it was facing a shortfall of some £158 million each year by 2020/2021. It became clear that for the CCG " doing nothing is not an option because by staying the same our healthcare would get much worse" [9]

3. National evidence, particularly the comprehensive review of NHS emergency and urgent care published in 2014 by the NHS Medical Director, Sir Bruce Keogh, showed that many people, who then attended A&E Departments could achieve better outcomes and less disruption to their lives by receiving urgent care in community settings, while patients with more serious or life-threatening emergency care needs had to be treated in specialist emergency care centres so as to maximise the chance of survival and good recovery.[11].

4. The CCG took a series of decisions ("the Decisions") which are the subject of the present application. Before the Decisions were made, Poole Hospital was one of three hospitals in Dorset giving acute care which is short-term treatment for patients with any kind of illness or injury. The other two acute hospitals in Dorset were the Royal Bournemouth Hospital ("Bournemouth Hospital") and the Dorset County Hospital ("Dorset Hospital") in Dorchester. The Decisions meant that Poole Hospital would no longer be an emergency hospital as it would become a "planned hospital" and its Accident and Emergency ("A& E") Department would be downgraded to a GP-led "urgent care centre" with emergency care only being available at Bournemouth Hospital and at Dorset Hospital. There was to be a new regime to provide care closer to people's home using teams based at local community hubs; this would enable many people to be treated without going to hospital, while many of those who were admitted to hospital would be released earlier than under the previous arrangements because more treatment and care can be provided outside hospitals. [29]

5. These decisions are of particular importance to the Claimant, who sadly suffers nineteen different health conditions and who has regularly needed access to Poole Hospital which is quite close to her home. She is very troubled about the additional time required under the new regime for travelling from her home to Bournemouth Hospital, rather than to Poole Hospital when Bournemouth Hospital becomes a specialist emergency care hospital. [2] and [4]

6. How were these decisions reached? These decisions were reached after very lengthy and detailed discussions with doctors, nurses, social care professional and other frontline workers from Dorset's health and care organisations as well as local authorities. This led to the launching of a formal consultation on 1st December 2016, which lasted for 12 weeks, closing on 28th February 2017. Two options were put forward in respect of acute hospital services. Option A had Poole Hospital as the major emergency care hospital with Dorset Hospital as a planned and emergency care hospital and Bournemouth Hospital as the major planned care hospital. Under Option B, Poole Hospital was to be the planned care hospital with Dorset Hospital as a planned and emergency care hospital and Bournemouth Hospital as the major emergency care hospital. Option B was the preferred option of the CCG because it was rated more highly on the issues of access and affordability than Option A in the consultation paper. [22] and [23].

7. As a result of the responses, the CCG commissioned additional work including from the South West Ambulance Trust on the effect of the proposed reconfiguration on emergency ambulance services. In addition, a detailed programme of events and workshops was organized between July and September 2017 to ensure that the consultation responses were shared and considered by the CCG's governing body and key partnership organisations during their detailed deliberations in preparation for the decision making meeting body on 20th September 2017. Some changes were made to the proposals but the recommendation for Option B remained the same. The Governing Body approved the recommendations. [26] to [29].

8. The first challenge to the Decisions was that the CCG failed to have regard to the relevant consideration of whether there would be a sufficient care force to deliver the new integrated model of community service. I rejected this challenge as there is ample evidence that the CCG considered appropriately whether there would be a sufficient care force for that purpose and worked out a strategy for ensuring that there would be sufficient social care workforce along the lines advocated by Dorset CC and considered all the material issues including that the workforce demands would depend on an uncertain matter which was "the readiness of the services and the timescales for changes in the CSR implementation plan". [91]

9. I am fortified in reaching that conclusion as first, there was no complaint from the local authorities on this issue. In addition, the local authority had a crucially important power under rule 23(9) of the Local Authority (Public Health, Health and Wellbeings Board and Health Scrutiny) Regulations 2013 to make a reference to the Secretary of State where it considers either that local authorities have not been adequately consulted on proposals for the substantial development of the health service in the area, or that the proposals are not "in the interests of the health service in its area". In this case, if the local authorities had concerns about whether there would be a sufficient social care workforce to deliver the CCG's new integrated model of community service, this would have been a matter of crucial importance to them as without a sufficient workforce, they would have been unable to comply with their obligations. They had not invoked the power at the time of the Decisions or in the 11months since then. [86]- [88].

10. The second challenge is that the CCG failed adequately to investigate and reach a conclusion on whether alternative community provision could be put in place before deciding to close hospital beds. I was unable to accept this point for a number of

reasons including that the CCG had considered numerous models and 65 potential options and there is nothing to suggest that there was a superior or a more effective alternative community provision that could have been put in place. [101].

11. The third challenge is that the CCG failed to comply with a requirement made by NHS England in the Bed Closure Test that required the CCG to show that significant bed closures could satisfy one of three new conditions before NHS England would approve them to go ahead. In this case, NHS England, who were the arbiters of whether the conditions were complied with, were satisfied that it had been complied with and that is determinative of the issue. The Governing Body was not entitled or required to look behind it and so this challenge fails[123]-[125].

12. The fourth challenge is that the CCG failed to consider adequately the impact of increased travel times in emergency cases to Bournemouth Hospital rather than Poole Hospital which was the more centrally located hospital. The Ambulance Trust analysed 21,944 cases and concluded that in 0.6% of those cases "the extended journey time may increase the clinical risk" (emphasis added). Against that, there is undisputed evidence that lives of patients with heart problems and stroke victims would be saved by the better facilities at Bournemouth Hospital on becoming an emergency care hospital as compared with those offered at Poole Hospital. In addition, the Chief Executive of Poole NHS Trust reported that some of the more seriously ill patients from Dorset - that is, those suffering from heart attacks or vascular problems - including residents of Purbeck, have been treated at Bournemouth Hospital and those arrangements have been deemed safe by Commissioners and Regulators and that those acutely ill patients received treatment within an acceptable time period. There was also evidence that for most people the impact of changes on travel times would be negligible and where patients may be subject to longer travel times, they would experience better outcomes. These and other factors led to me rejecting this claim and concluding that the CCG had secured an improvement in the services provided to the residents of Dorset. [155]- [157].

13. The fifth challenge is that the CCG did not provide sufficient information to consultees and the consultation was misleading in respect of two matters. The first matter was that consultation document indicated 24/7 consultant care was promised but these were stated to be ambitions. Second, it is said that the consultation document did not say that there would be large scale bed closures, but this point fails to appreciate that the CCG does not commission beds. In any event, there was much evidence that it was widely known that there would be bed closure. In addition, the consultation process was subject to scrutiny by the Consultation Institute's Independent Quality Assurance process and it was deemed to have reached Best Practice status. The consultation responses were independently analysed and reported on by Opinion Research Services and quality assured by the Consultation Institute. The Consultation Institute awarded the CCG "best practice" accreditation for the CSR consultation. In addition, the CCG's approach to consultation was also commended by Opinion Research Services. In any event, a consultation document "which is flawed in one, or even in a number of respects, is not necessarily so procedurally unfair as to be unlawful" (**Greenpeace**). These complaints fail by a substantial margin to reach the threshold for being unlawful

14. The Claimant's application for permission to appeal was refused.

Integrated Urgent Care Service

Sue Sutton, Deputy Director of Service Delivery, NHS Dorset Clinical Commissioning Group will provide a verbal update regarding progress with the procurement and implementation of a new Integrated Urgent Care Service.

The update will include:

- A response to the point raised by members on the topic of greater utilisation of assets, in the context of the Urgent Treatment Centre considerations, and how this correlates with having the right specialist staff in place to operate the equipment;
- The GP Online Consultations programme of work and how this works with the 111 service, with particular focus on the context of the Clinical Assessment Service;
- Considerations within the communication and engagement plan, which is intended to articulate the offer given by the service model, in order to meet the nationally mandated requirements of the service;
- The inclusion of the Improving Access to General Practice Services (IAGPS) (Urgent) service and plans to maintain this nationally mandated service beyond April 2019;
- Technology enablers in response to the points raised about monitoring health at home and the use of Skype.

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	17 October 2018
Officer	Rob Payne, Head of Primary Care, NHS Dorset Clinical Commissioning Group
Subject of Report	**Integrated Care System: Primary Care Transformation Programme Review and Evaluation**
Executive Summary	This report forms part of a wider report looking at progress in the implementation of the Integrated Care System across Dorset. The report focuses on the Primary Care Transformation Programme and provides: • A mid-point review and evaluation of progress in delivery of the Primary Care Commissioning Strategy and GPFV programme areas. • Details of the investment in sustainability and transformation of primary care and the impact of this. • Evidence of achievements and impact made against the five core transformation areas of the GPFV since the inception of the programme: Investment; Workforce; Workload; Infrastructure and Care Redesign. • Next Steps.
Impact Assessment:	Equalities Impact Assessment: Report provided by NHS Dorset CCG.

	Use of Evidence: Report provided by NHS Dorset CCG.
	Budget: Not applicable for DCC.
	Risk Assessment: Current Risk: LOW Residual Risk: LOW
	Other Implications: None.
Recommendation	That Members note the content and comment on the report and consider whether they wish to scrutinise the matters highlighted in more detail at a future meeting.
Reason for Recommendation	The work of the Committee supports the County Council's aim to help Dorset's citizens to remain safe, healthy and independent.
Appendices	1 NHS Dorset CCG: Primary Care Transformation Programme Review and Evaluation
Background Papers	None.
Officer Contact	Name: Dr Rob Payne, Head of Primary Care, NHS Dorset CCG Email: robert.payne@dorsetccg.nhs.uk

NHS Dorset Clinical Commissioning Group

NHS DORSET CLINICAL COMMISSIONING GROUP

PRIMARY CARE TRANSFORMATION PROGRAMME REVIEW & EVALUATION

1.1 The Dorset Primary Care Commissioning Strategy and GP Forward View (GPFV) Delivery Plan is designed to be implemented over a five year period aligning to the GP Five Year Forward View, Our Dorset Sustainability and Transformation Plan and the Dorset Integrated Community Services Strategy.

- This report provides:
- A mid-point review and evaluation of progress in delivery of the Primary Care Commissioning Strategy and GPFV programme areas.
- Details of the investment in sustainability and transformation of primary care and the impact of this.
- Evidence of achievements and impact made against the five core transformation areas of the GPFV since the inception of the programme: Investment; Workforce; Workload; Infrastructure and Care Redesign.
- Next Steps

2. Background

2.1 GPs are facing rising patient demand, particularly from an ageing population with complex health conditions, physical and mental health presentations:

- the population served by General Practice in Dorset is set to rise by as much as 50,000 in the next 10 years;
- the number of people aged over 65 in Dorset is currently 185,715, (24.3% of the total population). This figure is expected to grow to 278,573 (32.1% of the total population) by 2040.

2.2 Dorset CCG developed a GPFV Delivery Plan for 2017-19 approved by Directors on 19 December 2016 and NHS England in early 2017.

3. Funding

3.1 **£3 per head transformation fund** – The CCG investment to deliver at-scale General Practice sustainability and transformation is set out below:

Year	Year 1 (2016/17)	Year 2 (2017/18)	Year 3 (2018/19)
Investment	£500k	£1.1m	£1.3m
Focus of Development	Practices	Localities	Networks

3.2 This funding has enabled GPs and primary care teams to engage in the development and delivery of the local sustainability and transformation plans under the direction of the GP Locality Chair.

3.3 A large proportion of the funding has been delegated to localities to support transformation through:

- Protected Learning Time
- investment in clinical and business leadership
- project management resources
- innovation funding to allow localities to test out new ways of working.

3.4 A centrally held budget has been used to support:

- estates and infrastructure development
- workforce planning
- integrated access
- training
- community engagement
- National Association of Primary Care (NAPC) investment to support collaborative working at scale through the Primary Care Home model.

3.5 In addition, specific resource has been identified within the Primary Care Team (supported financially by NHS England) to support the overall programme implementation whilst also meeting the needs of the NHS England assurance programme of work which occurs at both a local, regional and national level.

3.6 Dorset has been in a position of readiness to benefit from other national funding programmes as a result of delivery of the local plan.

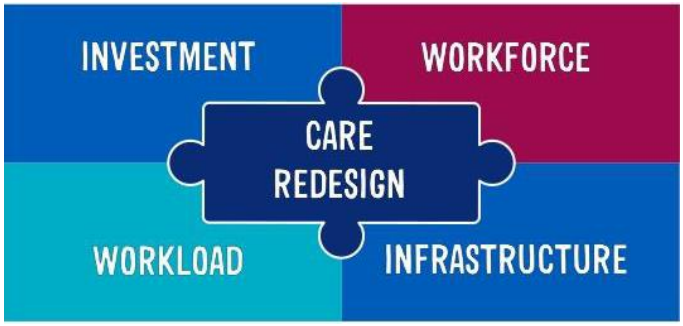
4. Evidence of Achievements and Impact

4.1 At the mid-way point through this five year programme we are starting to identify tangible outcomes and realise the benefits for primary care in Dorset. Significant progress has been made across all GPFV delivery areas.

4.2 Evidence has been drawn from the

- ***'Primary Care Outcomes Framework'***developed to monitor progress against Primary Care strategic ambitions.
- 13 Localities who continue to develop and deliver their 12 (2 localities working together) transformation and sustainability plans across all GPFV areas.
- ***12 GPFV Delivery Programmes*** that NHS Dorset CCG has implemented to support primary care transformation.
- International, national and local data also providing emergent evidence of the impact of the development of the ***Primary Care Home Model*** in supporting both national and local ambitions.

4.3 The following provides a summary of achievements and impact to date across the five areas of GP Forward View.



5. Investment

5.1 Plans are now in place to deliver the £3 per head investment in Primary Care transformation over two years to March 2019. This includes Dorset-wide initiatives such as the Primary Care Workforce Centre and Protected Learning Time for Transformation Programme teams as well as delegated budgets to support local Transformation leadership, collaboration and project management.

5.2 Planning for future investment in transformation is now underway and forms part of the discussions with NHS England in order to strengthen the role of Primary Care within the Integrated Care system. We are seeking to invest in both sustainability of General Practice, working closely with NHSE on General Practice resilience, as well as to continue to transform Primary Care to establish Primary Care Networks to serve the Dorset population.

5.3 As part of this work a review and evaluation of sustainability and transformation programme achievements over the last 18 months will be used to inform a business case for future investment. It is likely that we will be seeking to put in place a further programme of investment to 2021. This is in line with NHSE guidance for continued investment for GP Forward View delivery and transformation support for Primary Care as part of the national programme ambitions.

5.4 Specific achievements resulting from the transformation investment include:

- Development of **12 Transformation Primary Care Networks** working collaboratively to develop and deliver 12 Transformation and Sustainability Plans aligned to GPFV and with a clear focus on function.

- Strong **Leadership** and distributive leadership to drive forward the locality vision and build clinical and business capacity and capability.

- Menu of **support** and 'Team around the Primary Care Networks' to support transformation change and achieve the ambitions set out in Dorset's GPFV Delivery Plan

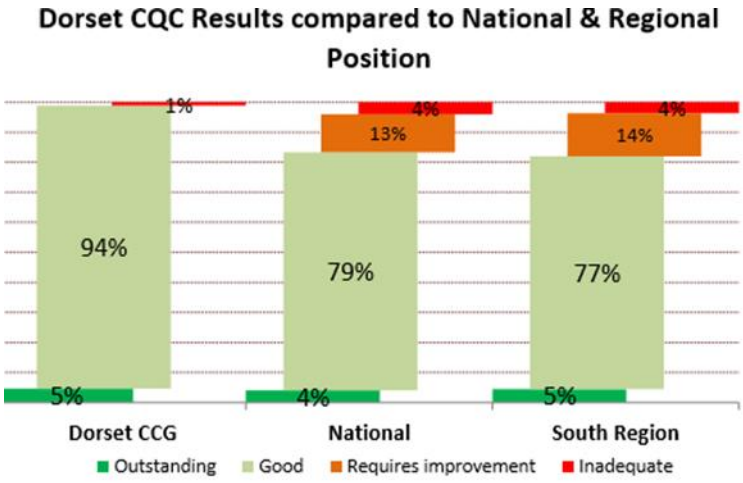
- Stakeholder **engagement** to ensure system support and integration especially in the context of the emergent ICS in Dorset.

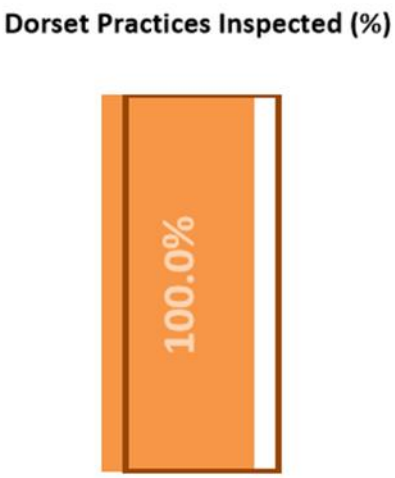
- Spectrum of Memorandums of Understanding developed at Primary Care Network level to facilitate collaborative working.

6. Impact on Improving Quality (CQC)

6.1 86 practices have had an inspection by the Care Quality Commission (CQC). The CCG has provided support to practices to improve quality and resilience through a menu of support and there has been a steady improvement in the quality and resilience of General Practice in Dorset.

6.2 As at March 2016, 19.4% of practices were rated good or outstanding by CQC. This low figure may have been as a result of not all practices being inspected. As at March 2017, this increased to 88.4% rated as good or outstanding and as at March 2018, this increased further to 99% of practices rated good or outstanding. For a comparison with regional and national averages as at March 2018, please refer to Figure 1 below.





6.3 Continued quality improvement within General Practice is being undertaken through a combined approach by the Quality and Primary Care teams undertaking joint quality and contract assurance visits. This combined with practice profiling and resilience support is aimed to keep an open and transparent environment to work with practices to ensure a proactive approach in improving quality and resilience. The ambition for 2018/19 is for Dorset to increase the number of practices rated as outstanding while maintaining the support needed to reduce risks of practices receiving less than 'good'.

7. Workforce: Achievements and Impact

7.1 Workforce profiles were completed for all localities and circulated in October 2017 to each locality for validation in order to support a Primary Care workforce baseline. Each profile included the baseline data for General Practice, identified a gap in Community Provider data and detailed the ICPCS modelling for each area.

7.2 The Workforce Redesign Lead for Primary Care was appointed in October 2017, using non-recurrent Transformation funding, to work with colleagues in Primary Care to develop the workforce profiles for Practices and localities and to inform workforce redesign to support the new models of care delivery. Updated profiles, including Community Provider data, were recirculated to localities in December 2017 with support offered for further validation of the baseline data and use of the Wessex LMC Practice Healthcheck tool to support development of local workforce plans.

7.3 As at July 2018, 58% of the localities have completed the Wessex LMC Practice Healthcheck tool to validate the baseline workforce and gain an understanding of the gap between current and the workforce recommendations by the ICPCS modelling.

7.4 In July 2018 the Workforce team gained access to the Models of Care portal, established by NHSE and the South West Academic Health Science Network. Contained within this is the General Practice Workforce Analysis Tool (WAT). Based on the information submitted to the Workforce Minimum Data Set via the Primary Care Web Tool which GP Practices complete on a quarterly

basis, the information collected is cleansed and released by NHS Digital in a flat spreadsheet (consisting of around 4million data points).

7.5 Whilst in its current published form this tool is not a resource that can be used by Practices and Workforce Managers in CCGs and STPs, the WAT will enable more accurate, timely and detailed profiles to be created on a Locality or federation level in the future. The WAT also provides us with comparisons between Dorset and the situation in similar areas as well as the national picture. This includes controlling for factors such as age of patients or relative deprivation of areas.

International GP Recruitment Programme (IGPR)

7.6 NHSE is leading on the international recruitment campaign for GPs. NHSE aims to recruit around 2,000 GPs from overseas by 2020. The overseas recruits will work alongside GPs trained in England to develop an exciting range of services away from hospitals in local community settings. Recruitment to the programme is being centrally co-ordinated and organised in phases across England. Dorset CCG submitted a bid on 28 February 2018 to be included in the programme. The Dorset bid for 33 international GP recruits is included in the national team's considerations to plan delivery based on the demand across all STPs.

Case Study

Developing Skill Mix – Clinical Pharmacists in Primary Care

East Bournemouth Locality led a successful bid to the NHSE National Clinical Pharmacist Programme to secure funding and training to support the recruitment of 3 Clinical Pharmacists. This collaborative approach across East Bournemouth and Central Bournemouth practices is now in the implementation stage and will see the three pharmacists working across all 8 practices by the end of 2018.

The three Clinical Pharmacists will work in general practice as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas. They will work with and alongside the practice teams, taking responsibility for patients with chronic diseases and undertaking clinical medication reviews to proactively manage people with complex polypharmacy, especially for the elderly, people in care homes and those with multiple comorbidities. They will provide specialist expertise in medicines use while helping to address both the public health and social care needs of a patient at the practice.

It is expected that key outcomes of this work include improving care and health outcomes for patients with improved access to care in general practice. Other benefits include:

- Supporting patients to get the best use of their medicines and identifying medicines related issues.
- Reducing potential, A&E admissions, attendances and readmissions
- Better care closer to home through home and care/residential home visits
- Expanding the general practice team to include clinical pharmacists, with their skills and knowledge. This will allow reallocation of general practice workload
- Increase GP practice capacity to see and help more members of the public
- Ensure safer prescribing and improvement in patient safety and quality of care
- Increase capacity to offer more on the day appointments and provided OOH/extended hours/on-call services.
- Improved integration with the community and hospital pharmacy teams
- Improvement in the clinical and cost-effective use of medicines.
- More efficient and effective communication between general practice and wider healthcare teams.
- Better integration with the wider healthcare systems/team's due to clinical pharmacists being key point of contact for primary and secondary care services.
- Optimisation of the patient journey through the healthcare system.
- Reduce pressure on urgent and emergency care departments by preventing avoidable admissions/readmissions.

8. Workload: High Impact Actions

8.1 Over 80% of practices are delivering two or more high impact actions.

8.2 Improvement in Managing Clinical Correspondence (MCC) is yielding significant benefits for GPs and practices. Early evidence shows a reduction in the GP workload of at least 30-40 minutes a day. If this is replicated in every practice in Dorset for every GP this means 240 hours a day or in excess of 60,000 hours a year that GPs can now spend on delivering direct patient call as well as other priorities. This innovation could deliver a £3 million time benefit to General Practice but more importantly it has started to address the increasing workload challenges that GPs today are facing.

Case Study

Implementation of Managing Clinical Correspondence by non-clinical staff

West Dorset Locality have successfully developed a centralised workflow approach to managing clinical correspondence for locality (all but one practice in the locality are signed up to MCC at scale). A Business Case is being developed whereby the locality will act as mentors for other localities to support them in their MCC development.

8.3 Practices are engaging in long-term conditions self-management support programmes including supporting a roll-out of Health coaches in GP practices which will be enhanced by a standardised Dorset model for non-clinical health coaching and social prescribing which is currently being procured. Training and education of practice staff will be made available to all surgeries either as part of the Personalised Care programme or via GPFV funding.

8.4 The General Practice Resilience Programme will provide £40 million over four years (until 2020) to support GP practices and to build resilience into the system.

8.5 The Resilience fund will deliver a wide Menu of Support to help practices become more sustainable. In 2017-18, 14 Dorset practices have benefitted from this scheme. Seven of these have completed and have action plans in place to address key areas of resilience, all of which have been approved by NHSE and the CCG.

8.6 We are now working with NHSE to plan investment in this programme for 2018-19. Agreement has been reached that the programme can support groups of General Practices working on local system resilience in partnership. The Primary Care team, working in partnership with locality groups of General Practices, are currently considering priorities for the use of this fund which is likely to include targeting locality areas currently facing the biggest resilience challenges due to planned changes in the local configuration of general practice or where there are practices facing difficulties in resilience planning.

Case Study
Supporting GP Resilience

In a change to the usual method of supporting practices facing resilience issues, NHS England provided financial support to both the practice that was facing resilience challenges and the neighbouring practice and patients affected by this.

The support was mobilised to provide:

- Detailed clinical evaluation of the issues facing the practice.
- Detailed managerial support in identifying the business challenges
- Clinical and Managerial leadership to produce an outline and detailed plan for continuing provision of Primary care to the practice patient list.

These led to an early decision that a merger of the two practices was the only real option for a controlled migration of patients and reduction in risk to both patients & the practices. The action plan listed in detail the areas that needed to be addressed and covered:

- Diagnostic & improvement
- Rapid Intervention
- Specialist Advice & Guidance
- Practice Management
- Coaching/Supervision & mentorship
- Workforce

Because of this intense and focussed support the practice successfully merger a 3,500 patient list from a very challenged practice in just a few months. Patients were risk stratified and supported thorough clinics, individual appointments or wider scale practice level engagement events.

9. Infrastructure (Estates): Achievements and Impact

9.1 **Estates and Technology Transformation Fund (ETTF) Progress -** The NHSE Estate and Technology Transformation Fund (ETTF), launched in 2015/16, is a multi-million-pound investment programme in General Practice facilities and technology. It has recently been confirmed that the programme end date has been extended from March 2019 to March 2020.

9.2 An update on the three Dorset projects is provided below:

Project 1 - New-build replacement for Wareham Health Centre:

- Revised Primary Care PID approved end of March 2018 to reflect the changing scope of the Wareham Project.
- Dorset HealthCare NHS FT (DHC) completed the Outline Business Case (OBC) for Wareham Hub in Summer 2018 and identified the preferred solution – new build on the middle school site.
- It is hoped that a single development project will be possible, ie incorporating both the ETTF funded primary care component and the Community Hub.
- A very positive ETTF project review meeting took place on 17 April 2018. Attendees included the NHSE national ETTF Programme Lead, members of both the Regional and Wessex Area NHSE teams, and CCG Primary Care representatives. Project issues and blockers were discussed in some detail and action plans agreed. CCG representatives will continue to work closely with the NHSE teams to ensure that emerging national guidelines on ETTF financial flows are applied to this complex multi-stakeholder project;
- The Full ETTF Business Case will now be developed and it is anticipated that it will be presented to this Committee in December 2018.
- Subject to approval of the Full Business Case late in 2018, the aim is to commence construction in March 2019 and to complete construction in March 2020.

Project 2 - Relocation of the Carlisle House Surgery into new leased premises:

- The combined OBC/FBC was submitted to NHSE for consideration at Panel on 23 July 2018.
- Subject to Panel approval and following the return of the tendered construction costs a final report will be presented to this committee in Autumn 2018.

- Subject to approval of the Full Business Case in early summer 2018, the aim is to commence construction in late 2018 and to complete construction in March 2019;

Project 3 - Refurbishment of the Parkstone Health Centre:

- A revised PID, created to reflect the changing scope of this project, was approved by NHSE Wessex Area team on the 1 March 2018;

- The detailed schedule of works is now being developed for agreement with the landlord (NHSPS);

- The Full Business Case is in development and it is anticipated that it will be presented to this Committee in October 2018;

- Subject to approval of the Full Business Case, the aim is to commence construction in November 2018 and to complete construction in March 2019.

9.3 **Premises Improvement Grants -** Whilst NHSE retains overall responsibility for Premises Improvement Grant Funding, the CCG's Primary Care Development team now has a robust process in place for managing the annual programme in Dorset.

9.4 In 2017/18 a total of £691,000 was allocated to 32 individual schemes in Dorset. Locally bids have been invited for funding in 2018/19 although the total amount of funding available has not yet been confirmed by NHSE.

9.5 Looking forward it is not yet clear whether this annual programme of Grant Funding will continue. It has been suggested that in future this funding will form part of the overall STP Capital Investment Plan (see below) and advice is being sought from NHSE on this.

9.6 Dorset STP Strategic Estate Plan and Capital Investment Plan - The guidance for refreshing NHS plans in 2018/19 asked all sustainability and transformation partnerships (STPs) to undertake a strategic, system-wide review of estates and develop a Capital Investment Plan.

9.7 The STP Estate Strategy needs to:

- underpin and express the STP's overarching strategy including acute, Primary Care, mental health, community, ambulance and specialist trusts;

- cover all services including acute, Primary Care, mental health, community, ambulance and specialist trusts;

- explicitly set out how it supports the STP's overarching clinical and financial strategy.

9.8 The STP's Capital Investment Plan needs to identify and explicitly prioritise the individual capital schemes, including schemes within Primary Care.

9.9 The Dorset STP Strategic Estates Group has created a prioritised schedule of all planned capital developments (system-wide) and has identified a number of priority schemes which are sufficiently well developed to allow a capital bid template to be completed. A number of capital bids have now been completed and submitted on 29 June 2018.

10. Infrastructure (Technology Enabling Care): Achievements and Impact

10.1 **GP Online Consultations -** The Primary Care team continues work with the Task and Finish group to re-examine the options for a GP Only 'GP Online Consultations' product and will procure via the NHSE Dynamic Purchasing system for practices.

10.2 In May, member practices received an update on the options for securing this support for their patients with details of framework providers discussed at the May Membership event. A Dorset procurement team including representatives from General Practice are working together with the regional NHSE team to procure a service provider. This process seeks to conclude during the summer to allow a phased implementation to commence in the autumn of 2018.

10.3 **NHS e-Referral Service (e-RS) -** A Project Board oversees assurance for this work and provides regular updates to OFRG. Our current position is:

- Utilisation continues to increase above target and in line with trajectory and quality indicators agreed for 18/19;
- A detailed Communications Plan is being implemented with Primary Care communications agreed with Wessex LMC.

10.4 **Electronic Prescription Service (EPS) - Repeat Dispensing**: Work continues to promote repeat dispensing and support has been sought from NHSE and the Academic Health Science Networks (AHSN). NHS Digital are currently working on improved resources, having employed a pharmacist lead to take the system forward. Evidence from NHSI has shown that the efficiency improvements in implementing repeat dispensing may save the system considerable funds. Advice from the NHS Digital National lead pharmacist for the programme has been sought, and new guides to implementation are planned to be sent out in the next financial year. It is planned to have a Dorset implementation group and bring together relevant stakeholders in order to re-launch when the new NHS digital resources come in. It is likely that this will include undertaking a practice suitability check before implementation.

10.5 **Patient Access to Online Services -** Dorset currently has an average of 17% of patients registered with GP Online services against a national minimum target of 10%. Locally we are aiming for 20%.

11. Care Redesign - Improving Access to General Practice Services (IAGPS): Achievements and Impact

11.1 A major component of the GPFV was the Improving Access to General Practice Services (IAGPS), which mandated the provision of services from 1830-2000 Monday to Friday and Weekends according to Local Need. In August 2017, due to its ACS aspirations, Dorset was selected to be an accelerator area for IAGPS, being set targets to achieve 50% of target population coverage by April 2018 and 100% by January 2019; this was to be delivered as part of a proof of concept phase, which would run from October 2017 through to March 2019. After a business case evaluation process, the Dorset population was split into three clusters, using existing Locality boundaries to group practices together, named East, Mid and West, with responsibility for provision being assumed a Foundation Trust in each area. The Governing Body took the further step in January 2018 of agreeing to incorporate the urgent (same-day) element of IAGPS as part of the reprocurement of Integrated Urgent Care (IUC) services. The routine (pre-bookable) element is being developed as part of locality transformation plans. The bracketed terminology from the National IAGPS guidelines was superseded by the terms urgent and routine, in order to support the concept of an integrated service, thus reducing confusion for the public. As a result of the planning guidance released by NHS England, a revised target of achieving 100% target population coverage by October 2018 was set. To date, the programme is on course to meet this target.

11.2 The first major milestone of the programme was the 50% target population coverage (measured using a calculation of clinical hours of 45 minutes per 1,000 population) for IAGPS was achieved, and surpassed, by March 2018. The actual % achievement across Dorset is shown below:

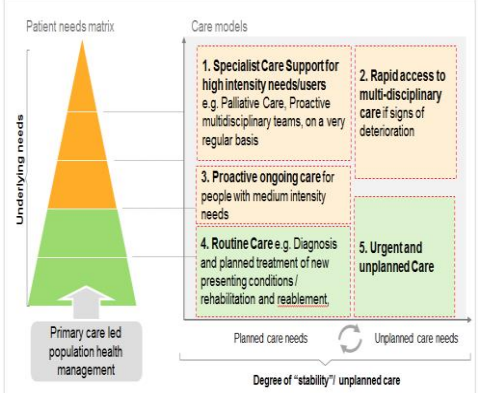
Area	25 - 31 March 2018
West Cluster (%)	109 hours (59%)
Mid Cluster (%)	112 hours (50%)
East Cluster (%)	172 hours (91%)
Dorset (%)	**393 hours (66%)**

11.3 IAGPS has arguably been perceived as the catalyst to achieving a cluster level response to CCG delivered programmes of work. The size 250k-300k population coverage is assessed to be appropriate in this context as it affords the provider the opportunity an agile and responsive model to affect a significant proportion of the population operationally as a whole without becoming so far removed that changes to service delivery become unworkable. This approach to service delivery is supported by a robust support system with colleagues (both clinical and non-clinical from primary, secondary and community sectors) in other clusters and managerial or

specialist staff at the CCG level. It could be further argued that IAGPS as a programme is a tangible example of working as an ICS, when the providers that make up the cluster groups are considered, and how they have been supported through other mutually beneficial programmes of work.

12. Care Redesign – Integrated Community and Primary Care Services (ICPCS): Achievements and Impact

12.1 **ICPCS Workforce Investment** - The case for change in community and primary care services is now well established. ICPCS workforce investment has been secured to focus on the population with complex need and enhance the proactive approach to identification and management of the most complex patients including rapid response and implementation of the frailty framework. The Outline Business Case details the workforce within each element of the model of care and the table below summarises the change in workforce and financial costs over 5 years expected as we support people with specialist care and rapid access to MDT care.



STAFF GROUP	SPECIALIST CARE FOR HIGH INTENSITY NEEDS		RAPID RESPONSE	
	WTE	£'000	WTE	£'000
GP	(13)	(1,472)	(1)	(85)
Consultant/GPSI	12	1,703	0	63
Practice Nurse	4	165	0	0
Nurse Practitioner	4	236	0	0
H&C Assistants	42	1,034	2	43
Community Nursing	47	1,812	3	119
Therapist	62	2,367	3	103
Pharmacist	16	780	0	0
TOTAL	**175**	**6,625**	**7**	**243**

12.2 It is anticipated that the locality plans will reduce:

- non elective admission and re-admissions for this population group
- occupied bed days in acute and community hospital settings
- people delayed in hospital
- the number of stranded patients in hospital settings
- the number of people requiring long term care home placements

13. Primary Care Networks

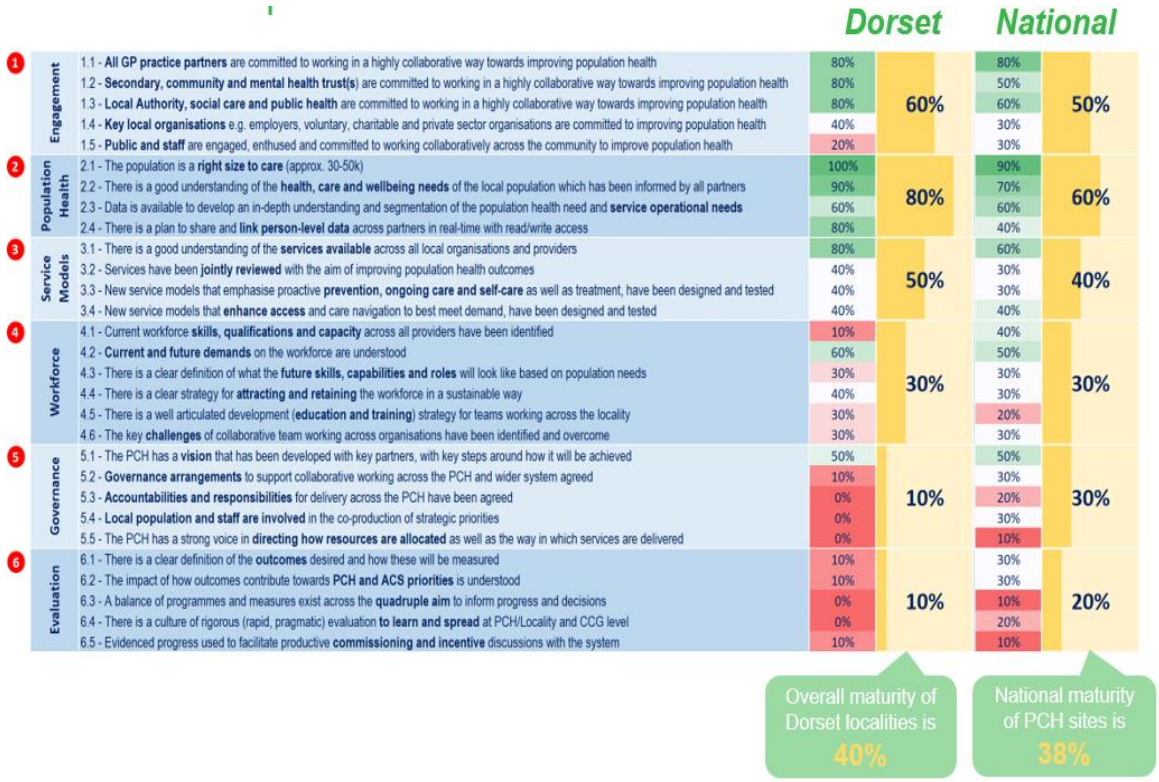
13.1 The development of **Primary Care Networks** forms part of NHS England ambitions to support General Practices working at scale (NHSE Planning Guidance, February 2018). The form and function of Primary Care Networks is currently evolving.

13.2 Primary Care Networks are expected to support person-centred care closer to home. In Dorset our planned roll-out of Primary Care Home sites will form part of this. Over time Primary Care Networks will be expected to enable an

extended range of services to be delivered in the community with a focus on population health management for physical and mental health; increased resilience to be able to better manage fluctuations in demand and capacity as well as strong engagement with local communities.

13.3 Early indications suggest better system outcomes are emerging as a result of the development of Primary Care Networks in Dorset (National Association of Primary Care NAPC). This is in line with the international emerging evidence base.

13.4 Further emerging evidence of impact can be seen in the summary Primary Care Home Development grid below. Comparing Dorset with the national picture of PCH, we are performing better than the national in terms of engagement, population health and service model development. Overall our maturity is 40% compared to the national maturity of PCH of 38%.



13.5 Next steps will be to link the development grid to the NHSE matrix to show progress towards ICS maturity at a local and aggregate level.

ICPCS Frailty

13.6 The Dorset Framework for Frailty has been developed through multi-sectorial collaboration with health and social care providers, voluntary and third sector organisations, patients and their representatives. It is endorsed by the Dorset Frailty and End of Life Care Reference Group.

13.7 The development of the framework is a response to the request for a common approach to the early recognition and identification of frailty as a long term condition, promoting early detection through case-finding, appropriate

assessment, risk stratification; and backed up by planned and coordinated care and support.

13.8 The vision is that all people living with frailty have their condition recognised early and proactively managed within an integrated coordinated care pathway which meets the needs and expectations of the individual, their carers and advocates.

13.9 The Frailty service specification forms a key part of the model of delivery of integrated community services new models of care. The specification went live from April 2018 and localities are working collaboratively to implement at locality level. Population health outcome based commissioning and system wide working is creating the environment to drive change. 65% of all Frailty plans demonstrate collaborative working with a target of 100% by March 2019.

13.10 Work throughout 2018 will support practices in delivering the model and addressing challenges / barriers to full delivery of the specification. Currently localities are at different points of the journey but all working to one specification. Plans put forward by the localities are encouraging with a large number demonstrating integrated plans to work collaboratively across primary care and other provider organisations. Primary Care Home is supporting this development including focus on integrated nursing. It is anticipated that the ICPCS plans will further encourage networking and integration to deliver outcomes.

Case Study

Locality Enhanced Frailty Service

Central Bournemouth Locality are developing and delivering an 'at scale' / collaborative frailty service model. The locality has worked together to agree a clinical and business model for a locality. The service is fully integrated with Bournemouth Hub and commenced from April 2018. Two practices in the locality share the employment of the frailty team to reduce risk (with risk sharing agreement) and have identified the development of a cluster wide venture organisation in their priorities for development.

Case Study

Weymouth & Portland Integrated Community Hub

Despite a more deprived population, Weymouth & Portland locality has achieved reductions in bed utilisation, admissions and readmissions. The Weymouth Locality Hub has a well-developed MDT approach supporting complex / frail elderly referrals through a community Virtual Ward approach (including rapid response and access to MDT). The hub has been operational for 2.5 years and is now embedded within primary, community and social care as the co-ordination and response hub supporting a number of high need patients as well as providing resilience and support to GP practices and Care Homes. Sessional clinical leadership from a Community Geriatrician, with GP Extensivist roles also providing frailty expertise and clinical leadership. Locality visiting service. ICPCS investment and development will continued to focus with this direction of travel along with a system partner focus on super stranded patients and variation between practices.

14. Care Redesign - (Right Care and Demand Management): Achievements and Impact

14.1 The Clinical Commissioning Local Improvement Plan (CCLIP) has been focusing on three areas from the nine key 'Collaborative Agreement' Specialities. These are:

- Trauma and Orthopaedics (MSK);
- Cardiology;
- Dermatology.

14.2 MSK is showing a reducing trend. In 2017-18 the volume of GP referrals reduced by 1.4% (-203), with a distinctive split between the localities, with increases predominately recorded in the East of the county. 2017/18 year-end figures show a further 14.0% reduction on 16/17, and the impact of the MSK triage service (implementation mid Oct 17) is now having a significant impact on the level of acute referrals.

Figure 6 illustrates the latest rolling 12 month figures highlighting the variation in the rate of MSK referrals to the main STP Providers (RBH, PHT & DCH) per 1000 registered list size - the highest 24.0 per 1000 in Christchurch. The rate in North Dorset is artificially low as referral activity to both Salisbury and Yeovil is not included in these STP only figures.

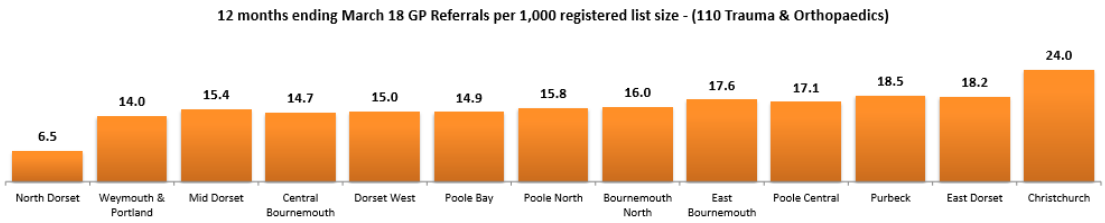


Figure 6: Variation in MSK referral rates across Localities

14.3 The MSK Right Referral Right Care group has representation from Primary Care, secondary care and the MSK triage service leads at Dorset Healthcare. This group is working together to continue to address variation. The group has identified the following project areas to take forward over the coming months:

- Developing a referral template for initial referrals from GPs into the MSK triage service (this was following a number of rejections back to the GPs from the triage service);
- Education and study days for GPs;
- Website presence for MSK triage service which can be used by both GPs and members of the public.

14.4 Cardiology is also showing a reducing trend. Last year the volume of GP referrals reduced by 1.4% (-124), with a distinctive split between the localities, with increases in the East of the county. Most notable were reductions in Dorset West (-19%) and Mid Dorset (-25%). 17/18 year-end figures indicate a further 2.5% reduction.

14.5 Latest rolling 12 month figures (Figure 7) highlight variation in the rate of Cardiology referrals per 1000 registered list size - the highest rate 17.2 per 1000 in Christchurch.

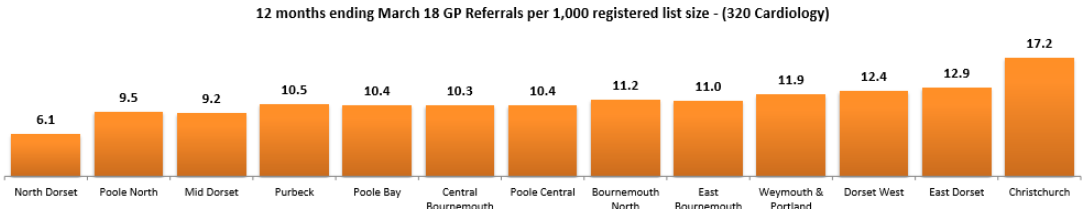


Figure 7: Variation in Cardiology referral rates across Localities

14.6 The Cardiology Right Referral Right Care group with representation from primary, secondary and community care are now focussing on:

- Creating a standard secondary care consultant outcome letter;
- Education and training;

- E-referral advice and guidance – there has been pan Dorset agreement to the E-Referral solution for cardiology;

- Direct Access to Echocardiography.

14.7 Dermatology has shown an increasing referral trend. Last year the volume of GP referrals increased by 5.2% (630), with increases recorded in all localities with the exception of Mid Dorset, North Dorset and Weymouth and Portland.

14.8 2017/18 year-end figures (Figure 8) indicate a 1.7% increase when compared to 2016/17, overall the trend has stabilised and the size of the current year to-date increase has reduced significantly over the last few months.

Profile by Locality	2015/16	2016/17	Change Actual	Change %
Bournemouth North	870	891	21	2.4%
Central Bournemouth	613	711	98	16.0%
Christchurch	1,184	1,365	181	15.3%
Dorset West	623	740	117	18.8%
East Bournemouth	1,072	1,091	19	1.8%
East Dorset	1,358	1,453	95	7.0%
Mid Dorset	685	661	-24	-3.5%
North Dorset	722	666	-56	-7.8%
Poole Bay	1,168	1,223	55	4.7%
Poole Central	1,119	1,182	63	5.6%
Poole North	860	923	63	7.3%
Purbeck	615	652	37	6.0%
Weymouth & Portland	1,095	1,070	-25	-2.3%
None	55	41	-14	-25.5%
TOTAL	12,039	12,669	630	5.2%

2016/17	2017/18	Change Actual	Change %
891	810	-81	-9.1%
711	787	76	10.7%
1,365	1,404	39	2.9%
740	752	12	1.6%
1,091	1,098	7	0.6%
1,453	1,416	-37	-2.5%
661	634	-27	-4.1%
666	599	-67	-10.1%
1,223	1,146	-77	-6.3%
1,182	1,147	-35	-3.0%
923	957	34	3.7%
652	648	-4	-0.6%
1,070	1,015	-55	-5.1%
41	26	-15	-36.6%
12,669	12,439	-230	-1.8%

Figure 8: Dermatology Profile by Locality

14.9 As part of the paper 'switch off' and to reduce the burden on Primary Care in terms of the E-Referral process there has been agreement across Dorset to implement a 'three routes in' approach to Dermatology services, as follows:

- Referral Assessment Service (RAS) - GPs will refer (including an image where possible) into the RAS service for the relevant provider who will then triage OR provide advice back to GP/ no further action;

14.10 Advice and Guidance, including tele-dermatology - GPs can now access Advice and Guidance including tele-dermatology for each acute provider;

- Fast Track - accessed through the existing Electronic Referral Service (ERS) process including an image.

14.11 The benefits of this approach will be to release capacity to reduce overall patient waits, prevent unnecessary patient appointments and provide quicker reassurance to patients without suspicious lesions.

14.12 **Tele-dermatology**: Linked to the above, work is progressing towards piloting an 'app' which GPs can use to take photos of skin lesions, send to secondary care and permanently delete photos from the mobile device used. There are currently 19 practices from across Dorset who have put forward an interest to be part of the pilot.

14.13 Discussions have taken place with the Primary Care Workforce Centre and recently identified funding for six GPs to undertake Dermatology GP with

Specialist Interest (GPSi) training, which will be a key feature of the integrated dermatology service.

14.14 The CCLIP for 2018 / 19 continues to have a requirement to focus on these areas for 2018 / 19 and embed the system wide approach to the management of demand and variation.

15. Care Redesign (Prevention at scale) – Achievements and Impact

Starting Well

15.1 Healthy lifestyle assessment is now embedded routinely within the Better Births project. Scoping is complete and the next stage is to co-produce options for implementation. Discussions are planned with Bournemouth University to include healthy lifestyle training within the midwifery curriculum for newly trained midwives

15.2 Work on building whole school approaches to health and wellbeing, with a focus on physical activity and emotional health and wellbeing is progressing well. A survey has been sent to schools about potential actions for schools, and a workshop was held to discuss next steps which will lead to production of a more detailed business case.

15.3 An intensive programme of work with health visitors and children's centres has ensured much closer working between teams, and is already having an impact on outcomes.

Living Well

15.4 The LiveWell Dorset service transitioned in-house on 1 April and the new digital platform was launched at the same time. In the first month the platform had more than 3,000 unique users, and delivered more than 50 coaching episodes via its online chat facility, and there were more than 60 requests for a call back from a coach.

15.5 The Health Checks task and finish group had its first meeting in May and has agreed some high level principles to inform the design of the future programme at locality level. Subsequent meetings will explore commissioning and contracting options, and co-production to inform how best to integrate and offer checks for people with learning disability and serious mental illness.

Ageing Well

15.6 Two pilot programmes for Escape Pain which aims to improve self-management of hip and knee pain have been run. These pilot programmes were in East Dorset and the intention is to roll out the programme across Dorset. Work is ongoing with the MSK triage service, primary care, and LiveWell Dorset to ensure that the service and referral pathway is embedded for future cohorts.

15.7 Altogether Better have now appointed a Development Manager and have confirmed the list of practices that will be engaging in the Leadership Programme for the Collaborative Practice model. Seventeen practices across

Dorset have engaged fully. Early feedback from one practice suggests there is a high degree of interest from registered patients in helping out more.

A text message to 5,000 people registered with one practice elicited 218 replies and 28 completed expressions of interest forms. Receptionist morale has improved considerably the practice reports.

15.8 Active Ageing – a project aimed at getting 55 to 65-year olds more active – is now underway, with a steering group and project manager appointed. The first engagement event with stakeholders and interested organisations has been held. North Dorset locality have expressed an interest in being involved in the pilot.

15.9 The award for the diabetes prevention programme (funded nationally) has been made to Living Well Taking Control (Health Exchange). Mobilisation of the service has commenced, working closely with the CCG and LiveWell Dorset and the service will start in 18/19.

Healthy Places

15.10 Spatial Planning – good links are being made between local planners and the Primary Care Infrastructure work. Broader developments are to be discussed at the Dorset-wide workshop planned for end June 2018.

15.11 Active travel – working alongside the Integrated Transport Planning project to include travel planning and maximising active travel in healthcare plans around access and how strategic plans for Poole and Bournemouth hospitals and hubs within GP localities are implemented.

15.12 Access to green space – A range of projects are now set up to encourage different groups of people to access their local green spaces, and these will be evaluated using the same framework to establish their impact and how well this is sustained. In Poole the projects focus on engaging young families through facilitated activities; in Dorset the projects are improving path conditions and removing barriers to public rights of way along specific routes with particular connections in mind e.g. connecting Littlemoor residents with Lorton Meadows nature reserve; in Bournemouth the project is to develop a group of volunteers (referred in by partners) with a focus on building positive mental health.

15.13 Healthy Homes – we have already upgraded over 160 homes against a target of 150 for Phase 2 and secured additional funding from the national Warm Homes Fund for specific areas of development. Key to ongoing development is better integration within GP localities to allow better targeting to vulnerable residents with specific cold-related conditions.

15.14 Public health link workers are now providing support to all Dorset localities, which includes

- use of Locality public health profiles to consider how best to target new ways of working to meet local need

- an increased healthy lifestyles offer through Livewell Dorset including digital referral, workforce development training and feedback to localities on service use and patient experience.

16. Lessons Learnt to date

- Strong and distributed leadership results in early buy in from locality practices and enables greater success moving forward.
- Recognition of a "burning platform" for change results in practices in localities being more engaged.
- Increasing patient facing clinical time improving models of care such as frailty and long term conditions management.
- A balance between addressing immediate issues, for example workload and long term change improves buy in and keeps momentum.
- Protected Learning Time (PLT) is essential to allow 'Head space' for practices.
- The value of a joint agreement (Memorandum of Understanding) cannot be underestimated in supporting a clear commitment to collaborative working.
- Making sure function drives form is essential or there is a risk of having form that does not deliver on the function.
- Recognise the value of building strong collaboration across the system to support change and buy in.
- The value of aligning incentives to accelerate change.
- Benefits of bringing together local plans to demonstrate how care can be delivered more effectively through strong system partnerships – such as that achieved in the IAGPS Cluster level working arrangements.

17. Next Steps

- Continue a co-production approach to support Dorset's Primary Care Network development working with locality transformation groups, the National Association of Primary Care (NAPC), LMC and NHS England including the National ICS support team;
- Provide locally focused support and advice around delivering new care models and frameworks for GPs to progress working at scale;
- Develop collaborative working more formally including governance and decision making processes.

- Provide support for primary care business development to strengthen leadership of Primary Care Networks.
- Continue to focus on developing resilience at practice and locality level – support improved primary care capacity and demand management.
- Increased focus on quality improvement and managing variation as a lever for change and collaboration;
- Development of Provider Leaders to strengthen leadership for Primary Care Transformation.
- Implement a Primary Care incentive framework to incentivise integrated, collaborative working and models;
- Expand the Primary Care Outcomes Framework to include other areas of the GPFV to demonstrate impact ;
- Work with ICPCS Portfolio Board, East and West IHCP to ensure primary care has a strengthened voice and is able to play a full and active role in the integrated care system.
- Further develop approaches to population health management, strengthening business intelligence support to Primary Care Networks.

18. Conclusion

18.1 This mid-point review has identified significant progress in Dorset in working towards the ambitions set out in our Primary Care Strategy and GPFV Delivery Plan.

18.2 We plan to continue to invest in primary care sustainability and transformation to further progress these delivery plans and realise our ambition as set out in our Dorset Primary Care Commissioning Strategy and GPFV Delivery Plan.

18.3 We will continue to focus on primary care provider development to establish Primary Care Networks which serve the whole Dorset population.

Rob Payne
Head of Primary Care
Dorset Clinical Commissioning Group

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Dorset Health Scrutiny Committee

Dorset County Council

Date of meeting	17 October 2018
Officer	Katherine Gough, NHS Dorset Clinical Commissioning Group
Subject of report	**Glucose Monitoring Device for individuals with diabetes**
Executive summary	This report outlines the processes followed in Dorset CCG to determine the NHS prescribing arrangements for the flash glucose monitor, Freestyle Libre®
Impact assessment:	Equalities Impact Assessment: NICE found that people with learning difficulties or certain mental health problems and pregnant women may particularly benefit from FreeStyle Libre. People with certain skin conditions or allergies may be unable to wear the sensor. An application for use in Adults was received by the CCG in March 2018, and an application for use in children received in June 2018.
	Risk Assessment: N/A - Report provided by NHS Dorset CCG.
	Other Implications: N/A
Recommendation	The Committee is asked to note and comment on the contents of this report.
Reason for recommendation	This paper is presented for information purposes following concerns raised by Councillors and members of the public regarding the availability of flash glucose monitoring to Dorset patients.
Appendices	Dorset CCG commissioning Statement Freestyle Libre August 2018
Background papers	NICE Guidance Freestyle Libre glucose monitoring

	Healthcare Improvement Scotland advice statement July 2018 www.dorsetformulary.nhs.uk
Contact	Name: Katherine Gough Job title: Head of Medicines Optimisation Tel: 01305 368946 Email: Katherine.gough@dorsetccg.nhs.uk

NHS Dorset Clinical Commissioning Group

Flash Glucose Monitoring Device: Freestyle Libre®

Freestyle Libre ® is a flash glucose monitoring system which monitors glucose levels using interstitial fluid levels rather than capillary blood glucose from finger prick testing.

Dorset CCG has always maintained an evidence based and cost effectiveness approach to making decisions on medicines and devices. The CCG aims to adhere to the statutory requirements to fund and commission drugs and devices with NICE technology appraisals (TA) within the required timescales and advise on medicines which are most cost effective and have a strong evidence base.

In the case of Freestyle Libre®, Dorset CCG published a commissioning statement in November 2015 to state that it was not commissioned. This was developed with a multidisciplinary team (MDT) of medical and pharmaceutical support. The product had come to market, and there was little evidence available.

NICE issued an innovation briefing on Freestyle Libre® in September 2017, but recognised that the evidence had limitations and the resource impact on health systems was uncertain: https://www.nice.org.uk/advice/mib110.

In November 2017, the device became available on NHS Prescription. At that point the previous commissioning statement was reviewed by a multidisciplinary team, our Diabetes working group which is made up of diabetes consultant specialists, GPs and senior pharmacists. This group found that:

> "There is limited data to confirm that use of FreeStyle Libre® will result in better controlled diabetes, an improvement in patient oriented outcomes such as a reduction in complications due to poorly controlled diabetes, hospitalisation rates or ambulance/GP call out rates, improvement in overall long-term diabetes control or quality of life. More data is also required to confirm effectiveness of this technology in less well controlled diabetes.
>
> There is limited data to support the routine use in children and young people."

Dorset CCG therefore decided not to support prescribing at this time until a full cost and clinical effectiveness review is available or further national guidance, such as NICE technology appraisal is issued.

At that time, the Regional Medicines Optimisation Committee (RMOC) North issued some limited criteria for prescribing. This was reviewed by the Dorset group, but as they had not

used any additional evidence than was looked at by the Dorset group, the criteria were not accepted. Dorset CCG raised concerns with the South Regional Medicines Optimisation Committee on the rationale behind their published information.

A further formulary application from adult diabetes services which was presented to the Dorset Medicines Advisory Group (DMAG) in March and to the CCG Clinical Commissioning Committee in April to seek permission to put forward a business plan for funding. At that point, no formal formulary applications had been made for use in children.

The April 2018, Clinical Commissioning Committee decided that a business case should not be progressed at this time, as there was no further evidence, or positive NICE technology appraisal, and the cost to the Dorset system was still unknown. Therefore, the CCG did not support prescribing of the device at this time.

Dorset CCG was not the only CCG upholding the position not to fund the device. Across the Southwest of England there remained a mixed picture. Work was undertaken to establish potential costs, and the estimates using an evaluation by the East of England NHS, estimated costs to Dorset to be over £2+ million, without evidence of improved outcomes. Consultants and GPs evaluated potential patient numbers, and local estimates ranged between several hundred patients and half of all type one diabetics.

This decision remained under review and each month there were reviews of published data and evidence to see if there was any further information to support use of the device.

The Dorset Clinical Reference Group (CRG) which comprises of medical and nursing directors across the System, raised concerns that there were some patients who could benefit from the device, and sought a further review in July 2018.

Also in July 2018, Healthcare Improvement Scotland announced that they would be making Freestyle Libre® available to patients meeting a set criteria. Within their evaluation they recognised that there was a general lack of transparency of the published evidence and thus decided that a de-novo economic analysis would better inform the cost-effectiveness and use of Freestyle in Scotland. They also carried out a budget impact model to forecast the potential cost. Rather than using the impact on HbA1c (a measure of glucose control), they looked at the impact on health benefits. Their overall assessment was:

Based on the results of the analysis presented, the Freestyle Libre® flash glucose monitoring technology appears likely to be a cost-effective alternative to self-monitoring of blood glucose levels in both T1 DM and T2 DM patients treated with intensive insulin therapy. The incremental cost effectiveness ratio of Freestyle Libre® falls within reasonable values of the willingness-to-pay thresholds for an additional QALY. The uncertainty of the results has been captured in the probabilistic sensitivity analysis, the results of which support the base case findings. The restricted populations within the IMPACT and REPLACE trials and the heterogeneity of the populations across the other evidence sources pose challenges to the generalisability of the model results to other populations. However, it is reasonable to assume the general conclusions are applicable to the Scottish real-world diabetes population.

The full comprehensive assessment can be found:

http://www.healthcareimprovementscotland.org/our_work/technologies_and_medicines/shtg_advice_statements/advice_statement_009-18.aspx.

The Scottish evaluation was the first full cost effectiveness recognised that there would be an additional cost impact for the system in using the new device. They looked at both type one and type two diabetes, though in England, the use at present is advised in type one only.

In addition, Health Technology Wales issued a clinical consensus statement that said: "Consider as an option for patients testing eight or more times a day".

Initial forecasting in Dorset was informed by a comprehensive analysis and commissioning statement developed by the East of England. It is understood that although it has not yet been approved and published, the regional team and CCGs in that area are considering a restricted cohort based on a refinement of the RMOC North guidance, and that it would be restricted to Consultant prescribing only in adults and children with fixed funding arrangements and audit.

Initially the new device was not suitable for drivers, who also had to use blood glucose strips before driving. However, the DVLA in April 2018 agreed that they would update their guidance to include monitoring of interstitial glucose levels, but until this is published, recommend only blood glucose test strips. This update is awaited.

In August 2018, RMOC North, indicated that they will soon begin to evaluate the audits from the use of the device following publishing of their criteria. This is awaited.

In August 2018, the CCG Chief Officer, CCG Medical Director and the Head of Medicines Optimisation met with the Associate National Clinical Director, Diabetes, NHS England to discuss this product.

As a result, a revised proposal for use of Freestyle Libre was developed with the clinicians that led the first proposal. This was presented to the Clinical Commissioning committee and approved for a limited cohort of patients, and for initiation by specialists only. This was supported by the CRG.

The current approved use for adults is detailed in appendix 1.

The full detail of the Dorset position is published on the formulary website: www.dorsetformulary.nhs.uk.

A further application for use in children has been presented to the Dorset medicines Advisory Group (DMAG) in September 2018 from paediatric consultants in the county, led by a Dorset County Hospital clinician. This was favourably received by the DMAG and a recommendation is going forward.

The number of CCGs that have made this device available is increasing, however most are with restricted criteria, often more restricted than the RMOC North and many are restricting prescribing to specialists, and for a limited period pending audit. This applies to the majority of the south west. Dorset CCG is not a major outlier in the approach taken.

COMMISSIONING STATEMENT ON THE USE OF FREESTYLE LIBRE® SENSORS

SUMMARY
The NHS Dorset Clinical Commissioning Group commissions the use of FreeStyle Libre® sensors for a restricted group of adult* patients with Type 1 diabetes.

BACKGROUND	FreeStyle Libre® is a flash glucose monitoring system which monitors glucose levels using interstitial fluid levels rather than capillary blood glucose from finger prick testing. • It consists of a handheld reader and a sensor, which is sited on the back of the arm. When the reader unit is passed over the sensor, the reader shows a reading based on interstitial fluid glucose levels. The sensor lasts for up to 14 days and then needs to be replaced. • The reader can show a trace for the last eight hours and displays an arrow showing the direction the glucose reading is heading. Flash glucose monitoring is not the same as continuous glucose monitoring (CGM). • A finger-prick test using a blood glucose meter is still required during times of rapidly changing glucose levels when interstitial fluid glucose levels may not accurately reflect blood glucose levels (i.e. acute illness such as Influenza, diarrhoea and vomiting), if hypoglycaemia or impending hypoglycaemia is reported, or the symptoms do not match the system readings. • FreeStyle Libre® users will still need to perform finger-prick blood tests prior to and during driving to meet current DVLA requirements, as FreeStyle Libre®, like CGM, measures interstitial fluid levels and not capillary blood glucose levels, though new legislation is anticipated and this may change when published.
RELEVANT NICE GUIDANCE	NICE MedTech Innovation Briefing https://www.nice.org.uk/advice/mib110 "A key uncertainty around the evidence is that the randomised controlled trial of people with type 1 diabetes included only adults whose diabetes was well controlled. The resource impact is uncertain, and depends upon the extent to which improved glucose control through the adoption of FreeStyle Libre® translates into fewer complications, reduced emergency admissions and less use of glucose test strips." http://www.healthcareimprovementscotland.org/our_work/technologies_and_medicines/shtg_advice_statements/advice_statement_009-18.aspx *"Based on the results of the analysis presented, the Freestyle Libre® flash glucose monitoring technology appears likely to be a cost-effective alternative to self-monitoring of blood glucose levels in both T1 DM and T2 DM patients treated with intensive insulin therapy. The incremental cost effectiveness ratio of*

	Freestyle Libre® falls within reasonable values of the willingness-to-pay thresholds for an additional QALY. The uncertainty of the results has been captured in the probabilistic sensitivity analysis, the results of which support the base case findings. The restricted populations within the IMPACT and REPLACE trials and the heterogeneity of the populations across the other evidence sources pose challenges to the generalisability of the model results to other populations. However, it is reasonable to assume the general conclusions are applicable to the Scottish real-world diabetes population."
FORMULARY STATUS	RED- for the following patient groups only 1. Type 1 Diabetic adult patients who are pregnant 2. Type 1 Diabetic adult patients with loss of hypoglycaemia awareness who have experienced a hypoglycaemic episode requiring assistance 3. Type 1 Diabetic adult patients who require third parties to carry out monitoring and where conventional blood testing is not possible Patients will be required to agree to a patient contract for use of the device to maximise potential benefit and undertake training on how to use the device. Results will be shared for audits of effectiveness.
PBR STATUS	Inclusive of tariff
COMMISSIONING IMPLICATIONS	It is yet to be established whether this treatment represents a cost-effective treatment option for the NHS, and data gathered from this limited cohort should be used to inform national data assessments.
RELEVANT CLINICAL DELIVERY GROUP	N/A
PATIENT PATHWAY IMPLICATIONS	There is a formulary for blood glucose testing strips for patients with Type 2 diabetes that has been expanded and updated. Patients with Type 1 diabetes are not restricted to this Formulary. For patients identified as meeting the criteria for use of Freestyle Libre in Dorset, the specialist service will need to arrange training, patient contract and appropriate follow up to establish that the product has shown benefit. Prescribing responsibility during this period remains with the specialists.
SUMMARY OF EVIDENCE TO SUPPORT FORMULARY STATUS	There is limited data to confirm that use of FreeStyle Libre® will result in better controlled diabetes, an improvement in patient oriented outcomes such as a reduction in complications due to poorly controlled diabetes, hospitalisation rates or ambulance/GP call out rates, improvement in overall long-term diabetes control or quality of

	life. More data is also required to confirm effectiveness of this technology in less well controlled diabetes. This limited cohort initiation will allow more data to be gathered to support use of the device. There is limited data to support the routine use in children and young people.
ASSESSMENT OF COST IMPLICATIONS	Current prevalence data suggests that 432 patients per 100,000 population have type 1 diabetes. If all eligible patients were switched to FreeStyle Libre® from current standard practice, the additional investment required is likely to be between £126k and £376k per 100,000 population (based on current retail price), excluding first year set up costs. In Dorset, this could amount to up to £2.86 million. For the cohort identified for initial use in Dorset it is estimated that there would be approximately 200 patients in total, spread across all sites and this should cost up to £200k.
REFERENCES	https://www.nice.org.uk/advice/mib110 https://westessexccg.nhs.uk/your-health/medicines-optimisation/clinical-prescribing-guidance/6-endocrine-system/3450-freestyle-libre-glucose-monitoring-system/file http://www.healthcareimprovementscotland.org/our_work/technologies_and_medicines/shtg_advice_statements/advicestatement_009-18.aspx
DATE	August 2018
REVIEW DATE	March 2019 or before, in light of new information, evidence or statutory guidance from NICE or other NHS bodies.

*this guidance is for use in Adults. An application for use in children is in process.

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Dorset Health Scrutiny Committee Forward Plan

Committee: 29 November 2018			
Format	Organisation	Subject	Comments
Report	Joint Health Scrutiny Committees	Clinical Services Review and Mental Health Acute Care Pathway Review – update	To provide an update regarding the work of the Joint Committees, including the additional scrutiny of transport to be undertaken by the Joint Committee considering issues relating to services provided by SWASFT
Report	Multi-agency	Mental Health Support for Children and Young People: Inquiry Day	To present a report of the Inquiry Day held in July and to consider recommendations
Report	Multi-agency	Suicide Prevention in Dorset	To present the outcome of a review into the progress of the Dorset Suicide Prevention Strategy
Report	NHS Dorset CCG	Review of Dementia Services	To present the strategic case arising from the review of Dementia Services
Report	Dorset HealthCare	Triangle of Care initiative	To raise awareness of Dorset HealthCare's work around enhanced carer support and involvement for carers of people with mental health needs
Report (TBC)	*Dorset Health Scrutiny Committee*	*Proposed Standing Joint Health Scrutiny Committee*	*To review the concept of a Standing (permanent) Joint Health Scrutiny Committee with Bournemouth, Christchurch and Poole.*
Report	Dorset Health Scrutiny Committee and Healthwatch Dorset	Annual Reports 2017/18 and Work Programmes 2019	To approve the Committee's Annual Report for 2017/18 and to discuss the Work Programme for 2019, taking into consideration the Annual Report from Healthwatch Dorset and their priorities
Report	Dorset Health Scrutiny Committee	Forward Plan – Dates of future meetings, including planned agenda items	To raise awareness of and agree future agenda items, meetings, workshops and seminars
Items for information or note			
Briefing	NHS Dorset CCG	Review of Mental Health Rehabilitation Services	To inform the Committee of a review being undertaken

Committee: 7 March 2019			
Format	Organisation	Subject	Comments
Report	Joint Health Scrutiny Committees	Clinical Services Review and Mental Health Acute Care Pathway Review – update	To provide an update regarding the work of the Joint Committees (CSR and SWAST) and the work of the Task and Finish Group looking at the CSR
Report	Multi-agency / Public Health	Housing and Health	To consider the extent to which inadequate housing in Dorset is having an adverse effect on residents' health
Report (TBC)	*Dorset Health Scrutiny Committee*	*Proposed Standing Joint Health Scrutiny Committee*	*To review the concept of a Standing (permanent) Joint Health Scrutiny Committee with Bournemouth, Christchurch and Poole.*
Report	Dorset Health Scrutiny Committee	Work Programme and Forward Plan – Dates of future meetings, including planned agenda items	To discuss the Work Programme for 2019 and to raise awareness of and agree future agenda items, meetings, workshops and seminars
Items for information or note			

Ann Harris, Health Partnerships Officer, October 2018

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	17 October 2018
Officer	Patricia Miller Chief Executive, Dorset County Hospital NSH Foundation Trust
Subject of Report	**Briefing Paper on Maternity and Paediatric services at Dorset County Hospital NHS Foundation Trust**
Executive Summary	In December 2017 NHS Dorset CCG took the decision to retain 24/7 Obstetric and inpatient Paediatric Services at Dorset County Hospital as part of a single service network across Dorset. This paper outlines how this decision is being progressed through work with health and care partners across Dorset, Bournemouth and Poole.
Impact Assessment:	Equalities Impact Assessment: Once service delivery proposals for both services have been developed, a full impact assessment will be required to ensure that all communities are able to access services safely.
	Use of Evidence: Any forthcoming plans will need to be evidence based and ensure that services are able to meet core national standards.
	Budget: A full business case will be required to support any proposals. This will then require approval via the Dorset Integrated Care System governance framework.
	Risk Assessment:

	Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW (for Dorset County Hospital NHS FT) Residual Risk: LOW (for Dorset County Hospital NHS FT)
	Other Implications: N/A
Recommendation	Dorset Health Scrutiny Committee are requested to note the update briefing.
Reason for Recommendation	This paper is for information only as no decision is required at present.
Appendices	1 Highlights of the Dorset Local Maternity Services Transformation Plan.
Background Papers	NHS England (2016): National Maternity Review Better Births NHS England (2017): Implementing Better Births; A resource pack for Local Maternity Systems
Officer Contact	Name: Patricia Miller Tel: 01305 254643 Email: Patricia.Miller@dchft.nhs.uk

Briefing Update: Maternity and Paediatrics

Background:

In September 2017, after the conclusion of the Clinical Services Review public consultation, the CCG's Governing Body made the decision to create a single maternity and paediatrics service for Dorset. The Governing Body also agreed to 'seek to commission the delivery of consultant-led maternity services integrated across Dorset County Hospital and Yeovil District Hospital for the Dorset population'. Dorset County Hoptial and Yeovil Hospital worked closely for a number of months to develop a sustainable service model. However, following the idenrification of a number of financial and service sustainability challenges across Somerset, Somerset Clinical Commissioning Group subsequently decided to carry out a review of clinical services across its own county, which included maternity and paediatrics services. This led to the cessation of the work between Dorset County Hospital and Yeovil Hospital.

As a consequence, Dorset Clinical Commissioning Group (DCCG) then signalled its 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.

In order to to achieve the above, the Dorset ICS will work to develop a delivery plan.

Maternity and Paediatrics services - Delivery Plan

The Trust will work with colleagues at Poole Hospital and Royal Bournemouth Hospital to develop a sustainable service delivery model for families in our local communities. To ensure this work takes into account the holistic needs of patients, engagement of colleagues from primary, community and local authority services will also be necessary.

The work of the delivery plan will be split into two phases over the period 2018 – 2020.

Phase 1 (2018/19) – To deliver a 'system-wide' local Maternity Services Transformation Plan concluding in 2019. The delivery of this plan is a national requirement as outlined in the following documents:

NHS England (2016): National Maternity Review Better Births

NHS England (2017): Implementing Better Births; A resource pack for Local Maternity Systems

The plan focuses on a number of areas set out by NHS England:

- Promoting safe and effective care
- Co-production with women and families
- Commissioning for outcomes
- Choice and personalisation
- Community hubs

- Neonatal care
- Postnatal care
- Information and technology

The Key Deliverables are as follows**:**

- Local needs assessment, benchmarking and an analysis of any gaps in service
- Co-production design / modelling including stakeholder events
- Piloting any proposed models of care
- Evaluation of these models prior to implementation

A high level summary of the plan is attached for information. This plan has been signed off by NHS England. Although it should be noted that final sign off is an iterative process as agreement is required by several levels of NHSE, both regional and national. With respect to the Dorset Integrated Care System, although the delivery of the plan sits with the One Acute Network Board, the Clinical Reference Group has an essential role in completing quality impact assessments on all proposals for service change to ensure that high quality, safe services are maintained.

Phase 2. The development of a Business Case showing what is required to deliver high quality, accessible and safe services on a consistent basis across East and West Dorset for women and children. This will include the following:

- 24/7 Obstetric Services at both Dorset County Hospital and Royal Bournemouth Hospital (Once the Major Emergency Hospital is created)

- An integrated approach involving Primary, Secondary, Social Care and Education, providing services for 0-16 year olds. The service will aim to achieve the best health and well-being outcomes for all children and young people through the succinct delivery of identification, assessment, treatment and support/care providing efficient and effective services and an Integrated Care Pathway for transition to adult services for eligible young people. The decision to delay the work on children's services until phase two was taken for two key reasons; firstly, the vast amount of change and transformation currently under way across the Dorset ICS means that the capacity of leaders and clinicians to undertake this work is limited. Secondly, Dorset County Council's Children's services will be a key partner in this work. As they are currently undertaking a significant improvement plan, it was felt that this work should delayed until they are able to participate fully.

As the work programmes identified above progress, further updates will be provided to the Dorset Health Scrutiny Committee.

Patricia Miller, Chief Executive, Dorset County Hospital
Senior Responsible Officer for Maternity and Paediatric Services under the Dorset ICS

Appendix 1

DORSET LOCAL MATERNITY TRANSFORMATION PLAN – DELIVERING BETTER BIRTHS

Date of the meeting	17.10.18
Author	H NETTLE, PRINCIPAL PROGRAMME LEAD, NHS DORSET CCG
Purpose of Report	To provide an update to the Dorset Health Scrutiny Committee of progress in responding to recommendations from the National Maternity Better Births Review

1. Introduction

1.1 In March 2017 NHS England published "Implementing Better Births; A resource pack for Local Maternity Systems" providing guidance to deliver the recommendations of the National Maternity Review Better Births by 2020/21.

1.2 The Local Maternity System (LMS) is essentially the maternity element of the local Sustainability and Transformation Plan (STP), with which it needs to be aligned.

1.3 In response to the National Maternity Review Better Births recommendations Dorset STP has established a Local Maternity System through the existing local maternity partnership group that is supporting and driving the implementation of the recommendations.

1.4 The Dorset Local Maternity System (LMS) has developed a Local Maternity Transformation plan (MTP) that brings together an action plan of existing work relating to the reconfiguration of services as a result of the outcome of the Clinical Services Review (CSR) and future actions that need to take place up to 2020-21 to deliver the recommendations set out in Better Births.

2. Dorset Local Maternity Transformation Plan

2.1 Dorset STP is one of seven sites nationally that was selected by NHS England to fast track implementation of initiatives to deliver selected Better Births recommendations. The project has been running since February 2017 and includes improved Postnatal Care and Better Personalised Care Planning.

2.2 Women, families and front line staff (such as midwifery, obstetrics, health visiting, GPs) across Dorset have been co-producing and designing the early adopter improved models of care. The Better Births needs assessment completed in September 2017 was informed from the views of local women, families and professionals. The engagement process included views from women, partners and their families who have had experience of maternity services in Dorset over the last five years. The CCG received 427 responses to the online maternity service survey, and 57 people attended the maternity

'Whose Shoes event'. The engagement activities were analysed and reported by Bournemouth University Market Research Group (MRG).

2.3 The Dorset Maternity Transformation Plan is an all-encompassing plan to deliver the Better Births recommendations and existing work relating to the reconfiguration of services as a result of the outcome of the Clinical Services Review and includes:

- Increasing **midwifery led care** (including homebirths) and reducing the over medicalised model that exists in Dorset.
- Continuing to support **safer maternity care** so that services progress towards the 2020 national ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025.
- Implementing **saving babies lives care bundle** that has been completed by Trusts.
- All three Dorset providers are signed up to the **NHS improvement maternal and neonatal safety collaborative**, including developing a learning collaborative to share learning across Wessex.
- Implementation of national funding to improve access to **specialist perinatal mental health services.**
- It is positive that most women in Dorset already see their named midwife for antenatal and postnatal care in Dorset and work continues to improve **continuity of care** during labour**.**
- The actions required as a result of the outcome of the Clinical Services Review (CSR).
- **Early Adopter Project:**
    - Work is progressing on improving **choice and personalised care** by:
        - Developing a pan Dorset maternity website that will provide a single point of access for women to self-refer to services.
        - The development of a pilot for a citizens portal for personalised care planning.
    - There has been an agreed **new postnatal care model** that includes**:**
        - The extension of the postnatal care pathway to offer women more support and contacts up to 28 days (instead of up to 10-14 days) before discharge.
        - The introduction of a consultant led post-natal clinic between 6-8 weeks postpartum for women who have specific medical needs following a traumatic and/difficult birth.

- In the early stages of the Development of Pan Dorset Antenatal and Postnatal Education package prioritising Emotional Wellbeing and Mental Health within the Early Adopter Project.

3. Leadership

3.1 The Local Maternity System has effective leadership with established senior leader (SRO) who is connected into the governance of the STP.

3.2 There is dedicated programme management and resource to support the delivery of the plan and work of the Local Maternity System.

4. Sustainability

4.1 There are opportunities for doing things differently in maternity care that will enable re-allocation of resources to support improved pathways of care and outcomes for mums, babies and their families.

5. Conclusion

5.1 The Dorset Local Maternity System has worked collaboratively with Dorset maternity system partners to develop a comprehensive plan that sets out the need, vision and action that is required to deliver Better Births up to 2020/21.

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	17 October 2018
Officer	Linda Power - Chief Operating Officer Dorset County Hospital NHS Foundation Trust
Subject of Report	**Briefing for Information - Repatriation of activity from Bridport Hospital to Dorset County Hospital**
Executive Summary	Dorset County Hospital NHS Foundation Trust (DCHFT) currently delivers a number of day case procedures from Bridport Community Hospital. This paper requests approval from partners in the repatriation of approximately 1,446 patients per year to support efficiencies within the service. This will enable shorter waiting times for all patients receiving this type of service and treatment. Dorset County Hospital will be able to provide a total of 4 sessions per week at the hospital site in Dorchester for the repatriated patient activity and will also provide the opportunity to support 4 additional Colonoscopy lists per week due to clinical equipment being made available in the theatre procedure suite. This equates to approximately 20 more patients being seen and treated per week. The impact on waiting times from referral to treatment will be a reduction in waiting times for Colonoscopy (diagnostic procedure essential for cancer diagnosis).
Impact Assessment:	*Equalities Impact Assessment:* The current service at Bridport is used from patients from various areas in Dorset and is not confined to Bridport patients only. The current service provision is inequitable as Bridport patients are the only group or patients outside of the DT2 area who have access to a service in their town. The change in the service would result in further travel for Bridport patients but will provide a service equitable with all other non DT2 patients. Increased provision at DCH may also decrease travel for other patient groups who are currently using Bridport.

	Use of Evidence: Report provided by Dorset County Hospital.
	Budget: DCHFT currently pay £127,529 per annum to Dorset Healthcare Trust (DHC) for the use of the site and facilities at the community hospital.
	Risk Assessment: Having considered the risks associated with this decision, the level of risk has been identified as: Current Risk: MEDIUM (for Dorset County Hospital NHS FT) Residual Risk: LOW (for Dorset County Hospital NHS FT)
	Other Implications: Impact on patient experience due to patients travelling further from home to have their treatment/diagnostic procedure.
Recommendation	To approve the direction of travel to enable further engagement with the local population, patients and GPs to explore the transfer of activity from the Bridport Community Hospital location to the Dorset County Hospital main site in Dorchester. To advise on whether a formal public consultation would be needed to support the change.
Reason for Recommendation	To enable improved efficiency of the service - this will enable patients to be seen more quickly and to receive their treatment in a timely way (by meeting the NHS constitutional access standard for this service). The efficiency will have the added benefit of reducing travel time for clinicians, which will result in improved provision of clinical cover on the Dorset County Hospital Site for urology services. The added benefit will be to support increased activity for Colonoscopy diagnostics and reduce the waiting times for patients with potential cancer diagnoses.
Appendices	Appendix 1 – Quality Impact Assessment (presentation slides)
Background Papers	N/A
Officer Contact	Name: Linda Power, Chief Operating Officer, Dorset County Hospital NHS Foundation Trust Tel: 01305 254272 Email: Linda.Power@dchft.nhs.uk

Repatriation of activity from Bridport Community Hospital to Dorset County Hospital NHS Foundations Trust

1. Background

1.1 Dorset County Hospital NHS Foundation Trust (DCHFT) currently provides Lithotripsy (treatment of kidney stones using ultrasound shock waves) and Cystoscopy (procedure that looks inside the bladder for diagnostic purposes) Services at Bridport Community Hospital.

1.2 Bridport Hospital is managed as part of Dorset Healthcare Trust (DHC) and the provider contract costs £127,579 per year. This includes the costs to provide administration and nursing to support the clinic lists and the clinic sessions, hotel services (e.g. cleaning), facilities, equipment, premises and relevant overheads.

1.3 The Lithotripsy and Cystoscopy Service treats approximately 1,446 patients per year at the Bridport site. This equates to 4 lists per week for Cystoscopy and 2 lists per month for Lithotripsy.

1.4 There are a number of reasons for reviewing the provision of these services on the Bridport site and consolidating the activity at DCHFT, they include;

a) Increasing productivity and efficiency of clinical time for DCHFT staff by removing travel time from the clinical job plans to gain an additional 1 hour per session to allow the team to treat more patients.
b) Increasing medical/clinical cover at the DCHFT site as individuals are present for queries/review.
c) Maximisation of the DCHFT procedure suite providing economy of scale as internal staff are utilised to support additional lists.
d) DCHFT proposal to repatriate activity will also provide an opportunity for DHC to reduce spend as replacement equipment will not be needed in the future from Capital funds. This includes replacement of the decontamination unit and clinical equipment such as stacks and scopes. The stack system costs approximately £80,000 to replace.
e) Reduction in potential loss of lists as DCHFT has a robust decontamination unit and also a service level agreement with Bournemouth Hospital to support during maintenance or breakdown.
f) Provision of a cost effective services as NHS funding is required to deliver high quality care whilst managing rising demand.

2. Proposal

2.1 Repatriate 1,446 patients to the DCHFT main site. This will require engagement and involvement with the local community and the Bridport Hospital staff who have been supporting the service to be able to design the patient pathway and to show how waiting times for patients will be reduced.

2.2 The proposal supports a transfer of the service back to DCHFT as soon as agreed by both parties and public engagement has been sought.

3. Risk Assessment

3.1 There are a number of risks associated with the repatriation of activity. The main concern is the reaction that the decision may have within our local population. Patients

have always supported services closer to home and this will raise concerns to the minority of frequent users of the service and potentially amongst local GP practices.

3.2 In order to manage the identified risks in the risk assessment a number of mitigation actions have been proposed as follows;

a) Public reaction to the loss of local service provision which may also lead to negative press interest – **MITIGATION:** It is proposed that all communications be undertaken by DCHFT to ensure a consistent message with support from DHC and Dorset Clinical Commissioning Group (CCG) to ensure clear and agreed communications and engagement with stakeholders.
b) Potential damage to professional relationships between DCHFT and local GP practices – **MITIGATION:** Full disclosure and inclusion in the process
c) DCHFT ability to recruit of staff in a timely fashion – **MITIGATION:** Start recruitment process early and to provide staff from DHC the opportunity to shadow at DCHFT to enable an informed decision regarding the opportunity to apply/transfer to DCHFT. Appropriate use of bank staff to manage vacancies.
d) Sweating assets at DCHFT – **MITIGATION:** Ensure robust capital replacement programme in place and appropriate maintenance contracts are procured.
e) Failure in decontamination at DCHFT resulting in a reduction in service – **MITIGATION:** Service Level Agreement in place already agreed with Bournemouth Hospital to cover unplanned maintenance of equipment if needed.
f) Less flexibility in delivery of service due to loss of additional location - **MITIGATION:** Ability to flex in larger footprint at DCHFT if required in times of high demand. Lists are more efficient as staff are not required to travel from base.

4. Option Appraisal

4.1 **Do Nothing** – Continue to provide a Lithotripsy and Cystoscopy Service at Bridport Community Hospital on the understanding that DCHFT will not gain the financial and productivity efficiencies suggested in this paper and waiting times for patients are likely to remain similar or deteriorate alongside capacity to provide the service.

4.2 **Repatriate Activity** – Transfer 4.5 sessions per week by the end of the financial year to improve efficiency of the service and the cover arrangements on DCHFT site subject to satisfactory public engagement.

5. Recommendation

5.1 To approve the direction of travel to enable further engagement with the local population patients and GPs to explore the transfer of activity from Bridport Community Hospital location to Dorset County Hospital main site in Dorchester.

5.2 To advise on whether a formal public consultation would be needed to support the change.

Quality Impact Assessment (QIA) Guidance

All services are now required to complete a QIA for each of their CIP schemes. The guidance and risk calculator on this slide should be used to complete the following Quality Impact Assessment Detail slide(s).

Patient Safety	• Clinical risk to patient • Health and safety risk to patient • Hazards which may impact upon patient safety • Environmental hazards for patients • Potential distress to patient • Infection Prevention and Control	**Clinical Effectiveness**	• Risk to outcomes for patient • Impact on pathway of care and best practice treatment • Readmission rates to acute provider • Mortality rate
Patient Experience	• Access (equality and diversity) • Communication • Impact of location or service change on experience as perceived by service user • Staff experience impacting on patient experience • Perceived reputation of trust from service users (public) • Length of stay for patient	**Mitigations**	• Actions to address staff and patient experience • Actions to ensure business objectives are met • Estates actions and communications required • Support services impact and actions to mitigate impact • Patient/public engagement required • Governance changes required • Equality and diversity adjustments required

Quality Indicator(s): Consider Key Performance Indicators (KPIs) and metrics such as incidents, complaints, clinical outcomes, staff satisfaction, patient satisfaction surveys, temporary staffing levels, bed utilisation, waiting lists, typing turnaround, staff sickness and absence.

Double click on the QIA calculator (right) to enter your scores. The calculator will automatically tell you your overall QIA score. Transfer your scoring on to the following Quality Impact Assessment Detail slide(s) for the relevant year

	Enter Consequence	Enter Likelihood	Automatic Score
Patient Safety	1	1	2
Clinical Effectiveness	2	2	4
Patient Experience	2	2	4
Overall Risk Score	5		

Quality Impact Assessment Detail

Scheme No.	Scheme Name	Patient Safety Score and Detail	Clinical Effectiveness Score and Detail	Patient Experience Score and Detail	Overall Score	Outline your key Mitigations	Quality Indicators (KPIs, metrics etc)	Comments from Director of Nursing and Medical Director
	Transfer of Activity from DUHFT	Consequence = 1 Likelihood = 1 Total risk = 1 Detail: No identifiable risk to patient safety. Actions are likely to improve the situation by ensuring increased support service from on site facilities at DCH	Consequence = 2 Likelihood = 2 Total risk = 2 Detail: Small identifiable risk to recruit further theatre staff. Service on this site will improve Medical clinician cover	Consequence = 2 Likelihood = 2 Total risk = 4 Detail: The current service provision is inequitable as Bridport patients the only group or patients outside of the DT2 area who have access to a service in their town. The change in the service would result in further travel for Bridport patients but will provide a service equitable with all other Non DT2 patients. Increase provision at DCH may also decrease travel for other patient groups who are currently	*5 – using risk calculator*	• *all communications be undertaken with support from DUHFT and Dorset CCG to ensure clear and agreed communications.* • *Full disclosure and inclusion in the process enabling them to manage behaviors and communications.* • *Recruitment of staff in a timely fashion – Start recruitment process early and use bank staff where appropriate. Explore recruitment of Bridport theatre staff where appropriate.* • *Sweating*	*Good patient experience via complaint monitoring and FERVs*	

Quality Impact Assessment Detail

Scheme No.	Scheme Name	Patient Safety Score and Detail	Clinical Effectiveness Score and Detail	Patient Experience Score and Detail	Overall Score	Outline your key Mitigations	Quality Indicators (KPIs, metrics etc)	Comments from Director of Nursing and Medical Director
						• *Local primary care providers to be informed of new pathway with dissemination of referral flow chart.* • *Move would be a pilot to be reviewed after initial 6 month period.* • *Discussions needed with RBCH over best care of patients requiring Medical ophthalmic inpatient intervention during daytime hours.* • *Paediatrics will be unaffected as these OOH surgical emergencies are already transferred to SUH.*		

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Dorset Health Scrutiny Committee: Glossary of abbreviations

ACS	Accountable Care System
A&E	Accident and Emergency
AT	Assistive Technology
BCF	Better Care Fund
CAMHS	Child and Adolescent Mental Health Services
CAS	Clinical Assessment Service
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CSR	Clinical Services Review
DCC	Dorset County Council
DCH	Dorset County Hospital NHS Foundation Trust
DCR	Dorset Care Record
DHC	Dorset HealthCare University NHS Foundation Trust
DHSC	Dorset Health Scrutiny Committee
DoH	Department of Health
DToC	Delayed Transfers of Care
DWAB	Dorset Workforce Action Board
EoL	End of Life
FFT	Friends and Family Test
FT	Foundation Trust
GP	General Practitioner
HDU	High Dependency Unit
HWB	Health and Wellbeing Board
ICS	Integrated Care System
ICU or ITU	Intensive Care Unit or Intensive Therapy Unit
IUC	Integrated Urgent Care
KPI	Key Performance Indicator
LGA	Local Government Association
LMC	Local Medical Committee
LoS	Length of Stay
MDT	Multi-Disciplinary Team
MH ACP	Mental Health Acute Care Pathway
MIU	Minor Injuries Unit
MOU	Memorandum of Understanding
NEPTS	Non-emergency Patient Transport Services
NHSI	NHS Improvement – The independent regulator of NHS Foundation Trusts
NICE	National Institute for Health and Clinical Excellence
NSF	National Service Framework
OAN	One Acute Network
OOH	Out of Hours
PALS	Patient Advice and Liaison Service
PAS	Prevention at Scale
PCCC	Primary Care Commissioning Committee
PHFT	Poole Hospital NHS Foundation Trust
RBCH	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
SLA	Service Level Agreement
SPOA	Single Point of Access
STP	Sustainability and Transformation Plan / Partnership
SWASFT	South Western Ambulance Service NHS Foundation Trust
ToR	Terms of Reference
UTC	Urgent Treatment Centre

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