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.

Appendix 1

Dorset County Council

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