# The Merger of Poole and Royal Bournemouth Hospitals

# Urgent considerations for Hospital Governors

**Defend Dorset NHS Residents Group**

**August 2020**

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## Executive Summary

We understand the Hospital Governors' remit is to establish that:
*"the Trust Board of Directors has been thorough and comprehensive in reaching its proposal (that is, has undertaken proper due diligence), and that it has appropriately obtained and considered the interests of members and the public as part of the decision-making process."*
In other words do the Governors believe that the Trust Board has:
- considered all the factors that ought to have been taken into account
- ignored all the factors that ought not to have been taken into account

Note: we have worked on the assumption that the Trust's Board of Directors has used Dorset Clinical Commissioning Group's (DCCG's) documents, including DCCG's reports on the Consultation, their Travel Times Analysis, their Decision Making Business Case and their Patient Benefits Case.

## Key Points

These are expanded on in the body text, with references to the evidence:

1 Context: Drivers for, and against, the merger
The merger is driven by a combination of staffing shortages, a projected revenue deficit, and promise of a substantial capital 'investment'. However, we believe this has resulted in blindness to the risks, which are therefore not acknowledged, quantified or mitigated. DCCG have to secure continuous improvement in health care and to show that the merger will result in an overall improvement in health care for residents. This is not supported by the available evidence, which shows that the collateral damage is serious, and substantial.

2 Will new Integrated Community Services reduce acute demand?
The planned 25% reduction in acute care relies upon the assumption that it is possible to substantially reduce acute demand by increasing services in the community, when the evidence does not support this. Even if the ICS could achieve this outcome, the proposed community services are not defined, they are minimally funded, and unstaffed.

3 The location of RBH - on the eastern border of Dorset
RBH is not easily accessible from most of Dorset. Distance combines with chronic traffic, poor roads, poor public transport access to RBH, residents without access to cars, prohibitive taxi fares, scarcity of ambulances, and scarcity, insecurity and tiny capacity of helicopters, to make matters worse still. This has serious implications for access to, and take up of, both emergency and routine hospital care at RBH, which will increase rural health inequalities, and will adversely affect patient experience and clinical outcomes.

4 The Patient Benefits Case
This fails to clearly identify and quantify the benefits and risks of the merger, so that it is impossible to weigh these up, and make an assessment as to whether there will be net clinical benefits, or not.

5 The risks of longer travel times, particularly in emergency

- There is no evidence base for 'centralising' care in rural areas where longer journeys to care outweigh any benefits on arrival. Every additional 10km (the distance between Poole and RBH) increases absolute mortality by 1%.
- In terms of relocating specialist services, 'swopping' Trauma A&E, Maternity and Paediatric care from Poole to RBH means very long travel times for Dorset residents who live west of Poole, some of whom have long journeys to access specialist emergency care at Poole now.
- While the current configuration enables all to access emergency care within 'safe' blue light times, the merger breaches 'safe' guidelines by removing access within 30-45 minutes in trauma, medical and maternity emergencies from tens of thousands of Dorset residents and all mums-to-be west of the conurbation, increasing risk to life, and of lives lived in disability, for adults, children, mums-to-be and babies.
- It is assumed that emergency patients will be in ambulances, and that, therefore, longer time to hospital does not matter. However, there is a range of time critical conditions that can't be treated in the ambulance, and an analysis of 1280 time critical cases seen at Poole in 2017 showed that 46% did not arrive by ambulance. In the case of maternity and paediatric emergencies, the evidence is that 80-95% self present.
- No credible clinical risk assessment has been carried out, so that the risks cannot have been quantified nor mitigated. Although DCCG recognised that longer travel times pose a significant risk for maternity and paediatric emergencies, the only risk assessment focused on ambulance patients, thus excluding the 80-95% of maternity and paediatric emergencies who do not arrive by ambulance. For this and other reasons the Consultant reporting back for the panel appointed by DCCG stated the risk assessment undertaken was "not fit for purpose".

6 Will one A&E at RBH be able to cope?
RBH will have a 'giant' A&E. The CQC rated a similar 'giant' A&E at Portsmouth as 'requires improvement'. RBH will have Poole's current 92,000 emergency take, the Royal College of Emergency Medicine says only 15% of whom can be treated in an Urgent Care Centre. All Poole's 38,600 emergency admissions will come to RBH, as Poole will no longer have emergency admissions. RBH A&E will support a larger population – 750,000 - than the two A&E's serve now: the conurbation catchment + W Hampshire (who will have easy access to Dorset specialist trauma, maternity & paediatrics at RBH) + developments. Yet RBH will have less beds than the two hospitals have now?

7 Have the interests of the public been duly obtained and considered?
The expressed interests of the public have been unduly ignored. As well as the 36,910 petitioners who opposed loss of services at Poole, the majority of consultation respondents opposed one A&E at RBH. Nine Councils and two elected members also opposed the plans, and there has been, and is, ongoing, and substantial, public opposition.

8 Has the impact of Covid 19 been taken into account?
The merger plans need to address the lessons learned in the first wave of Covid 19: the shortage of acute beds, the shortage of critical care beds and the high percentage of C19 transmission in hospital.

9 A possible compromise: A&E Local at Poole

While we do not want to lose any care or beds from Poole, if the changes are going ahead, we believe the merger needs to be conditional on ongoing, serious, consideration, involving all parties, of "A&E Local" at Poole. This is a full A&E that is closed overnight, and was suggested by the Independent Panel as a "possible viable option". There would be several years to plan for this and it would be easier to staff than the 24/7 A&E currently provided there. A full A&E closed overnight is a model that has been in use at Weston Super Mare for the past three years.

- Traffic to RBH is at it's worst during the day, and "A&E Local" would restore access to A&E within 45 minutes to tens of thousands of Dorset adults and children, saving lives and reducing disability.
- A&E Local would stabilise daytime maternity & paediatric emergencies, where onward travel to RBH would increase disability, or threaten life, mitigating the significant risk of longer travel time for these patients.
- There were just over 7,300 paediatric admissions to Poole in 2018/19. Parents will continue to bring very sick children, including babies and young children, to Poole. Paediatric support must be part of A&E Local.
- A&E Local would both provide timely access to care, and mitigate the need to transfer tens of thousands of patients, who currently attend Poole A&E, but would need to be treated or assessed in RBH A&E.
- A&E Local would provide timely access to care for Poole elective patients who have complications, and mitigate the need for transfer.
- A&E Local would mitigate the capacity issues at RBH A&E.
- A&E Local at Poole would support the management of C19 patients.
- Retention of some emergency beds at Poole would support the 78% of Poole's emergency admissions (28,500 patients out of 38,600) who will have further to travel in an emergency as a result of the merger.

10 Maternity – further support: midwives at Poole, SCBU at DCH
The merger should be conditional on serious consideration, involving all parties, of reinstatement of safe, accessible maternity care for all.

- A midwife-led unit at Poole would return access to non-specialist maternity care, within safe guideline times of 30-45, minutes for all.
- Reinstating the Special Care Baby Unit at Dorset County Hospital would mean mums-to-be in the west could safely access special care in an emergency, thus mitigating this acknowledged "significant risk".
- FOI's show just under 600 mums facing maternity emergency are cared for at Poole annually, some of whom would have journeys of 75+ minutes to RBH. Over a thousand newborns each year receive 'extra care' at Poole; around 500 need high levels of care, often to survive.

We ask Governors to exercise due diligence to ensure risks are identified, quantified and mitigated before approving the merger.

Thank you
Defend Dorset NHS residents group August 2020

**The Key Points expanded on, with references to the evidence**

**1. Context: Drivers for, and against, the merger**

DCCG stated in 2017[1] that they would have a £158 million revenue deficit if they did not reconfigure. There are also NHS staff shortages nationally, with a particularly high attrition rate in emergency medicine[2a], and in Dorset this plays out in unfilled posts and millions spent on Agency staff[2b].

There is therefore a non-clinical drive to close one of two A&E and Maternity Departments in the East, and to reduce beds, and staff, to try to reduce revenue costs. There is a belief that it will be cheaper and easier to staff and run one A&E and Maternity, than two, although it is not clear how more A&E patients can be cared for with less staff and less beds.
There is also the 'carrot' of £100 million[3] (later reported as £147 million and now as £250 million) government capital 'investment', conditional on the reconfiguration, with interest payable for the life of the asset.

However the merger cannot simply proceed on the basis that funding and staff shortages mean that there is no choice, as DCCG also has a duty to secure continuous improvement in health care. Hence DCCG has to make the case that the merger will bring net clinical improvement.

A Dorset A&E Dr gave this written evidence to Dorset Health Scrutiny[4]:
"The CCG has looked at the issue of patient safety with 'rose tinted glasses', which has led to a biased view towards their desired outcome and distracted them from the realities of the difficulty of providing safe, effective care for major treatment patients if Poole A&E is replaced by an Urgent Care Centre."

'Due diligence' uncovers a number of uncomfortable realities that have not been acknowledged, or addressed, that call the merger into question:

a) Peer reviewed clinical research demonstrates that each additional 10km to hospital (the distance between Poole and RBH) represents a 1% increase in mortality.[5]

b) DCCG's own documents cite a maximum 'safe' journey time of 30-45 minutes in maternity emergency, acute stroke and major trauma.[6] Clearly, removing Poole from the emergency care equation will move some areas of Dorset outside of access within these 'safe' times. Yet DCCG continue to claim reconfigured hospital care can be accessed from all Dorset areas within 45 minutes. When presented with SWAST actual data showing this was not the case, DCCG said: "NHS Dorset CCG does not hold any information that explains the difference between modelled information and actual recorded data", and went on to say they had "no access to SWAST records."[7]

1 p38 http://ourdorset.nhs.uk/wp-content/uploads/2018/07/Our_Dorset_STP.pdf
2a: "nearly three-quarters of emergency medicine trainees rated the intensity of their workload as heavy or very heavy, substantially more than any other specialty." https://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters
2b https://www.bournemouthecho.co.uk/news/17846108.poole-hospital-spends-6m-agency-nurses-five-years/
3 https://www.dorsethealthcare.nhs.uk/about-us/news-events/press/dorset-receives-over-100m-capital-funding-boost-health-and-care-improvements
4 A&E Dr written submission to Dorset Health Scrutiny Task & Finish Group, 22.8.2018, available on request
5 Nicholl et all (2006): "The relationship between distance to hospital and patient mortality" https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464671/
6 pp21-2 https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/travel-time-analysis-march-2015.pdf
7 DCCG response to FOI 104, 10.9.2019, available on request

c) In order to overcome the safety problems presented by actual journey times to reconfigured care, it has been claimed that all emergency patients attend hospital by ambulance, and that all these patients can receive the urgent care that they need in the ambulance. However:

- It is difficult to get an ambulance within any reasonable timeframe.[8a]
- There are a range of conditions that cannot be treated in the ambulance (see section 5, para 2), and an FOI shows that just under half of the 1277 A&E admissions enquired about self presented.[8b]
- In the case of maternity emergencies ambulance use drops to 23%.[8b]
- For paediatric emergencies ambulance use is less than 5%.[8c]
- The number of emergency admissions to Poole, who will face longer journeys to RBH, is 28,500, with 3,700 journeys beyond 'safe' times.[9]

d) Distance from home is a major factor in reducing utilisation of care. People on low incomes, including older people, and non-drivers, face particular challenges in accessing services for diagnosis, treatment and follow up, and in visiting relatives, especially during end of life care.[10] Literature reviews[(11, 12 & 13)] consistently show that longer distance means that people use services less, wait longer before accessing them, and miss follow up treatment.
A systematic review in 2016 showed that the further away a patient lives from the health care facilities that they need to attend, the worse the health outcomes are, compared to those who lived closer.[14]

e) Evidence regarding the effectiveness of 'giant' A&E's is not promising – Queen Alexandra Hospital in neighbouring Hampshire, which has a smaller catchment population than the single A&E at RBH would have, has been rated as 'requires improvement' since 2017[15], with reports of very difficult staff and patient experiences – see Section 6, f).

A further consequence of denying the risks of the merger is that risks have not been duly quantified, so there is no meaningful plan to mitigate them. The only clinical risk assessment actually excluded key groups - see section 5, iv). In addition to denying the risks in the "Patient Benefits Case", there are questionable unevidenced claims regarding perceived benefits – please see section 4 for detail and references.

The absence of clear key information quantifying risks and benefits prevents the Trust board weighing these factors up to arrive at a realistic assessment of whether the merger will result in net clinical benefits, or not.

8a 29.1.20 "Seriously ill wait more than an hour for ambulance" https://www.bbc.co.uk/news/health-51269618
8b Poole A&E FOI 4826: In 2017 of 1277 emergencies, 684 (54%) arrived by ambulance, 593 (46%) did not. Of 590 maternity emergencies cared for, 134 (23%) arrived by ambulance and 456 (77%) did not. FOI scanned at p90 http://keepournhspublicdorset.com/IRP.pdf
8c Dr I Mew Feedback 31.8.17: "of 40,000 paediatric attendances, 331 came by ambulance". Available on request
9 Poole A&E FOI IG6502: emergency admissions 2018/19 by postcode, available on request
10 Hine, J.; Kamruzzaman, M., 'Journeys to health services in Great Britain: An analysis of changing travel patterns 1985–2006'p. 284
11 Longley, M; Llewellyn, M; Beddow, T; Evans, R., R. Mid Wales Healthcare Study: Report for Welsh Government
12 Mungall, I.J., 'Ensuring equitable access to health and social care for rural and remote communities. Increasing centralisation and specialisation within the NHS: the trend has some adverse effects on access to care for rural and remote communities.'
13 Rural Health Implementation Group. Delivering Rural Healthcare Services.
14 Kelly, C.; Hulme, C.; Farragher ,T. et al., 'Are differences in travel time or distance to healthcare for adults in global north countries associated with an impact on health outcomes? A systematic review.'
15 16.4.19 https://www.bbc.co.uk/news/uk-england-hampshire-47938042

## 2) Can new 'Integrated Community Services' reduce acute demand?

The Clinical Services Review proposed that 'Integrated Community Services', closer to home, would reduce current demand for acute care and beds by 25%[16], thus enabling the reduction in A&E sites and beds. However:

a) Demand: There is no evidence to support the view that the demand for acute care and beds can be halted, much less reversed.[17] The need for A&E care and acute beds increases annually,[18a] with 42% increase in admissions over 12 years.[18b] Consultants in Emergency Medicine made the following comments to the consultation: "The Consultants strongly feel that the assumptions made within the CSR are not achievable, especially that 25% of the current emergency workload can be managed in the community and that there can be a commensurate reduction in the total number of inpatient emergency beds."[19]

b) Funding: There is wholly inadequate funding available for services 'closer to home' as DCCG is trying to close a revenue deficit. These services, properly provided, are likely to cost more, not less, than community hospital care, as there are no economies of scale.

c) Distance: Services are actually being moved further away from home, with local rehabilitation and palliative care beds being lost across Dorset, due to plans to close community hospitals and/or all beds in 5 of 13 Dorset locations and to open 'community bedded hubs' at Poole Hospital and at RBH.[20] CQC reports actually show 100 community beds 'disappearing' from 8 locations to date, with a further 82 to go.

d) NHS Staff: DCCG note in their Decision Making Business Case (p136): "there is a major challenge around the capacity of the existing workforce and the ability to attract and retain the additional workforce to implement the planned changes".[21]

   DCCG identify the scale of the challenge (p131): the NHS community staff establishment of 1830 FTE staff has a 14 % vacancy rate (256 staff vacancies), with an additional 670 staff needed for new integrated community services – so that over 900 staff needed to be recruited.[22] Asked for an update on recruitment on 17th February 2020, Tim Goodson reported approximately 100 of these posts had been filled in 2.5 years, suggesting a shortfall of over 800 NHS community staff.

e) Social Services staff for integrated community services: it was clarified in the Court of Appeal that no assessment of the social services staff needed for the integrated community services had been carried out.

16: DCCG Decision Making Business Case 2017 p104 https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/DMBC-CSR.pdf
17 Imison Shifting the balance of care https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-summary-web-final.pdf
18a https://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters
18b p1 https://www.health.org.uk/sites/default/files/Briefing_Emergency%2520admissions_web_final.pdf
19 Evidence to Dorset Health Scrutiny Task & Finish Group 22.8.18 Available on request
20 Community Beds: i) closed: Various 26, Ferndown 22, Wareham 16, Portland 16, Bridport 20 ii) to be closed Alderney 48, Westhaven 34. DCCG DMBC pp89-91 (reduction of Various beds and Bridport beds not stated)
21 DCCG DMBC 2017 p136 https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/DMBC-CSR.pdf
22 Ibid page 131

### 3) Hospital care at RBH is not accessible from most of Dorset

A number of factors make accessing care at RBH very challenging. In the case of emergency care, where time is of the essence, this is a matter of life and death, and of the extent to which lives are affected by disability.
As previously stated (section 1, d)), Literature Reviews show longer journeys deter and delay take up of emergency, elective and outpatient care, worsening rural health inequalities and adversely affecting clinical outcomes.

a) Location: RBH is geographically a long way away from most of Dorset, at the eastern edge of the county, on the other side of Bournemouth, in an area that was in Hampshire not many years ago. Locating major emergency hospital care there is not 'centralising' care for Dorset.

b) Traffic: there is chronic traffic across the conurbation, it is the 4th most congested location in the UK, based on SatNav data this January.[23] Traffic can become gridlocked both across the conurbation and around RBH now. The merger will result in more journeys in both these areas. Currently planned, A&E, and maternity care are available at both Poole and Bournemouth Hospitals; offering some care from one site only in future will inevitably result in more, and longer, journeys across the conurbation. Traffic at RBH will also increase given the 45% planned expansion of beds (from 741 to 977 acute beds[24], plus a 100 bedded 'community' hub[25]) and the 20% increase in staff (900 extra staff)[26].

c) RBH expansion: travel assessment and plan: There are concerns about the inadequacy of these in terms of mitigating increased traffic across the conurbation and at RBH (see b) above). The travel assessment claimed there would be less patients attending RBH despite at least 45% expansion in beds and 20% increase in staff.[27] No clear evidence was provided to support this assertion. Some of RBH's 72,600[28] elective admissions will go to Poole, but not all. Assuming the 62,000[28] daycase patients do go to Poole, the 'loss' of these patients, who do not stay overnight from RBH, will be more than made up for by the 38,600[29] emergency admissions coming to RBH, who stay an average of 4 days according to a Poole FOI[30], and generate visitors. The Travel Plan acknowledges that over 80% of those attending RBH come by car or taxi, and most staff also get to RBH by car.[31] Are the new bus route from Poole, and shared hospital car transport, enough to mitigate the increase – and during a pandemic? 900 extra staff need to be accommodated: permission was given for 450 car parking spaces.[32] Therefore extra patients will still not be able to park for appointments.

23 30.1.20 https://www.bournemouthecho.co.uk/news/18197871.bournemouth-ranked-fourth-congested-place-uk/
24 DCCG Decision Making Business Case 2017 p105 https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/DMBC-CSR.pdf
25 Ibid, p120 the number of 'community beds' planned at RBH is not reported, however 72 are planned for Poole, and 251 are needed across Poole/RBH if 'community beds' are to rise by 69 as claimed, despite the closure of 182
26 RBH Expansion: Transport Assessment submitted to Planning p35 5.1.1 Available on request as a pdf attachment
27 Ibid p36 5.1.4
28 15.8.19 RBH FOI response 1920215 Available on request
29 Poole Annual Report 2018/19 p14: https://www.poole.nhs.uk/pdf/Poole%20Hospital%20NHSFT%20Annual%20Report%20and%20Accounts%20201819%20Hi%20Res2.pdf
30 16.9.19 Poole FOI response FOI/IG/6037 Available on request
31 RBCH Travel Plan submitted to Planning p16 and p12 Available on request as a pdf attachment
32 Clarified by the Planning Officer at BCP Planning Committee 23rd July

d) Spur Road: The loss of the spur road to ease emergency access from the west. This was presented by DCCG to Joint Health Scrutiny in August 2017 as a definite mitigation for the longer journeys, however this is not now going ahead. JHSC recommended that: “the CCG ensure that plans to increase the level of service delivery at RBH would still be appropriate and achievable, should the spur road not progress.” It is not clear what has been done to mitigate the loss of the spur road.

e) Transport network, travel costs and health inequalities: Dorset has no motorways, and a poor road and transport network, particularly in rural areas. RBH is not directly accessible on public transport from many areas, it is not near a station, and it is on few bus routes. In areas of greatest deprivation large percentages of the population do not have cars. How will patients and visitors in remote locations be supported to access RBH? RBH is a long way from most of Dorset and the cost of taxis is prohibitive – it’s £55 one way from Swanage, for example. Longer distance to hospital deters and delays take up of all care, aggravating rural inequalities and reducing clinical outcomes – see section 1 d) for references.

f) Ambulances: As stated in section 1, c, the idea that it doesn’t matter that RBH is further away from most of Dorset because emergency patients will all arrive by ambulance is not borne out by the facts. Ambulances are a scarce resource, response times, particularly in rural areas, can be very lengthy, and where A&Es have closed in other areas, the demand for ambulances has increased. Just over half the emergencies arriving at A&E come by ambulance, and this drops to less than 5% for child emergencies. Around 15% of mums-to-be face ‘maternity emergency’ yet, only 20% of this very vulnerable sub-group use ambulances.

g) Helicopter: helicopters are a very scarce resource, shared with other counties, and reliant on voluntary funding. The air ambulance can carry one patient on a stretcher. A helicopter can land at RBH, or indeed helicopters have landed outside Poole Hospital, in Longfleet Road.

**4) The 'Patient Benefits Case'**
While it is relatively easy to list the disbenefits of the plans, and to start to quantify these, the benefits are less clear. The Patient Benefits Case[33] should quantify the benefits, and the risks, of the merger, weigh these against each other, and identify whether there are net benefits, or not. Instead, it ignores the risks – none are mentioned – focussing only on perceived benefits.

Even so, it is difficult to quantify benefits, as the text is unclear. For example, it is not clear what new care will be offered at RBH that is not available in a more accessible format across the Poole and RBH sites now, as services that we have at Poole, but which are being relocated to RBH, are listed as 'new' services. There is double, and sometimes triple, counting of benefits. Thematic assumptions are presented as facts throughout, and claims are made that are not supported by peer reviewed research evidence.[34]

One clear benefit of the merger is that having trauma A&E, specialist Maternity with neo natal intensive, high dependency and special care, Paediatrics, and Oncology beds at RBH will benefit those who live nearer to RBH than to Poole. Locating these services on the border with Hampshire will also attract a tranche of the West Hampshire population for whom the journey to Poole may deter access to these services now.

However, for the Dorset population who live nearer to RBH than to Poole, these services can still be accessed at Poole under the current configuration within 'safe' guideline times. For the West Hampshire population, care is accessible at Southampton within safe times.
Whereas, for a substantial tranche of the Dorset population outside the conurbation, the merger means the loss of access to emergency and maternity care within safe guideline times. See section 5 below.

Some of the biggest areas of concern regarding the Patient Benefits Case are that it contains incorrect assertions, benefits are asserted that are in fact risks, and risks to vulnerable maternity and paediatric emergencies are ignored:

a) Incorrect assertions in the Patient Benefits Case:

- There will be 24/7 consultant delivered care at RBH. Yet it was a pillar of DCCG's case to the High Court that this had never been promised.[35]
- There will be no transfers under the merger. In order to assert this, the assumption is made that no patients will have to be transferred from Poole Urgent Treatment Centre to RBH A&E.[36] Yet in 2018/19 their 38,600 emergency admissions made up over 90% of Poole's overnight cases, and Poole had 90,000 patients in total accessing A&E care. The majority of Poole's A&E attenders self present, and FOI's indicate that just under half of Poole's 38,600 emergency admissions also self presented. The admissions included 7,300 children and 600 maternity emergencies, where 80-90% self present. 500 newborns needed a high level of care. These patients would all have to get to RBH.[37]

33 https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/10/PatientBenefitCase-12_10_18.pdf
34 Defend Dorset NHS submission to the Independent Panel contains detail and references on pages 42-9: http://keepournhspublicdorset.com/IRP.pdf
35 & 36 P6 https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/10/PatientBenefitCase-12_10_18.pdf
37 Poole Annual Report 2018/19 p14: https://www.poole.nhs.uk/pdf/Poole%20Hospital%20NHSFT%20Annual%20Report%20and%20Accounts%20201819%20Hi%20Res2.pdf

The A&E Dr who gave evidence to Dorset Health Scrutiny stated that: "The data used by the CCG to look at the future of Poole and RBH A&E seems to be incorrect and inaccurate. The large proportion of patients who go to Poole A&E have tests and investigations done whereas the CCG stated that they were mostly minor injury patients."[38]

We believe it is dangerous to tell patients who go to Poole A&E now that they will be able to be treated at UTC. Yet it is still claimed that up to 85% of Poole's 72,000 A&E attenders will be treated in the UTC. Some claims relate to data that can only be known retrospectively - while it may be clear after tests in A&E that someone presenting with chest pain had indigestion, this cannot be assumed in advance. The Royal College of Emergency Medicine found that only 15% of A&E attenders do not need to be assessed or treated in A&E.[39]

As well as Poole UTC patients, there may be other patients who have to be transferred to RBH, such as elective patients, who deteriorate. What back up care will there be at Poole, if emergency admissions are to end? Will there be capacity to intubate a very sick child brought into the UTC in their parents' arms, if transfer to RBH without stabilisation is likely to cause disability, or worse? What will happen if a mum-to-be is giving birth en route to RBH in bad traffic, and stops at Poole UTC? What if SWAST have a cardiac arrest on board and Poole is nearest?

DCCG provided a list of what could be treated at the UTC during the consultation: it is identical to the list for a Minor Injuries Unit: "Minor injuries: sprains and strains, broken bones, wound infections, minor burns and scalds, minor injuries to the head and torso, insect and animal bites."[40] Following our meeting with DCCG on 17 February, we requested an updated list of what could be treated at Poole UTC, but we have not received this to date.

b) Perceived benefits in that are in fact risks, and some key omissions:

- Cardiac care: The Patient Benefits Case does not address the fact that 'centralising cardiac care' at RBH, where there is a cardiac centre now, means closing the cardiac unit at Poole. Time is of the essence in cardiac arrest and heart attack: 'minutes mean myocardium'. What will the loss of the Poole cardiology mean for the 136 patients treated there in 2018/19? The majority of cardiac arrest patients are taken there now because it is the nearest A&E.[40a &40b] Some patients are NSTEMI and can be treated more quickly there, or wait there for a bed at RBH.

- Stroke: Claims are made in the Patient Benefits case for 'centralisation' of Stroke services (p25)[41]. However, the urban research used to make the claims specifically notes that the research is not generalizable to rural areas such as Dorset, where lengthy travel times to access services undercut the benefits of better resourced services on arrival.

38 A&E Dr written submission to Dorset Health Scrutiny Task & Finish Group, 22.8.2018, available on request
39 https://www.hsj.co.uk/comment/beyond-the-official-data-a-different-picture-of-aande-attendances/5070973.article
40 Definition of an Urgent Treatment Centre https://www.dorsethealthcare.nhs.uk/patients-and-visitors/miu-and-ae
40a 2017: 38 cardiac arrest cases seen at Poole (p90), 30 at RBH (p92): http://keepournhspublicdorset.com/IRP.pdf
40b SWAST guidelines are to go to nearest ED if there is danger of cardiac arrest: p29
https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/swast-report.pdf
41 p25 https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/10/PatientBenefitCase-12_10_18.pdf

In fact, attempts to centralise stroke services in rural areas may make outcomes worse, as has happened in Shropshire. Lengthy travel times to Hospital, followed by essential tests that need to be carried out to determine if it's a clot or bleed stroke before treatment can commence, meant that the treatment window was exceeded in the vast majority of cases. Based on SSNAP82 audit data, the standardised mortality ratio worsened, with 25 more patients dying than would be expected.[42]

- Maternity: In order to assert that the merger will support maternity care, the Patient Benefits Case counts the 170 mums who have to transfer from RBH to Poole now, and who would not have to do so if specialist maternity care was available at RBH.[43] However, it does not mention the 4,500 mums who currently give birth at Poole, the 600 maternity emergencies seen there, or the 500 newborns who need intensive, high dependency or special baby care. This care is currently only available at Poole, as the Dorset County Special Care Baby Unit was closed outside the consultation, and will only be available at RBH under the merger. Some mums-to-be have long journeys to get to Poole, and would face longer car journeys still, of up to 75+ minutes, to access specialist maternity and newborn care at RBH.

- Children: The 7,300 emergency admissions seen at Poole, or the risks of longer travel times, are not mentioned in the Patient Benefits Case.

This issue is also dealt with in section 5, but the data bears repetition:

- What does the loss of Consultant-led Maternity, & Neo Natal Intensive High Dependency and Special care from Poole mean for the safety of mums in cars, in labour and giving birth, or their newborns, especially very premature newborns, having to travel on to remote Bournemouth Hospital through the fourth most traffic congested area in the UK?

- 590 mums facing maternity emergency were cared for at Poole in 2017/18, 77% did not arrive by ambulance.[44] Over a thousand newborns needed 'care beyond a normal delivery'. 80 babies needed intensive care, 171 needed high dependency care, and 195 needed special care. A further 576 newborns needed transitional care.[45]

- What of the 7,300 child emergency admissions (let alone A&E attenders), many of whose parents will face longer journeys with sick children in cars to get to RBH? Some will face very long journeys. 95% of children attending hospital do not arrive in ambulances, according to Dr Ian Mew.[46]

Dorset CCG states in their Equality Impact Assessment that longer travel time in labour, birth and paediatric emergency is a 'significant risk'.[47]

42 Letter written by Shropshire, Telford & Wrekin Defend Our NHS to their two CCGs dated 22 August 2018. Available at: https://drive.google.com/open?id=1HE6u-DHuv_hAFwQ1MSkaA3b4MkKD4cWG
43 p13 https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/10/PatientBenefitCase-12_10_18.pdf
44 Poole A&E FOI 4826: In 2017 of 590 maternity emergencies cared for, 134 (23%) arrived by ambulance and 456 (77%) did not scanned at p90 http://keepournhspublicdorset.com/IRP.pdf
45 Poole Maternity FOI 5146: in 2017/18 80 newborns needed intensive care, 171 high dependency care &195 special care scanned at p91 http://keepournhspublicdorset.com/IRP.pdf
46 Dr I Mew Feedback 31.8.17: "of 40,000 paediatric attendances, 331 came by ambulance". Available on request
47 Dorset CSR Equality Impact Report 2017 page 23: https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/11/CSR-EIA.pdf

**5) Longer travel times in emergency compromise patient safety**

Much is made of the idea that 'centralised' emergency care will be better, although the key research that Sir Bruce Keogh based this finding upon was undertaken in urban areas where time to reconfigured care was, at most, 30 minutes, and which specifically excluded the application of the research to rural areas where longer times to care was likely to outweigh any benefits.[48]

A Dorset A&E Dr giving evidence to Dorset Health Scrutiny stated that:
"There are a range of conditions that cannot be treated in the ambulance where time to hospital treatment is critical, as the patient could die at any moment. It cannot, therefore, be argued with any honesty that longer journey time to access treatment is irrelevant in these cases. The SWAST report[49] corroborates this and identifies many patients whereby longer transfer time could have led to patient deaths or disability.
It may be true that those arriving at a better resourced centre are likely to do better, however this does not address the issue of those who die en route, or for whom treatment has come too late to avoid permanent disability. While it would not be surprising if better resourced departments produced better outcomes, this is an argument for improving services at existing hospitals, not for closing A&E and Maternity Departments."[50]

Residents in rural Dorset, who will lose access to emergency hospital and maternity care within safe guidelines times under the merger, find that they have been discounted. Bournemouth is highly populated, and shortening what is an already 'safe' journey to Poole for many Bournemouth residents, by sending them to RBH instead, skews 'average' travel times post merger in favour of Bournemouth, and against less populated rural Dorset, whose residents already have long journeys to get to Poole Hospital.[51]

We will gather here evidence related to the disbenefit of lengthy travel times, try to quantify the likely impact on patients, and consider what risk assessment has been undertaken to date.

**i) 'Safe' guideline travel times in emergency**

a) The 'golden hour' in trauma is based on clinical research and applies from the time of the injury to receipt of care in hospital.[52]

b) DCCG consultants Steer, Davies Gleave to undertake the travel times analysis, and they cited 30-45 minutes as the 'maximum safe travel time' in acute stroke, major trauma and maternity emergency.[53]

c) Nicholl et al (2006) found that for each additional 10km travelled (about the distance between Poole and RBH) there was a 1% increase in absolute mortality.[54]

48 Morris et all (2014) "Impact of centralising acute stroke services in English metropolitan areas on mortality…" https://www.bmj.com/content/349/bmj.g4757
49 p10 (Maternity) pp15-16 (Adults) p24 (Paediatric) Dorset CSR: Modelling the Potential Impact on the Emergency Ambulance Service https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/swast-report.pdf
50 A&E Dr written submission to Dorset Health Scrutiny Task & Finish Group, 22.8.2018, available on request
51 p1 Dorset CSR: Modelling the Potential Impact on the Emergency Ambulance Service (link at 49)
52 The effect of a Golden Hour policy on the morbidity and mortality of combat casualties Kotwal RS Jan 2016 http://www.ncbi.nlm.nih.gov/pubmed/26422778
53 DCCG Travel Times Analysis page 21, 'maximum acceptable' travel time in maternity emergency, acute stroke and major trauma 30-45 minutes. https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/travel-time-analysis-march-2015.pdf
54 Nicholl et all (2006): "The relationship between distance to hospital and patient mortality" https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464671/

d) An ambulance is not a hospital. The Dorset A&E Dr above listed a range of conditions where time to hospital treatment is crucial, as the patient cannot be treated in the ambulance: stroke (Paramedic cannot know if it is a clot or bleed), heart attack, cardiac arrest, sepsis (cannot give antibiotics), meningitis, trauma, haemorrhage (Ambulances do not carry blood), respiratory emergency (Intubation only in cardiac arrest with unconscious patient), endocrine emergency, overdose.

e) Other conditions that cannot be treated in the ambulance: Maternity emergencies: premature birth, ectopic pregnancy, breach birth, shoulder dystocia, head stuck in the birth canal, prolapsed umbilical cord, cord around babys head. Paediatric emergencies: respiratory, injuries (head: CAT scan if unconscious), digestive dehydration/shock, endocrine, nervous, mental health, high fever, loss of consciousness.

f) DCCG's own Equality Impact Assessment noted that that longer travel time in maternity and paediatric emergency is a 'significant risk'.[55]

**ii) Actual Dorset travel times**

a) **The core population who lose 'safe' access to all emergency care**
There are tens of thousands of residents in Purbeck, and North Dorset, for whom Poole is the nearest hospital, and who are 40 minutes or more by blue light from Poole now.[57] While North Dorset patients can go to Salisbury, Purbeck patients will not be able to get to Dorset County, or RBH, within 45 minutes. Purbeck adults, children and visitors do not agree to be the collateral damage for the merger.

The 40+ minutes by blue light that it takes Purbeck adult and child trauma and medical emergencies, and mums-to-be, to get to Poole now does not include the time it takes for the ambulance to come, to 'load' the patient, and to 'unload' them at hospital. For these patients, and for a million holidaymakers, loss of A&E + maternity care at Poole means loss of 'safe' access to hospital care in an emergency. For the 46% of emergencies who do not get to A&E by ambulance, the journey will take longer still, as they do not benefit from blue light conditions.

An FOI response to Langton Matravers Parish Council showed that, over the 13 month period Nov 2016 – Dec 2017, the average time from a category 1 imminent danger of death call from Swanage and villages to SWAST, to arrival at Poole Hospital, was 1 hour 43 minutes. [56]

A subsequent Langton Parish FOI showed that the average blue light time, once the patient was on board, from all BH19 postcodes to Poole, was between 39 and 43 minutes.[57] It will not, therefore, be possible to travel by blue light another 8 miles across the conurbation to RBH, or another 10 miles to Dorset County, and still arrive within 45 minutes.

55 Dorset CSR Equality Impact Report 2017 page 23: https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/11/CSR-EIA.pdf
56 28.3.18 Letter from Langton Parish re FOI response 2442 16.2.18 from SWAST See pages 88-9 for scanned copy: http://keepournhspublicdorset.com/IRP.pdf
57 FOI response 2360 to Langton Matravers Parish from SWAST 22.12.17 page 3 Travel time to Poole from BH19 postcodes over 13 months between 38 mins 53 seconds and 42 mins 52 seconds Available on request

As SWAST have actual blue light travel times, it remains unclear why Steer, Davies Gleave[58] were commissioned by DCCG to hypothesise Dorset blue light travel times. SDG assumed that a blue light ambulance would always travel as fast as a private car at night. This formula generated significantly shorter times than the actual blue light times that SWAST records show. This means that actual Dorset blue light times, a crucial consideration, have never been addressed.

b) **Maternity:** There is an additional population, as well as Purbeck mums and babies, who will lose safe access to maternity care. Mums-to-be across Dorset who give birth under 32 weeks, or face maternity complications, have to get to Poole now, and will need to get to RBH under the plans. The special baby care service at Dorset County Hospital was closed outside of any consultation in 2017.

The journey to RBH is not achievable within 45 minutes from many Dorset locations, particularly given that the vast majority of mums-to-be do not arrive at hospital by ambulance. This journey will take up to 75 minutes from Portland. Nor can these mums access this care within safe times out of county. The nearest out of county unit to the west offering the level of newborn care that Poole offers now is at Exeter.

Dorset mums-to-be who face maternity emergency, and their babies, have not agreed to be the collateral damage for the merger.

How many mums and babies will be affected? It has been suggested that there are only a few mums-to-be who face maternity emergency, and that the number of babies needing extra care is small. However this is not borne out by the evidence.

- A Poole hospital FOI response shows that 590 maternity emergencies were cared for at Poole in 2017, of whom, only 23% - 134 of the 590 mums facing an unexpected emergency - arrived by ambulance.[59]
- Another Poole Hospital FOI response shows that over a thousand babies needed 'care beyond a normal delivery'. The baby data breaks down into 80 babies needing neo-natal intensive care, 171 needing high dependency care, 195 needing special care and 576 babies needing transitional care.[60a]
- A further Poole hospital FOI shows that in 2018/19, over 60% of newborns needing intensive care were born to mums living closer to Poole. For high dependency, special care and transitional care, it was very close to 50/50. However, while all the mums nearer to RBH could also get to Poole within safe times, this was not true for all the mums closer to Poole – 33 of the mums in that sample would have had journeys beyond safe times, in some cases of 60 minutes, to get to RBH.[60b]

58 DCCG Travel Times Analysis https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/travel-time-analysis-march-2015.pdf
59 Poole A&E FOI 4826: In 2017 of 590 maternity emergencies cared for, 134 (23%) arrived by ambulance and 456 (77%) did not p90 http://keepournhspublicdorset.com/IRP.pdf
60a Poole Maternity FOI 5146: in 2017/18 80 newborns needed intensive care, 171 high dependency care, 195 special care and 576 transitional care p91 http://keepournhspublicdorset.com/IRP.pdf
60b Poole A&E/Maternity FOI 6502 May 2020, available on request

NB Postcodes were attributed to Poole or RBH based on least distance. BH4 was allocated to Poole. There are a number of other Bournemouth postcodes (BH2, BH3, BH10 and BH22) that were all allocated to Bournemouth, where the distance to Poole is only slightly more than the distance to Bournemouth. The traffic around Bournemouth might mean the journey to Poole is actually quicker from these areas, which would move the data more in favour of Poole.

We were surprised when DCCG's Barrister asked the Court to exclude the Maternity FOI that listed the number of babies needing extra care at Poole in 2017/18, by the type of care they needed. The request was made on the basis that the document was submitted late, which was contested by our Barrister. We mention this here because we believe that any risk to newborns that might be posed by the reconfiguration was an extremely important consideration for the Court. Unfortunately the Judge agreed to exclude this evidence.

**iii) Distant overcrowded services with reduced quality of care for all?**
It is important to note here that peer reviewed clinical research shows that moving hospital care further away deters and delays take up of all care – whether emergency, planned, or outpatient care (see section 1, d). This will not best serve a population already adversely affected by health and socio-economic inequalities – obesity, premature death, low wages, no social mobility, who need genuine (not hypothetical) local access to health care at all levels, including timely access to emergency care.

The merger will adversely affect the rural low waged, who will have to rely on increasingly limited and costly public transport to access services that are further away, or to support loved ones who are inpatients in distant locations.

**iv) Longer travel times: the absence of a proper risk assessment**
In 2017 DCCG asked SWAST, who were looking into the operational impact of the merger on their service, to consider risk. However this was not the focus of the SWAST Report: "Dorset Clinical Services Review: Modelling the Potential Impact on the Emergency Ambulance Service".

However, part of the Report looked at patients who arrived at Poole Hospital by ambulance, over the 4 month period January-April 2017, finding that 3,067 ambulance patients would have longer journey times under the merger.[61]

The Report's focus on ambulance patients meant that the medical and trauma emergencies who self-present, and the vast majority of maternity and paediatric emergencies, who also self-present, were excluded.[62 & 63] This was despite DCCG's Equality Impact Assessment noting that longer journey times posed a 'significant risk' for maternity and paediatric emergencies.[64]

61 p1 SWAST Report: Dorset CSR: "Modelling the Potential Impact on the Emergency Ambulance Service" https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/swast-report.pdf
62 Poole A&E FOI 4826: In 2017 of 590 maternity emergencies cared for, 134 (23%) arrived by ambulance and 456 (77%) did not p90 http://keepournhspublicdorset.com/IRP.pdf
63 Dr I Mew Feedback 31.8.17: "of 40,000 paediatric attendances, 331 came by ambulance". Available on request
64 Dorset CSR EQIA 2017 page 23: https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/11/CSR-EIA.pdf

From the 3,067 ambulance patients who would face longer journey times, SWAST identified 1,636 patients who had a very high severity score (NEWS score of 7 or more).[65] However, almost 60% of these 1,636 patients were then removed from the sample by 'data cleansing'. And of the remaining 696, only 150, chosen at random, were reviewed, due to reporting time pressures.[66]

DCCG used this Report when asked by the High Court to calculate risk to patients, and noted that 132 ambulance patients admitted over 4 months, or 396 over a year, were at 'potential clinical risk' as a result of the merger.[67]

However this is an underestimate, due to the methodology, and substantial exclusion of vulnerable groups. Dr Ian Mew, Emergency Medicine Consultant, fed back on 31st August 2017, on behalf of the panel chosen by DCCG to review the risk identified in the Report, stating that, due to the exclusion of most maternity and paediatric patients "the modelling can not and must not be used to reflect the impact of journey times on these patient groups".[68]

Dr Mew[69] went on to note the exclusion of those facing the longest 'additional' journey times (the Report did not consider total journey times at all) saying: "it is the outliers for whom risk analysis should be directed."
He further commented that the power of the study was likely to be low, and a different model should be applied.

DCCG did later do further work on the very small sample of 34 cases listed in the Ambulance Trust Report, and reported in December 2018 that none of the cases would have been affected had they had to travel any further.[69a] However, this was disputed by the A&E Dr, who had previously determined, on the basis of the SWAST data, that around half were in imminent danger of dying so that any longer journey time could have proved fatal.[69b]

The Review revealed further issues: of the 34 patients at least 4, and possibly as many as 10, had died.[69c] For another 4 cases patient data was unreliable – on reviewing the notes it was found that the original diagnoses were incorrect. None of the 34 had a total journey time of more than 36 minutes.

However, it would be possible to have accurate data to assess risk by starting from the Poole emergency admissions, looking at their confirmed diagnoses to see if these are time critical (Poole Hospital say "a substantial amount of conditions could be considered time critical")[69d], and seeing where they have travelled from, to start to identify how many with time critical conditions would face longer journey times under the reconfiguration.

65 p14, & 66 p15 SWAST Report https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/swast-report.pdf
67 DCCG calculation for the High Court scanned at p94 http://keepournhspublicdorset.com/IRP.pdf
68 Dr I Mew Feedback 31.8.17 "Meeting to identify potential risks to patients following the publication of the SWASFT report: "Dorset CSR – Modelling the Potential Impact on the Emergency Ambulance Service" Available on request
69 Ibid
69a https://www.dorsetccg.nhs.uk/expert-review-concludes-that-csr-increased-ambulance-travel-times-would-not-have-changed-the-outcomes-for-patients-at-potentially-higher-risk/
69bAssessment of likely Ambulance fatalities, p95: assessment at http://keepournhspublicdorset.com/IRP.pdf
Assessment based on Report data in the at risk tables on pages 10 (Maternity), 15-16 (Adults) and 24 (Children) https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/swast-report.pdf
69c Death stated for 2 patients on page 4, 2 on page 8. However for other patients outcome unclear including p4 90 year old overdose no interventions, p8 80 year old head/spinal injury immobilised and vomiting no ED interventions, cardiac arrest p9 and it is possible that these patients also died https://www.dorsetsvision.nhs.uk/wp-content/uploads/2018/12/SWAST-Data-Review-FINAL.pdf
69d Poole Hospital FOI 6502 available on request

**6) The capacity of one A&E at RBH to cope**

There are very real concerns that one A&E at RBH will be overwhelmed

a) The merger represents a halving of A&E and Maternity sites in the East of the County.

b) Currently, over 90% of Poole's overnight admission patients are emergency admissions (38,600), and 72,000 patients attend Poole A&E each year.[70] About half the emergency admissions are by direct GP referral and bypass A&E,[71] so the number of patients accessing emergency care at Poole is actually over 90,000. According to the Royal College of Emergency Medicine,[72] only 15% of those attending A&E do not need to be assessed or treated in A&E. Most of the A&E attenders, and all the emergency admissions, will need to be cared for at RBH, as there will no longer be any emergency admissions at Poole.

c) More patients will access emergency and specialist care at RBH than access these services across the two hospitals now. The catchment population will be larger than that served by the two hospitals, as locating trauma A&E, specialist maternity, paediatric care and oncology beds on the Hampshire border will attract additional patients from West Hampshire, who have not previously had Dorset services on their doorstep. There are also substantial developments planned. We are looking at a catchment population of 750,000, an ageing population, which predicts high demand for health care: the Hidden Dorset report suggests 30% of Dorset's population will be over 65 by 2030.[73]

d) Despite DCCG projecting increased need for beds, acute beds will be cut under the plans. In their Decision Making Business Case (pp104-5) DCCG state that we have 1810 acute beds across the County now, that we will need 2467 beds, and yet the plan is to close 245 of the acute beds that we have now.[74]
It is further noted (p104) "To achieve the net reduction in beds, significant further work must be undertaken within the community to embed new ways of working and new models of care."[75]

e) Some of the planned bed closures (74) are at Dorset County,[76] however this does matter for services in the east, as, if the DCH beds are closed, this will result in longer waits for beds at DCH and will mean more patients have to be taken on to other hospitals. There will be no emergency admissions at Poole under the merger and indeed beds at Poole will reduce from 654 to just 247 (-407 beds). Although acute beds at RBH will increase from 741 to 977 (+236 beds), there will still be a net loss of 171 beds across the two hospitals.[77] How will RBH accommodate more emergency admissions patients with less beds?

70 Poole Annual Report p14
https://www.poole.nhs.uk/pdf/Poole%20Hospital%20NHSFT%20Annual%20Report%20and%20Accounts%20201819%20Hi%20Res2.pdf
71 Debbie Fleming Trusts CE: statement to Poole Health Scrutiny 17.12.18
72 https://www.hsj.co.uk/comment/beyond-the-official-data-a-different-picture-of-aande-attendances/5070973.article
73 Hidden Dorset https://www.dorsetcommunityfoundation.org/wp-content/uploads/2015/10/Hidden-Dorset-Report-Online-Version.pdf5
74 DCCG DMBC pp104-5 https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/DMBC-CSR.pdf
75 p104 Ibid
76 Ibid p105
77 Ibid p105

f) Consultants in Emergency Medicine inputting into the Consultation stated that: “The Consultants are concerned that a single-site model for emergency care ‘will create an emergency workload of patients that cannot be managed safely or efficiently’. They strongly believe that there should be two emergency departments in east *Dorset until such time as community services and primary care are able to reduce admissions by 25% as proposed* (a figure that is considered somewhat unrealistic given demand pressures).”

The Consultants further stated that they “cannot see how (primary and community services) will reduce the current Emergency Department workload by 25% in future” and “models of emergency care that have made similar assumptions as Dorset have had to be completely revised.”[78]

f) As previously stated the ‘giant’ A&E at Queen Alexandra has been in special measures. A Dorset A&E Doctor submitting comments to Dorset County Council Health Scrutiny noted that:
“Poole A&E is staffed to see around 180 patients/day but currently sees around 240. RBH A&E are experiencing the same increase. I’m not convinced that creating one A&E, which will be nearly the size of Portsmouth (actually the catchment population for Portsmouth is 675,000, where for RBH A&E it will be 750,000), where patients routinely wait 8-10 hours to see a Dr, is going to make anyone safer. The Portsmouth data is horrific, colleagues working there describe it as a ‘war zone’, and say they are overwhelmed by the volume of patients. This is not a model that Dorset should be considering following. Can the CCG assure the public that Portsmouth failures will not happen in Dorset?”[79]

78 Dorset A&E Dr evidence to Dorset Health Scrutiny Task and Finish Group 22.8.18 Available on request
79 Ibid

**7) The Clinical Services Review Consultation**

This has been included because part of the Governor's remit is to consider whether the interests of the public have been taken duly into account.
Can the Trust board of Directors have correctly obtained and considered the interests of the public as part of the decision-making process when the costly consultation process was described by a Bournemouth Academic as methodologically flawed?

A great deal of opposition has been expressed to plans to close A&E and Maternity at Poole, and relocate Paediatrics to RBH. The plans have been opposed by 9 Councils - Corfe, Langton and Worth Parishes, Portland and Swanage Towns, Purbeck District, Weymouth and Portland and Poole Borough's and Dorset County – and by 2 Dorset MP's, Oliver Letwin and Richard Drax. 36,910 people signed petitions to oppose the closure of services at Poole, and over 80 residents and Councillors wrote to, or made statements at, Dorset and Poole Health Scrutiny Committees.[80]

In DCCG's Interim Report on the consultation, it became clear that the 36,910 people signing petitions to retain A&E and Maternity Services at Poole Hospital had literally been discounted, with petition signatures being moved out of quantitative analysis, and into 'qualitative themes'. 36,910 people was almost four times as many as the 10,624 people who had completed the Consultation questionnaire question on this issue. Of the 10,624 respondents, the majority opposed one A&E at RBH, choosing either Poole for the location, or 'another option', usually to retain some emergency care at both hospitals.[81]

**8) Covid 19**

The merger plans predate the pandemic, so do not address it the issues raised. However, the lessons that we have now learned from Covid 19 are a factor that should be taken into account in considering the merger. These are:

a) There was a serious shortage of acute beds.
   Hospital beds, needed for C19 patients, were rapidly freed up by 270 patients being discharged untested into Dorset care homes between mid March and mid April.[82] At 17 July Office for National Statistics (ONS) data shows that 165 people had died of C19 in Dorset care homes, compared to 164 in Dorset hospitals.[83]
   Acute beds for C19 patients were also generated by cancelling all planned operations, however this cannot be the strategy going forward, and as plans stand, Poole beds would not in any case be used for emergency admissions. As previously stated, DCCG's Decision Making Business Case has a table (p105) showing that the plans are actually to reduce Dorset acute hospital beds by 245 beds.[84]

80 Dorset Health Scrutiny 17.10.18 "Feedback from councils & members of the public" and "Public Participation": https://moderngov.dorsetcouncil.gov.uk/CeListDocuments.aspx?CommitteeId=257&MeetingId=1304&DF=17%2f10%2f2018&Ver=2 6 councils listed + Purbeck District voted Dec 2017, Poole Borough and Dorset County referred. Oliver Letwin MP letter can besupplied
81 ORS Interim Report: blue pie charts p98: 10,624 answered, opposition to one A&E at RBH (B) always higher (A + Another Option). Petitioners discounted - in green 'qualitative themes' p99: 24,487 + 8,353 + 4,070 = 36,910 http://keepournhspublicdorset.com/IRP.pdf
82 FOI raised and reported by BBC Solent to BCP and Dorset Councils
83 ONS data re deaths to 17 July: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/weeklyprovisionalfiguresondeathsregisteredinenglandandwales
84 DCCG DMBC 2017 p105 https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/09/DMBC-CSR.pdf

b) There was a serious shortage of critical care beds.
A recent Dorset Echo article reported that there are just 65 critical care beds across Dorset. DCCG recently painted a worse picture still, when Tim Goodson stated at Joint Health Scrutiny on 1st July 2020 that, under the CSR plans, there would be just 30 critical care beds at RBH (none at Poole), which, he said, represented an increase in critical care beds for Dorset. 349 people in Dorset had died of COVID 19 by 17 July 2020, according to ONS.[85] As, of those who are hospitalised, about two thirds survive,[86] we can assume the number needing critical care beds was at least double, if not three times, the number who died. It is difficult to imagine that the care needs of approaching a thousand Dorset patients with C19 can be met by 30-65 critical care beds.

c) Two A&E and Maternity Departments best supports infection control.
In hospital infection control is crucial. The Chair of the Health Select Committee noted in parliament in June that 25% of C19 infections were contracted in hospital.[87] Hospitals are being asked to separate patients with, and without, C19, wherever possible.[88]

This calls into question the wisdom of halving the number of A&E and Maternity departments in the East under the merger, which will also prevent full separation of C19 and non C19 emergency admissions. The Trusts did try to separate maternity patients during the first wave of C19, as all mums-to-be went to Poole maternity, which is in a separate building, on a separate parallel road, to the main A&E at Poole. However this option won't be possible in future waves if the St Mary's maternity site has been sold off. There are also concerns about the "barn style" operating theatres proposed for Poole, given C19.

85 Office for National Staatistics data re deaths to 17 July:
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/weeklyprovisionalfiguresondeathsregisteredinenglandandwales
86 https://www.theguardian.com/uk-news/2020/apr/29/study-finds-a-third-of-uk-covid-19-patients-taken-to-hospital-are-dying
87 24.6.20 Jeremy Hunt Chair Health Select Committee during Commons debate on weekly testing for NHS staff
88 18.5.20 Health Services Journal: "Spread of C19 in hospitals causing national concern"
https://www.hsj.co.uk/patient-safety/spread-of-covid-19-in-hospitals-causing-national-concern/7027663.article

## Solutions

### 9) A&E: A possible compromise "A&E Local" for Poole

While we do not want to lose any care or beds from Poole, if the changes are going ahead, we believe the merger need to be conditional on ongoing, and serious, consideration, involving all parties, of "A&E Local" at Poole.
This is a full A&E that is closed overnight, and was suggested by the Independent Panel as a "possible viable option" for Poole.[89a & 89b]
There would be several years to plan for this and it would be easier to staff than the 24/7 A&E currently provided there. A full A&E closed overnight is a model that has been in use at Weston Super Mare for the past three years.

### A&E Local would:

Restore safe access to A&E: Traffic to RBH is at it's worst during the day, and "A&E Local" would restore access to A&E within 45 minutes to tens of thousands of Dorset adults and children, saving lives and reducing disability.

Support daytime maternity & paediatric emergencies: A&E Local could stabilise these patients where the UTC could not. Onward travel to RBH without intervention could increase disability, or threaten life. This would help to mitigate the significant risk of longer travel time for these patients.[90]

Support children: There were just over 7,300 paediatric admissions to Poole in 2018/19, and no doubt a much larger number of children coming into A&E. Parents will continue to bring their children in. It will be essential to have enough Paediatric specialism amongst staff to support these young patients.

Provide timely access to care, reduce transfers, and support RBH A&E:
For patients attending Poole who need A&E assessment or care, and for Poole elective patients with complications. By enabling some of Poole's emergency 'take' to continue to be seen at Poole, A&E Local would also mitigate the capacity issues at RBH A&E.

Support C19 management, RBH capacity, reduce journeys and enhance care
A&E Local at Poole would offer the option to separate C19 and non-C19 admissions over the two sites. It is difficult to see how C19 can be managed with less beds, or how RBH A&E can continue with more patients but less beds. Retention of some emergency beds at Poole would help mitigate both these challenges and would also support some of the 78% of Poole's emergency admissions (28,500) who will otherwise have further to travel in an emergency, beyond safe guideline times for thousands of patients.

### 10) Maternity: Midwives at Poole and SCBU at Dorset County

We believe the merger needs to be conditional on serious consideration, involving all parties, of the reinstatement of safe accessible maternity care.

This would also help to mitigate the significant clinical risk created by longer travel times for mums-to-be and their babies under the merger.[90]

89a 92 p10 13.1.20 Independent Panel: Dorset advice: https://www.gov.uk/government/publications/irp-dorset-advice
89b 9.10.2019 HSJ "Details of A&E Local Model revealed" https://www.hsj.co.uk/expert-briefings/performance-watch-details-of-the-aande-local-model-revealed/7026100.article
90 DCCG EQIA 2017 page 23: https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/11/CSR-EIA.pdf

We're sure Hospital Governors will agree that it is essential that all practical steps are taken to avoid harm to newborns. Very sadly, East Kent HUFT is in the news at the moment, because seven baby deaths have been deemed 'preventable'. At least two of these deaths relate to time to care:
Baby Harry Richord might have survived had there not been a delay in resuscitation at his birth that caused irreversible brain damage.[91a] Baby Archie Batten's mum was unable to access care at the hospital close to her as the maternity unit was closed, and faced driving herself for an hour on poor roads to Ashford. She decided to give birth at home. Although midwives were in attendance, there were complications, and, tragically, Archie died.[91b]

We want our Dorset maternity care to be the best it can be. The vast majority of the around 4,500 mums-to-be who give birth at Poole do not arrive at hospital by ambulance. Under the merger, many of these mums will be facing longer journeys, in cars. Some will be facing very long journeys. All longer journeys increase the possibility of birth or complications happening en route to the hospital, but these mums will be without ambulance support.

FOI's show just under 600 mums facing maternity emergency are cared for at Poole annually, some of whom would have journeys of up to 75+ minutes to RBH. Over a thousand newborns each year receive 'extra care' at Poole, and around 500 need high levels of care, often to survive.

FOI's also show that more newborns whose mums live closer to Poole needed intensive care in 2018/19. Although the other categories (high dependency, special care baby and transitional care) were evenly split, in every category the mums closer to RBH could get to Poole within 30-45 minutes, whereas 33 mums would have journeys beyond these times to RBH.

A midwife-led unit at Poole would return access to non-specialist maternity care, within safe guideline times of 30-45, minutes for all.

Reinstating the Special Care Baby Unit at Dorset County Hospital would mean mums-to-be in the west could safely access special care in an emergency, thus mitigating this acknowledged "significant risk".

91a 24.1.20 https://theisleofthanetnews.com/2020/01/24/courage-and-quiet-dignity-of-parents-praised-after-inquest-rules-seven-day-old-sons-death-was-avoidable/
91b 18.2.20 https://www.mirror.co.uk/news/uk-news/baby-boy-died-after-mum-21520293

## 11) Defend Dorset NHS involvement going forward

The Independent Panel reviewing the plans for the Secretary of State noted that local people should play a part in influencing the development of services, and the need for greater "co-production" from "interested parties", listing these as NHS, local government, Healthwatch and public and patient groups. Our group was specifically named as one who should be involved.[92]

It is perhaps understandable that we have not been more involved as we had supported the Claimant opposing the plans in Court, and indeed believe that the merger will increase risk to her life. However, we did not go to Court lightly, we did so because we felt our serious concerns were being ignored.

Following the Independent Panel advice we sought a meeting with DCCG and the Trusts. This meeting took place on 17th February, and was attended by a number of senior staff. We welcomed the opportunity to meet, and hoped the meeting would be an opportunity to agree a plan to address our concerns, and to discuss "A&E Local". We agreed in the meeting that a list of our outstanding concerns would be sent to Tim Goodson. These were sent on 26th February. We have since had a holding reply.

## 12) Conclusion

DCCG believe they need to reconfigure services to address their staffing and revenue deficits, and to access the central government investment.

However, the merger will create serious clinical risks, with lengthy travel times to emergency hospital care, well beyond safe guidelines. Tens of thousands self presenting at Poole UTC, but needing to be assessed or treated in A&E will have delayed access to emergency care and will need ambulances.

The merger will also lower standards for all, by creating 'giant' inaccessible and impersonal services at RBH, which will have to serve 750,000 patients, yet with less staff and less beds than the two more accessible A&Es offer residents and holidaymakers now.

It seems that conflict between financial and staffing challenges on the one hand, and patient safety and clinical outcomes on the other, has meant that the evidenced disbenefits of the merger have not been duly considered, quantified, or mitigated. Nor have they been weighed against clearly quantified and evidenced clinical benefits, in order to assess whether the merger will result in overall improvement in health care for the people of Dorset, or not.

We believe this means that, to the extent that the Trust board of directors has relied upon DCCG, they cannot have "undertaken proper due diligence, been thorough and comprehensive in reaching their proposal, and appropriately obtained and considered the interests of members and the public."

Adults and children travelling from Purbeck and mums-to-be and their babies across Dorset do not agree to be the collateral damage for the merger.

92 pp9-10 13.1.20 Independent Panel: Dorset advice: https://www.gov.uk/government/publications/irp-dorset-advice

The Independent Panel advice states that: “changes to services will be incremental and carefully considered with any new risks identified and mitigated.”

What is the plan for identifying the extent of, and mitigating, the risk of longer travel times for adult and child trauma and medical emergencies, for mums-to-be facing maternity emergencies, and for newborns needing specialist care?

What is the plan for ensuring that the very poor CQC assessment, and the very poor experience of staff and patients at the giant A&E at Queen Alexandra Hospital in Portsmouth, will not be replicated at RBH?

A&E: Following the Independent Panel advice that “A&E Local” is a possible viable model for Poole, we ask governors to consider approving the merger conditional on this option being fully investigated, costed and reviewed with full involvement of all parties throughout (NHS, LA, Healthwatch and patient and public groups, ours was specifically named by the Panel for inclusion).

“A&E Local” would obviate lengthy daytime journeys, when traffic is worst, for adults and children, by maintaining daytime A&E care at Poole. It will reduce the transfers and delayed access to care that will otherwise arise from Poole’s A&E attenders and admissions coming to the Urgent Treatment Centre. It will also help to address the ‘significant risk’ of longer travel times that the merger poses for maternity and paediatric emergencies,[93] by offering clinical facilities and expertise to stabilise and protect life before onward transport to RBH where necessary. “A&E Local” at Poole would also help relieve real concerns about the anticipated pressure on, and capacity of, RBH A&E, particularly during a pandemic.

Maternity: A midwife led unit at Poole would maintain access to maternity care within safe times for all. Where there are complications, the unit would offer early identification and support, particularly with a co-located A&E Local, and the option of onward ambulance transfer to RBH. Reinstating the Special Care Baby Unit at Dorset County would bring back accessible support for mums-to-be in the west who find themselves facing maternity emergency.

We believe the merger should be conditional on serious consideration, investigation and costing of returning safe services to Dorset through an A&E Local, midwife and paediatric support at Poole, and reinstating the Special Care Baby Unit so that there is accessible maternity emergency care at DCH.

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## 13) In summary: Residents requests of Hospital Governors

We ask Hospital Governors to ensure that their Board of Directors has exercised full due diligence.

We ask that the significant risks detailed in this report, are acknowledged, quantified and mitigated before the merger is approved, namely:

- The life-threatening clinical risks that longer travel times pose
- The lack of due clinical risk assessment
- The capacity of a single A&E at RBH to cope with need
- The resilience of our NHS in the Covid 19 world

In terms of mitigation, we ask for full consideration involving all parties of

- The maintenance of daytime A&E care at Poole
- The introduction of midwife-led maternity care at Poole
- The reinstatement of special care baby services at Dorset County Hospital.

Thank you

Defend Dorset NHS Residents Group August 2020

93 Dorset CSR Equality Impact Report 2017 page 23: https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/11/CSR-EIA.pdf