



Dorset Clinical Commissioning Group

YOUR NHS

Working together to shape
Dorset's Health

Improving Dorset's healthcare

Our proposals for changing the way
local community and hospital-based
services are organised.

Consultation document



- Visit our website: www.dorsetsvision.nhs.uk
- Email us: involve@dorsetccg.nhs.uk
- Call us: 01202 541946

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Jeżeli chciał byś ta informacje w języku Polskim proszę aby zadzwonić pod podany numer telefoniczny 01202 541946. Albo wyślij e-mail na communications@dorsetccg.nhs.uk

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1 Introduction

What this document is about

This consultation document sets out our proposals to improve health and care services in Dorset as part of a Clinical Services Review.

The Clinical Services Review (CSR) is being led by the NHS Dorset Clinical Commissioning Group (CCG). The CCG is the organisation responsible for commissioning – or planning and securing – healthcare in Dorset.

We launched this in-depth review in October 2014 with the aims of assessing the future health needs of people in Dorset and planning how best to meet them. This included looking at how well our current services work and how they might be reorganised and improved.

During the 12 months that followed, we did a great deal of work on how our acute/larger hospitals might develop and, originally, had hoped to go to public consultation in August 2015. However, extensive stakeholder and professional feedback made it clear that more work needed to be done in a number of areas – in particular around community services, where 90% of services are provided, and joint working between health and care providers. As a result, since August 2015 we have placed significant focus on community health and care services, as well as continuing to work on the options for acute hospitals.

Our proposals are ambitious and forward-thinking. They include large-scale changes to health and care services in both community and hospital settings.

The proposals we set out in this document are just that. We have not made **any**

decisions yet. The scale of the review makes it important that we hear your views on how our community services and acute hospitals might be delivered differently to provide safe, high-quality care in Dorset for now and the future. We will listen to your views and take them into account before making any decisions next year.

So we have launched a formal public consultation which will run for **12 weeks**. The consultation will ask what you think about our proposals on:

- why we need to change health and care services
- our vision for change
- changes to health and care provided in the community, outside of the major acute hospitals
- changes to how acute hospital services are organised

You will see that the CCG has said what its preferred options are for both acute hospitals and community services. This follows a request from senior leaders across the health and care system. This was also requested by NHS England. The reason for this was to give a better understanding of how services in Dorset could look in the future and what this could mean to you, personally, before asking for your views. It would also allow local health and care organisations to consider how they may need to plan.

Although we have named these preferred options, no decisions will be taken until after public consultation has been completed and public responses fully considered by the CCG Governing Body.



How to use this document

This document aims to give you the information you need to answer the questions we are asking about our proposals for change. The questions are set out in a pull-out questionnaire in the centre of this booklet. There is space for any additional comments you may wish to make. We want to take account of your views before making our final decisions.

The background information is set out in chapters with clear headings. We have used different colours to make each chapter stand out from the other. At the end of chapters five and six there are boxes which help direct you to the relevant sections within the questionnaire. We hope this will make it easier for you to refer back to these chapters when you come to complete the questionnaire. We have already heard from many people at different events, and throughout the consultation period there will be many more opportunities for you to find out more details about our proposals. These will include public meetings throughout Dorset and in West Hampshire, focus groups, telephone surveys and regular updates, including on our website, Facebook, Twitter and in the local media. Information will also be available at GP surgeries, hospitals and other public places.

What's not in this consultation

The consultation will not cover acute mental health services or primary care services (those based in and around GP surgeries, pharmacies, opticians and dentists).

This is because a separate consultation on acute mental health services will run alongside the CSR consultation. We are also drawing up separate plans for the way primary care services might be organised in future. You can read more about these in the draft Primary Care Commissioning Strategy which is available on www.dorsetccg.nhs.uk/aboutus/primary-care-strategy.htm. However, the document will refer to both mental health and primary care services in the context of other services.

**For details and updates please visit our consultation website,
www.dorsetsvision.nhs.uk**

Please read the consultation document all the way through before completing the questionnaire. Once you have done this you can post it free of charge to:

**Freepost SS1018
PO Box 530
Swansea
SA1 1ZL**

**Or, if you prefer, you can fill in the form online at:
www.dorsetsvision.nhs.uk**

All completed questionnaires should be returned to the FREEPOST address to arrive by Tuesday 28 February 2017

2 The need to change



2 The need to change



The need to change applies just as strongly to community services as it does to acute hospital services

We currently have good NHS services in Dorset. However, rising demand on services means we need to make significant changes to ensure you continue to have high-quality, safe care that the NHS can afford both now and in the future.

We want as many people as possible to live healthier lives for longer.

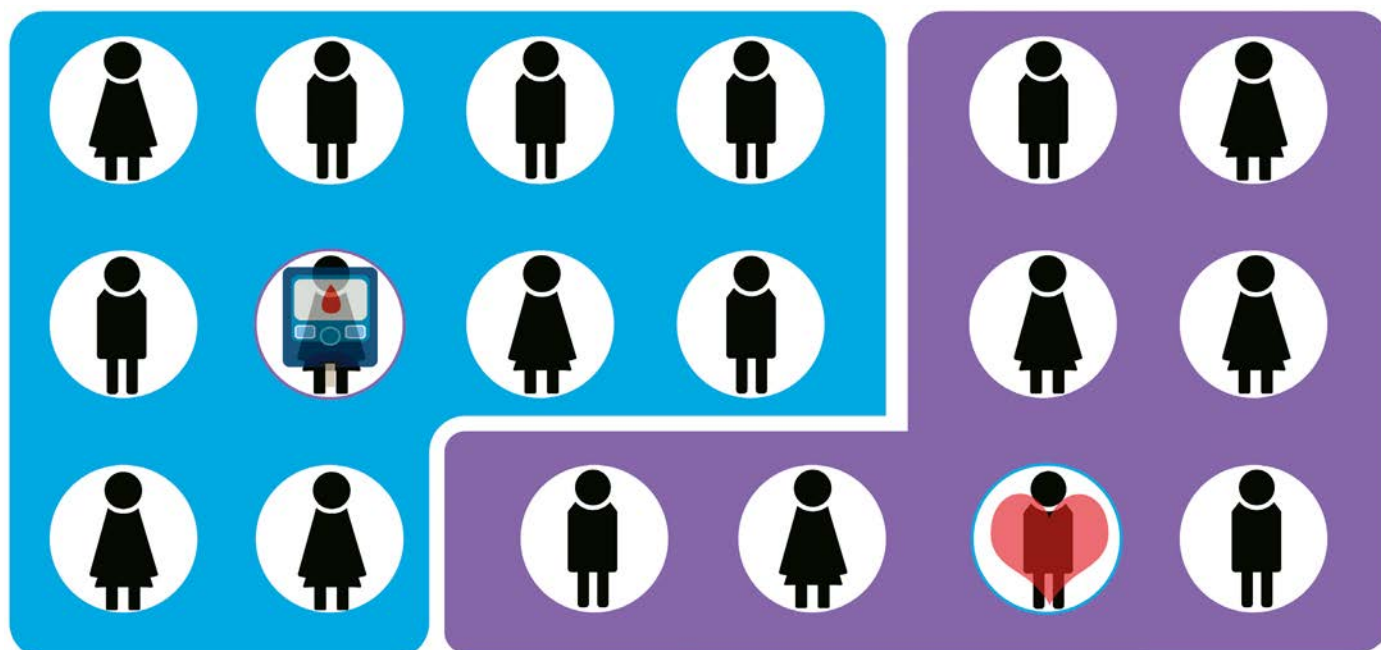
Doing nothing is not an option if we want to ensure people continue to receive the generally good care that is currently provided in Dorset.

Our changing health needs

By 2023 the population of Dorset will have grown from around 750,000 to over 800,000, with older people making up much of this increase.

People live longer than they did when the NHS was set up over 60 years ago. This is good news, but it brings new challenges – as we grow older, more and more of us are living with long-term health conditions. For example, by 2020, around one in 10 people in Dorset are predicted to have diabetes and one in eight to have heart disease. So the types of services we provide must reflect these changing health needs.

We must also reduce the inequality gaps that exist. The life expectancy varies by over 11 years between men living in the poorest and richest areas of Dorset.



1 in 10 local people will have diabetes
1 in 8 will have heart disease



We want everyone in Dorset to receive the same high quality of care, regardless of where they live, or what health conditions they have.



The variable quality of care

There are unacceptable variations in the quality of care that is currently provided across Dorset. For example, some patients say they cannot access the care they need outside of normal working hours or at weekends.

We want everyone to have the highest quality of care wherever they live and whatever time of the week, day or night. Expectations for meeting national quality guidance are high, and they are continuing to rise. We have to do more to ensure that they are met by all services. In most cases our services are good, but in others the evidence shows we need to do more.

Staffing difficulties

At present, more than 30,000 people work within our local health and social care system. The way that services are currently organised means we do not always have staff with the right skills where and when patients need them.

We have difficulties staffing some services because there are national and local shortages of some medical staff with key specialist skills and it is difficult to recruit to some posts. This includes GPs, mental health nurses, consultants working in accident and emergency and paramedics. We also face the prospect that quite a lot of our staff are coming up to retirement age in the next few years. We are now trying to recruit staff from other countries such as Portugal, Spain, Italy, Ireland and the Philippines.

These factors mean we often rely on expensive short-term medical staff, which makes it more difficult for patients to be seen by the same team over a period of time. We need to organise our staff better to make sure we can provide high quality and safe care in the future.

Financial pressures

The cost of providing healthcare in Dorset in the way that we do at present is more than the funding we have. Even though the money we get from Government grows at around 1.8% each year, the demand for services is rising three-times faster at 5.8% a year.

If corrective action is not taken, the NHS in England is expected to have a national shortfall of £22 billion each year by 2020/21. Last year our local NHS trusts providing hospital, community and mental health services had a shortfall of £23m. If we continue as we are now in Dorset, we forecast a local shortfall of £158m a year. (You can read more on how we propose to close the financial gap in [Chapter 7](#))

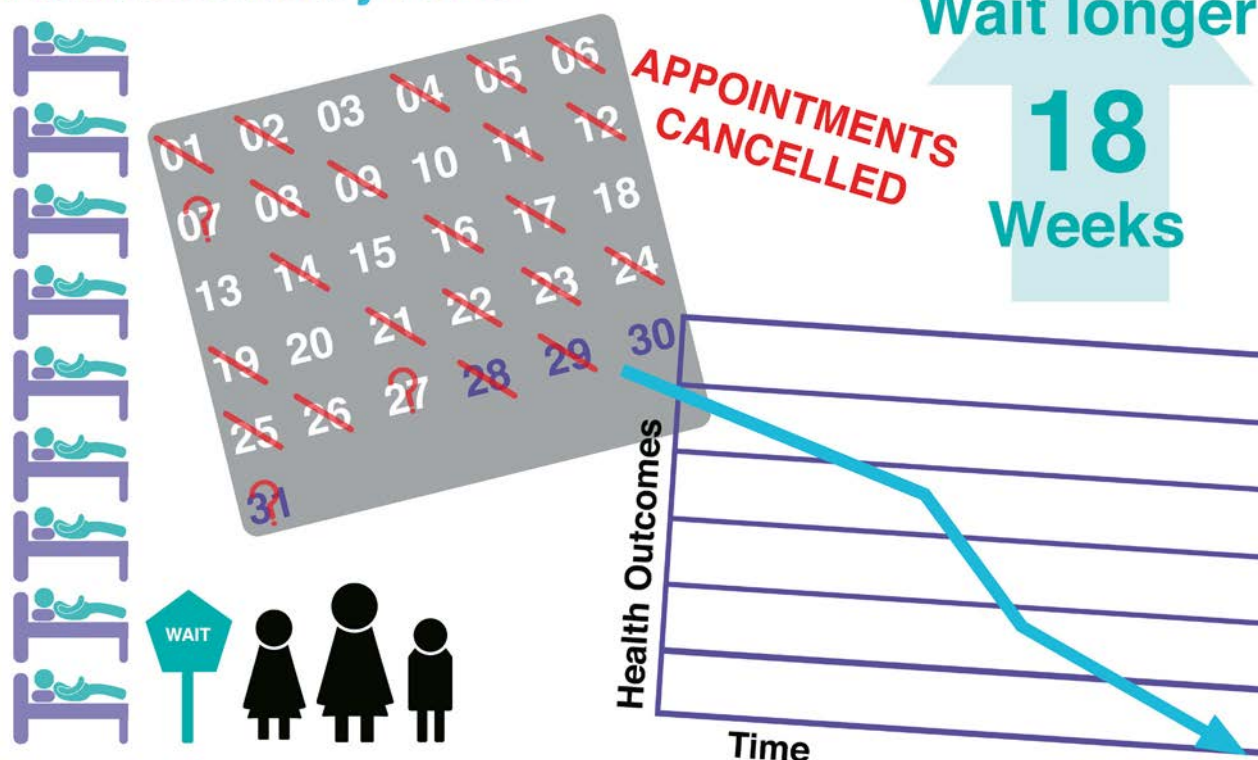
None of this is unique to Dorset: other parts of England are facing similar challenges. But it does mean we have to be more efficient. We need to use our resources, including our workforce, technology and buildings, in a way that brings the greatest benefit to local people.

What will happen if we don't change?

Doing nothing is not an option because by staying the same our healthcare would get much worse. Staff shortages and financial constraints are likely to lead to a situation where local people would face:

- more difficulties getting a GP appointment
- longer waiting times at A&E and other urgent and emergency services
- more operations in hospitals being cancelled
- insufficient hospital beds

Estimated 30% increase in Hospital Admissions by 2026



- greater problems seeing the most highly qualified doctors and nurses in hospitals
- unplanned service cuts with the stopping of some services and medical procedures from the NHS

Most importantly, doing nothing would mean:

- lower safety standards
- worsening health
- reduced survival rates

We do not want to see this happen in Dorset and we don't want to miss the opportunity to

transform services to meet the needs of future generations.

This means we have to make important decisions about how to do things differently across our community services and acute hospitals, so that we can save more lives and improve the care that people receive. The need to change applies just as strongly to community services as it does to acute hospital services.

Before we can make any decisions we need to listen to your views. Please answer the questions in the pull-out questionnaire in the centre of this booklet.

3 Our vision for change



3 Our vision for change



“Our vision is simple but effective: we want to change our healthcare system to provide services that meet the needs of local people and deliver better outcomes.”

To address the challenges outlined in **Chapter 2**, we have developed a vision for how healthcare in Dorset could be changed and improved.

Our vision is simple but effective: we want to change our healthcare system to provide services that meet the needs of local people and deliver better outcomes.

This vision applies to all children and adults in Dorset, regardless of gender, age, disability, ethnicity or sexuality. It also applies equally to people with mental health problems as people with physical health problems. Please read more in our **Equality Impact Assessment** on www.info.dorsetsvision.nhs.uk.

This requires five key ambitions to be delivered:



1 Services organised around you

We want to reorganise services so that we put people at the centre of everything that we do, whatever their differing health and care needs. This will mean services are shaped around local people and not to existing organisational structures or facilities.

2 Supporting you to stay well and take better care of yourself

We want to help everyone to stay healthy and reduce the risk of developing ill health. We also want to support you to take control of your own health and manage your health conditions. Alongside this we will work with local authorities to do more to tackle factors affecting wellbeing such as employment, housing and transport. This is because we do not think it is right to wait until people are unwell to support them. This will mean that people can live healthier lives for longer and reduce their need for health and care services.

3 Delivering more care closer to home

We want to extend the provision of health and care services beyond GP surgeries and hospitals into people's homes and our communities – the places where most people spend the majority of their time. This would mean that more care would be delivered closer to home, reducing the need to travel. There should be easy access to this care when you need it, including in the evenings and at weekends.

4 Integrated teams of professionals working together

We want to establish mixed teams of doctors, nurses and other health and social care professionals from our three local authorities to provide well-coordinated care. This will mean that patients do not end up having each of their health and care needs treated in isolation and be passed from one professional to another. Instead they can have all their needs considered together.

5 Centralising hospital services

We want to bring our acute hospital services up-to-date by having highly trained consultants available 24 hours, seven days a week in major specialist hospitals. This is because national evidence, particularly the comprehensive review of NHS emergency and urgent care published in 2014 by the NHS Medical Director, Sir Bruce Keogh, shows that there are better results and safer services for patients when specialist care is centralised. This means having acute hospitals focused either on urgent and emergency care for the most seriously ill patients and life-threatening conditions, or on planned care hospitals for when you need non-urgent or routine treatment. We estimate that an extra 60 lives could be saved each year by creating separate specialist roles for our acute hospitals.

The Government wants to see this happening across the NHS in England. This national ambition is explained in a document called the **Five Year Forward View** (available at www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf).

Each of the 44 local health and social care areas across the country has produced a **Sustainability and Transformation Plan (STP)*** to explain how they will implement this national plan.

The proposals within our consultation document would be an important part of delivering the STP in Dorset. Our plan can be seen on our consultation website, **www.info.dorsetsvision.nhs.uk**. The main themes are:

- a substantial expansion in the prevention of ill health
- a greater focus on self-care so that people have the confidence and support to manage their own health
- avoiding gaps in services and removing the boundaries that exist between primary and community care and services delivered in hospitals
- groups of GPs leading mixed teams of doctors, nurses and social care professionals so that they can make better use of their skills to meet patients' needs
- a different way of providing urgent and emergency care services that are fit for the future so that we can save even more lives and improve care

*Please note, at the time of going to print with this document all STPs were awaiting approval by NHS England. Visit our website for news and updates on STPs.



4 Pre-consultation engagement and involvement



4 Pre-consultation engagement and involvement

How we have involved local people and our staff in developing our vision and proposals

We have developed our vision and proposals for change by working closely with local health professionals and, importantly, the public and patients.

From the outset the Clinical Services Review has been led by doctors, nurses and other frontline workers. We have brought together the views of over 600 professionals, including consultants, GPs, nurses, midwives, paramedics and social care staff, to consider how healthcare should be changed in Dorset. This means that we have involved representatives from across our local GP practices, Dorset County Hospital NHS Foundation Trust, Dorset Healthcare University NHS Foundation Trust, Poole Hospital NHS Foundation Trust, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, South Western Ambulance Service NHS Foundation Trust, local authorities, and health services in West Hampshire and other surrounding counties.

These views have been complemented by those of local people and patients who have used our healthcare services. We have also sought the views of other NHS staff, MPs, councillors, health and wellbeing boards, neighbouring clinical commissioning groups, hospitals on Dorset's borders in Exeter, Salisbury, Southampton, Taunton and Yeovil and many more individuals and organisations.

The proposals have been informed by members of the public in the following ways:

29,000 pieces of feedback themed and used to inform the 'Need to Change'

18 Patient (Carer) and Public Engagement Group (PPEG) meetings – providing feedback and challenge at all stages of the CSR

525 local people attended public meetings during the formative stage of the CSR

84 diverse forums, meetings and events providing information and opportunity for involvement to 1,000s of people

3,900 Health Involvement Network (HIN) and **150** Supporting Stronger Voices members from our local communities

2 CSR young people's conferences co-designed and co-hosted with young people in October and November 2015

4,100 people have watched our animated film '**Need to Change**' (view it on our consultation website www.dorsetsvision.nhs.uk)

339 local people attended nine locality based Integrated Community Services (ICS) public engagement events that were hosted in March and April 2016 providing 2,162 pieces of feedback

26 locations across Dorset were visited by the ICS Roadshow during two weeks in June 2016 travelling 650 miles enabling 36 staff to speak with 100s of people who gave 1000s of pieces of feedback

157 people representing groups and organisations with an interest in community health and care in Dorset attended two public engagement events in June 2016 providing 100s of pieces of feedback



You said	We are doing
Work more closely together to provide care closer to home	<ul style="list-style-type: none">✓ improving prevention and self-help to enable people to stay at home and avoid hospital admissions✓ creating mixed teams providing care together – for physical and mental health✓ bringing services out of acute hospitals e.g. outpatients, day surgery, blood tests and scans
Improve access in terms of time, location and transport	<ul style="list-style-type: none">✓ bringing more services closer to home - considering travel time as a key evaluation criterion for future service delivery✓ linking with local authorities on their review of local transport services✓ supporting community/voluntary travel schemes✓ consulting with South Western Ambulance Service
Consider staff – recruitment retention and training	<ul style="list-style-type: none">✓ attracting primary care staff through a new Dorset specific recruitment website✓ working on having the right staff in the right places✓ ensuring that staff can work across health and social care✓ creating attractive career prospects for newly-qualified GPs
Work closely with the voluntary sector	<ul style="list-style-type: none">✓ developing stronger relationships with the voluntary sector✓ working in close partnership to build our community capacity
Have joined-up and innovative IT (information technology)	<ul style="list-style-type: none">✓ working on the Dorset Care Record so patient information is held in one place creating better communication with less duplication and delay✓ using technology to support people with long-term conditions at home✓ using Skype & e-mail for appointments
Money – how will changes be afforded and money saved?	<ul style="list-style-type: none">✓ reducing the need for hospital admissions by delivering care differently and increasing investment in prevention and community care✓ investing wisely in our local communities✓ using the same funding we have now but spending it very differently

You can read more about our pre-consultation public engagement and how it has been used to help shape our proposals in the documents available on our consultation website (www.info.dorsetsvision.nhs.uk) or you can ask for them by phoning us on 01202 541946

5 Integrated community services: options for change



5 Integrated community services: options for change



What do we mean by integrated community services (ICS)?

Integrated community services means bringing together primary care, acute hospitals (secondary care) community and voluntary services and social care to provide services around the patients.

This involves teams including GPs, nurses, therapists, consultant doctors, social workers and community mental health nurses, working together across traditional organisational boundaries.

Background

In the first 12 months after we launched the Clinical Services Review in 2014, a lot of work was done on how our acute/larger hospitals might develop.

However, extensive stakeholder and professional feedback made it clear that more work needed to be done in a number of other areas – in particular around care outside of acute hospitals, where 90% of services are provided, and joint working between health and social care providers.

Since August 2015, we have been developing ideas for community services, looking at new and different ways of organising care and exploring these ideas with local people, clinicians, providers and other stakeholders.

General practice will continue to be the foundation of the health system, with GPs working in larger groups across a range of sites, as part of the wider teams described earlier. This will ensure the future sustainability of general practice and deliver improved care and better access for patients. You can read more about our vision for the future of general practice in the **Primary Care Commissioning Strategy**, which can be read here: www.dorsetccg.nhs.uk/aboutus/primary-care-strategy.htm.

This chapter explains how we developed our proposals for the way in which community services could be integrated and organised in the future. We refer to this as '**a model for care**'.

It also explains how we arrived at our proposals for where these services might be located to best serve local needs. Throughout this chapter we will refer to '**community hubs**'.

What is a community hub?

One way that we could help to join-up and improve health and care services in the community for local people is by creating what we are calling community hubs.

Community hubs provide a joint health and social care team approach to caring for patients, particularly the elderly and frail. They will allow you to have outpatient appointments outside of acute hospitals and closer to home. Care is provided by an extended multidisciplinary team with health and care staff working together from a single central location.

Advantages include:

- longer opening hours for urgent primary care
- local access to diagnostic tests and scans
- economies of scale as the service could not be provided in every NHS location within available resources and need a minimum number of patients each day in order to be cost effective



Bridport Community Hospital – an example of mixed teams of professionals working closely together in a hub

At Bridport Community Hospital we already have a mixed team of professionals, including doctors, nurses and social care professionals, working together to support the most vulnerable local people. We want to create similar collaborative teams to assess and treat local people's needs across the whole of Dorset.

“I am a geriatrician and I focus on treating frail older people. By making myself available to the very capable community team who work at Bridport Community Hospital, I can support them to help patients with complex needs. It often means patients can continue to have their care provided either at home or closer to their home, and avoid moving around the healthcare system or an acute hospital stay. This is important because hospital stays can lead to a loss of independence, especially among older people. It will be good to see this system of close working between community and hospital based teams being rolled out across the county.”

– Dr Riaz Dharamshi, Geriatrician, Dorset HealthCare University NHS Foundation Trust





What are our aims?

The model of care we propose aims to:

- increase the number of people supported in community settings, such as their own homes or through community hubs, as an alternative to being admitted to our acute hospitals
- increase the range of services on offer in the community
- health and social care staff working in teams to support people with the most complex needs
- seven-day services and making them available for longer during the day
- improved use of community hospitals as community hubs by consolidation of some or increased use of others
- ensure that the mental health and physical wellbeing of patients are integral to local services

What do we have at present?

Currently we have 13 community hospitals – most with beds – and 97 general practices providing care in 131 sites.

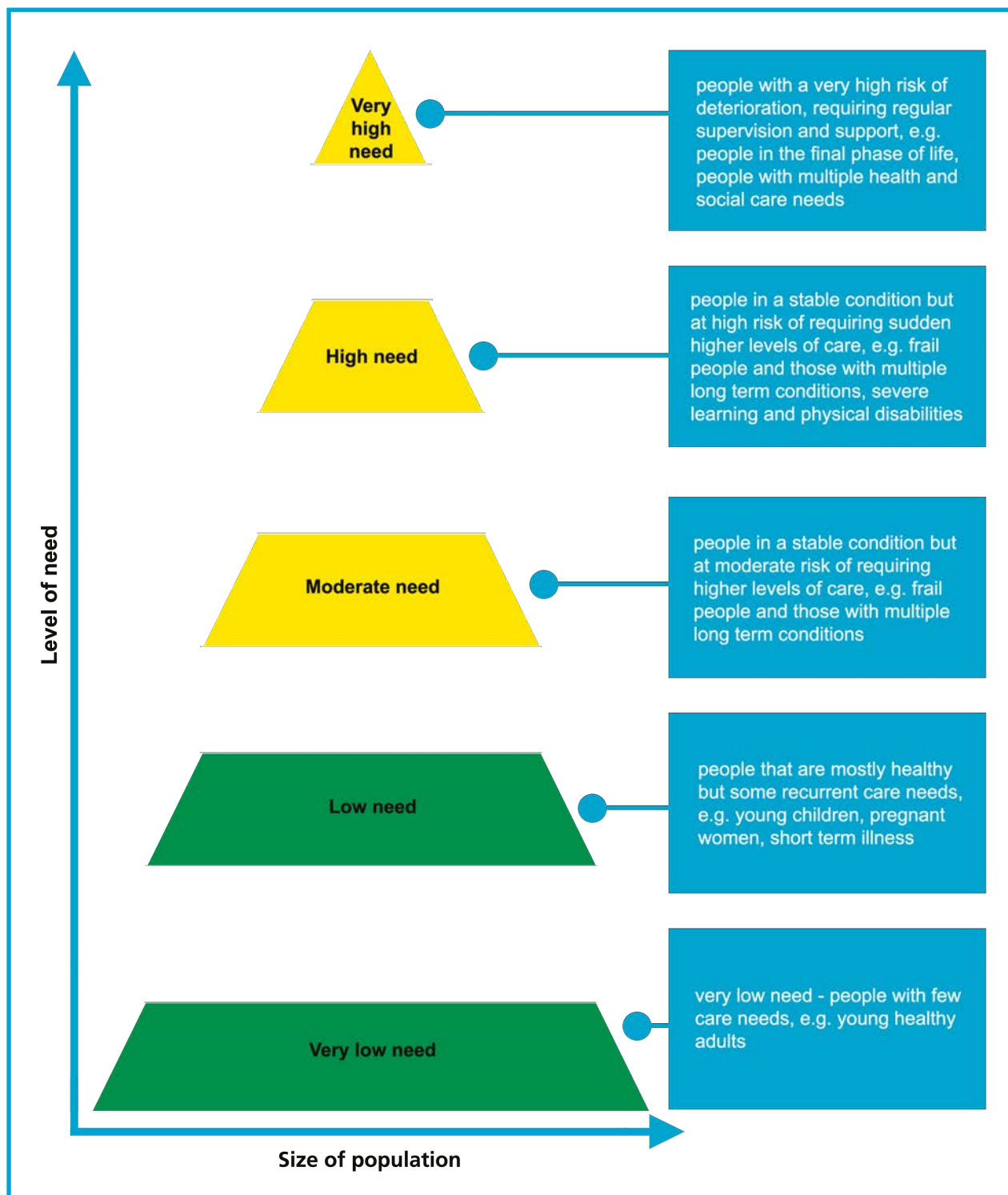
We believe that there is the potential to deliver better care closer to people's homes using community teams through a series of community hubs, like those described earlier, and primary care sites.

With public support to access services in these new ways, it will help us to meet the 25 per cent reduction in unplanned medical admissions and the 20 per cent reduction in unplanned surgical admissions that is required by our proposals for improving acute hospital care.



How did we develop the proposed options?

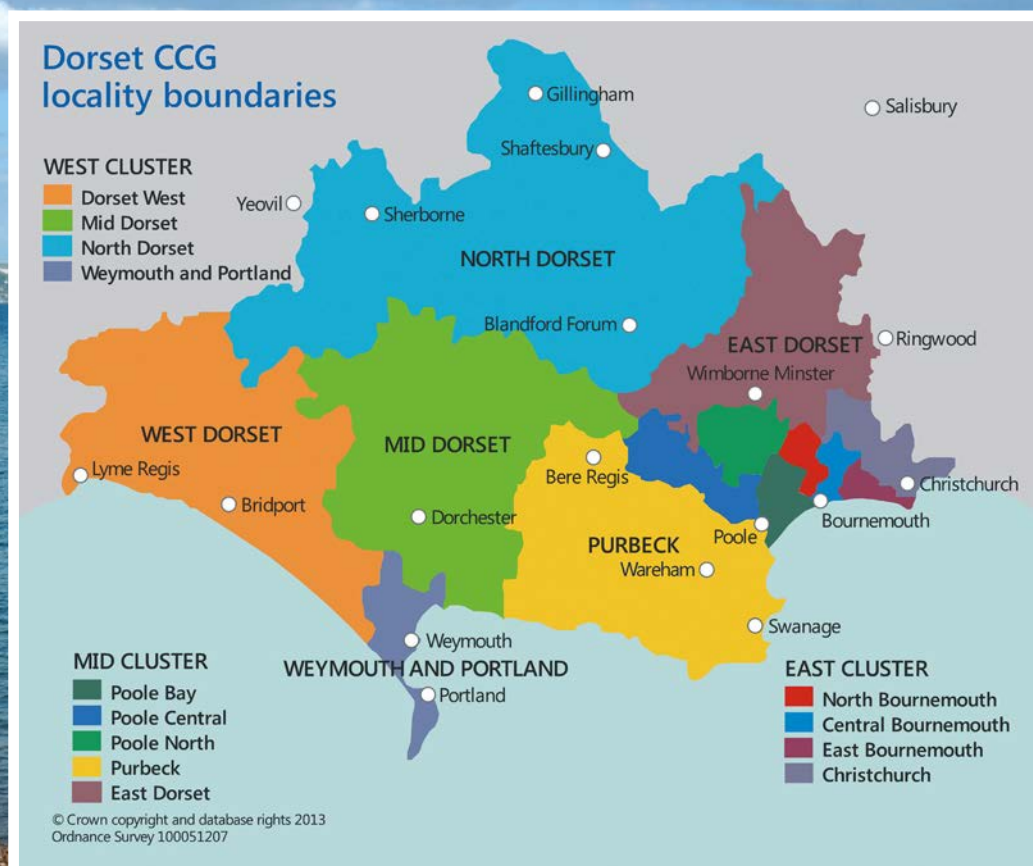
We know that patients have different levels of need at different times in their lives and therefore require different community care and support, so we have been looking at different models of care to meet local needs:



What do we mean by clusters and localities?

When we plan local NHS services we divide the county into three geographical areas that we call clusters: East, Mid and West. Within the clusters we have smaller areas that we call localities.

There are 13 localities in total, each with a catchment population ranging from 30,000+ to 80,000+. These areas are not the same as local authority boundaries. Please see the map (right).



Doctors and other health professionals adopted a five step approach to help them work out:

1. how much care will be needed in 2020/21
2. the size and type of workforce required
3. what could be done where – at home, in clinics, community beds
4. what capacity, such as beds and space, is needed in each locality
5. what are the options for local delivery of health and care services

Using this structured approach we looked at what might be needed to meet local population needs in each of the CCG's 13 geographical localities and in the three larger clusters.

All 13 localities (see map) will have access to:

- A rapid response team to assess and supply

care and support to people with complex and high needs

- A multi-disciplinary team of doctors, nurses, therapists, pharmacists, social care and voluntary sector staff to treat and care for people and promote their independence
- At least one community hub providing outpatient consultations for, for example, diabetes, elderly care, dermatology (skin care) and therapies such as physiotherapy, occupational therapy, foot and hearing clinics
- A base for integrated health and social care teams

In each cluster area (West, Mid and East Dorset) the following services would be delivered:

- a large community hub with beds or network of beds with:

- step-up beds from people's homes
- step-down beds from acute hospital
- a wide range of outpatient facilities
- day case facilities
- X-ray/other diagnostic facilities
- Urgent Care Centre for minor injuries and ailments, (if the community hub is not located with a major hospital) supporting people who historically go to the emergency department

In addition, in each cluster, people will have access to a community hub with beds and an urgent care centre.

The following services would also be available at locality level:

- mental health teams and integrated learning disability teams
- potential for a wider range of early help and community resources
- pharmacy

Patient benefits – what this would mean for local people

MORE access to urgent and routine care for more hours of the day so that you can be seen more quickly and at a time that is convenient to you with a range of services available 12 hours a day, seven days a week

MORE support when you experience an urgent health or social care need, with rapid access to more care provided at home and at the large community hubs with beds. We expect that this will reduce unplanned acute hospital admissions by 25%

MORE information and support so that you can take better control of your own health. We predict this would mean that 10% fewer people would need to attend an outpatient appointment and that there'll be a 25% reduction in follow-up appointments

MORE rapid discharges back to your home after a stay in an acute hospital or large community hub because of much closer working with social care

LESS need for you to travel to an acute hospital for care. We expect that more outpatient appointments and same-day treatments, the majority of phlebotomy and anticoagulation services and most therapy services would be provided in a community setting rather than in an acute hospital

LESS time for you to wait for appointments, x-rays, diagnostic tests and results because they will be available locally at community hubs

LESS health complications and poor outcomes for people with long-term conditions and frail older people because of the support available locally from a mixed team of health and care professionals

LESS need for you to have to repeat your health history to different staff because they would all have access to same patient information. This will reduce the possibility of there being errors with your care. You would also be able to access your own health records



What local people told us they want:

The ICS programme has engaged a wide range of people from around the county to provide views and input into the future design of Dorset's community services.

More services closer to home with joined-up/integrated

- health, social care and voluntary services
- physical and mental health services
- IT systems

Better

- prevention and education
- access (in terms of both time and location)
- staff recruitment, training and retention

Consideration of

- geography, demography and diversity
- transport difficulties
- affordability and savings

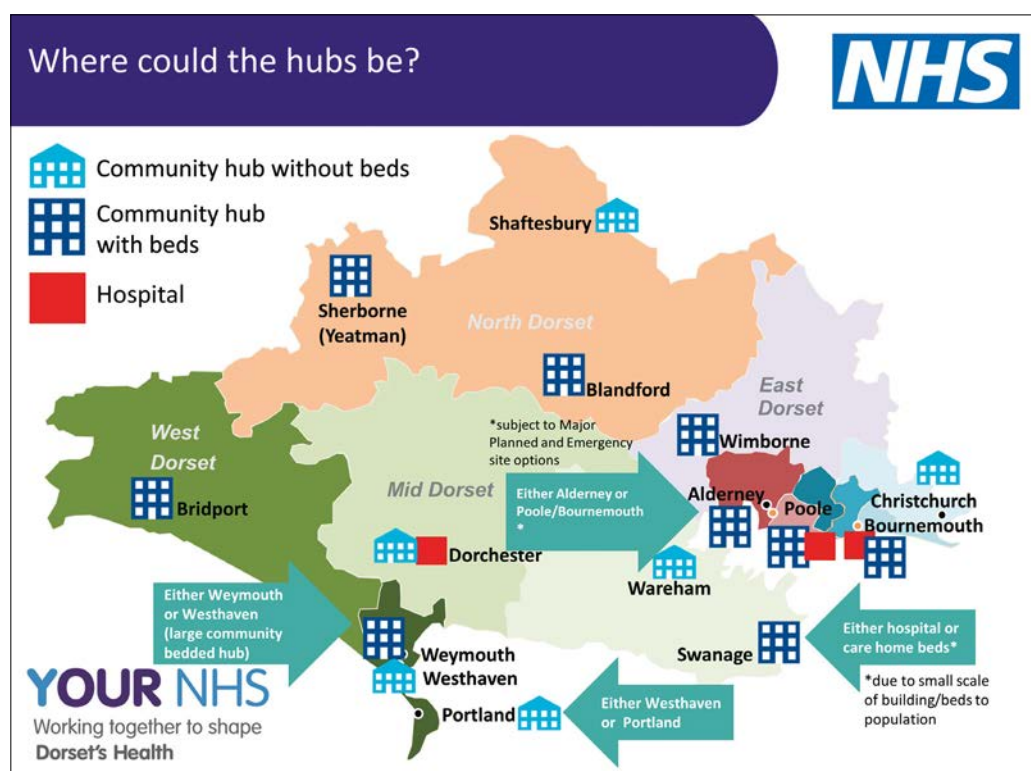
How we arrived at the proposed options for where community hubs might be located

We looked at 15 possible options for where we might have community hubs (visit our consultation website, www.info.dorsetsvision.nhs.uk, for more details). Please see the map below.

After detailed analysis and evaluation, we are proposing that there should be 12 community hubs across Dorset:

- seven with beds and a wide range of facilities including outpatients and diagnostic tests and
- five without beds but with a range of outpatient services, co-location of staff and the potential for other local community resources

To arrive at these options, we used the six evaluation criteria drawn up by doctors and other health professionals in conjunction with the Patient (Carer) and Public Engagement Group (PPEG), which was set up specifically to guide us during the Clinical Services Review. The same six criteria were used to evaluate the options for acute hospitals. See [page 30](#).



The following tables show how each option was rated against the evaluation criteria:

Criteria	Localities				
	North Dorset			Mid Dorset	West Dorset
	Blandford	Shaftesbury	Sherborne		Bridport
Quality of care for all	↔	↔	↔	↔	↔
Access to care for all	↔	↓	↔	*	✓
Affordability	✓	↓	✓	*	✓
Workforce	↔	↔	↔	*	↔
Deliverability	↔	↓	↔	*	✓
Other (e.g. research and development)	↔	↔	↔	*	↔

Criteria	Localities						
	Weymouth and Portland			Purbeck		East Dorset	
	Portland	Westhaven	Weymouth	Swanage	Wareham	St Leonards	Wimborne
Quality of care for all	↔	↔	↔	↔	↔	↔	↔
Access to care for all	↓	↓	✓	✓	↓	↓	✓
Affordability	↓	↓	✓	✓	↓	↓	✓
Workforce	↔	↔	↔	↔	↔	↔	↔
Deliverability	↓	↓	✓	✓	↓	↓	✓
Other (e.g. research and development)	↔	↔	↔	↔	↔	↔	↔

Criteria	Localities			
	Poole localities		Bournemouth and Christchurch localities	
	Alderney**	Poole (if Poole became the major planned hospital)	Bournemouth (if Bournemouth became the major planned hospital)	Alderney**
Quality of care for all	↔	↔	↔	↔
Access to care for all	↓	✓	✓	↓
Affordability	↓	✓	✓	↓
Workforce	↔	↔	↔	↔
Deliverability	↓	✓	✓	↓
Other (e.g. research and development)	↔	↔	↔	↔

✓ = Better Evaluation

↔ = Equal Evaluation

↓ = Lesser Evaluation

* No community hospital so no comparison

**Alderney was evaluated against both Poole and Bournemouth & Christchurch localities to compare how it rated in either option of Poole or Bournemouth becoming the major planned hospital.

You can find out more about our options by looking at the documents available on our consultation website (www.info.dorsetsvision.nhs.uk), in particular the **Pre-Consultation Business Case**.



We also took into account:

- the future number and location of beds needed
- population changes over the next five years
- average lengths of stays in community beds
- more people being supported in a community bed

The results indicated that over the next five years we will need 69 beds in addition to the 347 that we already have in the community, and that some beds would need to be redistributed to reflect local need, with an increase in the east of the county and reduction in the west.

We could also use short-term beds in care homes as an alternative to community hospitals in areas where the need is small or additional beds are required. Care home beds, with the right support from the community, would be more cost effective and more suitable for rehabilitation and end-of-life care.

Transport

Local people and our staff have told us that transport is a major consideration in deciding where community hubs might be located. So in order to assess the impact of transport on options for community hubs with beds, we looked in-depth at travel times.

The result of this analysis showed that if there were seven strategically located sites with beds compared with 12 at present:

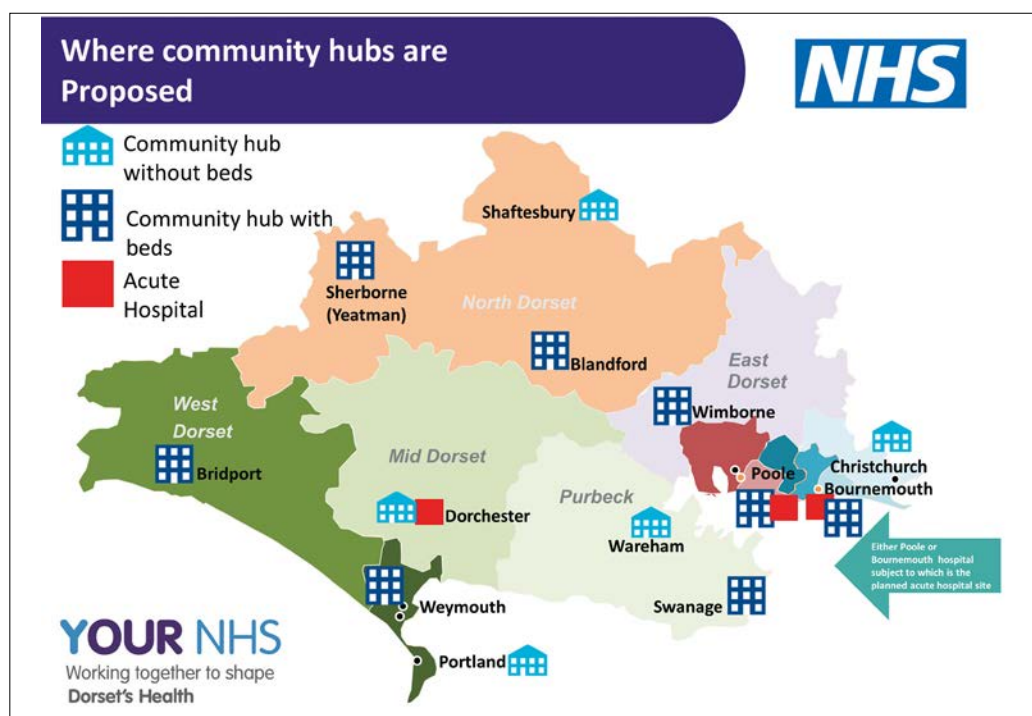
- **100%** of people would be able to

reach proposed community bedded sites within 32 minutes by private car, and

- **87%** within one hour by public transport
- **100%** of people would be able to reach a community hub (with or without beds) in 23 minutes by private car, and
- **91%** within one hour by public transport

We have focussed particularly on travel times in north Dorset, as the community hospital sites are on the locality boundaries. The population is also dispersed, with around 1,600 people registered with a North Dorset GP living out of the county in Somerset and Wiltshire. We also need to consider travel in the far east and west of the county and will work with local authorities and other partners to find innovative transport solutions.

Other factors that we took into consideration included the community hospital buildings to see which sites would be a suitable size, the potential investment required if any development was required, and the mutual dependencies of the two proposed options for acute hospitals (see more about this in **Chapter 6 on p36**).





The CCG preferred options for community hubs

No decisions will be taken on these proposals until public consultation is complete and the responses taken into account.

Community hubs with beds

Poole or Bournemouth hospitals (subject to public consultation on the preferred major planned hospital)

Wimborne Hospital

Bridport Hospital

Blandford Hospital

Sherborne Hospital

Swanage Hospital

Weymouth Hospital

Community hubs without beds

Shaftesbury (with care home beds)

Christchurch (with care home beds for the Christchurch and Bournemouth areas)

Dorset County Hospital (also an acute hospital)

Portland

Wareham (with care home beds)

Alderney, Westhaven and **St Leonards** would not be used as community hubs, either with or without beds. The services based there would be moved to other hubs. The three community hospital sites may be used for other purposes. Proposals for the future of acute mental health inpatient beds at Westhaven hospital (the Linden Unit) will be included in a separate consultation in the new year*. Proposals for the future use of Alderney Hospital will be

considered in a review of dementia services taking place over a longer timescale. St Leonards Hospital would close (see evaluation criteria on p24). In addition, it is recommended that we look for alternative sites for the local hubs without beds in Portland, Shaftesbury and Wareham. If better alternative sites are secured, these community hospitals will no longer be required, and will close.

Mental health services

Although mental health services are not part of this public consultation, they are just as important as any other service.

The CCG is leading a separate review of acute mental health services (*see above).

We have been working with services users, carers, the voluntary sector, Dorset police and NHS providers and so far have collected 3,355 views from these groups.

The review has looked at how services could be organised differently to better meet needs and is likely to propose potential new models for care.



The questions regarding Integrated Community Services can be found on pages 1-4 of the questionnaire. Please refer back to the information in this section to help you answer any questions you may have.

You can also visit our **Dorset's Vision** website, or attend any of our public events. A full list of dates and locations can be found at www.dorsetsvision.nhs.uk

6 Our proposed options for acute hospitals



6 Our proposed options for acute hospitals



Why do we need to change our acute hospitals?

The three main hospitals in Dorset – Dorset County Hospital, Poole Hospital and the Royal Bournemouth Hospital – currently provide a lot of the same services, but many are provided differently.

For example, all three have maternity services; two are led by consultants and one is led by midwives. All three have A&E Departments. All three are doing much of the same work and are struggling to meet increasing pressures from all year-round demand.

National clinical evidence shows that more lives are saved when people are treated in specialist centres with senior specialist staff available on site 24 hours a day, seven days a week. At the moment, none of Dorset's hospitals offer 24/7 consultant care on site.

As part of the Clinical Services Review the acute hospitals have become part of the NHS England 'One Dorset' Acute Vanguard, which is one of 13 national programmes of funding and support to help them work closer together.

This covers nine clinical areas, including: maternity; paediatrics;

cardiac; stroke; ophthalmology; imaging (scans); pathology and non-surgical cancer (radiotherapy and chemotherapy). It will also look at business support services.

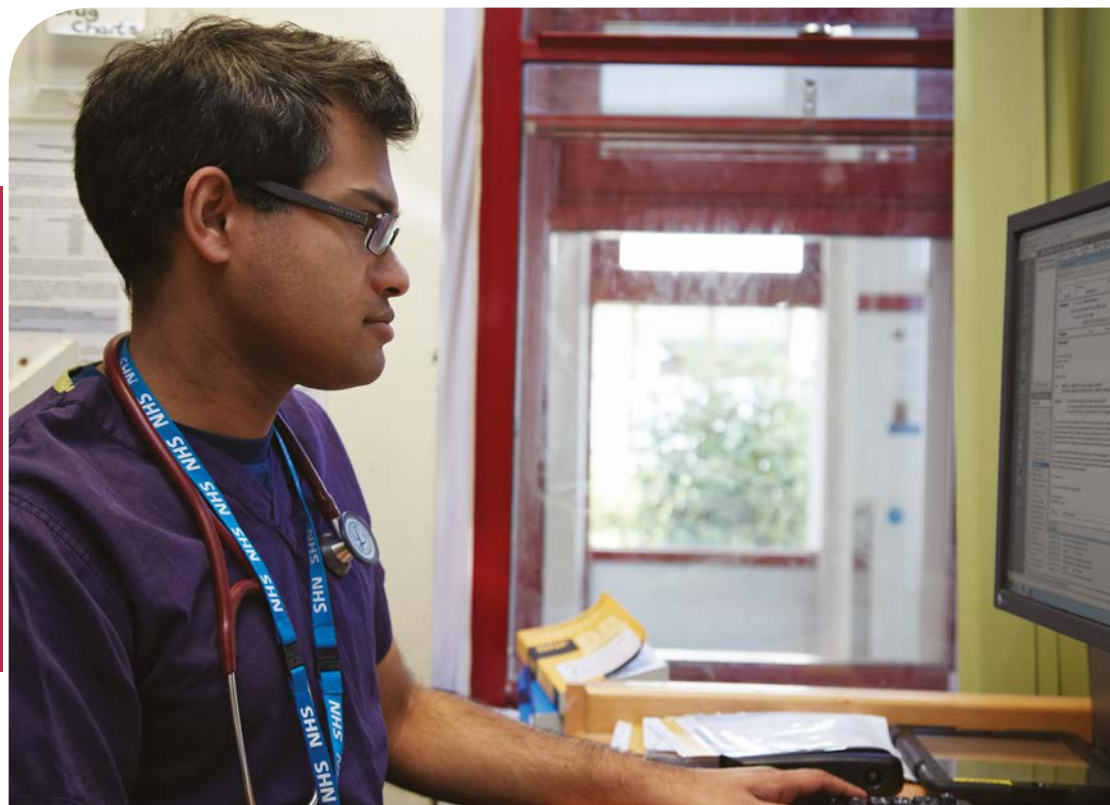
In addition to this, specialist services provided in acute hospitals need to be more coordinated to provide a single service across Dorset. Single clinical networks across the county would mean we could share staff and services. For example, there would be one Dorset cardiac service on three sites rather than three separate services.

How could acute hospitals be organised differently?

To maximise the resources to get the best outcome for patients, we believe that Poole and Bournemouth hospitals each should have a very distinctive role.

One could be a hospital for major **planned care**. This would allow for the continuous delivery of treatment within national NHS Constitution standards on waiting times being met, away from the disruption that urgent and emergency care can create.

“ National clinical evidence shows that more lives are saved when people are treated in specialist centres with senior specialist staff available on-site 24 hours a day, seven days a week. ”



The other could be a **major emergency hospital** with more consultants available more of the time to deal with urgent and emergency care. By specialising in this way we believe we can improve the outcomes for patients and save lives.

Patients needing planned operations or other procedures would benefit. Cancellation of their treatment on the due date will be far less likely in a hospital not having to deal with the most serious emergency cases.

Patients needing emergency care would benefit by being taken to a hospital with specialist consultant-led services where the ambition is to have these available 24 hours a day, seven days a week.

We propose that the major emergency and major planned hospitals would be better situated in the east of the county because that is where most people live. If we were to locate the major emergency hospital in the west of the county, it would mean more people having to travel longer distances for urgent and emergency specialist care.

We propose that Dorset County Hospital would remain a district general hospital serving the west of the county and be largely the same as it is now. However it would form part of a Dorset-wide set of networked clinical services with Bournemouth and Poole. The most seriously ill or injured patients needing specialist care would be transferred to the major emergency hospital in the east of the county. This is similar to what would happen now, with the most seriously injured patients going to Southampton or other specialist hospitals.

How did we arrive at the proposed options for acute hospitals?

Doctors and other health professionals came together in a number of clinical working groups (CWGs) and considered a large number of options for how services could be organised. For details of how we narrowed down the options please see [Appendix on p45](#) in this document or visit our consultation website, www.info.dorsetsvision.nhs.uk for more information.

The results were evaluated against the same criteria used for the integrated community services options ([see pages 24-25](#)). These tested the quality of care and patient safety; access to services; costs and affordability; the impact on our staff and on research and education, and whether the changes would be delivered within the required timescale (deliverability).

Since summer 2015 we have done a lot more work to further test accessibility, affordability and deliverability.

In doing this we considered:

- a wealth of evidence and best practice including Urgent and Emergency Care guidance and the national maternity review in 2015, resulting in the publication of the strategy *Better Births*
- travel times by blue light ambulance, public transport and private car to each of the hospitals
- how much it would cost to implement the proposals for each hospital
- whether the potential changes were viable at each site
- whether there were factors that would prevent them providing high-quality care



From this we arrived at two possible options for how acute hospitals might be organised differently.

The two options were:

Option A	<ul style="list-style-type: none"> • Poole Hospital – the major emergency care hospital • Dorset County Hospital – a planned and emergency care hospital • Royal Bournemouth Hospital – the major planned care hospital
Option B	<ul style="list-style-type: none"> • Poole Hospital – the major planned care hospital • Dorset County Hospital – a planned and emergency care hospital • Royal Bournemouth Hospital – the major emergency care hospital

We applied the same six evaluation criteria to these options. It gave us following results:

- **Quality:** We looked in detail at hundreds of pieces of published research and information on the quality of health services; patient and carer experience and clinical safety information. These showed where there are variations in quality under present arrangements, and confirmed that the proposals would improve quality equally under both option A and option B.
- **Access:** Overall the analysis shows that option B is easier to get to by a greater proportion of the population in the east of Dorset. When the population of West Hampshire is taken into account, option B is also better for the majority of services that would be based there.
- **Affordability:** Both options were shown to provide value for money by generating savings. The capital cost of option B – Bournemouth as the major emergency

hospital and Poole as the major planned hospital – is less than option A. This is a significant phased investment that will serve future generations in Dorset. Option A: £189m Option B: £147m. Option B is better.

- **Workforce:** Both options will improve the future sustainability of our workforce and therefore each option rated the same for this criterion.
- **Deliverability:** Fewer clinical services would move under option A than option B. However Option B (expansion of the Royal Bournemouth site) could be less disruptive to services during the construction phase than option A (expansion of the Poole Hospital site). This is due to the more modern construction of the Royal Bournemouth site and greater availability of space for planned and future development. Therefore each option rates the same for the time taken to make the changes.
- **Research and other:** All options will need to be taken forward in line with national and local policies for research and development (R&D) and education and training, so there is no difference between the options considered.

These results are summarised in the table below:

Criteria	Option A	Option B
Quality of Care for all	↔	↔
Access to care for all	↓	✓
Affordability	↓	✓
Workforce	↔	↔
Deliverability	↔	↔
Other (R&D)	↔	↔

✓ = Better Evaluation ↔ = Equal Evaluation
↓ = Lesser Evaluation

See **page 35** for more details.

What did the evaluation tell us?

Measured against the evaluation criteria, the

real differences between the two options were access and cost. The tables below highlight these differences:

Dorset population*	Bournemouth as the major emergency hospital	Poole as the major emergency hospital
% people reaching services in 30 minutes by blue light ambulance	95%	94%
% people reaching general services in 30 minutes by peak time private car	90%	80%
% people reaching general services in 60 minutes by peak time public transport	64%	75%

*Population includes all people whose nearest acute hospital is in Dorset.

A word about travelling times:

Travelling times to the acute hospitals need to be considered alongside our plans to bring more care closer to people's homes. We plan to set up Community Urgent Care Centres to offer same day rapid assessment, advice or treatment for illnesses and injuries which require urgent care but are not life threatening and do not need the full services of an emergency department. As a result fewer patients will need to travel to an acute hospital. You can read about these proposals in [Chapter 5](#).

For those who do, it will take a higher percentage of people less time on average to get to Royal Bournemouth Hospital than Poole Hospital in a blue light ambulance. A small proportion of people will have to travel further if they need specialist care in a centre of excellence.

When all the financial criteria were evaluated together, option B has significantly lower capital costs. Please see the table below:

	Total cost
Poole as the major emergency hospital and Bournemouth as the planned hospital	£189m
Bournemouth as the major emergency hospital and Poole as the planned hospital	£147m
Difference	£42m

Based on the evidence and results of the evaluation, we propose that option B should be the preferred option for the future development of acute hospital services in Dorset:



Option B

Poole Hospital – the major planned care hospital

Royal Bournemouth Hospital – the major emergency care hospital

Dorset County Hospital – a planned and emergency care hospital

It would allow us to:

- establish a dedicated specialist role for Poole Hospital as a major planned hospital and Royal Bournemouth Hospital as a major emergency hospital
- there would be access to these services for people from the whole of Dorset to give

better outcomes for patients and save more lives by creating centres of excellence

- continue to support Dorset County Hospital as a pivotal provider for planned and emergency services in west Dorset
- invest over £147m in local health services, including a new maternity hospital.

You can read more about the evaluation process and how we analysed travel times and costs and other factors in the documents on our consultation website (www.info.dorsetsvision.nhs.uk), or you can ask for them by phoning us on **01202 541946**.

The table on the next page summarises which services would be available at each of the proposed acute hospitals

We hope this will help you to understand the changes and consequences that would result from the options we propose on **page 31**. It highlights the different services that would be available at the proposed major planned care and major emergency hospitals in the east of the county. Services at the planned care and emergency hospital proposed for Dorchester in the west would remain broadly similar. The most significant change here is the proposal concerning consultant-led maternity and inpatient beds for children.

This proposal results from an independent review by the Royal College of Paediatrics and Child Health (RCPCH) published in April 2016. It found that maternity and paediatric services were highly valued by local people and provided by caring, dedicated staff. However, some aspects of care could be improved and updated as they cannot be sustained in terms of staffing, facilities and finances. You can read the full report on the CCG website: www.dorsetccg.nhs.uk/news/Review-of-services-published.htm.

It recommended that Dorset County Hospital (DCH) should open talks with Yeovil District Hospital about providing an integrated service to ensure safe and sustainable services for the future. These talks are continuing to take place over the next few months. However if this option is not possible, then DCH must integrate with teams in the east of the county to provide one service for Dorset.

N.B: Some RCPCH recommendations required immediate action and are outside of this Clinical Services Review. One was to re-designate the local neonatal unit at Dorset County Hospital as a special care baby unit for infants born after 32 weeks. We are working in partnership with NHS England specialist commissioners and clinicians from Dorset County Hospital, Poole Hospital and South Western Ambulance Service to address the immediate actions. The majority of babies needing special care would remain at Dorset County Hospital, and care will be transferred for very few premature babies – around 15 per year (out of a total of 1900 births at DCH) – to the closest unit with the appropriate expertise. This will affect about 1% of women delivering their babies at Dorset County Hospital.

At a glance: where hospital services would be under our proposals

	Major planned care hospital	Major emergency care hospital	Planned care and emergency hospital
Urgent and emergency	<ul style="list-style-type: none"> ● 24/7 Urgent Care Centre (To find out more about Urgent Care Centres please see diagram on p35) 	<ul style="list-style-type: none"> ● Consultant delivered* A&E with major trauma, such as road traffic accidents with life-threatening or very serious injuries ● Consultant delivered* emergency surgery ● Cardiac and stroke services that require urgent specialist care ● All delivered 24/7 	<ul style="list-style-type: none"> ● Consultant led* A&E with trauma unit for serious and life-threatening injuries ● Cardiac and stroke services that require urgent specialist care ● Emergency surgery 24/7
Planned and specialist care	<ul style="list-style-type: none"> ● Lower risk planned and day surgery (including cancer, orthopaedic surgery such as hip and knee replacements) ● Outpatients and tests and scans that need to be done in a hospital ● Networked single Dorset cancer service 	<ul style="list-style-type: none"> ● High risk, complex planned care (including cancer) ● Outpatients and diagnostics ● Networked single Dorset cancer service 	<ul style="list-style-type: none"> ● Lower risk planned and day case surgery (including cancer, orthopaedics such as knee and hip replacements) ● Planned non-surgical care ● Networked single Dorset cancer service
Maternity and paediatrics	<ul style="list-style-type: none"> ● Antenatal care ● Children's therapies, such as physiotherapy and speech and language therapy, and outpatients 	<ul style="list-style-type: none"> ● High risk maternity unit ● Inpatient consultant delivered services for very sick children ● Local neonatal unit (level 2: for babies delivered under 32 weeks) ● All delivered 24/7 	<ul style="list-style-type: none"> ● Integrated services with Yeovil District Hospital Or ● Part of Dorset-wide network with move to midwifery-led unit and paediatric assessment unit
Long term conditions, frailty and end of life care	<ul style="list-style-type: none"> ● Integrated service for frail older people ● Primary and community care services on site (hub) ● Mental health care services (not inpatient beds) ● Step-up/step-down beds* 	<ul style="list-style-type: none"> ● Integrated service for frail older people ● Primary and community care services on site ● Mental health care services (not inpatient beds) ● Step-up/step-down beds* 	<ul style="list-style-type: none"> ● Integrated service for frail older people ● Primary and community care services on site (hub) ● Mental health care services (not inpatient beds) ● Step-up/step-down beds*

*See Glossary on p47



MAJOR EMERGENCY OR URGENT CARE CENTRE WHAT WOULD THE DIFFERENCE BE?

Major Emergency Hospital



If you were in need of life threatening A&E services, under the new proposals there would be consultant-led services available to treat you 24/7:

- Loss of consciousness
- Serious confused state and fits that are not stopping
- Persistent, severe chest pain
- Breathing difficulties
- Severe bleeding that cannot be stopped
- Severe allergic reactions
- Serious accidents

Major Planned Hospital



The majority of non-life-threatening illnesses and injuries will still be treated in the Urgent Care Centre. These services will be available 24/7 but not consultant led:

- Sprains and strains
- Broken bones
- Wound infections
- Minor burns and scalds
- Minor head injuries
- Insect and animal bites
- Injuries to the back, shoulder and chest

Poole as the proposed major planned hospital:

- There is better access at the Bournemouth site as more of the population live in the east of the county. It is also better for patients living in West Hampshire (a considerable amount use RBH)
- A new road giving access both ways from the A338 is planned
- RBH has emergency access for helicopters on site (at Poole they have to land in Poole Park)
- RBH site is good for expansion
- Better outside space and patient areas are larger at RBH – the more modern building gives a better starting point
- If RBH became the planned hospital, up to 19 more

modern wards would need to be closed

- It has lower running costs
- It will be cheaper to develop and there would be less disruption to services while building was carried out
- Onward transfer to Southampton for specialist services is easier
- It would cost an additional £42m to develop Poole rather than the Royal Bournemouth Hospital. This is difficult to justify
- Poole is an older site and has more constraints and is more expensive to run
- Poole is better as the planned hospital site as the town centre location makes it easier for patients to get to and for public transport links (near the train and bus stations) NB: Most seriously ill patients going to the emergency hospital would be in a 'blue light' ambulance
- Poole's central location also makes it the better location for community beds.

Why the Governing Body named its preferred options

Appendix 1 explains the process we used to arrive at two possible options for acute hospital care in Dorset. Here we explain why the Governing Body named Royal Bournemouth as the preferred option for the major emergency hospital and Poole as the major planned care hospital.

Either Poole Hospital or Royal Bournemouth Hospital could have been the preferred option. Both hospitals scored equally when measured against quality of care, workforce, time to deliver, and Research and Development.

So it came down to access and affordability – in both these areas RBH was rated better as the proposed major emergency hospital and

The major emergency hospital would be the larger of the two proposed hospitals.

Using the larger and more up to date site at Bournemouth would make it easier to build on and expand. This would also mean lower building and running costs, and avoid closing

a number of more modern wards and patient areas.

The table below shows the major capital developments and benefits for the proposed reorganisation of hospitals:

Major Emergency Hospital	
Capital development	Benefits
Pathology	<ul style="list-style-type: none"> • Access to a single, more efficient unit complemented by a hot laboratory for processing urgent tests from the wards at the major planned unit
Emergency Department	<ul style="list-style-type: none"> • Additional space to accommodate increased capacity • Greater separation between adults & children's areas • Increased cover with 24/7 consultant-led services on site • Safe, high quality, sustainable service which meets national guidance
Additional beds and remodelled wards	<ul style="list-style-type: none"> • Move towards 4 bedded bays away from current 6 bedded • Will help to meet improved infection control guidance and standards • Provide consistent single room availability
Children's unit	<ul style="list-style-type: none"> • Move towards purpose-designed children's unit to improve patient experience, and operational effectiveness
Maternity Unit	<ul style="list-style-type: none"> • Predominately new build with sufficient capacity to meet future projected activity • Full en-suite rooms • Part of integrated single maternity service as recommended by Royal College review • Will support benefits to patients through: choice and personalisation; birth choice and specialist care
On-site helipad (only available if Bournemouth was to be the major emergency hospital)	<ul style="list-style-type: none"> • Move to 24/7 accessibility in line with Civil Aviation Authority requirements



Major Planned Hospital	
Capital development	Benefits
Pathology	<ul style="list-style-type: none">• A new hot laboratory for urgent tests requested from the wards
Urgent Care Centre	<ul style="list-style-type: none">• Improved patient flows• Links to primary care
Day case	<ul style="list-style-type: none">• Located next to other services needed to support integrated working and patient flow
Theatre & Recovery	<ul style="list-style-type: none">• Co-location of theatres to single efficient unit• Includes 6 laminar flow theatres for greater flexibility• Upgrading of present theatres• Provides service free from delays caused by management of emergencies

The following patient stories are drawn from real-life examples supplied by local doctors. They illustrate typically what happens now and how care might be delivered differently in the future.

Morgan is 18 and has a suspected broken arm after falling in his local skate park

- Access to highest quality urgent and emergency services

Now

- Morgan's friends take him to the nearest A&E centre, where he waits almost four hours to be seen
- He is assessed, x-rayed and his arm, which has a simple fracture, is put in plaster cast
- Morgan tells the doctors he is allergic to certain painkillers, but can't remember which ones. Hospital staff have to contact his GP surgery to check his records for allergies.
- Follow-up reviews to check his arm is healing properly all take place at the local community hospital. Morgan, who is studying for his A-levels, has to miss college to attend outpatient appointments

Under our proposals

- Morgan would travel to his local Urgent Care Centre
- Doctors would have immediate access to his medical history via the electronic Dorset Health Care Record, allowing him to receive suitable painkillers quickly
- He would be x-rayed and the results reviewed remotely by a specialist doctor at the acute hospital
- Morgan's follow-up reviews would take place at the fracture clinic at a local community hub with evening and weekend appointments available
- The specialist doctor would be able to give additional advice by video (e.g. by Skype) as required



Eva is 68 and lives in West Dorset where she cares for her husband Ron who has dementia. She has suffered hip pain for 18 months



- Access to highest quality planned care services supported by integrated community services

Now

- Eva makes her fifth visit to her GP in the last year to talk about her hip as the painkillers do not give her enough relief from the pain
- Her GP refers to see a specialist at the hospital six weeks later when she is told she needs a hip replacement. Eva visits Dorset County Hospital for her pre-operation assessments, but her operation is cancelled the day before its planned date because of a high number of people who needed to be admitted for emergency operations. Her daughter had booked time off work to help Eva and Ron after the operation
- Eva's operation is rebooked for a month later, when her daughter would not be able to take time off. When Eva has her hip operation she spends eight days in hospital. Ron has to have a respite stay at a care home
- Eva has her rehabilitation physiotherapy support provided at her community hospital. She also has to return to see the consultant in the hospital for a check-up to make sure she is recovering well

Under our proposals

- Eva would have more joined-up health and care services available in the community to consider not just her medical needs but the support required for Ron
- The non-surgery elements of her care – including her pre-op assessments – would take place at her local community hub
- The social care team based at the hub would be able to make arrangements for Ron
- This would make it possible for her family to make more definite arrangements to help and avoid Ron needing to temporarily go into a care home. Her daughter could book time from work with more confidence
- Eva would spend less time in hospital after the operation and have less chance of developing a hospital-acquired infection or post-operative complications



Barbara is 75 and has a stroke in the early hours of the morning at home in Puddletown

- Access to highest quality urgent and emergency services

Now

- Barbara is 75 years old and lives with her husband in Puddletown. She was at home when, in the early hours of the morning, she suffered a stroke
- Her husband, knowing it's important to act fast if a stroke is suspected, dialled 999. An ambulance arrived and she was taken to Dorset County Hospital, her nearest local hospital. Upon arrival she was assessed and treated by the general emergency doctors who were available on site

Under our proposals

- Barbara would be taken to the hospital that best meets her needs, which may be the Major Emergency Hospital, where she would have access to highly skilled, specialist staff 24/7
- She would be transferred back to her nearest local hospital as soon as it was medically safe to do so
- All stroke care in Dorset would be provided by one team of specialist consultants, working closely together to ensure they each maintain and build their skills and provide high quality stroke care throughout the county



What the proposed changes would mean for local people...

MORE access to the highest quality urgent and emergency services

A **NEW** new maternity, women and children's unit at the major emergency hospital and new theatres at the planned hospital

MORE improvements in health and better outcomes as we fulfil our ambition to have access to consultant-led services 24 hours a day, seven days a week

MORE lives saved because the most seriously ill patients would be treated by specialist teams with the right expertise in the right place at the right time

LESS risk of cancelled operations and hospital acquired infections for people needing planned care

LESS delays in being discharged from hospital

100,000 outpatient appointments moved out of acute hospitals and into a community setting

10,000 FEWER urgent care admissions to acute hospitals, as these could be dealt with at home or in the community

Helping to make change happen: supporting our workforce

Staff are at the heart of our NHS services in Dorset. Staff are vital in making any change a success.

We know we have great staff delivering great services, however there are some parts of Dorset and some services in Dorset where we do not have enough staff and we are struggling to attract people. We know that whilst there may be changes for some staff from their current arrangements, there is a role for everyone and we want to encourage and promote the benefits of staying, living and working in Dorset at such an exciting time.

We are working now on how we can support staff. We know staff may need to change the location they work from, perhaps the team they currently work in and the working environment. We know staff may prefer working in a hospital setting and working out in the community may be daunting. We also know that our NHS organisations and the working environments can often be very different. For all of these reasons, we will involve and re-engage with staff on with how we can best support them through the changes.



The questions regarding options for acute hospitals can be found on pages 5-7 of the questionnaire. Please refer back to the information in this section to help you answer any questions you may have.

You can also visit our **Dorset's Vision** website, or attend any of our public events. A full list of dates and locations can be found at **www.dorsetsvision.nhs.uk**

7 How will the proposed options help to close the financial gap?



7 How will the proposed options help to close the financial gap?

In **Chapter 2**, we explain why health and care services in Dorset need to change. We describe a £158m projected financial gap by 2020/21. This gap will result if we do nothing and health service provision and demand continue to expand at the same rate as the levels seen in recent years.

In this 'do nothing' scenario, we would expect costs to increase by at least 4% per annum, compared with an expected increase in income of only 2%. On a budget of £1billion this would be £40m per annum. If we can avoid growing costs at the rate of 4% between now and 2020/21, this would help us to close the gap of £158m.

The changes we propose within the CSR aim to use resources as efficiently as possible, and to minimise cost growth wherever we can.

A simple example would be that by concentrating teams of skilled staff across fewer sites, we could reduce the use of more expensive agency staff. This will also lead to improvements in patient care as permanent staff will be more familiar with all the operating procedures and the caring environment.

The CCG has identified £185m of areas to address this gap, as shown in the table below:

	£m
Financial gap	158
Savings	
Managing demand through the NHS's RightCare approach	28
Secondary prevention and active management	27
Outpatients	8
Acute efficiency savings	73
System reconfiguration	30
Acute reconfiguration	19
Total potential savings	185

NHS Right Care - Reducing unwarranted variation to improve peoples health: £28m

Every health economy in England is expected to embed the NHS RightCare approach at the heart of their transformation programmes. It is a programme committed to improving people's health and outcomes. It makes sure that the right person has the right care, in the right place, at the right time, making the best use of available resources. We expect to save £28m. An important part of this will be improving preventative care to avoid expensive treatments, which can result from conditions such as diabetes.

Secondary prevention and active management: £27m

By investing more in community and home care, we could minimise the pressure on acute care and avoidable emergency admissions in our hospitals. We have high levels of emergency admissions within Dorset, especially at weekends. Developing alternative ways of caring for people with complex but not life-threatening illness could reduce unnecessary admissions to acute hospitals. This is especially so in the case of frail, elderly people who can experience delays in returning home from hospital when medically fit to do so. This would include some of the improvements we are proposing such as 'step-up' beds in the community for people who become ill from home, community hubs and seven-day services.

Outpatients: £8m

Through advances in technology and our proposal to move over 100,000 appointments into the community, it should be possible to reduce the level of outpatient services in the hospitals.

Acute efficiency savings (cost improvement plans): £73m

Our local providers have agreed to find 2% savings on their costs through cost improvement plans, supported by the national Lord Carter review areas. This would see the delivery of more appropriate services with better outcomes for less money by maximising effectiveness across



the workforce and in areas such as supplies, information technology and estates. These plans have identified £25m in 2016/17 with a further saving of £48m from 2017/18 to 2020/21. The Acute Vanguard plans for Dorset clinical networks, pathology services and sharing of back office functions will be a key element in how this is delivered ([see p29](#)).

System Reconfiguration: £30m

All the local NHS provider trusts including Dorset Healthcare University NHS Foundation Trust (community and mental health services) have an opportunity to share services and network to a much higher level than has previously. Detailed plans are not yet available, but the aim will be to match the efficiency savings of £30m.

The three acute hospitals – **Dorset County Hospital NHS Foundation Trust, Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch NHS Hospitals Foundation Trust** – are jointly reviewing services to see if there is further potential for efficiency gains.

Acute reconfiguration: £19m

The proposed options for major emergency and planned care hospitals in the east of the county would mean fewer operations cancelled, fewer delays to discharge, less disruption to services and better staffing levels. This could result in savings through additional economies of scale, improved workforce planning and delivery of patient care at both of these sites.

In future all the acute services in Dorset will work in a more integrated way.

Capital costs

The changes we propose for acute hospitals will require capital investment of between £147m and £189m depending on which option is decided upon after public consultation. It is possible that these costs could be reduced by up to 25% as a result of local pricing.

Capital investment would be required at both the proposed major emergency and planned care hospitals as building development would be required, for example, to bring theatres up to new standards.

Charges for borrowing this money have been included in the savings calculations and would be repaid over a longer period – typically 20 years, rather like a mortgage on a house.

The capital cost of making the changes proposed for community services could be up to £20m. Some of this could be offset by the sale of buildings no longer required for NHS use, and some by using existing capital resources or fundraising. The agreed principle is that the community estate changes will be cost-neutral for capital investment, and so no additional borrowing is planned for.

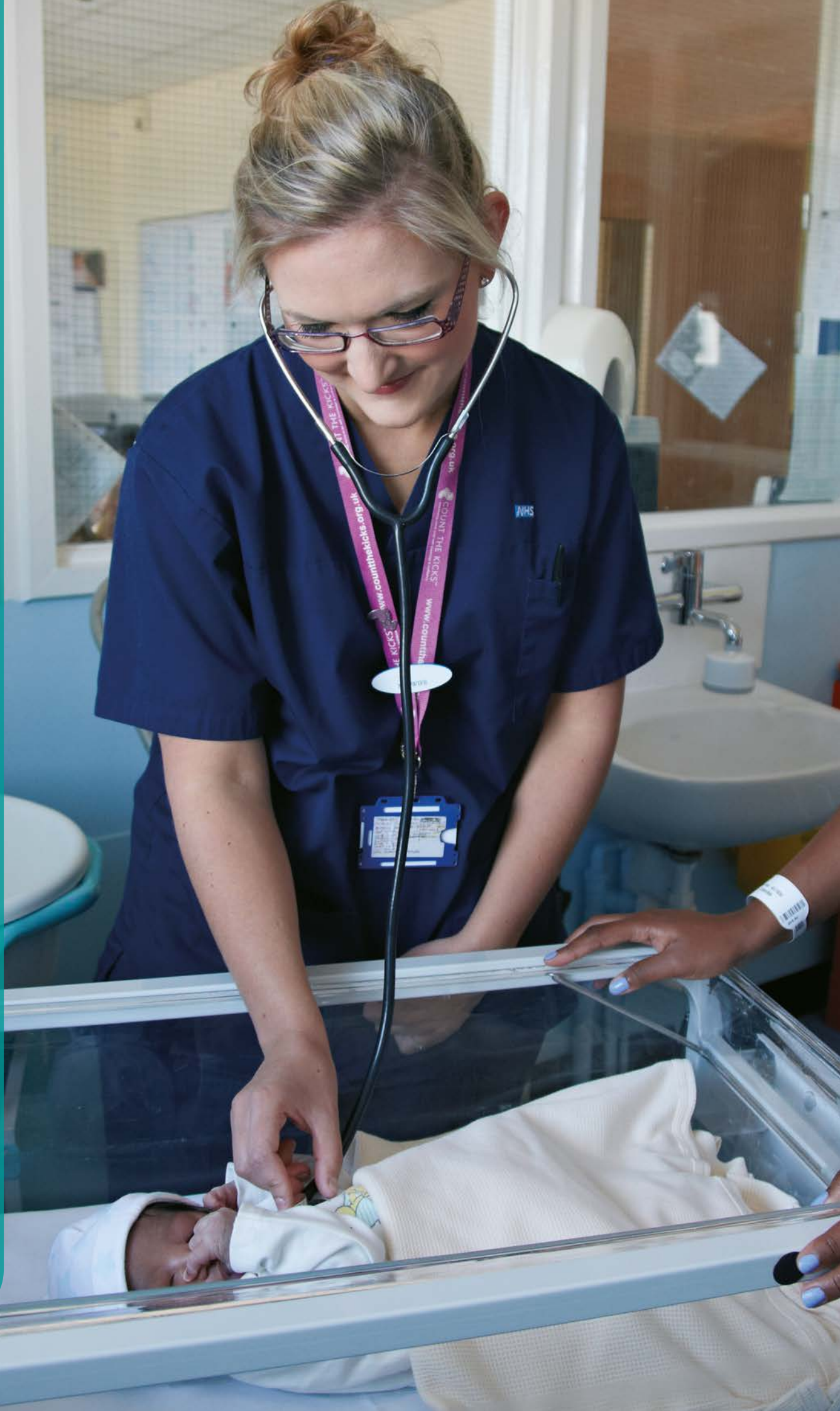
Securing the capital required will be essential for any changes to take place once public consultation has been completed and future decisions have been made.

Agreement to proceed to consultation by NHS England does not constitute approval for capital expenditure or confirmation of capital affordability.

A note about the figures

Figures in this document may be different to those that you will read in our Sustainability and Transformation Plan (STP). This is because the figures in this consultation document refer to services commissioned by Dorset CCG only. The STP includes figures for what we refer to as a 'whole system'. This includes other services which we do not commission, for example health care for non-Dorset residents, social care, public health and specialist services.

Appendix





How we narrowed down the options for acute hospitals

Before arriving at the preferred option, we considered 65 potential options for acute hospitals: from a single hospital to all possible combinations of types of hospital.

Doctors and health professionals in the **Clinical Working Group (CWG)** examined clinical research, national guidance and reports from various expert groups to help inform their discussions.

The CWG proposed that there should be a single 24/7 major emergency hospital with care delivered by consultant doctors in order to improve the quality of care across Dorset and save more lives. This was a key recommendation in the comprehensive review of NHS emergency and urgent care published in 2014 by the NHS Medical Director, Sir Bruce Keogh. We estimate that this would save at least 60 extra lives each year.

Dorset does not have this at present. It also considered that Dorset might have a hospital providing an emergency department and acute services but not necessarily with 24/7 consultant-led care, and a hospital providing local people with urgent care and less complex, high volume planned care.



This gave a large number of options for how acute hospital care in Dorset might be organised.

We drew a process to help reduce these options through a 'funnel'.

This gave us a long list of 21 options for how acute hospital care might be organised.

At this stage the options were general or generic; they did not give specific sites or named hospitals.

The same six evaluation criteria that were applied to the integrated community services were used to narrow down the options to a medium list of seven.

For example, some of the options were to have more than one major emergency site. These were excluded because they would spread specialist care across too many hospitals. This would mean that consultant doctors would not see sufficient cases to maintain their expertise, there would not be

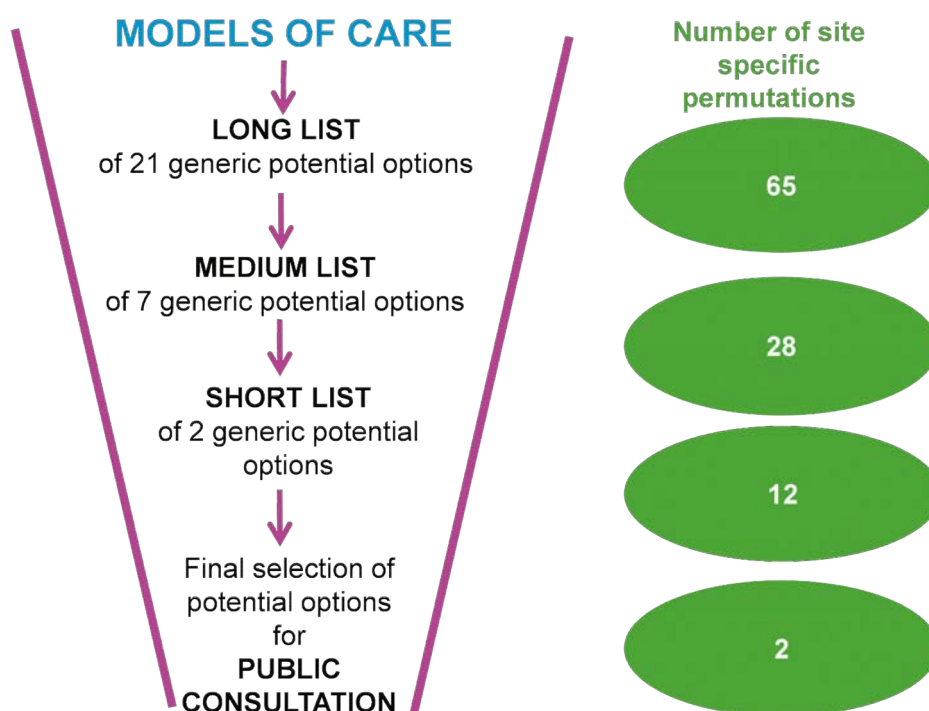
enough consultants to cover all four sites and it would increase costs to the local NHS.

Options of not having a major emergency hospital in Dorset at all were discounted because people needing the most specialised care would have to be treated at hospitals outside of the county. The CWG thought that the travel times for patients within Dorset would be too great.

Other options for not having at least a hospital with an emergency department and acute services in both the east and west of Dorset were rejected because local people would have to travel too far for these services.

A further option of building a new hospital on a new site in the middle of Dorset was considered but would have cost too much, taken too long to build and have a significant impact on travelling times for patients and staff.

This process of elimination gave us two feasible options for consideration.



Glossary

Acute hospital care – short-term treatment, usually in a hospital, for patients with any kind of illness or injury.

Clinical Working Group – groups of doctors, nurses, hospital consultants, paramedics and other clinicians, who meet monthly during the Clinical Services Review to develop potential options to improve NHS care in Dorset.

Commissioner – organisation responsible for planning, agreeing and monitoring health services.

Community hub – a site which delivers community services.

Community Services – the term used for any service delivered outside of the three acute hospitals in Dorset.

Consultant-delivered service – the consultant will be present in the hospital at all times (24/7) to deliver that service.

Consultant-led service – the consultant will be available at all times to deliver that service, but will not be present in the hospital at all times to do so (e.g. they may be on call from home).

Emergency care – hospital-based service available 24 hours, seven days a week for urgent medical care and medical and surgical emergencies that are likely to need admission to hospital.

GP locality – a smaller group of GP practices within the Dorset CCG area. There are 13 localities in Dorset, able to bring more detailed, local knowledge to Dorset CCG.

Integrated care – care which is co-ordinated around the patient, making sure all parts of the NHS and social care work more closely and effectively together.

Long term conditions – a medical condition that cannot be cured, but can be managed by treatment such as medication and other therapies. Examples include diabetes, heart disease and dementia.

Outpatient – a patient who attends an appointment to receive treatment without needing to be admitted to hospital (unlike an inpatient).

Planned care (also known as elective care or elective surgery) – a planned operation or medical care.

Primary care – services which are the main or first point of contact for the patient, usually GPs.

Provider – an individual or an organisation that gives a service in return for payment.

Secondary care – hospital or specialist care that a patient is referred to by their GP or other primary care provider.

Step-up beds – an alternative to hospital admission when the patient cannot be supported at home but does not need to be in an acute hospital.

Step-down beds – an alternative to early supported discharge when the patient cannot be supported at home but no longer needs to be in an acute hospital.

Urgent Care Centre – Offers same-day rapid assessment, advice or treatment for illnesses which require urgent care but are not life-threatening.

What happens next?

We will not make any decisions and will remain open-minded about the proposed options until after public consultation has finished. Once the public consultation has closed, the responses will be carefully analysed by independent experts Opinion Research Services Ltd (ORS), who are working with the CCG. The results will be fed back and used to help the Governing Body make its final decision in 2017.

The decision-making process will be robust, rigorous and fair. Details about progress will be made available on the **Dorset's Vision website.**

Get in touch

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