<table>
<thead>
<tr>
<th>Date of the meeting</th>
<th>18/05/2016</th>
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<tbody>
<tr>
<td><strong>Author</strong></td>
<td>Dr P Richardson, Programme Director, Design and Transformation</td>
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<tr>
<td><strong>Sponsoring Clinician</strong></td>
<td>Dr F Watson, Chair NHS Dorset CCG</td>
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<tr>
<td><strong>Purpose of Report</strong></td>
<td>The purpose of the report is to seek Governing Body approval to proceed to public consultation, subject to the further national assurance required, on the models of care for acute services and integrated community services and the reconfiguration of acute services that are recommended following further work on the Clinical Services Review since July 2015.</td>
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<tr>
<td><strong>Recommendation</strong></td>
<td>The Governing Body is asked to consider the report recommendations and to:</td>
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<tr>
<td><strong>a)</strong> Approve the updated acute hospital model of care and the CCG preferred site-specific option</td>
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<td><strong>b)</strong> Approve the proposal to proceed to consultation</td>
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<td><strong>c)</strong> Approve the proposed Integrated Community Services model of care and further development of the site-specific options</td>
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<td><strong>d)</strong> Approve the proposal to proceed through NHS England assurance</td>
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<td><strong>e)</strong> Approve the delegation of authority to the Chair and Chief Officer to make reasonable amendments to the public consultation proposal to address the external assurance feedback</td>
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<td><strong>f)</strong> Approve the delegation of authority to the Chair and Chief Officer to sign off the public consultation document.</td>
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<tr>
<td><strong>Stakeholder Engagement</strong></td>
<td>A full statement regarding engagement with members, clinicians, staff, patients &amp; public is included in the report.</td>
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<tr>
<td><strong>Previous GB / Committee/s, Dates</strong></td>
<td>Initial report on the Clinical Services Review – Consultation Options: May 2015 Governing Body</td>
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## 8.1 Monitoring and Assurance Summary

<table>
<thead>
<tr>
<th>This report links to the following Strategic Principles</th>
<th>Yes [e.g. ✓]</th>
<th>Any action required?</th>
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<tbody>
<tr>
<td>• Services designed around people</td>
<td>✓</td>
<td>Yes Detail in report</td>
</tr>
<tr>
<td>• Preventing ill health and reducing inequalities</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td>• Sustainable healthcare services</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>• Care closer to home</td>
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| All three Domains of Quality (Safety, Quality, Patient Experience) | ✓ | ✓ |
| Board Assurance Framework Risk Register | ✓ | ✓ |
| Budgetary Impact | ✓ | ✓ |
| Legal/Regulatory | ✓ | ✓ |
| People/Staff | ✓ | ✓ |
| Financial/Value for Money/Sustainability | ✓ | ✓ |
| Information Management & Technology | ✓ | ✓ |
| Equality Impact Assessment | ✓ | ✓ |
| Freedom of Information | ✓ | ✓ |

I confirm that I have considered the implications of this report on each of the matters above, as indicated ✓

Initials: PR
1. **Executive Summary**

1.1 This report sets out the progress of the Clinical Services Review. It describes how we are seeking to transform services across Dorset to meet the challenges faced by an increasingly elderly population with more complex health needs in an environment of restricted funding.

1.2 Delivering the recommendations in this report will start us on the journey towards meeting these challenges over the next 5-10 years and beyond. We are aiming to deliver a high quality, responsive, accessible, integrated health and care service across Dorset that is sustainable for the current and future generations.

1.3 There are 2 overarching objectives contained in this paper:

1) Reconfigure acute services to create an acute network of services across Dorset to allow sharing of experience and expertise and to meet the future challenges of delivering increasingly complex healthcare

2) Design an integrated community services model to deliver care closer to home which will reduce travel times and improve the number and quality of services available locally

1.4 If, following public consultation, we can achieve these objectives, this will 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 with access to these services from the whole of Dorset. This will give better outcomes for patients and save lives by creating centres of excellence

- Continue to support Dorset County Hospital as a pivotal provider for Planned and Emergency Services in West Dorset so we can better support the rural communities whilst providing high quality of care through our clinical networks

- Improve the acute hospital estate in East Dorset which could include a new maternity unit and allow over £100 million investment in our hospitals which will deliver better outcomes and improved patient experience

- Improve maternity and paediatric services by making decisions on development of community services and a single Dorset service approach that addresses national guidance and local patient needs

- Develop and support the mental health acute pathway review that is running concurrently to the Clinical Services Review to ensure mental health and wellbeing for patients is an integral part of local services
These should then enable Dorset to have:

- A more sustainable workforce across our hospitals to allow better care to be provided more reliably over the whole of Dorset in future years
- An integrated IT system to improve access to information for health and care staff and to enable more informed clinical decisions on patient care
- A financially sustainable NHS that allows for future investment in services for patients

2. Introduction

2.1 The Governing Body recognised the scale of the future challenges facing the healthcare of Dorset in 2013 and approved the initiation of the Clinical Services Review (CSR) programme in March 2014. The CSR remit was to develop a transformation plan for Dorset that would meet the changing need of our population, best practice standards and deliver a financially sustainable system.

2.2 The CSR concluded its review, analysis and design stage in May 2015. The review recommendations were in line with national guidance, the NHS Five Year Forward View and are supported by NHS England and the Clinical Senate. During May 2015, the CCG Governing Body approved recommendations to agree the model of care for acute hospital services, the site specific options for acute hospital services, the out of hospital approach (now termed the Integrated Community Services programme) and to proceed to public consultation (pending NHS England assurance).

2.3 Based on feedback from patients, public, clinicians and NHS England, a decision was taken following this approval to reschedule the public consultation to 2016 pending further work on the detailed review of acute and Integrated Community Services models.

2.4 This report sets out the progress of the CSR since May 2015 and seeks approval from the Governing Body to proceed to the formal public consultation to consult on whole system change in Dorset encompassing:

- approve the updated acute hospital model of care and the CCG preferred site-specific option
- approve the proposal to proceed to public consultation
- approve further development of the proposed Integrated Community Services model of care and further development of the site specific options
- approve the proposal to proceed through NHS England assurance
- approve the delegation of authority to the Chair and Chief Officer to make reasonable amendments to the public consultation proposal to address the external assurance feedback
- approve the delegation of authority to the Chair and Chief Officer to sign off the public consultation document
3. Background

3.1 The model of care for acute hospital services, the site specific options for acute hospital services and the Integrated Community Services (ICS) approach that were approved in May 2015 were all based on the requirement to meet the changing need of our population, best practice standards and to deliver a clinically and financially sustainable system.

3.2 The Governing body preferred ICS approach was to:

- Transform primary and community care towards consistent quality seven day services delivered in an integrated way
- Develop a rapid response to urgent care needs with a single point of access
- Integrate care for people with long term conditions and frailty by integrated locality based teams
- Improve care closer to home by delivering more outpatient and other planned care in the community
- Support people to recover independence quickly by improving home based support and use of technology
- Develop plans for a workforce that was fit for the future
- To develop proposals for community hubs to support the delivery of services at scale

3.3 The preferred acute hospital model of care and site specific options were to:

- Develop a Major Planned Care Hospital with an Urgent Care Centre
- Develop a Planned Care and Emergency Hospital
- Develop a Major Emergency Hospital
- Evaluate and consult on site specific options for the locations of the acute models of care

3.4 A Pre-Consultation Business Case was developed providing the technical evidence and rationale for the CSR, a detailed explanation of the model of care, options and processes by which recommendations were derived and engagement and assurance activities undertaken.

4. The Need for Change

4.1 The need for change has remained stronger than ever and we have published an updated ‘Need for Change’ (first published January 2015) in March 2016 which sets out the compelling story describing why Dorset’s health services need to change. We have identified the changes for both physical and mental health. The headlines are:

- A growing elderly population with changing health needs e.g. a 60% increase in registered diabetes patients expected by 2020
- More people in Dorset living with long term conditions
Variable quality of community care, with patients reporting difficulty accessing care at weekends and out of usual weekly hours

Variable quality of hospital based care, such as Dorset failing to meet some of the national access standards for suspected cancer

Further work required for parity of esteem between physical and mental health services

Difficulty sustaining staffing of services (under the current models of care) with high numbers of staff approaching retirement age and difficulty in recruiting staff such as GP’s, mental health nurses, paramedics and emergency medical consultants

A growing financial challenge with a projected gap between costs and available funding of £158 million per year by 2020/21 if we continue to provide healthcare in the way that we do now

4.2 Some of the initial forecasts made during the early stages of the CSR, such as the growing financial challenges, have since been shown to hold true. For instance the four Dorset acute and community providers have reported a combined deficit of over £27 million for the 2015-16 financial year. We have revised the original estimated funding gap of over £200 million in 2020/21 to £158 million to take into account the additional funding that has been allocated to the NHS in 2016-17. Despite the positive changes in NHS financial allocations in 2016-17 there remains a clear message that doing more of the same will not deliver safe and sustainable services in the future.

5. **Progress since May 2015**

5.1 We have progressed the depth and detail within our plans in a range of areas over the past year, these are outlined in the following section of this report.

5.2 The CCG initiated a series of Clinical Delivery Groups to provide a focus for more detailed planning and review of the CSR clinical models. These clinically led groups were constituted along themes similar to those of the working groups of the CSR with membership drawn from clinical and public stakeholder groups:

- Maternity and Family Health
- Urgent and Emergency Care
- Planned and Specialist Care (including Cancer services)
- Long Term conditions, frailty and end of life care
- A new group of Mental Health and Learning Disability (previously included as part of other working groups)

5.3 To help provide more details on the acute reconfiguration, an estates review was commissioned from Capita to provide financial cost information and outline estate plans for the acute reconfiguration options outlined in May 2015. This report had a remit to examine the site specific options to check that facilities for the site specific services were viable and affordable. Options to reduce capital costs were also explored with providers and assumptions in the clinical model were tested in order to make the options more cost-effective.
5.4 In order to address specific concerns raised by stakeholders with the proposed options for maternity and paediatric services, the CCG commissioned an independent specialist review of services led by the Royal College of Paediatrics and supported by the Royal Colleges of Obstetrics, Midwifery and Anaesthetics care (termed the Royal College review) to provide an expert peer review of the proposed models of care.

5.5 The three Dorset acute hospitals successfully bid to become a national vanguard site as part of the acute care collaboration programme launching Developing One NHS in Dorset. Based on the principles of the CSR this programme is seeking to accelerate the delivery of the CSR by establishing networked clinical services across Dorset starting with the following areas:

- Women’s health
- Paediatrics
- Cardiology
- Stroke
- Ophthalmology
- Non-surgical cancer services
- Radiology and Pathology
- Back office and IT functions

5.6 In addition to the acute hospital options, a programme was initiated to provide further detailed service planning for ICS. The focus on this programme is to work with Local Authorities and GPs, community and acute sectors to co-design services covering health and care, wellbeing and prevention that are either co-located in community hubs, delivered locally from public sector estate or delivered in patient’s homes by community based teams. In all cases the design principle of extensive engagement with public, patients and carers of Dorset remains central to these plans.

5.7 The acute and ICS programmes have engaged a wide range of stakeholders to provide views and input into the future design of Dorset’s healthcare services (see Appendix 1), including:

- The public, patients and carers of Dorset at a range of public events and meetings (Including The public and patient (carer) engagement group established specifically for CSR)
- The GP members who work in the 98 GP practices across Dorset
- Leading clinical views of the staff who work in Dorset’s NHS providers
- Other groups of people who have an interest in the planning and delivery of Dorset’s health system including carers, providers, local authorities, NHS England, Health and Wellbeing Boards, MPs, councillors and elected members, local Healthwatch, West Hampshire CCG, neighbouring trusts in Somerset, Wiltshire and Hampshire, Dorset Race Equality Council, Dorset Young People’s Forum and a wide range of community voluntary organisations
- Information has been made available on www.dorsetsvision.nhs.uk website at every stage of the programme
• Local authorities and Dorset Association of Parish and Town Councils have become much closer partners in the programme

5.8 Further details of the engagement and stakeholder groups are referenced in the Pre-Consultation Business Case along with the comprehensive programme of engagement undertaken.

6. Acute hospital care for Dorset

6.1 In this section of the report the further developments of the acute model of care are described and how these were used to develop the site specific options. Evidence is presented for each site specific option, based on evaluation criteria, and a recommendation is made for the CCG preferred site specific option.

6.2 This work aims to improve care and quality to deliver better outcomes by defining a more specialist role for each of our hospitals. The efficiencies generated under the new model of care would allow for investment in the hospital estate (e.g. A new maternity unit for East Dorset), less disruption to services from unplanned care, better recruitment and retention of staff and a more financially sustainable future for all of our acute hospitals.

Acute Model of Care-how the models were developed

6.3 One of the underpinning principles of the CSR is to be clinically led. Much of the development and design has taken place at large Clinical Working Group (CWG) meetings where Dorset’s healthcare providers are represented.

6.4 Clinical Working Groups 1 to 5 took place in 2014-15 and designed the model of care subsequently approved by the Governing Body in May 2015. The design is based on national best practice, advice and guidance from Wessex clinical networks and patient and public feedback. Specialist work was undertaken in each of the CWG clinical areas and submitted to the Wessex Clinical Senate for assurance purposes.

6.5 Subsequent CWG’s took place in 2015 and 2016 to further develop the options for acute services and to seek wider views from NHS and local authority stakeholders on the emerging models and associated developing options. The topic areas for each CWG are shown below:

- CWG 6 – Clinical network development and Integrated Community Services design
- CWG 7 – Management of acute medical patients in the Major Planned hospital, theatre utilisation between the Major Planned and Major Emergency Hospitals and review of maternity and paediatric services: progress so far
- CWG 8 – Mental health acute care pathway update, community service development and emerging models of care
- CWG 9 – Integrated Community Services community model and options for delivery
6.6 The Royal College review of Maternity and Paediatric Services was commissioned in Summer 2015, started work in Autumn 2015 and completed in March 2016. The report was published by the CCG in April 2016.

6.7 In considering the development of potential future acute hospital models, consideration has been given to the interdependencies between clinical services that may need to be co-located. For example the interdependencies between emergency surgery, critical care and high risk obstetrics were considered in the model for the Major Emergency Hospital.

Acute Model of Care—the results of our work

6.8 The Clinical Delivery Groups carried out work to outline the current service, future vision for the service and benefits to patients of the proposed new service. The service and pathway work has drawn on external expertise where available (such as the Wessex wide Operational Delivery Networks and Specialised Commissioners) and was reviewed by the Clinical Senate in April 2016. The patient pathways have been described for:

- Urgent and Emergency Care
- A&E and Trauma Services
- Cancer Services
- Long Term Conditions - Stroke
- Transient Ischaemic Attack
- Preventative Care after a Stroke
- Cardiology Services
- Diabetes
- Frailty
- Paediatrics and Neonatal services
- Maternity Services
- Dementia Services
- Child and Adolescent Mental Health Services (CAMHS)
- Adult mental health services and the Acute Psychosis pathway

6.9 The Royal College review found that Maternity and Paediatric services across Dorset are highly valued by local people and provided by caring, dedicated staff. However, some aspects of care could be improved and updated. In particular, offering better services in the community across Dorset was seen as essential. The review confirmed that Dorset’s maternity and paediatric services needed to change to remain safe and sustainable clinically and financially over the next 5-10 years. The recommendations were:

- Offer better services in the community and develop a Dorset-wide children’s community nursing service
- Create a Dorset-wide team of midwives, health visitors and nurses
- Provide easier access to home births
8.1

- Increase midwife-led care across the county
- Reorganise hospital care

6.10 For the West of the county, the recommendation was that there should be an urgent decision (within 6 months) to explore the integration of services between Dorset County Hospital (DCH) and Yeovil District Hospital resulting in one site delivering consultant led obstetric care and one site with a midwifery led unit. One site would then deliver an inpatient paediatric service and one site a paediatric assessment unit.

6.11 If the feasibility of this was not agreed within 6 months, the review recommended that there should be a Dorset wide network with a move to midwifery led unit and paediatric assessment unit at DCH with a high risk obstetric unit and consultant delivered paediatric inpatient site at the East Dorset Major Emergency Hospital. In addition, the DCH neonatal unit should be re-designated as a Special Care Baby Unit (for babies>32 week gestation). These changes would ensure safe and sustainable Maternity and Paediatric services that are fit for the future.

6.12 The detailed planning by the Clinical Delivery Groups, output from the CWG’s, recommendations from the Royal College’s review and the recommendations of the Clinical Reference Group were combined into a more detailed clinical model. The revised clinical model was then used in the further development of the site specific options for acute hospital care across Dorset, taking into consideration that aspects of the Royal College review are still in progress.

**Site specific options for acute hospitals – how the options were developed**

6.13 Site specific options were developed with the Clinical Working Groups 1-5 and the options for consultation were detailed at the Governing Body in May 2015:

- A Planned and Emergency Hospital should be located at Dorset County Hospital
- A Major Emergency Hospital should be located at the Poole or Bournemouth Hospital sites
- A Major Planned Hospital with an urgent care centre should be located at the Poole or Bournemouth Hospital sites

6.14 The models of care within these options meet the Keogh Review of Emergency Services\(^1\) vision by proposing:

- A highly responsive community based service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families for those people with urgent care needs (see ICS section below)

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\(^1\) NHS England’s *Transforming urgent and emergency care services in England End of Phase 1 report* (November 2013)
- An acute care model for those people with more serious or life threatening emergency care needs, to ensure that they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

6.15 Clinicians also took account of services offered outside of the county of Dorset such as specialist tertiary services delivered from Southampton and patient flows into Dorset from other counties such as Hampshire. Dorset patients receiving services from surrounding hospitals such as Yeovil and Salisbury were also taken into account.

6.16 Workshops were carried out between CWG 6 and CWG 7 with clinicians and managers to determine if the potential site capital costs could be reduced whilst maintaining the integrity of the clinical model for both options.

6.17 The deliberations from these workshops and the estates and financial calculations were taken to CWG 7. In summary, two principal variations to the original concept of the Major Emergency and Major Planned hospitals were discussed, both of which are believed to maintain the integrity of the clinical models of care as conceived in the CSR whilst reducing capital costs:

- Firstly to increase the proportion of medical patients who could be cared for safely on the Major Planned site from 10% of the medical take to 30%
- Secondly, if option B (see site specific options below) was to be implemented, to retain the ‘Derwent’ Suite as a dedicated elective orthopaedic theatre complex to reduce the requirement for new theatre construction on the Poole Hospital site

Site specific options for acute hospitals – the results of our work

6.18 The two site specific options that were identified by clinicians for delivering the model of care for acute hospital based services are shown in the diagram and table below:

![Diagram of site specific options](image-url)
Both options A and B are underpinned by Dorset’s hospitals working together as part of ‘One NHS’ in Dorset as outlined in the Dorset Hospitals Acute Care Vanguard proposal, to ensure all hospitals provide services in a networked way. This will improve workforce issues and deliver more responsive services to patients across Dorset. A summary of the services at each hospital is provided in Appendix 2.

In both options, Dorset County Hospital will continue to provide a planned and emergency service to support access to services in West Dorset. It is expected that between 1%-3% of people attending A&E at Dorset County Hospital may have their travel time impacted as a result of the proposals.

Services will develop into networked models under the acute care vanguard programme and the more complex and specialist services will be supported by the Major Emergency Hospital or by specialist tertiary providers (in much the same way as major trauma services are currently provided by Southampton University Hospital for West Dorset residents). The Major Emergency Hospital will provide some highly specialised services for the whole of Dorset, with tertiary specialist services continuing to be provided by Southampton. It is expected that between 5%-6% patients currently treated at a hospital in Dorset may transfer to the Major Emergency Hospital site in future.

The two proposals that were developed during the testing of the assumptions in the clinical models were evaluated at CWG 7 against the same evaluation criteria established during the CSR design phase. The CWG supported the proposals and they were referred on to the Clinical Reference Group for assurance.

In February 2016 the Clinical Reference Group received the proposals and the CWG7 views on both options. The Clinical Reference Group agreed with the evidence presented and the evaluation criteria rating for each proposal.
6.24 The Clinical Reference Group supported the medical patients proposal which would result in fewer ‘new build’ beds on the Major Emergency site thus requiring £25 million less capital under option A and £12 million less capital under option B. This proposal would also deliver a benefit of improved access times for residents close to the Major Planned Hospital.

6.25 The CRG did not support the theatre proposals at this time since the potential capital cost savings were relatively low and it was not felt that this justified changing the clinical model design of all routine elective surgery centred on the Major Planned Hospital site.

6.26 Having looked at the acute model of care and considered the site specific options, the evidence for each option has been evaluated in order to come to a recommendation.

Evaluation of the acute hospital options

6.27 The evaluation criteria developed by clinicians, the Patient and Public Engagement Group and the Finance Reference Group were used to evaluate both options (Appendix 3). The evaluation criteria are:

- Quality of care for all
- Access to care for all
- Affordability and value for money
- Workforce
- Deliverability
- Other (e.g. research and education)

6.28 Scrutiny of evidence against each criterion was based on data and information provided directly by local providers, publicly available published data or information supplied via reference groups and working groups and the knowledge, expertise and judgement of the professionals involved. In addition to the factual evidence provided, site visits were undertaken by the Governing Body in April 2016. At each visit the Governing Body received a brief tour of a section of the hospital site and a presentation by the hospital leadership team. The feedback from the visits was incorporated into a 2 day Governing Body workshop in April to further consider the site specific options and impact of the future site specific configuration across Dorset.

6.29 Quality of care for all was evaluated by assessing in terms of its impact on quality of care in 2019/20. The impact on patient safety, outcomes/clinical effectiveness and patient experience were all examined from clinical audit data or nationally published clinical standards data.

6.30 Access to care for all was evaluated by extensive and detailed travel time analysis undertaken by external experts and based on satellite navigation system data from hundreds of thousands of real time journeys. This was used to assess the impact on the population of possible changes from the current location of services to those contained within the CSR proposals. Impact on journey times to elective services, specialist services (recognising that only a
small proportion of patients would access specialist services) and emergency services were analysed. Service operating hours and impact on patient choice were also assessed under this criterion.

6.31 For the purpose of considering access to the Major Emergency Hospital in East Dorset two aspects were considered.

- Firstly the expected volumes of patients in Dorset requiring access to more specialised emergency services, such as those which are proposed to be centralised on the Major Emergency Hospital site. For a number of residents nearer the borders of Dorset, and for some in West Hampshire, the nearest hospitals providing such services will be outside Dorset, e.g. Royal Devon and Exeter Hospital or Southampton Hospital

- Secondly, the expected volumes and travel time impact of the options to patients in the East requiring access to low complexity urgent care services typically provided by District General Hospitals and similar to those proposed by the Planned and Emergency Hospital

6.32 Affordability and value for money was assessed with input from the Finance Reference Group by modelling the financial impact of the proposed clinical models and site specific options on capital costs, expected transition costs, income and expenditure, resulting number of organisations in financial deficit and the impact on net present value.

6.33 The Workforce criteria was assessed in conjunction with the Workforce Reference Group by the scale of impact of changes on the workforce, sustainability of the workforce and overall numbers of people moving to work outside of Dorset as a result of the changes.

6.34 Deliverability was assessed by examining the expected time to deliver and the impact on other policy areas/proposed changes to health and care services. This included movement of services, beds, facilities and staff.

6.35 Other (e.g. research and education) was assessed in line with national and local policies for research and development (R&D) and education and training.

Results of the evaluation

6.36 In many cases the evaluation highlighted benefits of each option that were not of a significant enough magnitude in each criterion alone to include in this paper. These benefits were taken into account in the final recommendation as supporting evidence. The results below are therefore a high level summary of each option for the criteria where the major benefits of each option are outlined. The detailed results of the evaluation are available in the Pre-Consultation Business Case (summarised in Appendix 4).

Quality of care for all

6.37 For quality of care for all, under all options being considered, it is expected that there will be significant improvements to quality of care through:
8.1

- Increased investment in integrated community services to reduce the rate of hospital admissions and provide care closer to home
- Increased volumes of care in the Major Emergency Hospital, resulting in improved quality of care for patients and less disruption to planned care in the Major Planned Hospital
- More differentiated services across Dorset meaning patients receive the right care in the right place

6.38 Analysis of hundreds of clinical audit measures, published clinical quality data, patient and carer experience data and clinical safety information highlighted the current variations in quality under the existing models and that the proposals would improve quality equally under both option A and option B. **Each option scored the same against this criteria.**

Access to care for all

6.39 For access to care for all, both options will result in an improvement in travel times for patients accessing hyper-acute services alongside an improvement in travel to local services that is expected with the ICS proposals.

6.40 The majority of the current A&E activity will remain on the Poole and Bournemouth sites under both options, with over 95% remaining on the Dorset County Hospital site. Under the ICS proposals, outpatients will move closer to people’s homes as clinicians recognised the majority of these did not need to be delivered in hospital. Inpatient activity is affected the most under both options due to the proposed changes for high volume elective surgery that would be carried out at the Major Planned Hospital and emergency admissions that would be carried out at the Major Emergency Hospital. Whilst the Major Planned Hospital will continue to treat patients in its Urgent Care Centre and accept 30% of the medical take, the majority of emergency patients requiring bed based care would receive treatment at the Major Emergency Hospital site given the improved clinical services available.

6.41 The overwhelming majority of patients require access to low complexity urgent care services typically provided by District General Hospitals, the majority of which would be provided at two centres in Dorset, the Planned and Emergency Hospital and the Major Emergency Hospital. The population of West Dorset and those in central Dorset would be closest to the Planned and Emergency Hospital in Dorchester. For the population living in the East of the county and West Hampshire, the population density is higher around the Bournemouth conurbation and West Hampshire than it is around Poole, thus option B is the more easily accessible site for these services.

6.42 Taking account of guidance relating to emergency travel and transfer times the CWGs and the Clinical Reference Group rated option A and B equally on quality, covering clinical effectiveness, patient and carer experience and safety.

6.43 For patients needing access to the low volume high complexity services provided on the Major Emergency Hospital site, option A offers the better access for the Dorset and West Hampshire population. The numbers of
patients requiring these type of services is relatively low when compared to those requiring access to less complex high volume emergency care.

6.44 Both options have differing effects on surrounding hospitals, with a greater proportion of patients expected to attend Southampton under option A (due to increased travel times to the Major Emergency Hospital from West Hampshire) and a greater proportion expected to attend Salisbury under option B.

6.45 Patient choice and service operating hours are scored equally for both options. Service operating hours will improve under the proposed clinical model moving towards a 24/7 service and all three sites will remain and support patient choice with significant patient benefits from the proposed model.

6.46 Overall, the analysis shows that option B is better for access as the proportion of the population needing highly specialised services is small and option B is more easily accessed 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.

Affordability and value for money

6.47 Both options were shown to provide value for money by generating savings in future revenues.

6.48 The table below shows the comparative costs of options A and B following the review commissioned from Capita of the estates implications for both sites. The cost figures are compiled using the nationally prescribed methodology. Actual local costs could be 20%-30% less than this based on real experience of commissioning similar construction work. These costs take into account the changes recommended by Clinical Reference Group on medical admissions.

<table>
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<th>National Methodology</th>
<th>Cost for Major Planned Hospital (£m)</th>
<th>Cost for Major Emergency Hospital (£m)</th>
<th>Total Cost (£m)</th>
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<tr>
<td>Option A</td>
<td>£33</td>
<td>£156</td>
<td>£189</td>
</tr>
<tr>
<td>Option B</td>
<td>£62</td>
<td>£85</td>
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6.49 When examining potential future estate development on Bournemouth and Poole hospital sites, in either option the intention is that all clinical activity would be consolidated onto the main Poole hospital site with the St Mary’s maternity site being vacated. There is a £42m (28%) price difference between option A and option B, based on the Capita calculations, although the actual cost could be around 20%-30% lower.

6.50 Both options will deliver an expected saving of around £30 million per year once operational. This means that the investment in option A will have a
payback time of 6.3 years and option B a payback time of 4.9 years, when considered using the national cost methodology. If local costs are considered the capital costs could reduce to between £100m-£150m. It is the efficiency saving generated by implementing the options that allow for the development and improvement of the estate on both Poole and Bournemouth sites.

6.51 Both options are similar for financial impact on income and expenditure, option A is less expensive (£6m) when considering transition costs and option B has a higher Net Present Value than option A (£12m).

6.52 When all financial criteria are evaluated together, option B is significantly better than option A based on the lower capital requirement.

Workforce

6.53 Both options are considered to have a similar impact on the workforce in terms of overall numbers of staff changing place of work when travel from home is considered. When assessing workforce in relation to service transfer, option A would retain more of the existing workforce on their current place of work than option B, due to fewer services requiring transfer.

6.54 Both options are considered to result in improved sustainability of the workforce as they result in fewer sites needing to provide 24 hours, seven days a week delivered care for the same service. The duplication of services between sites in East Dorset is also reduced. Both options result in increased volumes of work in their services which will maintain staff specialist expertise – this is especially true if more specialist staff move to working in a clinical network approach where they provide care across all three of Dorset’s acute hospitals, rotating through different types of hospital/unit or community facility. Each option scored the same against this criteria.

Deliverability

6.55 In considering deliverability, fewer clinical service moves are required under option A than option B with potentially less disruption to services under option A. This impact is taken into account in the evaluation of transition costs and workforce criteria as outlined above.

6.56 Estates guidance suggested that Option B (with expansion of the Royal Bournemouth site) could be less disruptive to ongoing service delivery during the construction phase than option A (with expansion of the Poole Hospital site) due to the more modern construction of the Royal Bournemouth site and greater availability of space for planned and future development. Each option scored the same against the deliverability criteria.

Research and education

6.57 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 not considered to be any difference between the options considered. Each option scored the same against this criteria.
6.58 All the evidence provided to assess against the evaluation criteria is included in an updated Pre-Consultation Business Case and was used to inform views on which option would deliver the best services for the people of Dorset.

**The CCG recommended Acute Hospital preference**

6.59 In considering the evidence local stakeholders requested that the CCG determine a preference for one option, noting that this is a preference. A final decision will be reached by the CCG once the public consultation has completed and the results taken into account.

6.60 A summary of the evaluation of both options, noting this is the summary of the major benefits highlighted above, is outlined below:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Option A</th>
<th>Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care for all</td>
<td>↔</td>
<td>↔</td>
</tr>
<tr>
<td>Access to care for all</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Affordability</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Workforce</td>
<td>↔</td>
<td>↔</td>
</tr>
<tr>
<td>Deliverability</td>
<td>↔</td>
<td>↔</td>
</tr>
<tr>
<td>Other (R&amp;D)</td>
<td>↔</td>
<td>↔</td>
</tr>
</tbody>
</table>

↔ = Equal Evaluation
✓ = Better Evaluation

6.61 Based on the evidence and results of the evaluation, it is recommended that Option B is the CCG preferred site specific option for the future delivery of the acute hospital model of care in Dorset.

7. **Integrated Community Services**

7.1 In this section we describe the previous work undertaken in developing the ICS approach, the further development of the ICS model of care and how we used this to start to develop the site specific options. This work aims to deliver better services to patients by delivering them closer to home in a more integrated way with more personalised care based on the needs of patients.

**Integrated Community Services - how the community model was developed**

7.2 During early 2015, Clinicians across Dorset from primary and community care attended 13 locality events to consider out of acute hospital models of care and the way in which the system could be organised to deliver the model. They considered:

- The current service model
- Potential challenges
- Potential opportunities
- Potential ways to organise delivery in the future
7.3 The detailed output from this work formed the basis for the ICS approach and led to a more detailed workplan to progress the model of care and to develop site specific options.

7.4 Following the Governing Body approval to proceed with the ICS approach, a programme was developed to explore future models of care and configuration of community services across Dorset.

7.5 The programme has been overseen by an ICS steering group consisting of GP, local authority, acute and community provider service representation. In exploring future models, current best practice and published evidence were used to explore ways in which the challenges outlined in the need for change could be met by community based services. This work has been undertaken in parallel to the acute reconfiguration activity recognising the interdependencies that exists between these two programmes.

7.6 The community modelling started with the results of the CSR and built on these to develop the model for community services. In doing this the programme considered the workforce profiles, high level financial forecasts, estates information, current and future activity projections, population growth and travel times data. The modelling considered the acute hospital options A and B as both these can affect community service configuration in their localities. Assumptions on which community models were based were tested and amended with Clinicians and managers at two events in March and April 2016 and continue to be refined.

7.7 The early results of the programme on the community models were presented at Clinical Working Group 8, further modelling at CWG 9 and a summary provided to the Clinical Reference Group in March 2016 and April 2016. A draft of the community model and potential service configuration was presented to the System Leadership Team, CCG Governing Body and the ICS Steering and Reference Groups in April 2016. Nine public engagement events with over 300 attendees were held in March and April 2016 along with input from the Patient and Public Engagement Group and the Stronger Voices forum (Appendix 1). Views from all attendees have been fed into the future model design.

7.8 In addition to the ICS programme, a local Dorset Vanguard was initiated and funded by the CCG in September 2015. The remit of this programme was to design integrated community services at scale along with other local service provider stakeholders and patients.

**Integrated Community Services - the results of our work**

7.9 The community model is based on stratifying the local population needs. This then allows us to look to configure service delivery around these needs in the most appropriate way. The five broad groupings of population need are outlined below.
When the categories of need are then used to examine the services that could be designed to meet that need, a range of care models have emerged. These care models are in place in other parts of the country and have been shown to be highly effective in the delivery of community based care. A summary of the five care models and how they map to the population need is outlined below:

Initial workforce analysis has indicated that if care is delivered in new community care models, the majority of the workforce is in place across the system to meet the future service demands. This would require some recruitment, changes in skill-mix across staff groups and amended ways of working, including the development of nursing and allied health professional roles across community and primary care services.

Modelling of the impact of the new models of care has shown that the required 25% reduction in non-elective medical admissions and the 20% reduction in non-elective surgical admissions that underpin the acute model of
care can be met. This will require improved community based support and better access to step up beds for short term rehabilitation, with acute, community, primary care and the local authority working together in a more co-ordinated way.

7.13 The proposed service configuration model is evolving with stakeholders and initial results have shown that there is potential to deliver better care closer to people’s home in a series of community hubs and primary care sites. Currently Dorset has 13 community hospital sites with beds and 98 GP practices delivering care in 135 sites. The community model of ICS would potentially allow for development of expanded integrated teams delivering more services and working from fewer community hubs and primary care sites.

7.14 In examining the public sector estate across Dorset there are a range of options for service delivery. The options could involve a range of consolidation of services on some sites, such as those with community hospital beds, to allow us to use our estate more effectively and invest in re-purposing or developing of other sites. The modelling has shown that this is also possible to develop new community hubs and expanded routine care sites within the existing estate. It has become clear that to meet the future need of our population we should make better use of the resources that are invested in Dorset’s healthcare buildings.

7.15 The options for the site specific configuration depend on the level of consolidation of sites and will need to be co-designed with local stakeholders to suit the local geography and need of the population. A range of options will apply to the different localities across Dorset with a varying range of consolidation and development in the categories outlined below.

<table>
<thead>
<tr>
<th>Types of sites</th>
<th>Current position</th>
<th>Proposed direction of travel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater number of sites</td>
<td>Fewer number of sites</td>
<td></td>
</tr>
<tr>
<td>13 sites with beds</td>
<td>Number of sites with community beds</td>
<td>TBD</td>
</tr>
<tr>
<td>98 practices, 135 sites</td>
<td>Number of GP practice sites delivering routine care</td>
<td>TBD</td>
</tr>
<tr>
<td>Fewer number of sites</td>
<td>Greater number of sites</td>
<td></td>
</tr>
<tr>
<td>sites for urgent care &amp; outpatients</td>
<td>Number of sites acting as hubs for urgent care and outpatients</td>
<td>15-20 sites</td>
</tr>
</tbody>
</table>

Cluster and locality specific configuration
As an example, an option may be to consolidate community hospital beds currently provided over two sites onto one, re-purpose the site that no longer provide bed based care and develop expanded routine and urgent care services from larger primary care sites in the locality.

We have used our developing modelling programme and information as a starting point for site specific options for the new community model. This has taken into account our criteria for quality of care, access to care, affordability and value for money, workforce, deliverability and other (e.g. R&D).

In order to assess the impact of site specific options on travel times, we have carried out travel time analysis and modelling. The analysis has demonstrated that, 95% of people would be able to access community bedded sites within 20 minutes by private car and 90% within an hour by public transport with potentially as few as 6 strategically located sites with community beds compared to the current 13. Whilst the review is not currently proposing only 6 sites with community beds, the results question the use of resources and future sustainability of the current configuration.

Similarly, access to primary care and community services in a scenario of fewer community sites with beds and establishment of primary care hubs without beds, would be possible by car within 8 minutes for 90% of the population and 25 minutes by public transport with just 25 well placed primary care locations. Again, this is not currently being proposed, but it does point to the current 135 sites as over-stretching our resources, both workforce and financial. As mentioned above, a single solution will not suit all areas and we will seek to explore what would be right for the different needs of the local population with stakeholders. Further travel analysis is currently underway.

We have also considered the interdependency of the two site specific acute options, option A and option B in our community modelling and this is reflected in the analysis undertaken. The development of site specific options for the community model are subject to further engagement and consultation with stakeholders, including joint work on understanding the implications for adult social care services across the three councils and will be presented to the Governing Body in the coming months.

The local Dorset Vanguard attracted 6 GP federations successfully bidding to design integrated community services. The 6 federations presented initial thoughts at public engagement events in March and April 2016 and are due to provide their plans for integrated services towards the end of April when they will be considered along with the Integrated Community Services programme outputs in development of a Dorset wide ICS Strategy.

The proposed community clinical model was supported by the Clinical Reference Group on 21st April 2016 and the next steps are to further engage with NHS and Local Authority staff, patients, public and carers in Dorset to refine the community model and site specific options. These will be evaluated using the evaluation criteria used for the acute configuration options and presented to the Governing Body for further consideration prior to public consultation.
8. Mental Health

8.1 Dorset CCG’s mental health team have been working extensively for the past two years to bring about significant change to the mental health services and to develop parity of esteem. This work has been closely linked to other elements of the CSR and in particular with elements of the ICS programme.

8.2 Parity of esteem is being embedded within every aspect of the work the CCG is taking forward in order to ensure mental health is valued equally with physical health. This means we will be tackling mental health issues with the same energy and priority as we have tackled physical illness.

8.3 The CCG is leading the Mental Health Acute Care Pathway (MHACP) Service Review a specific pan-Dorset review including services such as inpatient assessment and treatment, psychiatric liaison, crisis response and home treatment, street triage and community mental health teams. The MHACP design is being co-produced by service users, carers, the voluntary sector, NHS providers and Dorset Police, all of whom bring different insights into the system.

8.4 During the view seeking phase, the CCG received 3,355 comments in total and Bournemouth University’s Market Research Group independently analysed these with findings used to inform future service model design.

8.5 The project is currently in the modelling phase which is aiming to produce a Strategic Outline Business Case by the end July. We expect this to include up to three options for the potential new model of care that will be taken to public consultation.

9. Enablers for change

9.1 To enable service transformation the enabling workstreams set up during the CSR process have continued to develop plans and programmes to support the overarching transformation plan.

9.2 Digital Dorset has continued to advance the procurement of the Dorset Care Record (now at tendering stage) and record integration is a key strategic priority of the pan Dorset Informatics Reference Group.

9.3 The Finance Reference Group is providing specialist input on future costs of the service models and on financial sustainability of local providers.

9.4 We have developed a workforce plan for Dorset which includes health, social care and primary care. The plan brings together national and local data and information in a consistent format across the five Clinical Delivery Groups. It includes the aligned programmes of work where relevant, as well as sections on Primary Care and Social care.
10. Patient Benefits of the models of care and site specific options

10.1 Delivering our two overarching objectives of the acute care reconfiguration and development of ICS models of care will go a long way towards meeting the challenges set out in the need for change. There will be significant benefits in delivering a high quality, responsive and accessible integrated health and care service across Dorset that is sustainable for the current and future generations.

10.2 If, following public consultation, we can achieve these objectives, this will 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 with access to these services from the whole of Dorset to give better outcomes for patients and save lives by creating centres of excellence
- Continue to support Dorset County Hospital as a pivotal provider for Planned and Emergency Services in West Dorset so we can better support the rural communities whilst providing high quality of care through our clinical networks
- Improve the acute hospital estate in East Dorset which could include a new maternity unit and allow over £100m investment in our hospitals which will deliver better outcomes and improved patient experience
- Improve maternity and paediatric services by making decisions on development of community services and a single Dorset service approach that addresses national guidance and local patient needs
- Develop and support the mental health acute pathway review that is running concurrently to the Clinical Services Review to ensure mental health and wellbeing for patients is an integral part of local services

10.3 These should then enable Dorset to have:

- A more sustainable workforce across our hospitals to allow better care to be provided more reliably over the whole of Dorset in future years
- An integrated care record to improve access to information for health and care staff and to enable more informed clinical decisions on patient care
- A financially sustainable acute and community sector that allows for future investment in services for patients

10.4 These benefits can be considered against the evaluation criteria to demonstrate how we intend to meet requirements asked of us by our patients and public in the initial consultation and engagement phase of our programme (Appendix 6)
11. **Next Steps**

11.1 The next steps of the CSR transformation programme are to seek the views of stakeholders via a formal public consultation and to seek further assurance on the programme by external stakeholders to allow the programme to progress to a commissioning decision in 2017 (Appendix 5).

**Public Consultation**

11.2 The main objectives of the public consultation on the acute model of care and site specific options are:

- to enable and help people in and around Dorset to be aware of the critical challenges facing local health and social care services and understand that things need to change and what the possible options are
- to hear peoples’ views on the possible changes to the way health care is organised in Dorset
- to find out if there is any additional information we need to be aware of to help us make our decisions

11.3 The CCG has worked with the Patient and Public Engagement Group to develop consultation objectives and principles resulting in a consultation pledge. The pledge states that we will:

- Share what we have been told
- Involve a wide range of people
- Use clear and simple language
- Ensure sufficient time to be involved
- Work in partnership to reach out to Dorset’s diverse population
- Ensure good value for money
- Use the feedback to inform decision-making

11.4 A number of proposed consultation themes and linked objectives have been developed on which we will determine public views and levels of support. These are shown in the table below:

<table>
<thead>
<tr>
<th>Thematic area</th>
<th>Public views about and levels of support around</th>
</tr>
</thead>
<tbody>
<tr>
<td>The need to change</td>
<td>Why change is required and acceptance that the status quo is neither sustainable or desirable</td>
</tr>
<tr>
<td>Our vision for healthcare in Dorset</td>
<td>Agreement with the CCG’s overarching vision</td>
</tr>
<tr>
<td>Transforming our out of acute hospitals to provide high quality,</td>
<td>Changing model of Integrated Community Services care focused on bringing more care closer to people’s homes, offering a greater</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Thematic area</th>
<th>Public views about and levels of support around</th>
</tr>
</thead>
<tbody>
<tr>
<td>safe and sustainable care</td>
<td>range of services locally (based on a scale model), and making best use of estates.</td>
</tr>
<tr>
<td>Transforming our acute hospitals to provide high quality, safe and sustainable care</td>
<td>Changing model of acute hospital care with centres of excellence that can offer specialist and day-to-day acute emergency, urgent and planned care. Consulting on site specific options (Option A and B) for new ways to organise care</td>
</tr>
<tr>
<td>Implementation of the agreed solution</td>
<td>Any specific issues of note or to be aware of during implementation (e.g. public transport routes, sequencing of new and old services)</td>
</tr>
</tbody>
</table>

11.5 The specific questions that will be asked during the public consultation stage have yet to be determined and will be developed in the consultation planning between now and September 2016.

11.6 The recommendations in this report will be subject to the Stage 2 assurance (stage 1 assurance was successfully completed in 2015) carried out by NHS England and subsequently submitted to NHS England’s national Investment Committee. Investment Committee approval is required before the CCG can commence public consultation. The stage 2 assurance is timetabled for June 2016 and the Investment Committee for August 2016.

Assurance

11.7 In early June 2016 NHS England will consider the external assurance from the Health Gateway review team and the clinical Senate Council advice following their independent review as well as a more in-depth assessment of how the CCG is meeting the four key tests:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Support for proposals from clinical commissioners

11.8 Providing NHS England is satisfied with this information, and the programme passes the stage 2 assurance process, a submission is made to the NHS England national Investment Committee.

11.9 NHS Dorset CCG recognises the decision that was made by the Competition Commission (now the Competition and Markets Authority (CMA)) in relation to a proposed statutory merger between Royal Bournemouth and Christchurch NHS Foundation Trust and Poole Hospital NHS Foundation Trust. NHS
Dorset CCG will engage fully with competition regulators (NHS Improvement and the CMA) to ensure any competition law concerns are fully addressed.

11.10 NHS Dorset CCG has and will continue to take into account its duties under the NHS Act and other relevant legislation including the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013.

11.11 NHS Dorset CCG has ensured that its Public Sector Equality duties have been met in the proposed clinical models with Equality Impact Assessments being developed for the new service models to identify and address any equality issues arising.

12. Conclusion

12.1 The Governing Body is asked approve the recommendations contained within the frontis.
<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Engagement Activity</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Acute Hospital Service Summary</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>Evaluation Criteria</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Options Evaluation Summary</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Programme Timelines</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>Patient Benefits</td>
</tr>
</tbody>
</table>
Appendices

Appendix 1: engagement activity

A high level summary of engagement activity undertaken to date is outlined below and is ongoing:

- **29,000 pieces of feedback themed and used to inform the “Need to Change”**.
  In November 2014, at the start of the CSR consideration was given to what local people had already been saying. Bournemouth University was commissioned to analyse 29,000 qualitative pieces of feedback collected through 4 Dorset-wide surveys. They reviewed themes around access to services (time and location), integrated working and communication. The outcomes were shared with all working groups and used to inform the need to change.

- **12 Patient (Carer) and Public Engagement Group (PPEG) meetings – providing feedback at all stages of the CSR**.
  In December 2014 the PPEG was formed. The group comprises about 20 local people with a wealth of life-experience across Dorset’s geography, demography and diversity. It is chaired by a National Patient Leader and meets regularly, providing feedback at all stages of the CSR. Views fed directly into assurance, reference and clinical working groups. Key outputs include:
    - Requesting a public facing “Need to change” document (produced Jan 2015).
    - Directly informing the development of the CSR Evaluation Criteria (Feb 2015).
    - Designing consultation principles for the CSR (March 2015).
    - Producing a “Guide to person-centred discussions” – shared widely with clinical working group, clinical delivery groups and community vanguards (December 2015).

- **Pan Dorset Engagement Leads Forum set up – representatives from 18 partner organisations**.
  In December 2014 the pan Dorset Engagement Leads Forum was set up. This forum is attended by engagement leads from health and social care providers, the local authorities, the voluntary sector, public health Dorset, Healthwatch Dorset, NHS England (South) and South West Ambulance and Dorset Fire and Rescue. The forum was set up to share information, intelligence and approach to engagement, to align work, to reduce duplication and act as a professional group for developing, critiquing and enhancing participation across the county. This approach was applied collectively to the CSR.

- **Public Meetings hosted across the initial CSR design phase – attended by 525 local people and filmed to reach out to a wider audience, including the working well, seldom heard etc.**
  During the initial design phase of the CSR the same information that was shared with clinicians and other working groups was shared with the PPEG and through a series of public meetings. A trio of public meetings were held in December 2014, January 2015 and February 2015. One of each trio was filmed to enable
the messages to be shared more widely, providing opportunity for information and involvement via the website, Facebook and twitter to a wider audience, including the working well, seldom heard, etc.

- **Information and opportunity for involvement provided at 84 forums, meetings and events.**
  Across the CSR information and opportunity for involvement has also been provided to thousands of people at numerous forums, meetings, and public shows. These included voluntary sector health and care forums, learning disability groups, equality and diversity forums, Dorset Youth Council, etc.

- **3,900 Health Involvement Network (HIN) and 150 Supporting Stronger Voices members - regularly informed and involved.**
  Information and opportunities for involvement around the CSR regularly sent to HIN members via the CCG “Feedback” bulletin. 150 CCG patient, carer, lay and public representatives invited to 6 monthly forums with CSR as a standing agenda item.

- **Engagement with NHS West Hampshire CCG**
  CSR presentations given to Involvement Steering Group, New Forest Locality and Patient Public Engagement Group. Information communicated regularly. CSR patient/carer survey in New Forest area - 277 survey responses received and shared with NHS Dorset CCG.

- **CSR and Young People**
  CSR poster co-designed with young people. 2 x CSR young people’s conferences co-designed and co-hosted with young people in October and November 2015.

- **Views collected across the CSR.**
  Across the CSR comments and questions have been collated for further consideration as appropriate. Recently, the strongest themes were presented in an information walk through at 9 public engagement events around community services.

- **Simple animation of the “Need to Change” produced and shared with over 4,100 people. 95% understand the need to change.**
  In response to suggestions from PPEG, the public and Healthwatch Dorset a simple 3 minute animation illustrating a) the need to change b) what is being done about it and c) how people can get involved was produced in October 2015 – to reach out more widely to the working well, the seldom heard, the hard to reach etc. This has been viewed by over 4,100 people and those who completed a simple feedback survey 95% said that having watched the animation they understand why local health and care services need to change.

- **9 locality based Integrated Community Services (ICS) public engagement events were hosted in March and April 2016. 339 local people attended providing 2,162 pieces of feedback.**
  In response to the need to co-design integrated community services with local people a series of 9 public engagement locality based events were held across
Dorset in March and early April 2016. This is an important stage in on-going engagement or participation work in Dorset – with a vital local community focus. The focus of each event was to listen and learn from local people, with lived-experience and knowledge of each area, exploring what they felt we need to consider when developing health and care services in their particular area of Dorset. Their views were also sought on emerging models of care. A high-level overview was shared at Clinical Working Group 9. The 2,162 pieces of feedback have been collated and themed and 9 individual reports and a master report produced. Feedback is being shared to inform emerging models and local people will then be updated.

- Engagement “roadshow” being planned for June and July 2016.
  Local people have asked us to come to where they are and to provide engagement opportunities across a wider geographical area. During June and July 2016 we will be covering a wide area of Dorset’s geography in a mobile vehicle – providing information and an opportunity for people to provide us with their feedback, views, concerns and questions. As with all previous engagement work - all views will be used to inform emerging models and options that will be taken back out to public consultation.
Appendix 2: acute hospital service summary

## Planned Care and Emergency Hospital summary of services

| **Urgent and emergency care** | 24/7 Consultant led A&E with 14/7 consultant presence  
|                            | Trauma unit  
|                            | Hyper-acute cardiac  
|                            | Non-interventional cardiac  
|                            | Hyper-acute stroke service  
|                            | Stroke unit and stroke rehabilitation  
|                            | Emergency surgery 24/7  
|                            | Acute medical admissions  
|                            | Acute oncology  
| **Planned and specialist** | Level 3 Critical Care  
|                            | High volume lower risk planned and day case surgery including cancer  
|                            | Planned medical interventions/admissions e.g. chemotherapy  
|                            | Networked single Dorset cancer service  
|                            | Interventional radiology  
|                            | Outreach radiotherapy  
|                            | Outpatients and diagnostics  
| **Maternity and Paediatrics** | Urgent decision (within 6 months) to integrate services between DCH and Yeovil District Hospital resulting in one site delivering consultant led obstetric care and one site with midwifery led unit; one site delivering inpatient paediatric service and one site with paediatric assessment unit.  
|                            | If no integration with YDH then Dorset wide network with move to MidwiferyLed Unit and Paediatric Assessment Unit (as per RC recommendation)  
|                            | Special Care Baby Unit (>32 weeks)  
| **Long term conditions, frailty and End of Life care** | Integrated frailty service  
|                            | Primary and community care services on site  
|                            | Step up, step down beds  
|                            | Mental health care services (not inpatient beds)  

*Services provided 24/7 across Dorset on a networked basis Indicative no. of beds: ~320 - 360

## Major Emergency Hospital Summary of services

| **Urgent and emergency care** | 24/7 consultant delivered A&E with major trauma  
|                            | 24/7 hyper-acute cardiac, stroke  
|                            | 24/7 consultant delivered emergency surgery in line with NCEPOD* recommendations  
|                            | Acute medical admissions  
|                            | 24/7 Gastrointestinal bleed rota  
|                            | Acute oncology  
| **Planned and specialist** | Level 3 Critical Care  
|                            | Higher risk low volume planned care including cancer  
|                            | 24/7 interventional radiology  
|                            | Outpatients and diagnostics  
|                            | Networked single Dorset cancer service  
| **Maternity and paediatrics** | 24/7 High risk obstetrics unit for maternity  
|                            | Alongside midwifery led unit  
|                            | 24/7 Inpatient consultant delivered paediatrics  
|                            | Local Neonatal unit level 2  
| **Long term conditions, frailty and End of Life care** | Integrated frailty service  
|                            | Primary and community care services on site  
|                            | Mental health care services (not inpatient beds)  

*National Confidential Enquiry into Patient Outcome and Death  
Indicative no. of beds: ~900 – 1,100
## Major Planned Care Hospital summary of services

### Urgent and emergency care
- 24/7 Urgent Care Centre (as part of Dorset's Urgent Care Services) – GP led with consultant input in networked arrangement with integrated GP out of hours services.
- Sub-acute medical admissions (up to 30%)
- Rehabilitation beds

### Planned and specialist
- High volume lower risk planned and day case surgery including cancer
- Enhanced planned recovery unit
- Planned medical interventions/admissions e.g. chemotherapy
- Outpatients and diagnostics
- Networked single Dorset cancer service

### Maternity and paediatrics
- Antenatal and postnatal care
- Children’s therapies and outpatients

### Long term conditions, frailty and End of Life care
- Integrated frailty service
- Primary and community care services on site
- Step up, step down beds
- Mental health care services (not inpatient beds)

*Indicative no. of beds: 180 to 300*
## Appendix 3: evaluation criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Sub-criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of care for all</td>
<td>Clinical effectiveness</td>
<td>Improved delivery against clinical and constitutional standards, access to skilled staff and specialist equipment, comparison of current clinical quality of sites</td>
</tr>
<tr>
<td></td>
<td>Patient and carer experience</td>
<td>Improved patient and carer experience (overall holistic/personalised care, respect and involvement in decisions and consistency) with excellent communication and improved estate</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>Expected impact on excess mortality, serious untoward incidents</td>
</tr>
<tr>
<td>Access to care for all</td>
<td>Distance and time to access services</td>
<td>Impact on population weighted average travel times (blue light, off-peak car, peak car, public transport) to reflect average impact for emergency and elective treatment and total impact for more isolated and/or rural populations</td>
</tr>
<tr>
<td></td>
<td>Service operating hours</td>
<td>Ability of model to facilitate 7 day working and improved access to care out of hours</td>
</tr>
<tr>
<td></td>
<td>Patient choice</td>
<td>No. of sites delivering emergency, obstetrics, elective, outpatients, diagnostics; no. of Trusts with major hospital sites</td>
</tr>
<tr>
<td>Affordability and value for money</td>
<td>Capital cost to the system</td>
<td>Capital requirement to achieve required capacity &amp; quality</td>
</tr>
<tr>
<td></td>
<td>Transition costs</td>
<td>One off costs (excl. capital &amp; receipts) to implement changes</td>
</tr>
<tr>
<td></td>
<td>Net present value</td>
<td>Total value of each potential option incorporating future capital and revenue/cost implications and compared on like-for-like basis</td>
</tr>
<tr>
<td></td>
<td>Meet license conditions</td>
<td>Meets regulatory requirements e.g. surpluses generated by each Foundation Trust</td>
</tr>
<tr>
<td>Workforce</td>
<td>Scale of impact</td>
<td>Potential impact on current staff and retraining required</td>
</tr>
<tr>
<td></td>
<td>Sustainability</td>
<td>Likelihood to be sustainable from a workforce perspective, facilitating 7 day working and taking into account recruitment challenges and change in what work force does i.e. ability to ensure sufficient people with the right skills in the right places?</td>
</tr>
<tr>
<td></td>
<td>Loss of Dorset workforce</td>
<td>Potential impact on staff attrition due to change</td>
</tr>
<tr>
<td>Deliverability</td>
<td>Expected time to deliver</td>
<td>Ease of delivering change within 3-5 years</td>
</tr>
<tr>
<td></td>
<td>Co-dependencies with other strategies</td>
<td>Alignment with other strategic changes (e.g. Better Together, national and local NHS strategies) and provides a flexible platform for the future</td>
</tr>
<tr>
<td>Other (e.g., research and education)</td>
<td>Disruption to education &amp; research</td>
<td>Disruption to Research and Education</td>
</tr>
<tr>
<td></td>
<td>Support current &amp; future education &amp; research delivery</td>
<td>Support for current and developing research and education delivery e.g. meeting college standards of training individuals and service specifications</td>
</tr>
</tbody>
</table>
Appendix 4: options evaluation summary

<table>
<thead>
<tr>
<th>Option</th>
<th>Improvement</th>
<th>Problem Identification</th>
<th>Service Delivery</th>
<th>Efficiency</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Option 2</td>
<td>+</td>
<td>+</td>
<td>+</td>
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<tr>
<td>Option 3</td>
<td>+</td>
<td>+</td>
<td>+</td>
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<td>+</td>
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<tr>
<td>Option 4</td>
<td>+</td>
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<td>+</td>
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</tbody>
</table>

Note: The table above provides a summary of the options evaluation, highlighting areas for improvement and potential problems. Each option is rated for improvement and problem identification, as well as for service delivery, efficiency, and safety.
Appendix 5: Programme timelines
### Appendix 6: Patient Benefits

<table>
<thead>
<tr>
<th>High level criteria</th>
<th>Benefit</th>
</tr>
</thead>
</table>
| Quality of care for all       | • Care centred around the patient  
• Meeting patients’ physical and mental health needs  
• Improved outcomes: morbidity and mortality  
• Saving more lives by having 24/7 consultant on site led care  
• Provide centres of excellence  
• Right care in the right place at the right time  
• Improved communication between clinicians across the health community  
• Ensuring people have a positive experience of care  
• Provide seamless integrated care  
• Meeting national quality standards for key specialist services  
• Reduced hospital admissions  
• Reduced length of stay  
• Increased focus on prevention and wellbeing |
| Access to care for all        | • Care delivered closer to home for more people  
• More services available 7 days a week  
• More services available for 24 hours a day  
• Easier access to hyper-acute and specialist services  
• More services delivered in the community |
| Sustainability and value for money | • Closing predicted financial gap of £158 million per year by 2021 using:  
  ➢ new models of care  
  ➢ cost avoidance  
  ➢ in-house productivity improvements  
• Increased efficiency and reducing variation  
• Further savings beyond 2021 through prevention |
| Workforce                     | • Sustainable workforce with availability 24/7 where appropriate  
• Attract and retain high calibre staff to Dorset  
• Greater focus on multidisciplinary working  
• Improved efficiency of working practices and reduced pressures on workforce  
• Sufficient volumes of care per consultant to maintain skills and expertise |
| Deliverability                | • A solution that can be largely implemented within 5 years  
• Service models supported by national |
<table>
<thead>
<tr>
<th>High level criteria</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>guidance and best practice</td>
</tr>
<tr>
<td></td>
<td>• Support from national bodies</td>
</tr>
<tr>
<td>Other (e.g. research and education)</td>
<td>• Improved opportunities for training and education of clinicians in Dorset with networked working</td>
</tr>
<tr>
<td></td>
<td>• Enhanced ability to attract research and development work and funding</td>
</tr>
<tr>
<td></td>
<td>• More able to adopt new technologies, techniques and treatments</td>
</tr>
</tbody>
</table>