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NHS DORSET CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

CLINICAL SERVICES REVIEW – CONSULTATION OPTIONS

Date of the meeting	20/05/2015
Author	Dr P Richardson - Programme Director, Transformation
Sponsoring Clinician	Dr F Watson -Chair NHS Dorset CCG
Purpose of Report	The purpose of the report is to seek Governing Body approval to proceed to public consultation on the models of care options that are recommended as an outcome of the first stage of the Clinical Services Review.
Recommendation	The Governing Body is asked to consider the report recommendations and, if thought fit, to determine whether to: (a) agree with the out of hospital approach (b) agree with the acute hospital models of care and site specific options (c) **approve** the proposal to proceed to consultation (d) **approve** the delegation of authority to the Chair and Accountable Officer to make minor amendments to the consultation proposal to address the external assurance feedback (e) **approve** the delegation of authority to the Control and Assurance Group to sign off the consultation document
Stakeholder Engagement	A full statement regarding engagement with members, clinicians, staff, patients & public is included in the report
Previous GB / Committee/s, Dates	Clinical Services Review Controls and Assurance Group 12th May 2014

Monitoring and Assurance Summary

This report links to the following Strategic Principles	• Services designed around people • Preventing ill health and reducing inequalities • Sustainable healthcare services • Care closer to home		
	Yes [e.g. ✓]	**Any action required?**	
		Yes Detail in report	**No**
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. Introduction

1.1 The Clinical Services Review (CSR) programme has now concluded its review, analyse and design stage. This report sets out the findings of this work and seeks approval from the Governing Body to move to the formal public consultation stage of the programme to consult on whole system change in Dorset encompassing:

- The system wide out of acute hospital approach
- The models of care for acute hospital services
- The two site specific options for delivering these models of care

1.2 The review, analyse and design stage of the programme was carried out between October 2014 and May 2015 in accordance with the fundamental principles that underpin the CSR:

- Clinically led
- Evidence based
- Embedded public and patient voice
- Whole systems approach
- Honest and open conversations and information sharing
- Explicitly meeting the Secretary of State's four tests for service change:
    - Clear basis in clinical evidence
    - Strong public and patient engagement
    - Commitment to current and prospective patient needs and choice
    - Involvement and support from clinical commissioners

1.3 This report builds on previous reports received by the Governing Body on the progress of the CSR and summarises the process and outcomes from the review, analyse, and design stage leading to the concluding recommendations for public consultation.

2 Report

2.1 Given the changing needs of our population, best practice standards and the funding that will be available, in March 2014 the Governing Body approved a recommendation to conduct a comprehensive review to ensure that we are able to look after everyone's health as well as possible.

2.2 Our vision is for an integrated local health system. The CSR supports this vision with the overriding aim of ensuring that everybody who receives healthcare in Dorset has access to safe, high quality and sustainable healthcare.

2.3 The process for the review, analyse, and design stage of the CSR has centred around the development of GP led clinical working groups covering:

- Urgent and emergency care
- Planned and specialist care
- Maternity and paediatrics
- Long term conditions and frail older people

2.4 The importance of mental health care was recognised within each of these working groups and was explicitly included in their considerations.

2.5 Over 300 local clinicians have been involved in discussions to develop the out of acute hospital and in acute hospital options. Led by clinicians the four clinical working groups (CWG's) engaged clinicians from across Dorset, as well as representation from West Hampshire CCG, NHS England, the Local Medical Committee (LMC) and social care colleagues from the local authorities.

2.6 Five CWG meetings were held between November 2014 and May 2015. The table below summarises the main discussion areas at each of these meetings:

CWG 1 November 2014	What are people's needs? How are services currently being provided? Is there a need to change?
CWG 2 December 2014	What is the local, national and international evidence and best practice? What does good look like? What models of care in and out of acute hospitals can best meet people's needs?
CWG 3 January 2015	What models of care in and out of acute hospitals can best meet people's needs? (continued from CWG2) What are the potential options we have for organising the delivery of acute hospital services (e.g. what range of services could we have and where could they be located)
CWG 4 February 2015	What are the potential options we have for organising the delivery of acute hospital services (continued from CWG3) Review of how Dorset might meet its Out of Acute Hospital ambitions
CWG 5 March 2015	What are the preferred options for the delivery of services (assessments against the agreed evaluation criteria)

2.7 Throughout the process these clinically led discussions have been shared with a wide range of people including:

- The public, patients and carers of Dorset
- The GP members who work in the 100 GP practices across Dorset

- The staff who work in Dorset's NHS
- 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, Dorset Community Action, Dorset Race Equality Council, Dorset Young People's Forum and a wide range of voluntary organisations
- Information has been made available on www.dorsetsvision.nhs.uk website at every stage of the programme

2.8 The views and feedback from these groups were collated with feedback from the Big Ask and Citizens Panels to inform subsequent discussions:

- In 2013 The Big Ask survey gathered over 6,100 views about what people want from local healthcare services
- The Big Ask and Citizens Panel together provided over 29,000 individual qualitative comments about services.

Appendix 1 summarises who has been involved in the CSR pre-consultation.

3 Need to change

3.1 At the beginning of the review a significant amount of evidence and data was gathered to enable us to describe the current picture of healthcare across Dorset and to understand the challenges we face in terms of demographics and health needs now and in the future.

3.2 In January we produced and published:

- *The need to change* document (Appendix 2)
- A technical summary and
- An extensive supporting compendium of evidence

which set out a compelling story describing why change was needed. The headlines were:

- A growing elderly population with changing health needs
- More people in Dorset living with long term conditions
- Variable quality of out of hospital care with patients reporting difficulty accessing care
- Variable quality of hospital based care, particularly for some more specialist services
- Difficulty staffing services, particularly some specialist services requiring consultants on site 24 hours a day 7 days a week
- A growing financial challenge with a projected gap between costs and available funding of between £167 to over £200 million per year by

2020/21 if we do nothing differently and continue to provide healthcare in the way that we do now

4 What good looks like

4.1 The clinicians in the working groups drew on their clinical knowledge, their experiences of working practices, UK and international evidence, to define 'what good looks like' across the clinical working groups.

4.2 An integrated model of care was described that incorporated the following ambitions:

- The provision of more care closer to home
- More patient centred care
- More and better use of multi-disciplinary teams
- Greater support for self-management
- Greater focus on prevention
- Collaborative working
- Services provided 24 hours a day 7 days a week where required
- Meeting national quality guidance
- More senior level assessment and signposting to services (ensuring patients are seen by the right person in the right place at the right time)

4.3 The ambitions articulated by the local clinicians resonate strongly with the five key elements for success contained in Professor Sir Bruce Keogh's letter[1] to the Secretary of State for Health and the Chairman of NHS England (Appendix 3) in which he states that we must:

- provide better support for people to self-care
- help people with urgent care needs to get the right advice in the right place, first time
- provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E
- ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery
- connect all urgent and emergency care services together so the overall system becomes more than just the sum of the parts.

[1] Professor Sir Bruce Keogh KBE, MD, DSc, FRCS, FRCP is the National Medical Director of NHS England. This letter appears at the front of NHS England's *Transforming urgent and emergency care services in England End of Phase 1* report (November 2013)

4.4 The models for delivery of out of acute hospital care and acute hospital care being developed in Dorset, further support and build on this national vision.

5 Out of Acute Hospital Care

5.1 Models for the delivery of out of acute hospital care were discussed and included self care and care that starts at home as well as services that are delivered in general practice, mental health and community hospitals.

5.2 Local clinicians identified some services that could move from acute hospital to community settings in the future. Some examples of this were:

- Rehabilitation (e.g. physiotherapy after a broken leg)
- Interventions under local anaesthetic (e.g. mole removal)
- Outpatients (e.g. removing plaster cast)

5.3 They further identified some services that could be delivered in a stand alone health facility for planned operations and treatment. Some examples of this were:

- Rehabilitation (e.g. post operative recovery following a hip replacement)
- Interventions under local anaesthetic (e.g. vasectomy)
- Interventions under general anaesthetic (e.g. knee replacement)
- Outpatients (e.g. pre operative specialist assessment)

5.4 Clinicians across Dorset from primary and community care have 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 have considered:

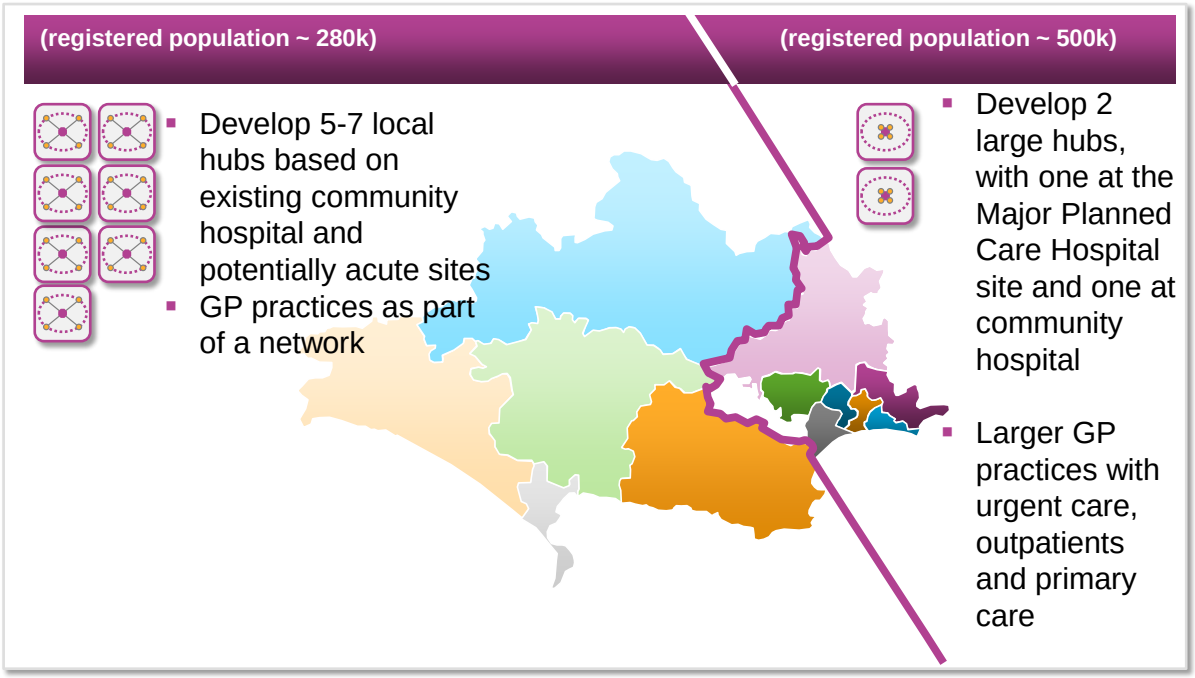
- The current service model
- Potential challenges
- Potential opportunities
- Potential ways to organise delivery in the future

5.5 Ambitions were developed to transform Dorset's out of acute hospital service provision. The table below shows potential opportunities to improve benefits to patients:

8.1

	From	To
Transformed primary care	Variations in performance 5-7 day services	Consistent quality 7 day services
Rapid response to urgent health needs	Multiple overlapping services Limited access out of hours	Single point of access Access to a range of professionals
Integrated care for people with long term conditions and the frail older people	Fragmented services and duplication of effort	Integrated locality based teams providing seamless services to patients
Efficient planned care close to patients' homes	Patients travelling to acute hospital location	Outpatient and other planned care delivered at scale in the community
Support for people to recover independence quickly	People kept in hospital	Home-based support services available Improved use of technology to recover independence
Workforce for the future	Clinical staff spending time on inappropriate tasks, travel and with little IT support	Highly skilled staff to deliver physical and mental health care Staff using their specialist skills more Enhanced IT support

5.6 The proposal is to develop hubs to support the delivery of services at scale.



Illustrative purposes only

A hub may typically include but not be limited to:

- Consultation rooms
- A community room
- Pharmacy
- Therapy area
- Community health services
- Diagnostics
- Childrens services
- Equipment store

5.7 In developing the in hospital and out of acute hospital proposals, Dorset Clinical Commissioning Group (CCG) recognises that there will be an impact upon the services provided from community hospitals. At this stage, the impact is not fully developed or known and, in this context, the CCG appreciates the need to further refine and develop the provision of care from community hospitals across Dorset. This is an on-going piece of work which will be aligned to the proposals for both acute and out of acute hospital care.

6 Acute hospital care for Dorset

6.1 The clinical working groups considered services that are delivered in a main acute hospital setting. They have defined three different types of acute hospital service models for Dorset which are broadly aligned with the national definitions contained in *Transforming urgent and emergency care services in England: Update on the Urgent and Emergency Care Review, NHS England* (15 August 2014), with some locally determined variances.

6.2 The different types of acute hospital service models are described as:

- Major Planned Care Hospital with an Urgent Care Centre (previously referred to by the CSR team as purple services)
- Planned Care and Emergency Hospital with A&E services (previously referred to by the CSR team as yellow services)
- Major Emergency Hospital with A&E services (previously referred to by the CSR team as green services)

6.3 A summary of the services for a Major Planned Care Hospital with an Urgent Care Centre are shown in the table below:

Urgent and emergency care	• 24/7 Urgent Care Centre (as part of Dorset's A&E network) – GP led with consultant input in networked arrangement with integrated GP out of hours services • Sub-acute medical admissions • Rehabilitation beds
Planned and specialist	• High volume low complexity planned and day case surgery • Enhanced planned recovery unit • Planned medical interventions/admissions e.g . chemotherapy • Outpatients and diagnostics
Maternity and Paediatrics	• Antenatal and postnatal care • Children's therapies and outpatients
Long Term Conditions and frail older people	• 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 – 300

This will provide an opportunity to focus on the provision of high quality, high volume services providing excellence in planned care.

6.4 A summary of the 24 hours, 7 days a week services for a Major Emergency Hospital with A&E services are shown in the table below:

Urgent and emergency care	• 24/7 consultant delivered A&E with trauma • 24/7 hyper-acute cardiac, stroke • 24/7 consultant delivered emergency surgery in line with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations • Acute medical admissions • 24/7 Gastrointestinal bleed rota
Planned and specialist	• Level 3 Critical Care • High complex low volume planned care • 24/7 interventional radiology • Outpatients and diagnostics
Maternity and Paediatrics	• High risk obstetrics with 24/7 consultant presence for maternity • Alongside midwifery led unit • Inpatient consultant delivered paediatrics 24/7 • Neonatal Intensive Care Unit level 3
Long Term Conditions and frail older people	• Integrated frailty service • Mental health care services (not inpatient beds) • Primary and community care services on site

Indicative no. of beds: ~ 900 – 1,100

This will provider for the first time in Dorset 24 hours, 7 days consultant presence in A&E. There is a strong evidence base that this will save lives[2] (Appendix 3).

[2] Professor Sir Bruce Keogh KBE, MD, DSc, FRCS, FRCP is the National Medical Director of NHS England. This letter appears at the front of NHS England's *Transforming urgent and emergency care services in England End of Phase 1* report (November 2013)

6.5 A summary of the services for a Planned Care and Emergency Hospital with A&E services are shown in the table below:

Urgent and emergency care	• Consultant led A&E with 14/7 consultant presence* • Hyper-acute cardiac – Monday to Friday, 8 hours a day* • Non-interventional cardiac – 12/7 in line with 7 day a week working* • Hyper-acute stroke service 14/7* • Stroke unit and stroke rehabilitation • Emergency surgery 14/7* • Acute medical admissions*
Planned and specialist	• Level 3 Critical Care* • High volume low complexity planned and day case surgery • Interventional radiology - Monday to Friday, 8 hours a day* • Outpatients and diagnostics
Maternity and Paediatrics	• 24/7 consultant led cover with approx. 60 hours per week on labour unit and 128 hours on call at night (either resident or at home if within 30 minutes)* • Alongside midwifery led unit • Neonatal care* • Develop paediatric assessment unit 16/7*
Long Term Conditions and frail older people	• Integrated frailty service • Primary and community care services on site • Mental health care services (not inpatient beds)

Indicative no. of beds: ~ 320 – 360
(* services provided 24/7 across Dorset on a networked basis)

6.6 The existing acute hospital provision across Dorset represents three variations of the Planned Care and Emergency Hospital with A&E (previously expressed as yellow) services.

6.7 None of the acute hospitals in Dorset currently have 24 hours a day, 7 days a week consultant delivered on site services across the range of key specialties where national quality standards identify this as being important for best outcomes.

Interdependencies

6.8 Some acute clinical services have interdependencies – this means they need to be co-located. When considering the development of potential future acute hospital models this needs to be recognised. These services are:

- Full service 24 hours 7 days a week consultant delivered A&E
- Emergency surgery
- Critical care

- High risk obstetrics
- More complex specialist elective surgery
- Interventional radiology

7 Options for Acute Hospital Care

7.1 By working closely with both clinicians and the Patient and Public Engagement Group, a number of high level evaluation criteria have been developed. These criteria were used in the process of narrowing down the potential number of generic service options. 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)

7.2 In January 2015 the clinicians started to consider 21 possible options (non site specific) produced by applying the models of care in different permutations (with a maximum of up to three sites). This provided a long list of 65 site specific combinations.

7.3 The clinicians agreed that from a quality perspective, people in Dorset should be able to access a Major Emergency Hospital with A&E services within Dorset but that only one of these would be clinically sustainable. Using the evaluation criteria this narrowed down the number of non site specific options from 21 to 7 with 28 site specific combinations.

7.4 During February/March 2015 the Clinical Working Groups and the programme's reference groups (which include the Clinical Reference Group, Patient and Public Engagement Group, Workforce Reference Group, Finance Reference Group and Chief Executives) considered the list of 7 non site specific options against the evaluation criteria and subsequently reduced the options to a short list of two generic options for the acute hospital delivery model with 12 site specific combinations.

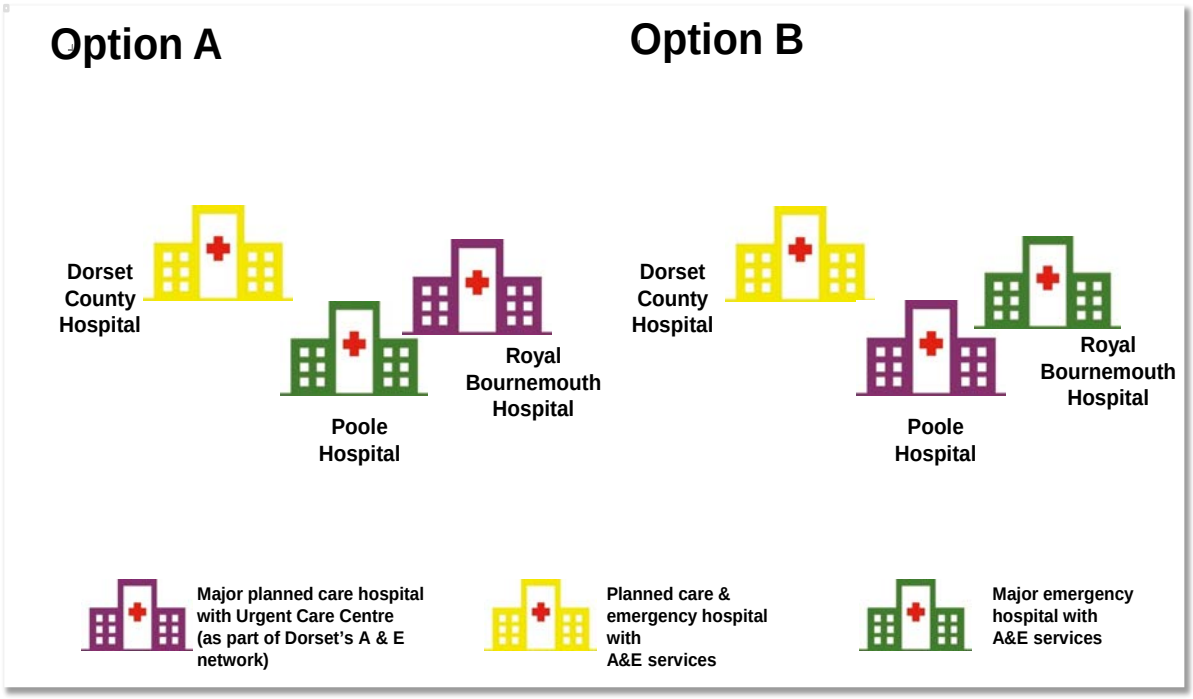
7.5 The reduction from 7 generic options to 2 generic options was because the clinicians identified that they would want to be able to offer acute hospital services in both the east and the west of the county.

7.6 A further more detailed assessment using the evaluation criteria which includes financial assessments and travel time analysis was used to identify the final proposed generic option for public consultation with two site specific variations.

7.7 In considering the final options for consultation the clinicians identified that a Planned Care Hospital with A&E services should be located in the west of the county to ensure good access for all of Dorset's population and a Major Emergency Hospital with A&E services should be in the east based on

population and travel time analysis. The clinicians also took account of services offered outside of the county of Dorset and patient flows into Dorset from other counties.

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



	Dorchester	Poole	Bournemouth
OPTION A	Planned Care and Emergency Hospital with A&E services	Major Emergency Hospital with A&E services	Major Planned Care Hospital with an Urgent Care Centre
OPTION B	Planned Care and Emergency Hospital with A&E services	Major Planned Care Hospital with an Urgent Care Centre	Major Emergency Hospital with A&E services

8 Benefits

8.1 It is expected that delivering the out of acute hospital and acute hospital models of care will deliver the following benefits against the high level evaluation criteria:

High level criteria	Benefit
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 • 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 • Seamless integrated care • Meeting national quality standards for key specialist services • Reduced hospital admissions • Reduced length of stay • Increased focus on prevention
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 between £167 to over £200 million per year by 2021 using: ➢ new models of care ➢ cost avoidance ➢ in-house productivity improvements • Increased efficiency and value for money • 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

High level criteria	Benefit
Deliverability	• A solution that can be largely implemented within 5 years • Service models supported by national guidance and best practice • Support from national bodies
Other (e.g. research and education)	• Improved opportunities for training and education of clinicians in Dorset with networked working • Enhanced ability to attract research and development work and funding • More able to adopt new technologies, techniques and treatments

9 Consultation

9.1 The main objectives of the public consultation are:

- to enable and help people in and around Dorset to be aware 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

9.2 The CCG has worked with the Patient and Public Engagement Group (PPEG) 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

9.3 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:

Thematic area	Public views about and levels of support around
The need to change	Why **change is required** and acceptance that the status quo is neither sustainable or desirable
Our vision for healthcare in Dorset	Agreement with the CCG's overarching **vision**
Transforming our out of acute hospitals to provide high quality, safe and sustainable care	Changing model of **out of acute hospital** care focused on bringing more care closer to people's homes, offering a greater range of services locally (based on a scale model), and making best use of estates.
Transforming our acute hospitals to provide high quality, safe and sustainable care	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
Implementation of the agreed solution	Any **specific issues** of note or to be aware of during implementation (e.g. public transport routes, sequencing of new and old services)

9.4 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 August 2015.

9.5 The Governing Body is asked to note that the report recommendations will be subject to the Stage 2 assurance carried out by NHS England. This assurance is required before the CCG can go to consultation. The CSR proposed timetable is attached at Appendix 4.

9.6 NHS England will also look at 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 in this review . Providing the NHS England panel are satisfied with this information, and the programme passes the stage 2 Assurance process, then the CCG can go to consultation.

9.7 Dorset CCG recognises the decision that was made by the Competition Commissioning (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. Dorset CCG will engage fully with competition regulators (Monitor and the CMA) to ensure any competition law concerns are fully addressed.

9.8 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.

9.9 Extensive work has been done as part of the CSR to ensure that benefits to patients of the proposed options can be realised and are clearly demonstrated and articulated. We believe that the proposals constitute a good case for service change and are likely to address any competition concerns.

9.10 Dorset CCG is also currently leading a review of the mental health acute care pathway which is running alongside the work of the CSR. It is anticipated that the mental health review will involve a period of public consultation which will run after the CSR public consultation has concluded and will take account of the outcomes of the CSR consultation as appropriate.

10 Conclusion

10.1 The Governing Body is asked approve the recommendations contained within the frontis.

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APPENDICES	
Appendix 1	Who we have involved pre-consultation
Appendix 2	The Need to change
Appendix 3	Transforming urgent and emergency care services in England Urgent and Emergency Care Review End of Phase 1 Report (NHS England November 2013)
Appendix 4	CSR Programme Proposed timetable