



Dorset's Clinical Services Review
shaping your local NHS

Clinical Services Review – Case for Change

4 February 2014

NHS
Dorset
Clinical Commissioning Group

Foreword

As clinical leaders in Dorset, we believe that the case for making changes to how we deliver services in Dorset is compelling and places a clear responsibility on us now to deliver better healthcare that will benefit patients in years to come.

We believe that improving the way our services are delivered will enable better co-ordination of care, ensure that patients and their carers have access to the right help in the right setting and improve quality of care and value for money. Our health system has managed to meet recent financial challenges, however without change it will be unable to continue to do so and we must act now to ensure that future generations continue to receive an excellent standard of care.

As the commissioners of services in Dorset we will take on this challenge. Its scale should not be underestimated, but neither should the rewards of getting this right – better healthcare, more people supported and a more efficient system.

This document has been created to capture the detailed rationale for why we believe services need to change. We have reviewed the evidence and information on how our health system is performing with over a hundred of our leading clinical colleagues and patient groups. We are committed to listen to our patients, carers and staff throughout the process of change and make sure that we are always working to create a system that works, first and foremost, for them.

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Dr Paul French, *Locality Chair for East Bournemouth*

Dr Richard Jenkinson, *Locality Chair for Christchurch*

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Working with:

Poole Hospital NHS Foundation Trust

Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

South Western Ambulance Service NHS Foundation Trust

NHS England

West Hampshire Clinical Commissioning Group

Poole Local Authority

Dorset Local Authority

Bournemouth Local Authority

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The Case for Change

1. SUMMARY

Dorset's healthcare system in general provides a good quality of care for the local population. However, like other areas across England, the local health economy is struggling to provide the best-quality care:

- **People's health needs and expectations are changing** placing different demands on the system. The health status of people nowadays is fundamentally different to that of 20 years ago, let alone 50 years ago when many of our health facilities were established. People are living for far longer, more people are living with chronic diseases and proportionately fewer people suffer heart attacks, strokes, or major accidents – and if they do, they are more likely to survive and only need to spend a few days in hospital. But health care services are not always organised in the best way to support today's healthcare demands. We need to adapt and change services to provide high quality care for people at home or in the community (where clinically appropriate) and to ensure everyone can benefit from modern day medicine and technological advances.
- **Treatments are becoming increasingly specialised** offering the potential to improve quality of care further by enabling access to the latest treatments and techniques whatever the time of day or day of the week – but this does require more specialised services to be based around larger centres in order to enable specialist staff to build their skills and capabilities, and to ensure all patients have access to specialist skills and equipment.
- **The current healthcare system is clinically unsustainable** driven by demand pressures, insufficient level of out of hospital services and staff shortages. Both nationally and in Dorset, there has been an increasing pressure on the urgent care system including emergency departments with increasing number of people being referred to hospitals or attending emergency departments due to lack of alternative care settings. This, combined with a lack of community, rehabilitation and domiciliary facilities suitable to re-able people and speed their discharge from hospitals, have resulted in patients not always receiving the best care possible.
- **The current healthcare system is on the brink of spending more money than it receives** and without change, the situation will get worse. Current services are not set up to enable our staff to work as efficiently or as effectively as they could or to deliver as much health care as could be provided to the population of Dorset if services were better organised.

In order to address these challenges, NHS Dorset Clinical Commissioning Group (CCG) has initiated a Clinical Services Review (CSR) to develop proposals and options for delivering more effective models of care for healthcare services across Dorset, to be tested through public consultation in the future. The review is clinically led and, in developing proposals, clinicians are reviewing and considering research into best practice care as well as data from local providers along with financial analysis and the views and opinions of staff, patients, carers and the public.

2. INTRODUCTION

2.1 Who we are

NHS Dorset Clinical Commissioning Group (CCG) is the main commissioning organisation for the whole county of Dorset. The group is a membership organisation, formed of all 100 local GP practices in the county. Our mission is to support the people of Dorset to lead healthier lives and our principal work is to plan, develop and buy health services on behalf of the local people.

We are responsible for buying:

- Planned hospital care such as outpatients and routine surgery (e.g., hip replacement or cataract removal)
- Urgent and emergency care, including the 111 and 999 services
- Community health services
- Mental health services
- Learning disability services
- Rehabilitation care
- Maternity, children's and family services
- NHS continuing healthcare
- GP prescribed drugs

All 100 GP practices are sub-grouped into 13 locality groups (or geographical areas), which have been involved in commissioning services for the local regions for many years. Each locality has a Locality Chairperson (a local GP), who is also a member of our Governing Body. This ensures our decisions are clinically-led.

NHS England also plans, develops and buys health services for people in Dorset. NHS England is responsible for buying more specialist services, for example cancer services, as well as primary care services including GP practices, dental care, pharmacy and optician services.

2.2 Why we are undertaking this review

The local health economy in Dorset is struggling to provide the best-quality care to the local population. There are several reasons for this.

First, and most importantly, **the health needs of people living in Dorset have changed dramatically** since the time that the current healthcare services were established. Just 30 years ago, the average life expectancy in England was around 72 years for men and 78 years for women, and the most common conditions facing people were injuries, heart attacks and strokes.

Nowadays, people live until they are 90 years or more – indeed some of the parts of the country with the longest life expectancy are in Dorset. And, thanks to healthier lifestyles (in particular, lower rates of smoking), and new treatments such as statins and clot removal/clot busting treatments, death rates from heart disease have halved over the last 20 years.

At the same time we have seen **other changes in our healthcare services** – for example new treatments such as minimally-invasive surgery have completely changed the way in which we treat people with conditions such as gall bladder disease and many cancers. There was a time when people spent three or four weeks in hospital after major surgery; nowadays, it is often three or four days and a large number of patients receiving surgery are discharged on the same day.

Of course, people having better treatment and living longer and healthier lives is good news. But with this comes new types of healthcare needs. We are struggling to meet the needs of an ageing population that suffers from longer-term diseases such as diabetes and dementia. Our current healthcare services now need to adjust to these new demands.

We have money and staff tied up in hospitals and buildings, even though we know we could do far more for people if we could invest more in preventative, primary and community care services. We also know that many acute illnesses, episodes of acute trauma and long-term diseases, can all have an impact on mental health and that we need to get better at managing mental health problems as much as physical ill-health.

There are other compelling reasons to change the way we are working. We recognise that although the population in Dorset generally enjoys a good quality of healthcare services, **not all services are as good as they could be**. There are greater differences than there should be in how well some doctors, nurses and other clinical staff work together, resulting in some patients getting better results than others from their healthcare services. This is as true in GP services as it is in hospital based care. The challenge we face in the future is how to continue to deliver good quality services and improve services where they aren't as good as we would want.

One area of variation is the **time of the day or day of the week**. Data from across the country shows that patients admitted to hospital outside of “normal” working hours do less well than patients admitted when there is a full contingent of senior staff present. Services which have moved to become 24x7 services (e.g. heart attack centres) do not find this variation. A number of emergency services in Dorset do not have consultant staff on site on a 24x7 basis and this may be a factor in contributing to some of the variation seen.

Other challenges come in the form of **new technologies and treatments** which are now available but require staff to be highly experienced in the delivery of those treatments. We know that providing these services requires specialist staff who see sufficient numbers of patients within their niche area to build and maintain their skills. Centres that have staff seeing and managing sufficient patient volumes are getting better results than those which do not.

Furthermore, **our current services are not set up to enable our staff to work as effectively as they could**. We have staff vacancies in some areas and sometimes end up employing expensive agency staff. In other areas we have highly-trained staff doing tasks that other less-trained staff could do. Further, our staff can spend considerable time travelling between facilities, or taking notes, or asking patients and their carers for information that someone else has already collected or asked about. This is not a good use of highly trained staff time and results in gaps in our current services. It can also be detrimental to the patient experience.

Finally, **the current healthcare system is on the brink of spending more money than it receives**. We spend money on some services that do not necessarily result in benefits for patients and we spend money on services that could be provided at higher quality for less money if they were better organised. All the hospitals and community providers in Dorset are expected to spend more money than they receive in 2014/15 and the local health economy is expected to spend between £167m and £240m more than it receives each year by 2020/21, if no further savings and efficiencies are delivered between now and then. Given the wider national picture, there is not going to be sufficient ‘bail out’ funding available and the system must find a way to live within its means. This means that if we were to do nothing, in the future some people will not get the care they could be receiving if the current services were organised more efficiently.

2.3 The national context

None of this is unique to Dorset: other parts of England are facing similar challenges in redesigning services. NHS England is rallying local areas to be proactive and to develop local solutions to address the scale of the change that is required. NHS England and other national bodies recently published the “Five Year Forward View”¹, their own assessment of how the health service is doing and

high level recommendations on what needs to change to improve. The review recommended:

- Substantial expansion in preventative care and public health measures to improve the health status of the population
- A greater focus on supporting people to manage their own care
- The creation of a range of new innovative models to breakdown the boundaries patients experience between primary and secondary care
- The re-design of urgent and emergency care

The recommendations also suggest social care could take on a bigger role in supporting the shift of care outside hospitals, and suggests social care could be embedded in new multispecialty community providers led by GPs or hospitals with joint budgets for health and social care.

Other national guidance supports new, improved models of care, ranging from Royal College Guidance to national reviews such as Sir Bruce Keogh’s review of seven day working. One such document is the “NHS Call to Action”² which notes, “... *We know there is too much unwarranted variation in the quality of care across the country. We must place far greater emphasis on keeping people healthy and well, in order to lead longer, more illness-free lives, preventing rather than treating illness. There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long term conditions. The resulting increase in demand, combined with rising costs, threatens the financial sustainability of the NHS. These issues will need fundamental changes to how we deliver and use health and care services...*”

Dorset CCG agrees with these views and that is why it is taking a proactive, responsible approach to discuss and address these challenges.

3. OUR HEALTH NEEDS ARE CHANGING

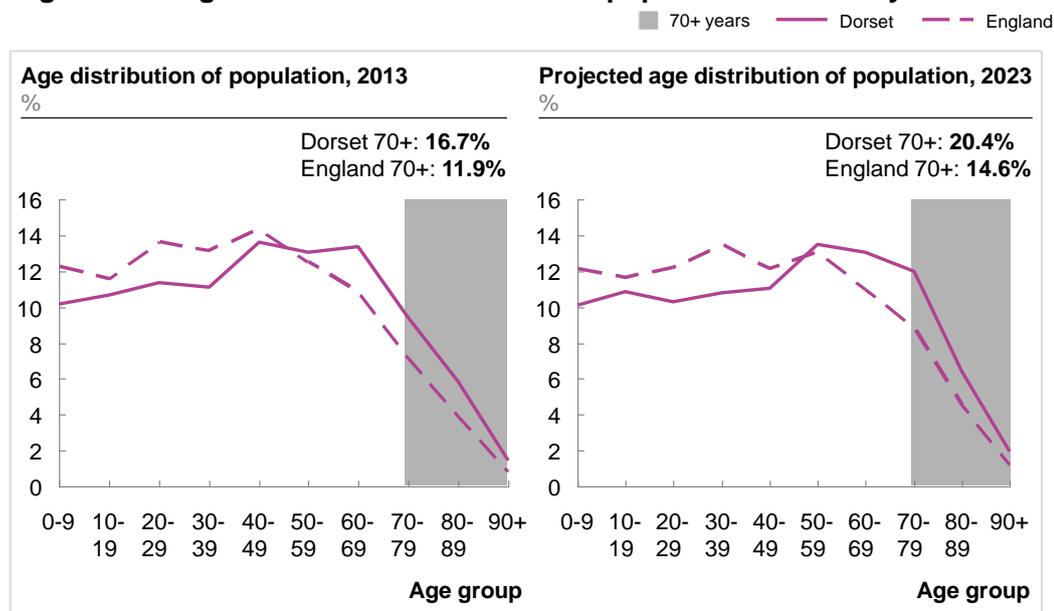
3.1 Demographic and socioeconomic profile

The population of Dorset³ – today around 754,000 – is expected to grow to over 800,000 by 2023. (This annual growth of 0.6% is slightly lower than the overall England average of 0.7%).

The age profile of Dorset is older than the England average: around 17% of the population are over 70 (vs. England average of 12%). The population over 70 is expected to grow four times faster than the growth rate of the total Dorset population, and by 2023 one in every five Dorset residents will be over 70 (an

increase of 30% between 2013 and 2023). At the same time, the core working age population (20-59) is expected to decline by about 1% while children and young people below the age of 20 are expected to grow by 7%.

Dorset’s population will continue to be older than the England average with more than 20% of the population over 70 by 2023



Source: ONS 2012; based on Sub-national Population Projections



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Overall, Dorset’s population enjoys better-than-average social and economic conditions⁴. However, there are some areas where the health needs are far greater, often as a result of greater socio-economic deprivation. For example, men in the most deprived areas of Weymouth & Portland die 11.3 years earlier than those in the least-deprived areas⁵; for men in Bournemouth the gap is 10 years⁶. This means that a man in a deprived area in Weymouth and Portland is expected to die at the age of 73 years rather than 84.3 years and a man in a deprived area in Bournemouth is more likely to die at the age of 74 years rather than 84 years.

3.2 Disease profile

In general Dorset’s population enjoys better-than-average health— for example there are relatively low rates of smoking prevalence and obese children. However, there are some health behaviours which are more problematic than in other parts of the country. For example a relatively high number of women smoke while pregnant and flu vaccination coverage for those aged over 65 or at-risk is not as good as it could be⁷.

With old age comes the increased likelihood of having a long-term condition or becoming frail. Dorset's current disease prevalence profile reflects its older population with a higher prevalence of hypertension and coronary heart disease (CHD)⁸. Rates of diabetes, stroke and heart disease are expected to grow faster than the South West or the England average. By 2020, around 1 in 10 of the population could have diabetes and around 1 in 8 could have CHD⁹.

3.3 Projected demand for healthcare

The ageing population and increasing numbers of people with long-term conditions will result in increased demand for healthcare services.

If we do nothing, these factors combined would result in an increase in A&E attendances of 22% and of hospital admissions of 30% in 10 years time¹⁰. For out of hospital settings, these factors would result in an increase in GP contacts¹¹ by 26% and community care referrals and first contacts¹² by 24%.

3.4. Public expectations for services into the future

Dorset CCG and the local authorities have conducted numerous patient and public surveys and focus groups, most notably recently "the Big Ask"¹³, in order to understand patients' and carers' needs and preferences and how well the current system is meeting these needs.

Overall, people would like to see easier and more available access to care while at the same time recognising the importance of specialist care.

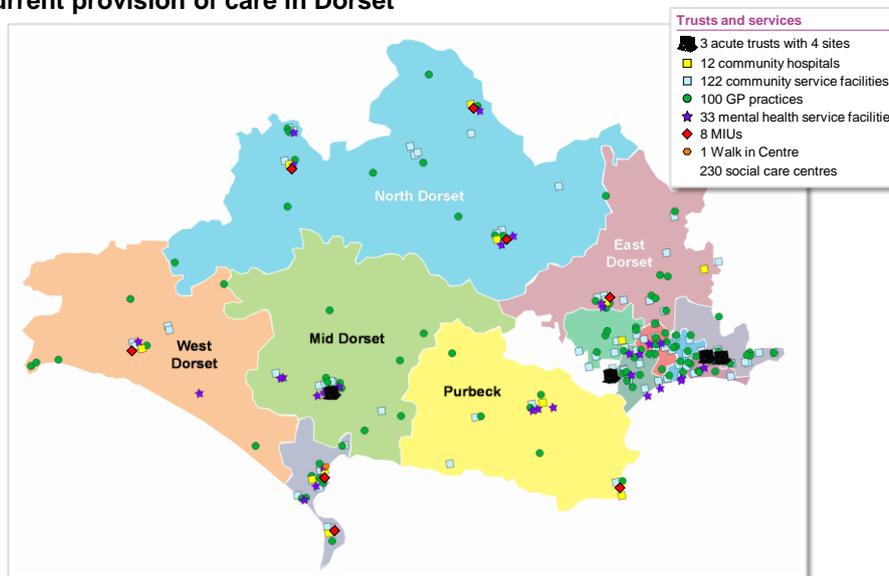
More specifically they would like to see:

- Reduced variation across GP practices, with all practices offering consistent out-of-hours services
- More services (including blood tests and physiotherapy) to be provided in local settings such as community hospitals and GP practices with longer opening hours
- Consultant-led services in hospitals available seven days a week even if patients need to travel further to receive those services
- Specialist centres, to which patients would be willing to travel in order to get the best treatment.
- Despite this willingness to travel, transport options and associated costs are significant concerns (both for the patients and visiting relatives)
- Better communication between hospitals and GP practices and between specialist centres and general hospitals.

4. OUR CURRENT QUALITY OF CARE DELIVERY

NHS health services for the population of Dorset are currently provided by 100 GP practices, other primary care services such as dentistry, pharmacies and opticians, three main acute hospitals (Dorset County, Poole General and the Royal Bournemouth), 12 community hospitals and a range of community and mental health services. Ambulance and telephone advice services are provided by South Western Ambulance Services NHS Foundation Trust. In addition, healthcare services interface with adult and children's social services provided by the three local authorities (Bournemouth, Poole and Dorset). We also recognise the contribution of informal carers and the many voluntary and support organisations that work across Dorset to support people with their health and care needs.

Current provision of care in Dorset



SOURCES: Dorset Healthcare
Dorset's Clinical Services Review
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Some residents of Dorset use hospital services in neighbouring areas, especially Salisbury and Yeovil Hospitals, and each year a small number of patients receive more specialist services at Southampton, Bristol, Exeter and centres further afield.

Overall, services are currently delivering a good quality of care most of the time. However, there are areas for improvement and the system cannot afford to be complacent given the growing challenges as outlined in the following sections.

4.1. GP practices

Across Dorset, there are around 642 GPs working from 100 practices across 13 localities. Practices vary significantly in size, from single-handed GP practices to practices with 12 GPs working from one site. The number of people registered per

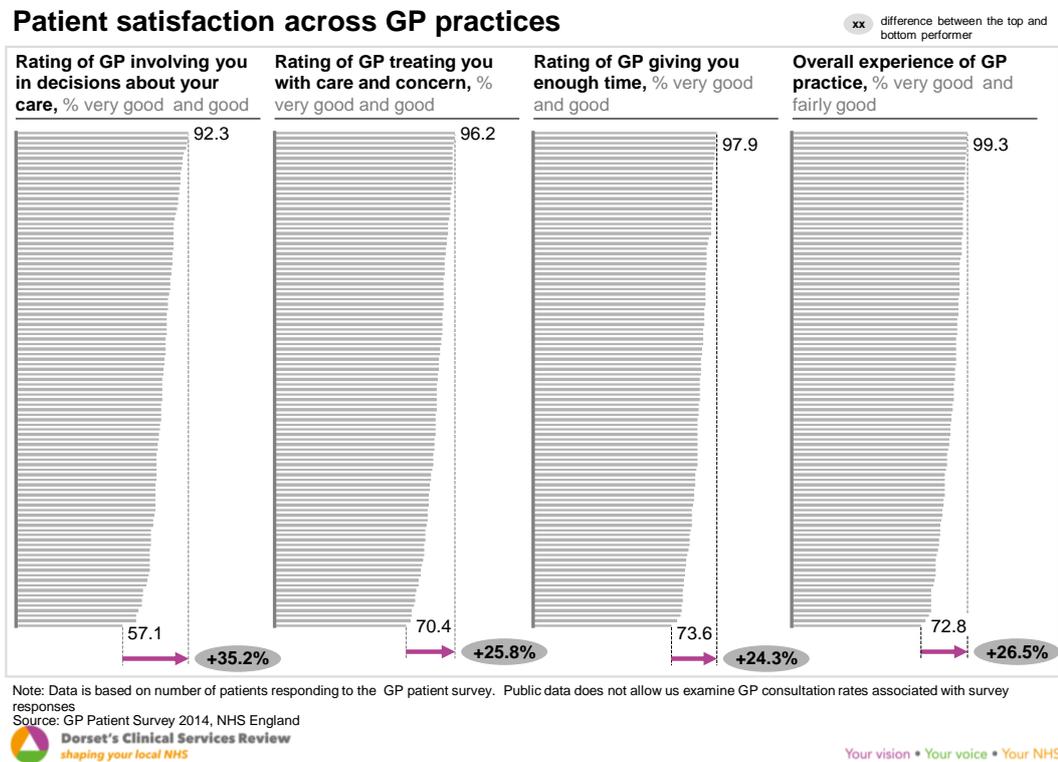
GP (adjusted to take into account that some work part time) also varies widely from practice to practice, ranging from under 1,000 to over 4,000 people registered with a whole time equivalent (WTE) GP.

Most of the GP practices in Dorset have core opening hours between 08:00 and 18:30. Provision of extended hours appointments is highly variable with a large number of practices providing extended hours on a one day or part week basis. Only a few practices have extended opening across the whole week. The majority of extended opening is offered in the evening with only small numbers providing early appointments (i.e., before 08:00). Most practices are closed at weekends but there are a number that do provide reduced services on a Saturday only. There are a small number of schemes that are run on a locality, or federated, basis which enable access to health services on Saturdays. For the most part there is no Sunday opening across Dorset.

Given the geographical characteristics of Dorset, with pockets of rural areas where reasonable public transport options are limited, some of the local communities rely significantly on their GP practices for the majority of their healthcare provision.

There are significant variations in how patients rate their GP practice¹⁴ – see graphic below. This was echoed by the key findings from the “Big Ask” (as outlined above).

Patient satisfaction across GP practices



Dorset has a high rate of emergency admissions to hospital – particularly for the over 65s where Dorset has a rate 16% higher than the England average¹⁵. These overall figures mask a significant difference between GP practices – some practices are admitting nearly twice as many of their patients to hospital as other practices even after adjustment for socio-demographic differences.

There are also significant variations in the quality of care provided by GP practices in Dorset. For example, across Dorset people with diabetes are not receiving as good care as they could be, with a number of practices not ensuring patients receive regular health checks and the right treatments¹⁶. This can result in a number of people having higher rates of blood sugar than they should⁸, which in turn causes kidney failure, heart disease, serious eye problems and amputation of feet and legs.

Outside the standard opening hours, general practice is available through the 111 service offered by the South Western Ambulance Services NHS FT. Out-of-hours services saw some of the largest variations across GP practices in Dorset in terms of ease of access, perceived speed of services and overall patient experience¹⁷. When the public in Dorset was asked to provide comments regarding “when services are provided”, GP out-of-hour services was one of the key areas where the public expressed expectations for better availability.

4.2. Community and mental health services

Community and mental health services are mainly provided by Dorset Healthcare University Hospital FT from community hospitals and through a range of community and home-based services.

A study conducted by the Oak Group¹⁸ showed that over 60% of the admissions into the community hospitals are from the three main acute hospitals. A high proportion of these admissions are not considered necessary, and over 50% of the bed days are currently due to these “inappropriate admissions” and / or continuing stays which could have been provided elsewhere. Other health systems, such as Torbay, have found that nursing home placements can be significantly reduced through an intensive period of rehabilitation and assessment at home. The majority of the community beds could be better used as half of the beds are currently being occupied by patients who could be cared for at home and a third could be cared for in nursing homes. This would be better for patients – we know that people find it easier to maintain their own independence when they are supported to live at home and suffer less confusion and disorientation than when they are in a longer-term place of stay. This is backed up by academic evidence that shows that the longer an elderly person stays in hospital, the less likely they are to return to live independently in their home. This is especially true for the frail elderly¹⁹.

Other community services, including district nurses, health visitors, chiropodists and occupational therapists, provide a crucial part of the healthcare landscape. But community staff are often not supported to work as efficiently and effectively as they could be. For example, they often don't have immediate access to patients' health records and so waste time trying to find out about people's health status and previous conditions; they sometimes find that long journeys are wasted because a patient has been admitted to hospital or is being seen by someone else; and sometimes their extensive training and skills are not used as well as they could be.

Many patients with physical long-term conditions can also experience depression, anxiety and other mental health problems and, similarly, patients with serious mental illness have significantly increased mortality due to physical health issues. Currently services are not equally focussed on improving the mental health of patients as they are on improving their physical health and many people with mental health conditions are treated in an inequitable manner by physical health services.

Although the Dorset population generally enjoy a good level of access to mental health services, in some areas services could be improved. For example:

- A relatively low proportion of patients on the Care Programme Approach were followed up within seven days after discharge from psychiatric inpatient care²⁰
- Psychiatric Liaison Services play a key role in helping support patients with medically unexplained symptoms, reducing the need for costly physical admissions and investigations. There is a small dedicated consultant-led psychiatric liaison service in both Poole General Hospital and The Royal Bournemouth Hospital between nine to five, Monday to Friday, but no support at the Dorset County Hospital. Outside the working week, there is only limited support, often leading to trade-offs between supporting the demand from patients at A&E or the demand of patients and their carers in crisis at home.

The provision of Child and Adolescent Mental Health Services (CAMHS) is recognised nationally as needing to improve. NHS England's review of CAMHS tier 4 (most serious) services²¹ was triggered by reports of acutely ill children having to be transferred to mental health trusts far away from home, and even being admitted onto adult mental health wards. The shortage of beds in CAMHS tier 4 services across the country had also been caused by children "being inappropriately admitted to specialised units" as a result of "gaps in CAMHS tier 3 services and other local health and social service provision" and "weaknesses in commissioning and case management" in tiers 1-3 services. Dorset can do more to prevent childhood mental illness becoming a chronic condition for people in their adult lives.

4.3. Acute hospital provision

Hospitals broadly provide three types of healthcare that require specialist skills and knowledge not available in general practice or in the community:

- Emergency care – accident and emergency (A&E) departments, and emergency admissions to hospital
- Planned and specialist care for example outpatients, diagnostic tests and planned (or elective) surgery
- Maternity (including obstetric) care and paediatrics (children’s care).

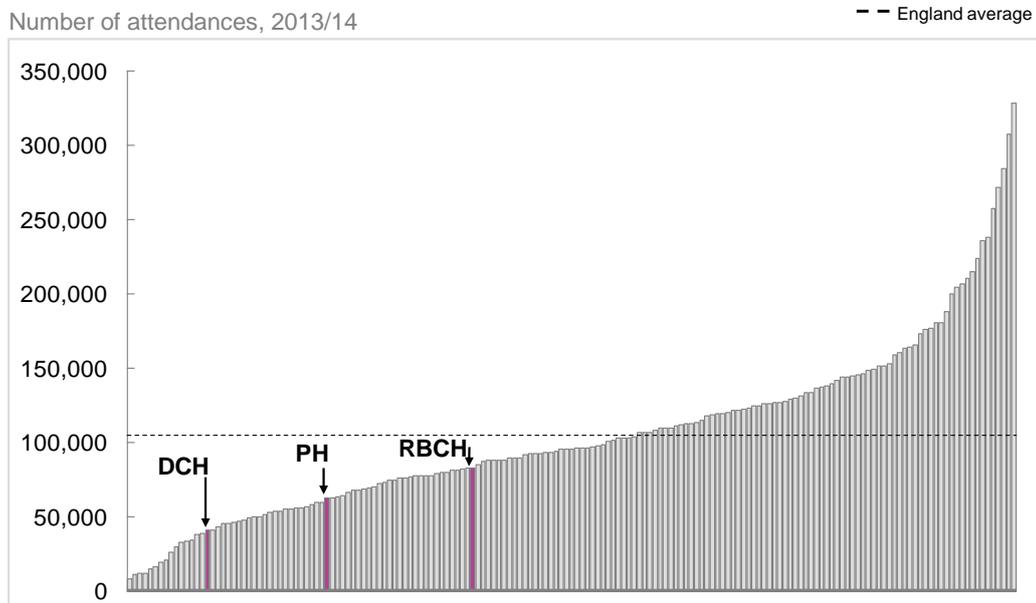
However, there are elements of these services that can be offered by community and GP providers such as providing diagnostic tests in a GP practice or a community hospital or outreach specialist appointments.

The three areas are often interdependent, and all rely on support services such as diagnostic services (x-ray, CT and other imaging services as well as blood tests and pathology services) and intensive care units.

The three main acute trusts have similar and over-lapping service provision. All are relatively small compared to other hospitals in England.

(a) *Emergency care*

A&E attendances by Trust



Source: HES 2013/14

A&E attendances across the three acute trusts have increased over the past few years, in line with other parts of the country²². The reasons are often debated, but what is clear is that a large number (over half) of people attending A&E departments have minor conditions, with a number of them requiring no investigation or significant treatment. This is particularly the case at Poole General Hospital where one third of people attending the A&E department required no investigation or significant treatment.

We know that if we do not provide an adequate or responsive service to those with less serious, but nevertheless urgent care needs, we risk allowing such problems to become worse. We also know that a failure to meet people's needs outside of hospital results in them seeking help from those services that are highly responsive – particularly A&E.

This is not good for patients as the current model of A&E departments does not enable doctors and nurses to understand an individual's health condition and background (they do not have access to patients' GP records) and does not provide an opportunity to make sure that various preventative measures (e.g., cervical screening tests or breast screening tests) are up to date. It also prevents those with major emergencies being seen as quickly as they could be.

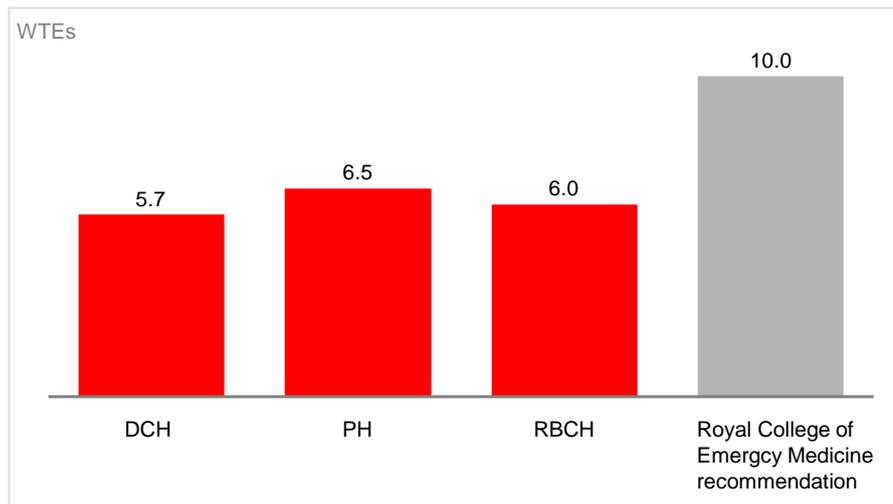
Most urgent care problems are not life-threatening, but for a number of people can be made worse by multiple long term conditions that can deteriorate overtime. For these problems, people may need help and advice or treatments delivered as close to home as possible.

Current quality of care for patients admitted as an emergency is not as good as it could be. This is particularly true for people needing emergency surgery where the three hospitals do not meet national standards for high quality services²³ (e.g., formal calculation of risk of peri-operative mortality, explicit arrangements of review by elderly medicine). This is partly due to them being relatively small units and so having too few highly-experienced senior doctors and associated staff to provide a service around the clock. National research has found that patients admitted to hospital outside of "normal working hours" do less well than patients admitted during the day on Monday-Friday.

As emergencies can happen at any time of the day or night, there needs to be round the clock consultant cover for each hospital accepting emergencies. For instance, the Royal College of Emergency Medicine recommends having Emergency Medicine Consultant presence in any full Emergency Department at least 16 hours a day, 7 days a week. To run a rota of this duration takes at least 10 consultants per Emergency Department. However currently the Dorset hospitals are operating with lower numbers of consultants than this recommended level: Dorset County Hospital has 5.7 Emergency Medicine consultants, Poole General

Hospital has 6.5 Emergency Medicine consultants and Royal Bournemouth Hospital has 6 Emergency Medicine consultants.

Current emergency medicine consultants across the three acute Trusts vs. the Royal College of Emergency Medicine recommendation

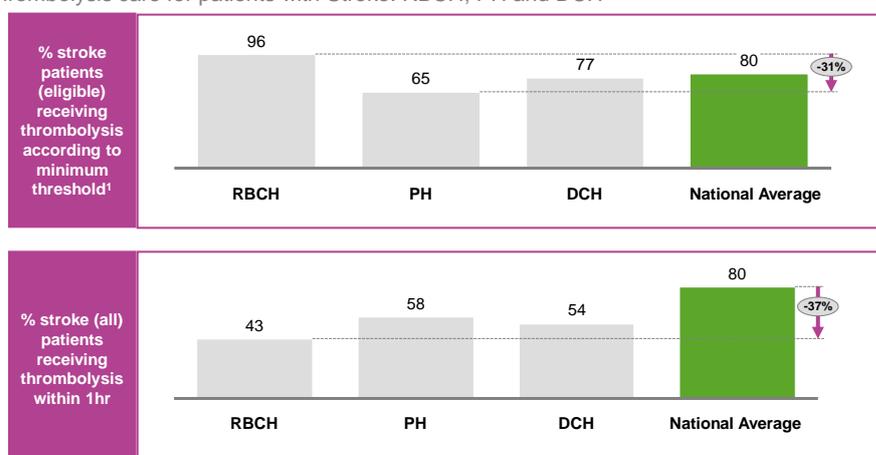


Source: Workforce data from the Trusts (January 2015); Royal College of Emergency Medicine

Emergency treatment for people having a stroke in Dorset is also not as good as it could be. National audits reveal that the percentage of eligible stroke patients receiving thrombolysis varies from hospital to hospital, while the percentage receiving treatment within the crucial first hour is considerably below the national average potentially leading to poorer outcomes for stroke patients.

Quality of care for Stroke patients

Thrombolysis care for patients with Stroke: RBCH, PH and DCH



¹ Eligible patients: patient aged < 80 yrs where onset of stroke to hospital arrival is 3.5hrs, patients where patients aged 80+ where onset stroke to arrival is 2hr

Source: SSNAP April - June 2014

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In acute cardiac care a critical factor influencing patient outcomes is the time it takes for a patient to receive primary percutaneous coronary intervention (PPCI) having had a heart attack. In Dorset some units perform less well than in other parts of the country²⁷. Furthermore, for patients with more complex heart conditions (for example those with a non ST elevated myocardial infarction or n-STEMI), research suggests that being admitted to specialist cardiac units under the care of a consultant cardiologist results in better outcomes for patients. This is not currently the case for all patients in Dorset²⁷.

When people are admitted as an emergency to hospital, in recent years, they have ended up staying longer. This can be due to difficulties in discharging elderly people to home and can result in a deterioration of their condition with the risk of falls, infection, increasing confusion and pressure ulcers. Patients have a higher risk than the England average of developing pressure ulcers in some Dorset Hospitals²⁴.

Delays in moving patients out of hospital beds are predominately due to waiting for further NHS non-acute (community) care, residential home placement, nursing home placement or care packages in their own homes²⁵. These longer lengths of stay occupy facilities and consume resources that could be redirected to provide alternative and more appropriate care to support the people of Dorset.

(b) Planned and specialist care

Access to planned care services is good across Dorset with the majority of services meeting the national target of 95% of patients treated from referral by their GP within 18 weeks²⁸.

There are some variations in the outcomes across the three hospitals, most notably in cancer management. For example the percentage of people with bowel cancer who die within 90 days of treatment varies from 2.7% to 5.5% across the county²⁹ – this compares to an average of 4.3% for England as a whole. There are similar variations in the treatments offered to patients with lung cancer and other serious diseases³⁰.

Medical research shows that specialist doctors who provide care for larger numbers of patients with a particular condition achieve better results than those who only see a small number. The Keogh report³¹ says “*For highly specialised services, there is a clear relationship between the volume of activity experienced in a service and clinical outcomes*”.

Nationally and internationally, this is leading to the creation of specialist centres able to build expertise amongst the staff and invest in the latest technology. Several specialist services in the hospitals across Dorset operate independently rather than as a network, resulting in dependency on single individuals or, for some sub-speciality areas, not having an expert within the Dorset region.

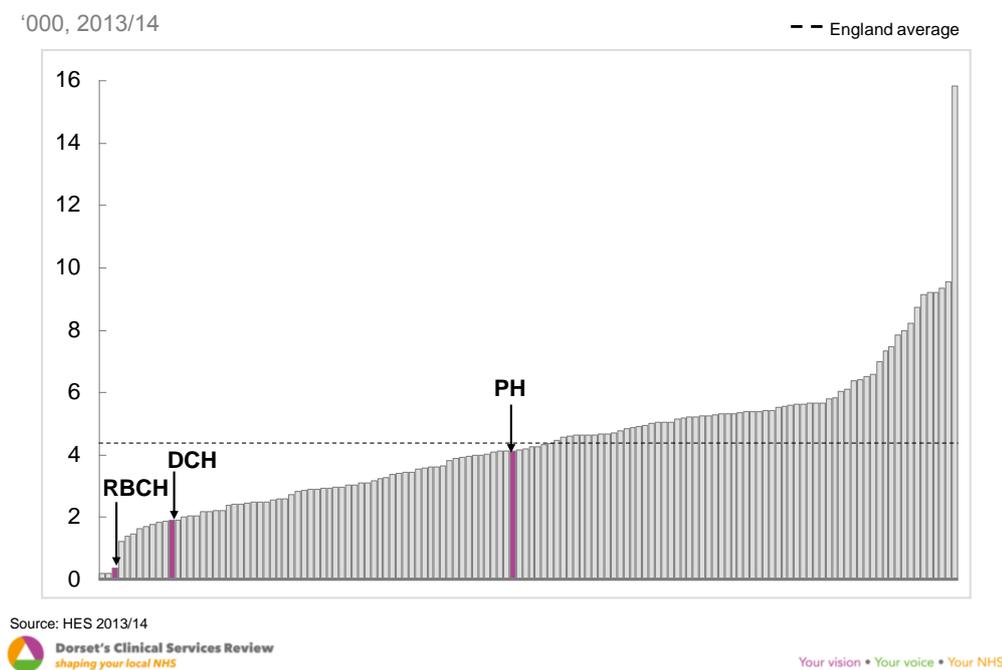
(c) Maternity, Obstetric and Paediatric care

Pregnancy is a normal physical process and for the vast majority of women is a safe event. Midwifery led care should be provided for women with straightforward pregnancies.

There are consultant obstetrician led units at Dorset County Hospital and Poole General Hospital: Dorset County Hospital is classed as a small unit, delivering around 2,000 births per year, and having 40 hours on-site consultant cover per week. Midwives deliver the lower risk births. Poole General Hospital is a larger unit, with around 5,000 births per year, and has 60 hours of on-site obstetrician cover per week. Poole General Hospital also has an alongside midwife-led unit, delivering over 700 births per year.

Royal Bournemouth Hospital has a freestanding midwife-led unit, delivering fewer than 500 births per year (a midwife to birth ratio of 1 to 10³²). There is no consultant cover at Royal Bournemouth Hospital so any women who develop complications in labour need to be transferred to Poole General Hospital. There are a small number of women from Dorset who deliver at Yeovil and Salisbury Hospitals.

Maternity deliveries by Trust



Nationally, senior decision making has been shown to improve outcomes and safety and there is a national drive to increase the number of consultant obstetrician hours on labour wards. Women are at least as likely to go into labour at night as during the day and at weekends as well as during the week but the current model of staffing means that between 62% and 76% of the time there is not a consultant obstetrician on the labour ward.

Dorset County Hospital and Poole General Hospital both operate paediatric inpatient units with over 16,000 unplanned admissions²³. However a large proportion of unplanned admissions are for less than 24 hours (over 40% in both hospitals) suggesting that these are largely for observation rather than intervention. Nationally, there has been a 28% increase in unplanned admissions in the last 10 years, almost entirely short stay admissions of under 24 hours³³ and often because of an “ambulatory-care-sensitive” condition such as respiratory tract infections and gastroenteritis. The increasing numbers of acute admissions does not reflect increasing numbers of sick children as the number of childhood deaths (for those under 14) decreased by 17% between 1999 and 2012 in England and Wales³⁴.

There are no paediatric services at Royal Bournemouth Hospital other than elective surgery, and no facilities for paediatric emergencies.

4.4. The interface between services

The Clinical Services Review is in line with the vision set out in NHS England’s ‘Five Year Forward View’¹, with regards to ensuring seamless interfaces between

services and across settings for patients. The ‘Forward View’ describes how provider organisations can work together to help make this happen. One of the proposed approaches describes groups of GPs working with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the Multispecialty Community Provider. Another approach describes an integrated hospital and primary care provider – a Primary and Acute Care System - combining for the first time general practice and hospital services, similar to Accountable Care Organisations that have been adopted by other countries. These new national models are being discussed and explored locally as part of the Clinical Services Review discussions.

4.5. The interface with transport services

Ease of access to health care services in Dorset is varied and can be challenging for some local people:

- Many people have access to private transport. Car ownership in Dorset is higher (61%) than the England average³⁵.
- Due to the rural nature of some areas in Dorset, there are constraints on access to public transport and public services – for example over 15% of the population has no easily accessible public transport connection to an acute hospital or takes more than 90 minutes to the nearest acute hospital via public transport. The lack of public transport is particularly extreme in rural areas, with just under 50% of the population in West Dorset and around 30% in North Dorset having no easily accessible public transport options to acute hospitals or taking more than 90 minutes to the nearest acute hospital via public transport³⁶.
- The majority of people are physically able to leave their house (number of housebound people per 1,000 population is 4.2 in Dorset Local Authority, 1.9 in Poole Local Authority and 2.6 in Bournemouth Local Authority³⁷). Therefore for those without access to private transport or public transport, there is the possibility to provide more tailored transport services. The voluntary sector is already supporting some GP practices in Dorset, providing volunteer transport services.

4.6. The interface with local authority provision

While decisions about social care budgets are not within the scope of this review, the linkage between social services and health care is being considered.

Many clinicians across Dorset, along with patients and their families, point to the lack of integration between different parts of the healthcare system and between health and social care services.

Specifically, there are concerns about delayed discharges from hospital which can be attributable to difficulty accessing adult social care services and the difference in funding sources, with NHS care being free at the point of delivery while many aspects of social care (after the first 4-6 weeks of re-ablement) are not. These delays impact negatively on patients, increasing the risk of confusion, falls or hospital acquired infections, and result in inefficient use of health and social care resources.

The CCG has joint contracts with a number of residential home, care home and domiciliary care providers within Dorset, Bournemouth and Poole. Issues regarding significant shortfalls of available workforce, staff competencies in relation to registered nurse capabilities and a transient workforce are having major impacts on delivering high quality care. Furthermore, residential and care home owners are also facing significant financial challenges and a number of banks have started to call in loans previously provided to purchase care homes.

Establishment of Better Care Funds between the CCG and the local authorities supports the integration of healthcare and social care, and, in effect, redirects funding away from urgent and emergency care towards early intervention and care planning (or potentially the cross-subsidy of some aspects of social care). Examples nationally include early intervention and prevention schemes, helping people to stay independent for longer and receive care and support in their homes or closer to their homes, and support to delay the need for long-term care and unnecessary hospital admissions. There is also a strong focus on extending the shared information and advice service open to everyone, providing signposting so that people can access the services and support that they need. This includes services for people leaving hospital and more help in arranging services for people who fund their own care.

A number of initiatives locally are already underway, including those looking at urgent care, information and advice, services for people leaving hospital and developing integrated locality teams.

Furthermore, there is joint work between the three local authorities (Dorset, Poole, and Bournemouth) and Dorset CCG's Clinical Commissioning Programmes with several jointly established workstreams.

5. OUR WORKFORCE CHALLENGES

Dorset is facing a number of workforce challenges both within hospitals and outside of hospitals that need to be addressed.

Nationally, and within Dorset, there is a shortage of key workforce groups such as emergency medicine trainees and consultants. Many hospitals are struggling to recruit to substantive consultant posts in emergency medicine, paediatrics and other specialties. This results in an over-reliance on short term 'locum' or agency staff who are significantly more expensive (they are paid on day rates rather than provided a salary) and in addition incur additional training costs and administration costs for organisations. Royal Bournemouth Hospital spends 4.9% of its total staff costs on agency staff while Dorset County Hospital and Poole General Hospital spend 2.8% and 1.7% respectively³⁸. As a result this is a less cost effective workforce model.

Furthermore, specialist resources are spread across the three acute hospitals making it difficult for each hospital to ensure that consultants are present (as part of a rota) to deliver and direct care seven days per week and up to 24 hours per day as mentioned in the earlier section. This means there are worse outcomes for patients who become ill or sustain an injury at evenings and weekends.

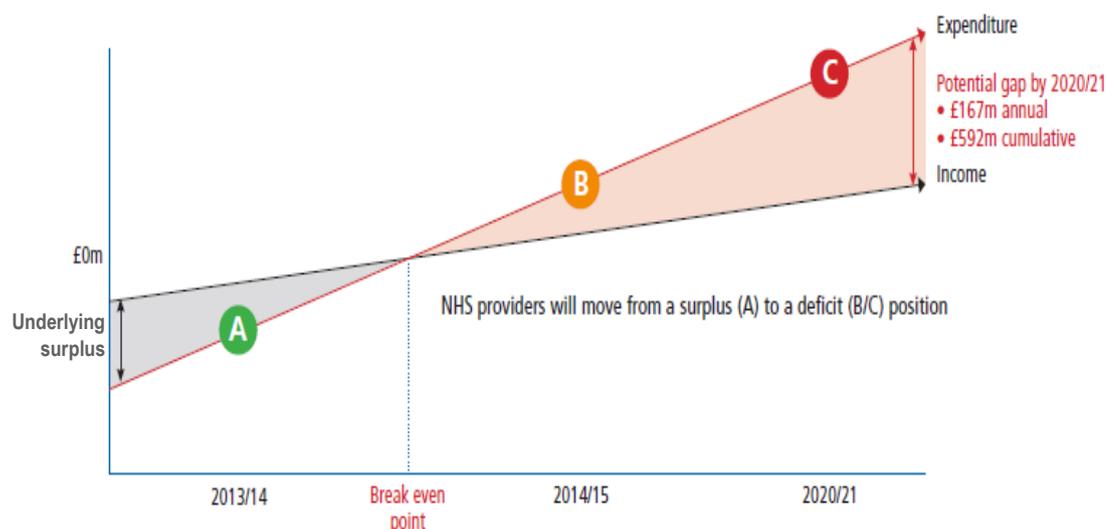
A rota that covers 24 hours a day for 7 days a week requires a minimum of 8-10 consultants. However addressing this challenge is not simply a question of funding more posts as in order to maintain skills, each consultant needs to be seeing a sufficient number of patients. So, even if staff were available, and even if we wanted to spend our limited resources on them, they would not be able to gain sufficient experience to maintain their specialist skills in the current model of care.

The GP workforce is also under pressure across Dorset, with many practices failing to recruit to posts and failure to fill training posts. There is also recognition that there is an impending challenge as many GPs approach retirement age. However, again it is not simply a case of seeking to train and employ more GPs. National and international research suggests that multi-disciplinary teams, often led by a doctor but including a range of professional staff, can achieve better results than GPs working by themselves.

6. OUR GROWING FINANCIAL CHALLENGE

In England, continuing with the current model of care will result in the NHS facing a funding gap – between income and expenditure – of around £30bn (approximately 22% of projected costs) in 2020/21. In Dorset the figure for the same period is calculated at between £167m and £200m per year, depending on the demands on the service and inflation costs.

Our money - ensuring affordability now and in the future



Source: Dorset CCG

 Dorset's Clinical Services Review
shaping your local NHS

Your vision • Your voice • Your NHS

The above figures drive the need for year on year efficiency targets that need to build on top of each other every year; therefore the challenge to the NHS becomes significantly greater. Traditional productivity improvements (e.g., cutting costs of supplies), will not be enough to plug the future funding gap. NHS England's analysis suggests that the overall efficiency challenge will increase to 5-6% by 2015/16, just to keep pace with reduced resources and rising demand and costs.

Health care services in Dorset are subject to national requirements and improvements such as ensuring easier access to high quality primary and community care, better performance management, reducing length of stay in all hospitals, keeping the pay bill manageable by spending wisely on locum and agency staff, reducing duplication, improving information management and better procurement practices all have a role to play in keeping health spending manageable and showing value for money.

The five main provider Trusts (including the ambulance service) in the area are coming under increased financial pressure. Due to increased activity and new expenses incurred to meet clinically mandated minimum staff numbers the hospitals are now projecting a combined forecast underlying deficit of £16.6m in 14/15. Looking to the future this deficit is set to increase. Cost inflation and the need to meet new clinical service standards will drive up the cost to deliver

services. At the same time increased activity together with a tariff (price) deflator applied nationally means hospitals will receive less money than they currently receive for the activity they will carry out in the future.

In addition, recent spending settlements for local government have not kept pace with demand for social care services. Unlike health funding, social care funding is not protected by a 'ring-fence'. Local authorities have to decide how much of their budget to spend on local need, and this competes with essential services such as street lighting, bin collection and housing services etc. As a result, financially challenged councils have (in some locations), felt compelled to reduce spend on social care.

Reduced social care funding and the pressure on social care due to increasing population needs can drive up demand for health services, with cost implications for the NHS. The CCG is already having to take on a greater burden of this through the increased requirements of 'continuing healthcare' services. We therefore need to consider how health and social care spending is best allocated in order to provide integrated services.

We need to look at our health spending and how investment in prevention and primary/community care may be increased over time. Partnering with Public Health, working with local authorities, Health & Wellbeing Boards, and the voluntary sector and refocusing the workforce on prevention (where we can), will help shape services that are better able to support people in primary and community care settings.

7. COLLECTIVELY WE CAN RISE TO THE CHALLENGE

7.1. Clinical Services Review

Dorset health and social care services are facing the same pressures locally as other parts of the country are nationally, and incrementally improving the current system will not be enough. We are expecting a 6% rise in population between 2012 and 2020; more importantly a 60% increase in over 65s in the same period. Currently we know that about 1 in 5 people in Dorset are living with a long term condition or disability that affects their health. In order to meet these challenges and improve the quality of care provided across Dorset we need to review and redesign our services, changing the way they are provided across our hospitals, GP practices and other community care sites.

We need to ensure that people in Dorset have access to the right care in the right places, supported by the right infrastructure - balancing the time it takes to travel across the county with the need to see the right healthcare professionals. Higher quality, more effective treatments for patients need to be provided more

consistently where they are needed. Care needs to be provided in a more integrated way, in partnership with social services and local government, so that it is clear to patients and their carers who is managing their care and that they can seamlessly transition between care settings and care providers.

More investment needs to be made in out of hospital services, so that care is more consistent and of a higher standard, bringing better routine treatments closer to home and supporting more services outside hospitals, where they are needed. Alongside this, clinical teams need to be established so patients needing specialist treatment can be certain they will be seen by experienced specialist clinicians, who are familiar with, and who regularly treat, patients with similar conditions.

This also implies the need to look at more efficient use of NHS buildings and equipment and more targeted investment in both, as well as reduced management costs by planning care across a larger area and achieving savings on a larger scale.

Redesigning services will enable us to improve the quality of services and increase quality of life and life expectancy within the resources available.

Dorset CCG is undertaking a Clinical Services Review to consider how the case for change can be best addressed by identifying potential options for future ways of delivering care in Dorset. The health care system must change to make improvements in quality and to ensure that the money available for NHS services is used efficiently and effectively to get the most health 'gain' for local people.

The review is being led by clinicians from primary, acute and community care working across Dorset and involves patients, their carers and the public along with health and care leaders.

Four clinical working groups have been established: 'Maternity and paediatrics' (family health & children's care), 'Planned and specialist care', 'Urgent and emergency care' and 'Care for frail elderly people and for people with long term conditions' with GPs, consultants, nurses, paramedics, allied health professionals and other expert clinician members. The groups will provide the CCG Governing Body with advice on how Dorset's health and social care professionals believe services should be developed to meet the needs of the people in Dorset.

In addition the review has established a Patient and Public Engagement Group to help critique, challenge and advise on the work from a patient, carer and public perspective as it progresses through the initial evidence gathering and design stage.

It is the statutory responsibility of the health service commissioners, the CCG Governing Body and NHS England, to commission the services that are needed to best support the population of Dorset. The commissioners will review the potential service options developed by the Clinical Working Groups and will actively seek the opinions of the public and local providers through a formal period of

consultation prior to taking any decisions about the pattern of services they wish to commission in the future.

A number of principles underpinning the CSR have been identified – these are:

- Putting patients and the public first: the review will provide proposals that lead directly to improved outcomes, reduced health inequalities and more efficient models of care.
- Change must be clinically led, taking account of a wealth of information including patient, carer and public insight and research, and their feedback on ‘what matters’, and underpinned by a clear, clinical evidence-base. Clinicians have a key responsibility to build support within the local clinical community on the case for change.
- Each proposal or recommendation should be tailored to local circumstances.
- Commissioners (Dorset CCG and NHS England) have a leading role in the design and development of proposals coming from the CSR and must decide how best to secure services that meet patients’ needs, including ensuring patients have a choice of services and providers as per government health policy.
- Local authorities are essential partners; through Health & Wellbeing Boards, joint Health & Wellbeing Strategies, Health Overview Scrutiny Committees and the integration agenda (Better Together programme).
- Effective partnership working between commissioners and providers will underpin the success of the review.

The review has no predetermined solutions or options. Bold, new thinking is needed and a wide range of potential answers needs to be considered. We will continue to listen and recognise the importance of patient, carer, public and staff feedback as we consider these.

7.2. Conclusion

It is imperative that commissioners and providers collectively work together to consider changes that could improve the standard of care for our local population. This is about improving quality of care and spending the available funding for healthcare in Dorset wisely for maximum health gain for the local population.

We can either sit back and keep a model of NHS care that is destined to fall behind the needs of our patients and their carers and become increasingly unaffordable, or, as NHS England is encouraging us to, work together to consider ways to change things now and offer all members of our society the best care we can give them.

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