Dorset Clinical Commissioning Group

DRAFT Operational Plan 2017/18 to 2018/19

November 2016

Contents

Introduction

Welcome to our 2017/18 to 2018/19 Operational Plan, which builds on the successes we have seen and sets out what we need to do over the next two years to meet the scale of challenges we face.

The last twelve months have seen us continue to grow and develop into an organisation that is confident to face the challenges ahead and has the experience to make some potentially major decisions about healthcare in the local area to achieve our ambition.

We have a successful track record and strong commitment to collaborative working across our health and care system, acting as one integrated health and care system. This has enabled us to work together as the Dorset Sustainability and Transformation Plan (STP) footprint and to develop 'Our Dorset' STP (page 7) and puts us in an excellent position to deliver it.

Our plan responds to and has been informed by:

- national NHS policy and guidance- NHS Operational Planning and Contacting guidance 2017 – 2019;
- 'Our Dorset' Sustainability Transformation Plan (STP);
- the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy; and
- the NHS Constitution; and
- benchmarking resources, in particular the NHS RightCare 'Commissioning for Value'.

The plan sets out the high level work programmes for how; over the next two years we will work with partners across the system to:

- drive forward transformation and deliver our vision set out in our STP
- deliver the national priorities;
- improve health and wellbeing;
- improve quality of care and
- improve efficiency and productivity;

The plan recognises the need to ensure that robust and sustainable financial performance is maintained alongside the delivery of safe and high quality service and outlines the key funding allocation and financial challenges for the CCG.

Our plan is underpinned by detailed activity and financial, trajectories, supported by workforce and digital plans. Performance will be managed through the CCG's governance structures and as a system through the Systems Leadership Team.

'Our Dorset'- Sustainability and Transformation Plan on a Page

Vision: provide services to meet the needs of local people and deliver better outcomes

Our Challenges

Health and Wellbeing – Variation in health and wellbeing outcomes for different people across Dorset
Care and Quality – Difference in the quality of care received by people across our area and short comings in reaching national standards
Finance and Efficiency – Increasing pressure on resources within the system- annual financial gap of £229m within the Dorset health system, with further £20m shortfall in NHS England Specialist Services and shortages of some staff.

Our programmes and priorities

Prevention at Scale – will help people to stay healthy and avoid getting unwell through:

- *Tackling wider determinants of health*
- *Upgrading primary prevention*
- *Extending secondary prevention*
- *Supporting people to live independently*

Integrated Community Services – support individuals who are unwell by providing care at home or in the community through:

- *Integrating health and social care*
- *Developing Community Hubs**
- *Ensuring sustainable Primary Care*
- *Developing Urgent Care**
- *Transforming Mental Health and Learning Disability Services*

One Acute Network – will help those who need the most specialist support through a single acute care system across Dorset

- *Acute Reconfiguration**
- *One NHS in Dorset (Acute Vanguard) – includes transforming:*
  - *Cancer*
  - *Maternity & Paediatrics*
  - *Cardiology*
  - *Pathology*
  - *Stroke*
  - *Imaging*
  - *IT & back office*

* Part of the Clinical Services Review

Underpinned by our enabling programmes

Leading and Working Differently – focuses on giving the health and care workforce the skills and expertise needed to deliver new models of care. Programmes include:

- *Working differently*
- *New ways of delivery*
- *Single Leadership*

Digitally-Enabled Dorset – Increasing the use of technology in the health and care system to support new approaches to service delivery

- *Shared care record*
- *Intelligent working*
- *Independent self care*
- *Digital Dorset shared service*
- *Continuing digital operations*
- *Enabling technologies*

Overseen through

System Leadership Team – Comprises of Chief Executives, Chairs and the Director of Public Health Dorset, from across the Dorset system, as follows:

- *Dorset CCG*
- *Dorset County Hospital NHS Foundation Trust*
- *Poole Hospital NHS Foundation Trust*
- *Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*
- *Dorset HealthCare University NHS Foundation Trust*
- *Dorset County Council*
- *Bournemouth Borough Council*
- *Borough of Poole Council*
- *South Western Ambulance Services NHS Foundation Trust*

Outcomes

Health and Wellbeing

- *Helping more children and young people grow, develop and achieve*
- *Stay healthier for longer, leading to fewer people classified as overweight or obese, smoking, and drinking alcohol*
- *Taking control over own care*

Care and Quality

- *Equal standard of care*
- *Improved health outcomes*
- *Improved access to services 7 days a week*
- *More joined up care*
- *More opportunities to be cared for closer to home*
- *Improve patient experience*

Finance and Efficiency

- *Closing the financial gap*
- *Reduced waiting times*
- *Increase in efficiency of services*
- *The right workforce to meet our future care needs*

Context

Our operational plan has been developed in the context of national policy and local needs, illustrated in the diagram below.

National

NHS Mandate

Five Year Forward View

9 Must do's for 17/18 to 18/19

Local

'Our Dorset' Sustainability and Transformation Plan

Dorset CCG Operating Plan 2017/18 to 2018/19

Local challenges

We know that to have sustainable health and care services in Dorset we need to work collaboratively as one integrated system to deliver the vision we set out in our Sustainability and Transformation Plan

Overall the population of Dorset enjoys relatively good health with a higher life expectancy than the England average, with a predicted total population increase of 6% by 2020. The specific challenges we face, set within the context of the three gaps as follows are:

Health and Wellbeing	•increasing elderly population •increasing numbers of people living with long term conditions •inequalities in life expectancy
Care and Quality	•variation in quality of care; •standards achieved not meeting national targets; •shortage of key workforce groups
Finance and Efficiency	• CCG financial gap of £158m (STP Footprint gap of £229m, includes NHS specialist commissioning)

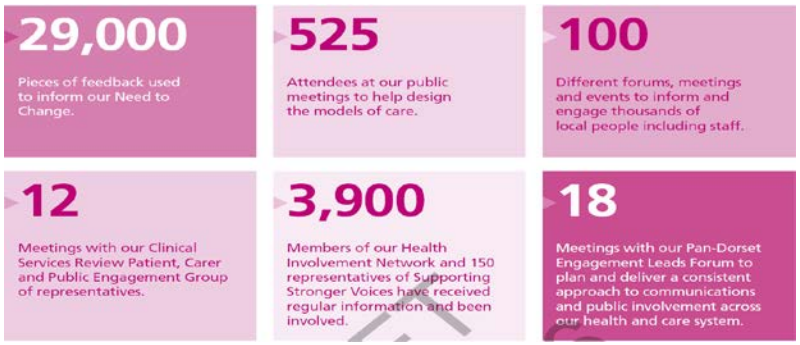
Key Achievements to Date

In our Operational Plan for 2016/17 we set out the challenges we are facing and our plans to deliver transformational change, ensuring the delivery of national priorities, and quality was maintained throughout, whilst closing the three gaps of:

- health and wellbeing;
- care and quality; and
- finance and efficiency.

During 2016/17 we have continued to strengthen the relationship we have with partners across the system and made progress in many areas of work; key highlights are as follows:

- worked across the system to develop 'Our Dorset' Sustainability and Transformation plan, and have established the System Leadership Team and system wide programme management approach through which this will be driven;
- continued to engage with our stakeholders to inform them about our plans for the future of Dorset's health and care services (the Clinical Services Review, including plans for acute and community services) as illustrated below;

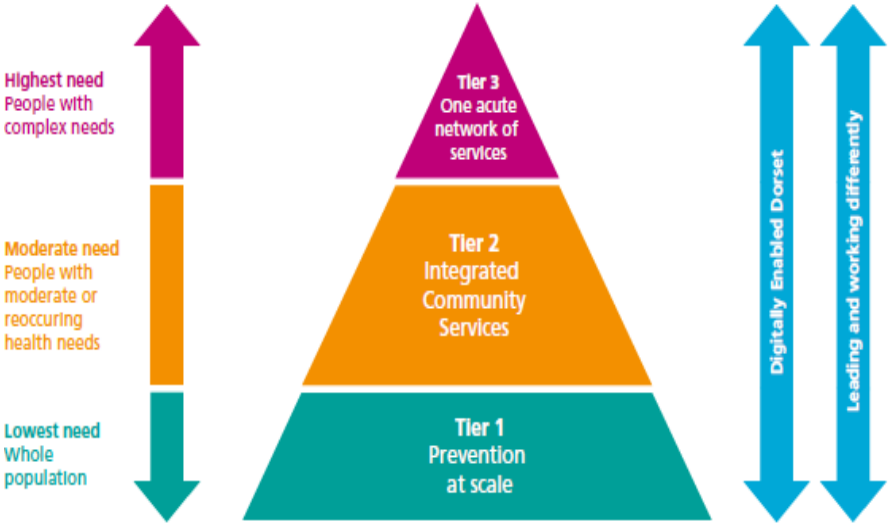


- production of a comprehensive consultation plan and consultation document, which have received good practice accreditation from the Consultation Institute;
- redesign of the Dorset vision website with new content such as animations and a clickable map ready to be launched for the start of public consultation;
- continued to engage with our members through a variety of mediums including, membership events, Hot Topics (education sessions), locality meetings, regular bulletins;
- working with both our Health and Wellbeing Boards to refresh the Health and Wellbeing Strategies;
- implementing the Weymouth Urgent Care Centre and Weymouth and Portland Integrated Care Hub;
- implemented Christchurch community hub;
- implemented integrated teams in Bridport;
- Implemented 24/7 labour line to support women in early pregnancy;
- Improved antibiotic prescribing rates in primary care and achieved nationals measures;
- development and roll out of the primary care workforce centre and Doorway to Dorset recruitment campaign;
- working with partners across health and care to understand and develop plans for the estate within Dorset;
- developed the roadmap for Dorset 2020 Vision which will support the transformation of the health and care system and is a key enabler of our programmes.

Delivering 'Our Dorset' Sustainability and Transformation Plan

During 2016/17, health and social care partners across Dorset came together to develop 'Our Dorset' STP, which sets out a clear vision: we want to *provide services which meet the needs of local people and deliver better outcomes* (http://www.dorsetccg.nhs.uk/aboutus/substainability.htm)

To deliver our vision we have three interconnected programmes of work to drive forward changes to our services in order that we meet the differing health and care needs of local children and adults, as illustrated below.



Our three programmes of:

1. **Prevention at Scale** - will help people to say health and avoid getting ill;
2. **Integrated Community Services** - will support individuals who are unwell, by providing high quality care at home and in community settings;
3. **One Acute Network** - will help those who need the most specialist health and care support, through a single acute care system across the whole of Dorset.

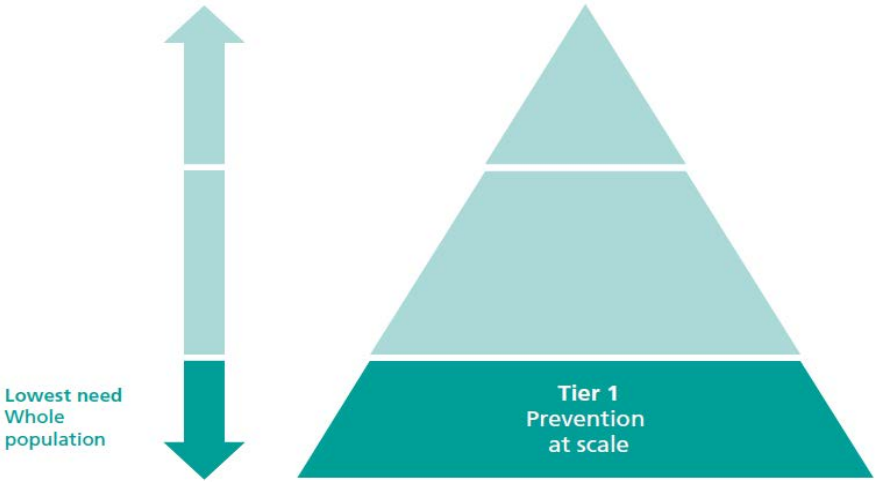
These programmes are supported by two enabling workstreams of:

- **Leading and Working Differently** - which focusses on giving the health and care workforce the skill and expertise need to deliver new models of care in an integrated health and care system;
- **Digitally Enabled Dorset** - which will increase the use of technology to support new approaches to service delivery.

Delivery of our STP will be overseen through the System Leadership Team, with each organisation individually and collectively accountable. The following section of our operational plan sets out the priority for each of our workstreams over the next two years, outcomes for each of the 5 programmes and detailed deliverable for the workstreams within the programmes.

Prevention at Scale

The Prevention at Scale Programme forms the foundation of all our plans and underpins all the work we will do. It also runs through our Integrated Community Services and One Acute Network Programmes as illustrated below.



Through this programme we aim to improve the health and wellbeing of our current and future population by reducing unacceptable difference in health and life expectancy of difference group of people in Dorset, including those with mental health problems. We also aim to ensure sustainable health and care services but reducing demand for services, in particular for those with long term conditions.

The Health and Wellbeing Strategies of our two Health and Wellbeing Boards (Dorset and Bournemouth and Poole) have been refreshed to align with our STP and detailed programmes are being developed; emerging themes have been identified as follows:

- **healthy environments** - shaping both built and natural environment promoting schemes such as active travel and use off green spaces and coastlines;
- **champion development** - actively promoting and supporting volunteers in the community;
- **healthy schools** - supporting schools to take up healthy approaches such as Food for Life and emotional health and wellbeing;
- **scaling up individual behaviour** - supporting self-care and personalisation through extending Live Well Dorset service;
- **reducing variation in secondary prevention of cardiovascular disease and diabetes** - supporting the development of models of care and delivery;
- **health at work** - development of a common framework across all partners;
- **physical activity plan** - bringing together public, voluntary and commercial sector to look at potential large scale interventions.

Outcomes

By end of 2018/19, through our Prevention at Scale programme we will contribute to the following outcomes:

- improvements in potential years of life lost
- reduction in childhood obesity;
- reduction in deaths from preventable causes
- reduction in deaths from CVD.

This programme is overseen by a Senior Responsible Officer- Director of Public Health, Public Health Dorset, and has a dedicated Portfolio Director – Consultant in Public Health.

In supporting this work the CCG will continue to work closely with partners across the system to:

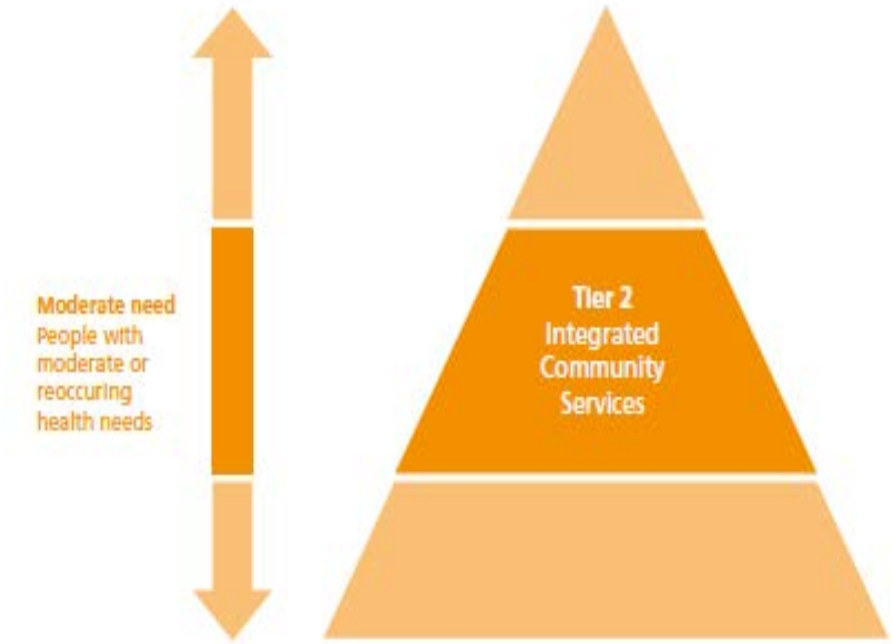
- ensure prevention, health and wellbeing remains at the heart of Dorset's planning and delivery;
- understand inequalities in the use of our services to inform planning and service needs;
- understand and reduce the variation in services (see page 27);
- support referrals into our healthy living programme 'Live Well Dorset';
- support self-care programmes and initiatives such as 'My Health, My Way';
- smoking cessation programmes, including smoking in pregnancy;
- review and implement diabetes models of care;
- contribute to the physical activity programme;
- continue to develop and implement health at work programme.

Key Deliverables

Milestones	17/18	18/19
Continue to develop and refine the prevention at scale implementation plans to support STP delivery	✓	
Develop additional pathway into 'Live Well Dorset'	✓	
Continue to commission self-care programme, work with public health and enhancing digital options (see digital page 22)	✓	
Reduce variation in secondary prevention of diabetes and CVD	✓	✓
Contribute to the developing multi-sector, multifaceted physical activity programme	✓	✓
Implement a range of programmes to support health and wellbeing, building on progress made in 2016	✓	✓
Develop diabetes models of care	✓	
Implement diabetes models of care through a phased programme	✓	✓

Integrated Community Services

Through our Integrated Community Services (ICS) programme we will transform general practice, primary and community health and care services in Dorset so that they are truly integrated and based on the needs of the population, as illustrated below.



The section provides an overview of the individual workstreams which make up our integrated community services programme, key milestones for the next two year and measures, which set out how we know we have delivered.

The workstreams within this programme are:

- integrated community hubs and teams;
- primary medical services-General Practice;
- mental health;
- learning disabilities.

Outcomes

By end of 2018/19, through our ICS programme (in conjunction with others) we will contribute to the following outcomes:

- reduction in outpatient appointments (3% new, 15% follow up);
- 15% reduction in non-elective medical and surgical admissions;
- reduce community hospital length of stay from 32 to 24 days for step up and by 3 days for step down;
- reduce the number of delayed transfers of care to achieve rate of 3.5% across all providers;
- increase dementia diagnosis;
- £XX to help to close the financial gap

This programme is overseen by a Senior Responsible Officer- Chief Executive from Dorset HealthCare University NHS Foundation Trust, and has a dedicated Portfolio Director – Deputy Director of Service Delivery, Dorset CCG.

Integrated Community Hubs and Teams

Through our integrated community services workstream we aim to improve people's health and wellbeing, increase care closer to home, and improve people's experience of services.

We will do this through the implementation of community based services which will be led by multidisciplinary teams of professionals working together to meet the physical and mental health needs of people of all ages and through the reconfiguration of community hospitals and establishment of community hubs and further implementation of integrated community teams.

The hubs will provide:

- urgent care (see page 20);
- community hospital beds and short term care home placements;
- community outpatients;
- community diagnostics;
- day case facilities/theatres;
- early help support;
- health and wellbeing services;
- primary mental health services.

During late 2016/17 we will consult on the site specific options for community hubs as part of the clinical services review consultation (CSR) (see page 18). Key deliverable during 2017/18 to 2018/19 can be seen in the table overleaf.

Key Deliverables

Milestones	17/18	18/19
Community Hubs		
Full business case for revenue and capital implications of ICS model	✓	
Complete decision making on community hub configuration post public consultation: • Confirm number of community hubs • Confirm range of services within each hub and the numbers of beds at each community hub with beds • Define other primary care facilities for the delivery of community outpatients • Phase 1 of short term care home bed provision • Establish Step up beds in the west of the county • Implementation of first wave of community hubs	✓	
Phase 2 of short term care home provision expansion		✓
Reduce community hospital length of stay from circa 32 days to 24 days step down and 3 days step up.		✓
Implementation of wave 2 community hubs		✓
Integrated Community Teams (health and social care)		
Implement integrated health and care teams to enable 0.5% of the population (all people with very high needs) being supported	✓	
Expand teams so 5% of the population (all people with high needs) are supported		✓
Expand teams so 15% of the population with moderate need will be receiving co-ordinated signposting, advice and support, personalised to their needs.		✓

Our community hubs are expected to be supported by strengthened networks of GP practices, offering patients wider range of services. Our plans for transforming General Practice can be seen in the next section.

Transforming General Practice

Our vision for General Practice is that it will continue to be the foundation of the health system, maintaining its position as the leaders of primary care, retaining its identity and registered list. It will build on these strengths by working in larger groups to achieve sustainability and maintain continuity of care for patients, as part of wider primary and community teams, across a range of sites delivering care with improved access, quality and outcomes, as close as possible to people's homes.

We will do this by using the national and local tools we have at our disposal to support and work with our practices still recognising the importance of enhancing the continuity of care and building long term relationships with patients, to find the best model for them within their local area and provider landscape.

Our Primary Care Commissioning Strategy (when published add in link) sets out how we will transform General Practice reflecting the General Practice Forward View and deliver the following ambitions by 2020:

- improve the quality of GP services;
- improve patients experience, empowering people to take control of their own health;
- reduce health inequality gap;
- improve outcomes, reduce unwarranted variation and accurate disease prevalence for all areas we are outliers;
- all practices working at scale as part of multidisciplinary teams;
- a sustainable General Practice model which is attractive to work in;
- improved extended and consistent access;
- a paperless health system.

Key Deliverables

Milestones	17/18	18/19
Implement local transformation programme to enable 40% the population to be receiving GP Services from practices who are part of a collaboration, working at scale		✓
Technology enabling the delivery of care through implementing the Dorset Care Record and Digital Dorset	✓	
Improving the primary care estates, working in partnership with integrated community services infrastructure development priorities and plans		✓
Improve access to general practice by providing additional consultation capacity per 1,000 population including on-line consultation systems, address inequality in access and commission additional capacity for evening and weekends reflecting local need		✓
Design a rolling Annual Programme of Quality Improvement and set specific standards to address variation and improve outcomes through implementing the Time for Care Programme and 10 high impact changes	✓	
Deliver workforce development plans to address General practice resilience, supporting the development of skill-mixed teams for delivery of new models of care	✓	
Prevention –work with localities to develop models of care which facilitate supported self-care, improved health and wellbeing including training for care navigators	✓	
Support the organisational development of general practice to enable primary care to be equal partners in new collaborative arrangements	✓	
Further develop commissioning of primary care to deliver care at scale		✓
Implementation of the integrated community services new care models to reflect local care needs		✓

Transforming Mental Health - adults

We are committed to tackling mental health with the same energy and priority as we have tackled physical illness in order to deliver parity of esteem in line with the Five Year Forward View (FYFV) for Mental Health. Through our programme we aim to:

- implement early intervention programmes to prevent the development of mental health problems;
- support as many people as possible to stay independent through our integrated community services;
- improve support for people at times of crisis through improved links with our acute services.

We will continue to work with partners across the system to:

- deliver the **acute pathway review** and crisis care concordat;
- review and develop a pathway for **complex care and recovery** including delivery of a system wide Individual Placement Service;
- deliver integrated physical and mental health provision to people with **severe mental illness** (SMI);
- deliver **Early Intervention Services** to ensure people with first episode of psychosis are treated in a timely and evidence based manner- ensuring 53% of people access treatment within 2 weeks of referral;
- deliver increased access to **Improving Access to Psychological Therapies service** to deliver national target of 75% in 6 weeks and 95% in 18 weeks 99.4%;
- improve identification, care, treatment and support for people living with **dementia** to achieve the national standard of 66.7%;
- review and design an all **age psychiatric liaison** service;
- work with Public Health Dorset and local authorities to develop a **Suicide Strategy**
- understand the workforce gap and how to attract and develop the people we need to deliver services.

Key Deliverables

Milestones	17/18	18/19
Acute Care Pathway and Crisis Care Concordat		
NHS England Stage 2 Assurance and consult on options	✓	
Implementation of Acute Care Pathway	✓	✓
Complex Care and Recovery Pathway		
Development of business case including view seeking and modelling (consulting on options if required)	✓	
Implementation of services		✓
Integrated Physical and Mental Health		
Commission health screening and interventions to reach 2100 people in 2017/18 and 4200 in 2018/19 in Dorset on SMI register	✓	
All Age Psychiatric Liaison Services		
Review psychiatric liaison services to reflect outcomes of CSR consultation, develop business case	✓	
Implementation of services	✓	✓
Dementia	**17/18**	**18/19**
Dementia review- development of strategic outline business case	✓	
Dementia Review- Consultation and decision by Governing Body	✓	✓
Dementia Review- Implementation of services		✓
Continuation of Memory Advice Service	✓	✓
Dementia Diagnosis- Increase numbers of Care plan reviews (face to face review of their care plan within the last 12 months) March 2017	✓	✓
Dementia Training- review, monitor and evaluate services	✓	✓

Transforming Mental Health - children

As part of our transforming mental health programme, over the next two years we will continue to work in partnership to deliver our **Pan Dorset Children and Young People's Emotional Health and Wellbeing Strategy**.

Our Vision is that all children and young people (CYP) have positive emotional well-being and mental health so that they:

- achieve positive goals and ambitions.
- grow up to be confident and resilient and can contribute to society.
- feel safe and can find the right help easily when they need it and can trust this help.
- are experts in their own care.
- want to be involved in how services are delivered and developed, not just for themselves, but also for other CYP and their families.

We will work with partners to:

- improve access and waiting times to specialist treatments;
- improve access to young people's eating disorders services;
- improve all age liaison services;
- reduce suicides rates amongst children young people;
- develop a system wide approach to early intervention and prevention;
- enable schools to support children and young people's emotional wellbeing and mental health;
- support staff working in primary care.

Key deliverables

Children and Young People Emotional Wellbeing and Mental Health		
Implementation and monitoring progress of strategy	✓	✓
Eating Disorders- deliver self-referral scheme and embed IAPT approach	✓	
Undertake scoping of options for all age liaison service and agree potential service offer and test market	✓	✓
Develop and implement action plan to reduce suicide in children and young people by 10% from baseline	✓	✓
Implement redesigned school nursing service	✓	
Prototype new models of digital service delivery	✓	
Support education initiatives to support primary care staff	✓	
Strengthen pathways and develop shared care arrangements between primary and specialist services	✓	

Transforming Learning Disabilities

The CCG recognises that children, young people and adults with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. They should have a home within their community, be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.

During 2016 we developed our Local Joint Transforming Care Plan (TCP), and established a Transforming Care Board with Local Authority partners from Dorset County Council, Poole Borough Council and Bournemouth Borough Council and NHS England. This Board will progress the transforming care agenda.

Key areas for development are:

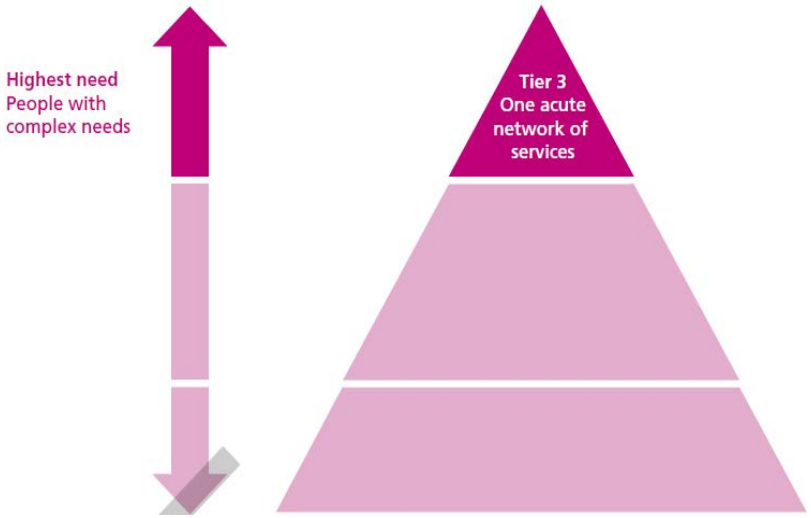
- avoid hospital admission unless absolutely necessary;
- ensure any admission will be determined by a Gateway Care and Treatment review (pre admission Care and Treatment Reviews/Blue Light meeting);
- repatriate current inpatients;
- develop housing options for people at risk of hospital admission or placement breakdown and improve the skills of the workforce guided by the Skills for Care LD workforce framework to enable people to be supported effectively in the community in the long term.

Key Deliverables

Milestones	17/18	18/19
Discharge four people with LD from out of area hospitals per year into Shottsford House	✓	✓
Discharge one person with LD from out of area hospital each year into new build bungalow in Dorset	✓	✓
8-12 people per year to use the new short term crisis flat in Poole; avoiding some hospital admissions	✓	✓
The crisis service at Shottsford to develop to prevent hospital admissions.	✓	
Design housing model for people at risk of hospital admission or placement breakdown	✓	
Co-produce and deliver programme of staff training to support and maintain people to live independently in the community	✓	
Increase uptake of LD health checks and review LD health checks programme	✓	✓
Review person centred planning approaches across Dorset and develop improvement plan	✓	
LeDeR - develop improvement plan - milestones to be agreed with local review programme.	✓	

One Acute Network of Services

Through this programme of work we aim transform acute services in Dorset so they meet the complex and specialist needs of our population, as illustrated in the diagram below.



Through this programme we aim to develop distinct roles for the three general hospitals in Dorset in order to implement the clinical recommendations of Sir Bruce Keogh and the Five Year Forward View and to develop single network of clinical services.

The section provides an overview of these workstreams which make up our one acute network of services programme, key milestones for the next two year and measures, which set out how we know we have delivered.

The Workstreams within this programme are:

- acute reconfiguration, part of the clinical services review (CSR);
- Cancer Services;
- maternity and paediatric (child health) Services; and
- urgent care;
- 'One NHS' in Dorset Acute Vanguard Programme- led by providers across Dorset.

Outcomes

By end of 2018/19, through our ICS programme (in conjunction with others) we will contribute to the following outcomes:

- reduction in outpatient appointments (3% new, 15% follow up);
- 15% reduction in non-elective medical and surgical admissions;
- reduce community hospital length of stay from 32 to 24 days for step up and by 3 days for step down;
- reduce the number of delayed transfers of care to achieve rate of 3.5% across all providers;
- Implementation of the maternity review;
- £XX to help to close the financial gap.

This programme is overseen by a Senior Responsible Officer- Chief Executive from Poole Hospital NHS Foundation Trust and Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and has a dedicated Portfolio Director – Deputy Director of Service Delivery, Dorset CCG and Programme Director Vanguard Programme.

Acute Reconfiguration

The CCGs clinically led Clinical Services Review was completed in May 2015, and received Governing Body approval to go to consultation in May 2016 (subject to NHS England assurance) and NHS England assurance in September 2016.

During late 2016/17 we will consult on the site specific options for community hubs (page 11) and the changes to acute hospitals. The CCGs preferred option being:

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

Across the three hospitals, this will enable us to increase the amount of consultant-led care, including an ambition to deliver 24/7 consultant care in some specialities at the Major Emergency Hospital. This aligns Dorset's plan with the model of care set out in the Keogh Urgent and Emergency Care Review (2013) which evidence shows saves more lives.

Our Integrated Community Services programme, in particular community hospitals and hubs that form a single health and care system for Dorset, will support our acute network. Through organising our services in this way, so that they are delivered as part of a single system of health and care in Dorset, will help us develop a sustainable, coherent system for current and future generations.

The final configuration will be determined following analysis of the public consultation results and a decision by the CCG Governing Body in mid 2017, subject to Competition and Markets Authority approval. Further information is available at http://www.dorsetsvision.nhs.uk

Key Deliverables

Milestones	17/18	18/19
Complete consultation, CCG GB decision, regulatory approval	✓	
Detailed design and implementation planning	✓	
Start full business case, seek funding approval	✓	
Start planning and logistical approval	✓	
Complete full business case		✓
Obtain board and regulatory approval to proceed		✓
Obtain financial approval and identify and source capital required		✓
Complete planning and logistical approval		✓
Initiate first phase of reconfiguration		✓

As part of our one acute network of services we will be working closely with our acute providers to transform cancer and maternity services, to work in a networked approach across Dorset, which includes the sharing of rotas. Our plans for these areas can be seen in the next section.

Cancer Services

The CCG is committed to ensuring early diagnosis and access to effective treatment for cancers. It is recognised that more than one person in three will develop cancer at some time in their lives, and one in four will die of the condition; this needs to be improved. We are working closely with partners across the system to implement the National Cancer Taskforce Report.

We have developed an outcomes based commissioning framework which sets out the standards and outcomes required from our local service providers.

In our commitment to working in partnership, both system and regionally we are supporting the Dorset system to establish and embed the one Dorset Cancer Partnership and are working closely with Wessex Cancer Alliance to take forward the National Cancer Strategy.

Early diagnosis and stages of cancer are also a key priority in Dorset; the stage at which cancer is diagnosed being a key indicator of likely outcome.

One year cancer survival is a good indicator of whether cancer is being diagnosed early and whether access to optimal treatment is available. In Dorset the one year cancer survival rate is 71.6% which is higher than the English average of 70.2%. We are implementing risk stratified follow up as part of our commitment to implementing the survivorship programme of work along with provision of treatment summaries.

We will also reduce variations in services through identifying the opportunities within RightCare and using this approach to inform service developments.

We will continue to work with providers to support the achievement of the NHS Constitution Standards, utilising the contractual leavers available should performance fall.

Key Deliverables

Milestones	17/18	18/19
Establishment and maintenance of the one Dorset cancer network- provider led to move to one cancer service across Dorset	✓	✓
Review and implement opportunities identified within RightCare	✓	✓
Implement 28 day diagnosis pilot project	✓	
Implement the NICE NG12 two week wait referral guidelines including GP direct access to some diagnostic tests	✓	
Implement treatment summaries for all cancer patients	✓	✓
Implementation of one system for risk stratified follow up of cancer patients across Dorset	✓	✓
Review of CNS form and function	✓	✓
Agree and implement lung pathway	✓	✓
Work with providers to implement commissioning framework for cancer services	✓	✓
Implement recovery package	✓	✓

Maternity and Paediatrics (child health)

We are committed to ensuring safe, high quality and sustainable care for all women and children with access to the right care at the right time across the county that embraces the development and use of new models of care and technologies, while cost effective.

We are developing outcomes based commissioning frameworks which has been informed by Better Births – National Maternity Review, Wessex Vision for Maternity Services and the Royal College of Paediatrics and Child Health (RCPCH) review (April 2016) and local insight from clinicians across Dorset. These frameworks set out the standards and outcomes required from our local service providers for maternity and paediatric services.

In delivering these frameworks and outcomes from the RCPCH review, we will support talks between Dorset County Hospital and Yeovil District Hospital who are developing options for solutions for families within the West of Dorset and South East Somerset as well as supporting Bournemouth and Poole in a solution for the East of Dorset.

In addition to this we are working in partnership with NHS England Specialist Commissioning and clinicians from Dorset County Hospital, Poole Hospital and South Western Ambulance Services to address the immediate actions identified within the RCPCH review regarding neonatal services.

Following consultation we will support the implementation of the new models of care 'One Dorset' approach.

Since April 2016 we have had in place a Dorset perinatal mental health pathway and pan Dorset specialist community perinatal mental health service. We will continue to ensure that all midwives have training in screening for mental health conditions during pregnancy, ensuring this is a feature of the delivery of maternity care. Perinatal mental health is a key feature in the reducing indirect maternal deaths.

We will also reduce variations in services through identifying the opportunities with partners including public health, reviewing RightCare and using this approach to inform service developments.

We will continue to work closely with public health Dorset to implement programme to improve the health and welling of children and mothers including the roll out of immunisations, breastfeeding initiatives, childhood obesity prevention and treatment programmes.

We are working with health organisations and local authorities to identify opportunities for integration, support provider service improvements and to intervene earlier to improve outcomes for children and young people. New models of care for integrated community children's health services will be implemented across Dorset.

Key Deliverables

Milestones	17/18	18/19
Work with providers to implement commissioning framework for maternity and paediatrics	✓	✓
Review opportunities identified within RightCare	✓	
Improve personalisation and postnatal care in maternity services	✓	
Work with partners to deliver programmes to reduce childhood obesity including breastfeeding initiatives	✓	
Implementation of new models of care (subject to consultation)	✓	✓
Decision on options for west Dorset and South East Somerset and East Dorset models	✓	
Implementation of new models of care for the integration community children's health services (subject to consultation)	✓	✓
Implementation of immediate recommendation from RCPCH	✓	✓

Urgent Care

Transforming how urgent care services are provided is a key part of our plans for Integrated Community Services. We want to develop a rapid response to urgent care needs with a single point of access.

Enhancing the provision of community based urgent and emergency care is essential if we are to reduce inappropriate attendances at A&E, reduce inappropriate hospital admissions and deliver care closer to home.

The refinement of the modelling for integrated community services has now enabled us to consider what the pattern of urgent care needs are which will inform the pattern of future delivery.

In our commitment to working in partnership, both system and regionally, we are hosting the Wessex Urgent Care Network programme management function and are developing the detailed action plan to support this network. This plan will link all elements of urgent care services including the development and implementation of the networked approach to urgent care services across Dorset.

Working with partners we continue to implement our A&E improvement plan to deliver the 95% A&E four hour target which focuses on five nationally mandated initiatives.

We have developed a joint health and social care strategy and action plan for Delayed Transfer of Care (DTOC) to reduce the number of delayed transfers of care to achieve rate of 3.5% across all providers with a further ambition to reduce to 2.5% together with a reduction in bed days lost due to delays. In addition to this we will also aim to achieve a rate of 7.5% across all community hospital sites.

Dorset has one of the lowest conveyance rates to A&E in the country, achieving approximately 40% conveyance rates. Our aim is to maintain or further reduce conveyance rates, where appropriate, through appropriate use of alternative urgent care services, such as ambulatory emergency care services and enhance MIUs/ urgent care centres.

Key Deliverables

Milestones	17/18	18/19
Determine the urgent care requirements across both community and acute sectors in line with ICS and one acute network programme	✓	
Continue to deliver the 5 priority areas identified within the A&E delivery Board and to deliver the action plan	✓	✓
Re-procurement and implementation of NHS 111 out of hours in line with Keogh and ICS modelling	✓	✓
Take on lead commissioner role for SWAST 999 for the South West region	✓	✓
Develop Integrated urgent care access and advice as part of re-procurement of NHS111 and out of hours	✓	✓
Progress discharge to assess model of care	✓	
Develop trusted assessor role and integrated discharge services across Dorset	✓	
Implement DTOC action plan	✓	✓
Continue to implement four priority standards for seven day working as part of provider service delivery improvement plans	✓	✓

Enabling Delivery

To realise the ambitions we have set our operating plan we have three enabling programmes which focus on ensuring the workforce and leadership is in place (leading and working differently), we utilise technologies to enable us to better support people across the system and to enable self-management (Digitally enabled Dorset) and integration of health and social care through Better Care Fund.

The following section provides an overview of these programmes and their key deliverables for the next two years

Leading and Working Differently

To enable us to transform services set out in our STP we know we need to work more closely across different organisational boundaries for the benefit of patients and to help address our workforce challenges; recognising we need to work collectively as a system to deliver an integrated seamless services, and to maintain and develop professional skills.

We have worked across the system to develop the Leading and Working Differently Strategy, which has identified the following four priority areas:

- development of our leader and organisations;
- recruitment and retention of our staff;
- developing our staff;
- supporting staff through change.

This strategy is being led by the Dorset Workforce Action Board and has a detailed implementation plan in place.

The CCG is working to support and develops its own staff as well as leading on programmes of work to support the system. This is set out in the CCG's Organisational Development Framework and implementation Plan.

Key Deliverables

Milestones	17/18	18/19
Understand and support the wellbeing of our workforce through confident and competent line management support	✓	
Support the development of a culture which encourages and drives individual and team performance, holds people to account to deliver and act as ambassadors of the organisation and its values	✓	✓
Develop and embed an ethos of customer and staff satisfaction, aligned to internal and external assurance activity and scrutiny	✓	✓
Focus on governing body development and clinical succession planning	✓	
Ensure the development and implementation of a learning and development plan aligned to the organisational needs analysis to deliver transformational leadership and enhance staff personal effectiveness	✓	✓
Review, as appropriate the organisational structure of the CCG to ensure that they remain fit for purpose and responsive	✓	
Engage with the Business Support Services Review, remaining clear about the core function and business of the organisation	✓	
Establish an organisational approach to role based working, ensuring that we focus the right skills in the right place at the right time	✓	✓

This programme is overseen by a Senior Responsible Officer- Chief Executive from Dorset County Hospital NHS Foundation Trust and has a dedicated Portfolio Manager – Director of Engagement and Development, Dorset CCG.

Digitally- enabled Dorset

Our vision is to support the transforming health and social care system with a collaborative Dorset NHS Digital service. Local people and sustainable delivery of better outcomes will be at the core of everything we do. We will adopt and exploit the best available technology to ensure appropriate digital services empower people in their homes, communities and care settings.

We will do this through the delivery of our six workstreams, which are summarised as follows:

- **Shared Care Records** – supports the transformation of our integrated community services and one acute network programme though sharing the right information at the right time;
- **Intelligent Working** – focussing on business intelligence capability and capacity to support service planning and delivery through a better understanding of local needs;
- **Independent Self Care** – empowering people to help them stay healthy, well and independent through digital technologies;
- **Digital Dorset Shared Service** – single shared IT services across NHS in Dorset;
- **Continuing Digital Operations** – Custodians of uninterrupted existing services (business as usual);
- **Enabling Technologies** – high performing resilient and collaborative foundation providing successful digital operations.

This programme is overseen by a Senior Responsible Officer- Director of Transformation, Dorset CCG and has a dedicated Portfolio Manager – Chief Information Officer, Dorset CCG.

Key Deliverables

Milestones	17/18	18/19
Shared care records		
Implementation of Dorset Care Record	✓	✓
Implementation of transfer of care documents- acute to primary care (17/18) acute setting to social care (18/19)	✓	✓
Implementation of a single pathology laboratory information management system	✓	
Joining medicines records across care settings	✓	✓
Intelligent working		
Creation of a System data warehouse and create analytical and reporting best practice	✓	✓
Independent self-care		
Digital enablement of integrated community hubs- business case approval	✓	
Phase 1 and 2 implementation of digital support to community hubs	✓	✓
Digital enablement of integrated records and community teams	✓	✓
Roll out Skype for consultations	✓	
Implement telehealth and assistive technologies	✓	✓
Implement access to own records, personal held records	✓	✓
Further develop Live Well Dorset	✓	✓
Develop information resources for My health my way, My life my care, national.nhs.uk	✓	
Digital Dorset shared services		
Development of migration plan for new model	✓	
Implementation of migration plan	✓	✓
Enabling technologies		
Implementation of upgraded harmonised basic operational technologies	✓	✓

Health and Social Care Integration- Better Care Fund

The Better Care Fund (BCF) has been established across the three local authorities (Dorset County Council, Borough of Poole and Bournemouth Borough Council) and NHS Dorset CCG, and is made up of a number of key schemes designed to support delivery of the BCF objectives.

Our BCF plan for 2017/18 to 2018/19 will be used to set out the milestones and relevant pooled funding arrangements for key deliverables, acting as the joint operational plan for integration of health and adult social care, underpinning the work of integrated community services (see pages 10-16) over the coming two years.

Our approach for the period of this operational plan is to continue with one strategic vision for the pan-Dorset BCF. However, in recognition of proposed local government reorganisation in the pan Dorset footprint on an East/ West basis, we are proposing that each Health and Wellbeing Board will have its own detailed BCF plan, this will enable localisation.

Our key deliverables for 2017/18 and 2018/19 will be determined over the next two months, in light of delayed national guidance.

Key Deliverables

Milestones	17/18	18/19

Through the individual Workstreams within our transformational programme and our enabling workstreams we will make progress in closing the three gaps of:

- health and wellbeing gap;
- care and quality; and
- finance and efficiency.

The following section details our plans for improving quality, safety and patient experience and finance over the next two years.

Improving Quality, Safety and Patient Experience

In Dorset recent Care Quality Commission (CQC) Inspections have identified areas of good practice despite the pressures in our system. However, a number of services fall short of good quality standards. We recognise that there are areas where there is too much variation in the quality of services, standards not always being achieved, not enough staff where and when they are needed.

To ensure that the services we commission and the care provided to patients is safe and high quality we take an active approach through a range of formal and informal reviews and discussions with providers, the use of contractual levers, and through the implementation of quality improvement plans, including implementation of CQUINS and Quality Premiums (see page XX) .

We encourage the services we commission to engage with their patients/service users to ensure that they are fully informed about the care and treatment they are being offered and receive opportunities to exercise their personal choice in the care they receive.

Compassionate care is as important as the quality of treatment. We work with our providers of care to ensure that our patients, their families and carers are treated with compassion, respect and dignity, in safe environments and are protected from harm.

It is essential, as we deliver transformation on the scale identified within the STP and our two year operational plan that we maintain a strong focus on ensuring safe, high quality services continue to be delivered. In doing this during 201718-2018/19 we will:

- improve quality and outcomes as measured through the NHS Improvement and Assessment Framework;
- continue to roll out of **'Seven Day' services'** across health providers, with particular focus on the four clinical priorities (see page 16);
- improve the **use of medicines**, including antibiotics (see page 25);
- work with partners to ensure the safeguarding of adults and children;
- continue to ensure good quality of services provided within **Primary Care** (see page 11);
- continue to work with providers to implement **plans to improve quality of care, aiming to achieve good or outstanding CQC ratings**;
- continue to monitor the **impact of staffing** on quality in acute hospital settings through our contract review process; in line with the recommendations of the National Quality Board (see page 21);
- continue to work with providers to reduce **avoidable deaths** including reviewing and publication of findings and actions taken;
- continue to improve processes and assessments, implementing best practice for **NHS Continuing Health Care and Continuing Care for Children**;
- continue to implement the **five cost effective high impact interventions** as recommended in the National Audit Office (NAO's) Health Inequalities Report (see prevention at scale page 8);
- implement ~Right Care to minimise unwarranted variations in outcomes.

Medicines Management

Priorities for 2017/18 and 2018/19 will be to maintain the cost effective and evidence based approach to prescribing advice within primary care and across the health community with the pan Dorset formulary. The medicines team will:

- build on progress in achieving the Antimicrobial measures by reducing variation in prescribing through education and audit, implementation and updating of the antimicrobial strategy to reflect national priorities.
- support commissioning and transformation of services through horizon scanning to provide early insight of new medicines and their potential impacts;
- promote joint working with local pharmacist to increase uptake of electronic repeat dispensing;
- build on the uptake of the PINCER tool in practices to support high risk medication reviews, and promote safe medication use using polypharmacy tools and new prescribing data.
- promote appointment of practice and locality based pharmacists in line with the Primary Care strategy, and networks of pharmacists supporting practices
- maintain a focus on safe medicines use, challenging high or inappropriate prescribing of medicines with known safety or abuse potential;
- benchmark within the CCG and across the sub region and NHS England using the Medicines Optimisation Dashboard, NHS Benchmarking and Right Care addressing areas where the CCG is an outlier;
- ensure a local focus on optimisation of medicines is aligned to national priorities through use of materials such as NICE key therapeutic topics.

CQUINS

The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals. The CQUIN schemes in provider contracts in 2017/18 and 2018/19 will include the national and local schemes of:

National CQUIN Schemes

- NHS staff health and wellbeing (all providers);
- proactive and safe discharge (acute and community providers);
- reducing 999 conveyance (ambulance providers);
- NHS 111 referrals to A&E and 999 (NHS 111 providers);
- reducing the impact of serious infections (acute providers);
- wound care (community providers);
- improving services for people with mental health needs who present to A&E;
- (acute and mental health providers);
- physical health for people with sever;
- e mental illness (community and mental health providers);
- transition for children and young people with mental health needs (mental health providers).

Local CQUIN Schemes

The CCG intends to develop a low number of local CQUIN schemes for 2017/18 and 2018/19 to reflect the challenges faced by the system. The local schemes identified are:

- To be confirmed

Quality Premiums

The Quality Premium Scheme (QP) is a framework set up to reward commissioners for improvements in the quality of service they commission and incentivises CCGs to improve patient health outcomes, reduce inequalities in health outcome and improve access to services.

National Quality Premium Indicators

- early cancer diagnosis;
- GP access and experience;
- continuing healthcare;
- mental health;
- bloodstream infections.

Local Quality Premium Indicators

- To be selected from RightCare indicators – to be confirmed

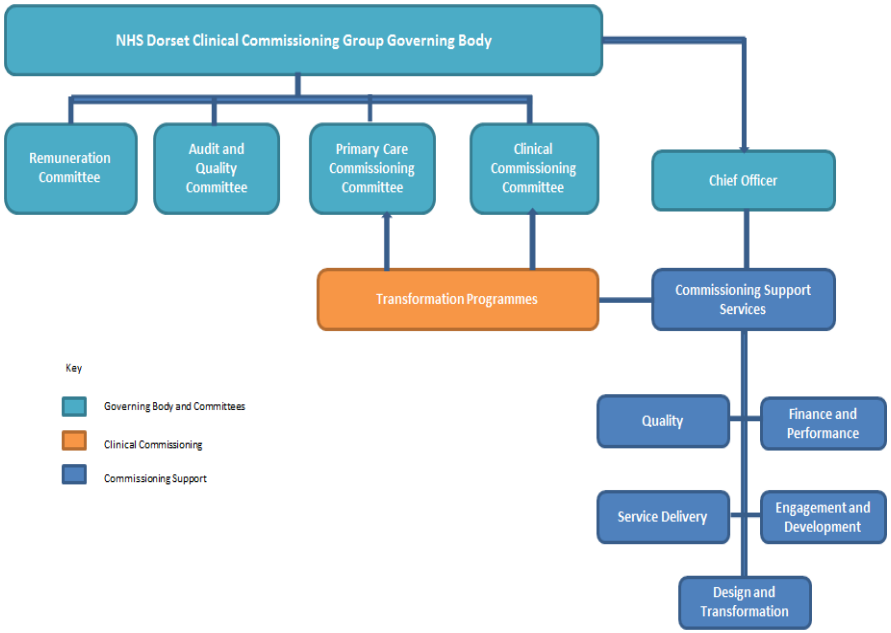
Finance and performance

This section is in development and will include:

- Overview- including:
  - how we are meeting business rules;
  - opening budget for 17/18 and 18/19;
- Impact of programmes on closing the financial gap, including:
  - Impact of transformation programmes;
  - RightCare;
  - Demand management;
  - Provider CIPs.
  - Better Care Fund;
  - Activity summary to support plans.
- Potential financial risks.

Governance

The CCG's internal governance arrangements are illustrated below. The CCG provides assurance to NHS England Wessex through regular assurance meetings and also provides regular updates on its progress and performance to Health and Wellbeing Boards, Joint Commissioning Boards and System Leadership Team.



Monitoring Performance

The CCG has a robust approach to performance management, building upon a strong base developed over previous years.

Quality standards and outcomes set out in 'The Five Year Forward View' and NHS Improvement and Assessment Framework, including the elements within the CCG Quality Premium and financial performance are monitored and reviewed as follows:

- reporting bi-monthly on progress against CCG commissioning outcomes and ensuring where appropriate agreed outcomes are reflected into acute and non-acute contracts;
- reporting on progress against outcome and performance measures set out in The Five Year Forward View and NHS Constitution Standards. These are reported bi-monthly to the executive team and quarterly to the CCG Board;
- reports on the progress against the Quality Premium measures incorporating the NHS Constitution and agreed local health measures.

To enable effective commissioning we have in place established networks and early warning mechanisms in place to minimise risk to the delivery of plans. However, where a risk to delivery is apparent we will manage this through existing structures and using appropriate contract controls and levers with providers.

As a system, to deliver our programmes, we have agreed to move towards an aligned system wide programme management approach with our programmes being led by a Senior Responsible Officer (Chief Executive from the system) supported by a Portfolio Director. The system wide governance is described in our STP (http://www.dorsetccg.nhs.uk/aboutus/substainability.htm).

We recognise that the next two years will be challenging for us across the system and as individual organisations. We have considered and assessed the potential risks to the delivery of our Operational Plan 2017/18 to 2018/19 and our STP. These risks and mitigating actions can be seen in the next section.

Risks and Mitigating Actions

The table below identifies key risk and mitigating actions from both a CCG and STP- System View linked to the CCG Corporate Risk Register and Governing Body Assurance Framework.

RISK	SEVERITY	LIKELIHOOD	MITIGATION
CCG RISKS			
Organisational self-interest – ineffective partnership working resulting in ineffective integration of services (Corporate Risk Register S03).	**H**	**M**	Robust clinical delivery groups in place with appropriate communications networks, partners and stakeholders. Development of joint priorities and action plans.
Failure to deliver control total (Corporate Risk Register FIN21)	**H**	**M**	Robust financial management process in place Robust, align operational plans in place across the system
NHS providers sustainability – impacting on service delivery and implementation of service changes (Corporate Risk Register S02).	**H**	**H**	Work with providers to ensure safe, effective and efficient implementation of services. Continued monitoring and review of contracts.
Impact of diminished cash reserves impacts on ability to pay core function on time (Corporate Risk Register S02)	**H**	**M**	Support providers to deliver the efficiency required to deliver a balanced position.
Impact on NHS providers, particularly secondary care in transferring money to the Better Care Fund, and diverting from front line NHS services. (GBAF 3.2).	**H**	**M**	CCG to align contractual spend against pooled fund.
Increase in secondary care referrals.	**H**	**M**	Full range of evidence based pathways and referral protocols in place; Contract levers and activity thresholds in place.
Public, patient, stakeholder challenge and judicial review (Corporate Risk Register 025).	**H**	**M**	Detailed communications and engagement plans for each service change ensuring involvement through each stage of the process. Regular media/press releases to ensure wide involvement.
Urgent care/A&E pressures impacting on system sustainability, discharge and patient care (Corporate Risk Register CDG4.1, CDG 4.2).	**H**	**H**	System resilience group have system wide plans in place to mitigate against these pressures.
STP - SYSTEM WIDE RISKS			
Access to Sustainability and Transformation Plan Funding for Dorset including provider request for additional financial support and capital funding (Corporate Risk Register S01).	**H**	**H**	Work across the system to establish the system benefits of funding coming into Dorset.

Delivery of Sustainability and Transformation Fund (STPF) objectives (Corporate Risk Register S03).	**H**	**H**	Work across the system to establish how the objective of the STPF can be delivered.
Local Authority financial position post comprehensive spending review impacting on social care and transformation (Corporate Risk Register O31).	**H**	**H**	Work across the system to identify service areas which may be reshaped to release savings and assist with communications in support of changes.
Primary care pressures including the sustainability of the workforce, finances and impact of devolution (Corporate Risk Register O36).	**H**	**M**	Implement primary care development plan. Devolved commissioning of primary care enable local decisions. Work with LMC and Deanery to identify placements and support programmes for workforce development.
System wide workforce pressures (Corporate Risk Register O36).	**M**	**M**	Work with Health Education England, LMC and Deanery to identify placements and support programmes for workforce development.
Capacity within the system to deliver all Workstreams (Corporate Risk Register O36).	**M**	**M**	Clear delivery mechanisms in place and additional focussed project support.
Wider political appetite and support- balancing cost, quality, service delivery, outcomes and patient preference (GBAF 4.1).	**H**	**M**	Engagement and involvement, testing levels of ambition of all partners at each stage.
Impact of NHS transformation programmes on social care services.	**M**	**M**	Work with social care to understand and mitigate potential risks.