Agenda Item:

13

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	22 May 2015
Officer	Director for Adult and Community Services
Subject of Report	**NHS Dorset Clinical Commissioning Group Delivery Plan Refresh**
Executive Summary	NHS Dorset CCG has refreshed its delivery plan to reflect the changes in national policy and local priorities. The focus for delivery as articulated within the plans continues to be on the three transformation programmes of: • Clinical Services Review; • Better Together and Better Care Fund; • Systems Resilience (formerly Urgent Care).
Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Report provided by NHS Dorset Clinical Commissioning Group
	Budget: Not applicable.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: ~~HIGH~~/~~MEDIUM~~/LOW (Delete as appropriate)

	Residual Risk ~~HIGH~~/~~MEDIUM~~/LOW (Delete as appropriate) *(i.e. reflecting the recommendations in this report and mitigating actions proposed)*
	Other Implications: None.
Recommendation	Dorset Health Scrutiny Committee members are requested to consider and comment on the contents of this report.
Reason for Recommendation	The work of the Committee contributes to the County Council's aim to protect and improve the health, wellbeing and safeguarding of Dorset's citizens.
Appendices	1 NHS Dorset CCG Delivery Plan 2014/15 to 2015/16 Refresh.
Background Papers	None.
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1. Introduction

1.1 As part of the national planning cycle and in line with requirements, NHS Dorset CCG has refreshed its Two Year Delivery Plan 2014/15 to 2015/16.

1.2 The plan has been refreshed to reflect the planning guidance *'The Forward View into Action: Planning for 2015/16'* published in December 2014 and the subsequent technical guidance set out the planning requirements for 2015/16 in order to deliver the vision set out in the Five Year Forward View.

1.3 The paper provides members with an overview of NHS Dorset Clinical Commissioning Groups Refreshed Delivery Plan 2014/15 to 2015/16.

2. Report

Background and Overview of National Requirements

2.1 The planning guidance is the first jointly produced planning guidance from the six national bodies and reinforces the need the whole of the NHS to work together to deliver the vision set out in the Five Year Forward View (October 2014). The national bodies are as follows:

- NHS England;
- Care Quality Commission;
- Trust Development Agency;
- Monitor;
- Public Health England;
- Health Education England.

2.2 The focus remains on the following areas:

- Prevention;
- Empowering patients and engaging communities;
- Working across the system to deliver transformation- 'New Models of Care';
- Developing Primary Care;
- Improving Quality and Outcomes;
- NHS Constitution Standards;
- Improving Mental Health services.

2.3 It also sets out a number of enablers to support delivery such as implementation of new innovations, developing the workforce, and IT solutions.

2.4 In terms of funding the focus continues to be on efficiencies and reducing the funding gap, but with additional funding identified for the following areas to drive improvements:

- £1.5bn front line (via CCG and direct commissioning allocations);
- £250m primary and community care infrastructure;
- £200m supporting Five Year Forward View (Vanguard);
- £30m additional mental health investment.

NHS Dorset CCG Delivery Plan 2014/15 to 2015/16 - Refresh

2.5 The Delivery Plan 2014/15 to 2015/16 has been updated to reflect the realignment of priorities of the CCG and in order to support the delivery of the vision set out in the Five Year Forward View.

2.6 The content of the delivery plan has been refreshed and continues to focus on the following areas:

- Commissioning Transformation
  - Clinical Services Review,
  - Better Together Programme and Better Care Fund,
  - Urgent Care and Systems Resilience;
- Primary Care Development;
- Improving Quality;
- Membership Development and Engagement;
- Clinical Commissioning Priorities - CCP priorities have been realigned to clinical working groups with the exception of Mental Health which remains as a separate programme;
- Commissioning Support Priorities - to support delivery of this plan and to ensure the CCG delivers all of its statutory responsibilities.

Quality Premiums 2015/16

2.7 As part of our plans CCGs are required to select Quality Premiums measures which are paid to CCGs in 2016/17 to reflect the quality of the health services commissioned by them in 2015/16.

2.8 CCGs were asked to choose two local QP in addition to the eight nationally defined QP measures; the CCG has selected the following indicators and is currently developing trajectories against these.

National Quality Premium Indicators

- Reducing potential years of lives lost through causes considered amenable to healthcare;
- Urgent and emergency care:

  - Avoidable emergency admissions;
  - Delayed transfers of care which are an NHS responsibility;
  - Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.
- Mental health:
  - Reduction in the number of patients attending an A&E department for a mental health-related needs who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.
- Improving antibiotic prescribing in primary and secondary care.

Local Quality Premium Indicators

- Estimated diagnosis rate for people with dementia;
- Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement and rehabilitation services.

Monitoring Performance

2.9 The CCG has in place a robust performance management process and will continue report regularly through directors and Governing Body meetings.

2.10 In addition to this the CCG also provides regular updates to both Health and Wellbeing Boards on our transformation programmes.

3.0 Conclusion

3.1 Committee members are asked to note and comment on the report.

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May 2015

NHS DORSET CLINICAL COMMISSIONING GROUP

REFRESHED DELIVERY PLAN 2014/15 to 2015/16

DRAFT V2 March 2015

Contents

INTRODUCTION

Welcome to our refreshed 2014/15 to 2015/16 Delivery Plan, which builds on the successes we have seen during 2014/15 and has been refreshed in light of the changing environment and 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.

We have been on a journey of discovery and exploration; our clinical leaders and membership have played a vital role in continuing to shape our organisation and forged new partnerships and built on existing relationships.

NHS England's "Five Year Forward View" published in October 2014 recognises the financial challenges which face the NHS and social care over the coming years and indicates a drive towards closer integration and joint commissioning between health and social care services, the development of different models of provision, including multispecialty community providers and primary and acute care systems and the transformation of primary care. The plan also describes a stronger role for the voluntary sector with more emphasis on putting patients in control of their own care. It also emphasises the need to exploit the use of technology and the role of public health in achieving better outcomes for communities

Last year we committed to undertake a Clinical Services Review to look at and further understand the challenges facing healthcare throughout the whole county. In doing this we have come together as a health and care community with a clear mandate to develop a more integrated care approach to redesign the model of health and social care in Dorset, responding to the change drivers articulated in the Five Year Forward View. We have engaged with the public, patients, clinicians, partners and other stakeholders so they can inform our review, our models of care and how they want us to consult with them.

Over the next 12 months our focus will continue to be on this journey, with our partners and stakeholders to deliver the required system wide transformation needed to realise the ambition we set out in our strategy so that in five years' time you will see:

- Integrated health and social care services designed around the individual;
- Financially and clinically sustainable services delivered in an innovative way;
- Focus on service not organisations.

DELIVERING NATIONAL PRIORITIES

NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, Public Health England and Health Education England have come together to issue the first joint planning guidance called *The Forward View into Action: Planning for 2015/16*, coordinating and establishing a firm foundation for longer term transformation of the NHS.

The guidance reiterates the challenges facing the health and care system of a growing and ageing population, increasing demand for services which are already under pressure, delivering new standards of care and increased access (e.g. seven day working) in a financially constrained system.

NHS Dorset CCG is committed to delivering the priorities identified within *'The Forward View into Action: Planning for 2015/16'* to ensure that everybody in Dorset has access to safe high quality health care which makes the most of clinical and technological advances and best practice, whilst being affordable in the long term, therefore ensuring long term system sustainability. In doing this we will:

- improve the outcomes for patients as measured through the five domains of the NHS Outcomes Framework and the seven outcome ambition measures;
- promote better prevention of ill health and reduce inequalities that exist across Dorset;
- ensure that we continue to focus on improving people's mental health as well as their physical health;
- ensure that all of our stakeholders are involved and engaged through every stage of service development and change;
- transform service models with partners to deliver high quality, integrated care, incorporating innovative technologies;
- maintain the focus on the essentials as follows:
  - **Access** - we will ensure services are accessible, timely and convenient and deliver the NHS Constitution standards;
  - **Quality** - we will focus on patient safety, experience and effectiveness and will work with providers to implement the actions required from the Francis, Berwick and Winterbourne View Reports and ensure that we achieve the standards and pledges set out in the NHS Constitution;
  - **Innovation** - we will continue to be committed to supporting research and implementing innovative solutions to care delivery;
  - **Value** - we will continue to strive to ensure the best use of our resources, delivering high quality, sustainable services.

LOCAL DELIVERY IN 2015/16

If the NHS in Dorset is to have sustainable health and social care services that are fit for the future, we need to continue to work collaboratively across the system with stakeholders, partners and providers to make courageous decisions regarding how local services are best provided and delivered.

Over the last 6 months as part of our Clinical Services Review we have been working to better understand the pressures on the health system in Dorset. The challenges we face in Dorset are summarised as follows:

- **increasingly elderly population** placing a high demand on health and social care services- over 70s expected to increase by 30% over next 10yrs;
- **increasing number of people living with long term conditions** - by 2020 1 in 10 people will have diabetes and 1 in 8 Coronary Heart Disease, rates of dementia continue to rise;
- **inequalities in life expectancy** - Dorset- 6.7yrs men, 4.7yrs women; Bournemouth- 10yrs men, 4.4yrs women; Poole- 6.8yrs men, 5.7yrs women;
- **clinically unsustainable system**- shortage of key workforce groups including emergency medicine trainees and consultants, high use of locum or agency staff, difficulty in recruiting to GP posts;
- **financial challenges** of £167m annually (£592m cumulative).

Further detail on the challenges we face and why we need to change can be seen in **Appendix 1** Clinical Services Review – Need for Change (Feb 2015).

Priorities for Delivery

In response to these challenges we will maintain the focus on our transformation programmes as follows:

- **Clinical Services Review;**
- **Better Together Programme and Better Care Fund;**
- **Systems Resilience (Urgent Care).**

These programmes are inter-related and will be delivered in partnership across the health community in Dorset. Further details of these arrangements can be seen on page 14.

We are committed to working jointly with NHS England in reviewing and developing **Primary Care Services** as these are fundamental to ensuring a modern health care service fit for the future, as we take on our role as Joint Commissioners of Primary Care Services.

We will continue to focus on ensuring that those who have **Mental Health needs or Learning Disabilities** are treated in the same way as any other patient, ensuring parity of esteem. Through our Mental Health and Learning Disabilities Programme we will focus on psychosis and dementia pathways.

We will maintain our focus on **Quality and Safety**, **Membership Development and Engagement and Continuing Healthcare**.

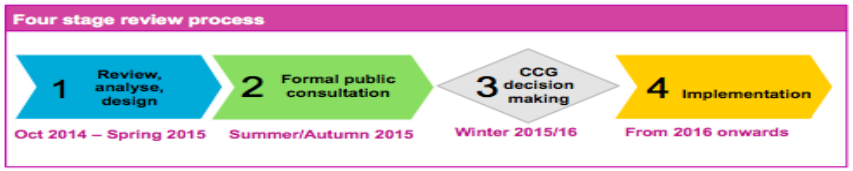
Our clinical commissioning priorities for delivery during 2015/16 can be seen on pages 15-17 and 19.

CLINICAL SERVICES REVIEW

Programme overview

To meet the changing needs of our growing population and to improve the quality of care for all we need our services in Dorset provide the best quality, specialist and up to date care delivered by the right people in the right place. Services must also be affordable now and into the long term.

Our system review comprises four stages to achieve these changes:



During 2014/15 we have made considerable progress by working intensively with clinicians, health and care leaders and patient, carer and public representatives. We have:

- Reviewed a wealth of evidence from local, national and international health systems to help us describe the current picture of healthcare in Dorset and from this identified a *Need to Change* (see Appendix 1);
- Considered the public's experiences of, and aspirations for, local health services provided in *The Big Ask* (a Dorset wide health survey conducted in 2013 with over 6,100 respondents), four Citizen Panels surveys carried out between 2012 and 2014 and a wide range of other view seeking activity. Together, over 29,000 qualitative comments have been collected;
- Established 'what good should look like' and key enablers;
- Identified the models of care;
- Identified potential options for the delivery of care.

Our commitment to being clinically led has seen us put considerable focus on bringing together around 150 clinicians from across Dorset each month in four clinical working groups looking at long term conditions and frail elderly, maternity and paediatrics, planned and specialist care and urgent and emergency care. Throughout, we have also had extensive engagement with our public, patients and stakeholders through a variety of mechanisms:

- a series of open public events across Dorset. Each event has been filmed and the videos and presentations are available on our website, media coverage and social media activity has also been undertaken;
- Monthly meetings with our Patient and Public Engagement Group, chaired by a national patient leader. This group of 25 people has provided regular feedback into design stage;
- A programme of GP practice and locality meetings;
- Staff briefings at the CCG and across providers;
- Meetings, briefings and the distribution of an e-bulletin to a wide range of other health and care stakeholders.

Expected outcomes for patients, their carers and the health system

- delivery of care closer to home;
- services which are designed around people;
- integrated 'whole system' services;
- sustainable workforce;
- improved quality and outcomes;
- value for money.

Programme timeframe

- April to May 2015: finalisation of pre-consultation business case outlining proposals for options for consultation;
- May to August 2015: external assurance of pre-consultation business case by Clinical Senate and NHS Gateway Review;
- August to November 2015: formal public consultation;
- December 2015 to March 2016: analysis of consultation responses and development of decision-making business case;
- March 2016: Governing Body decision on options.

BETTER TOGETHER PROGRAMME

Programme overview

The Better Together Programme aims to transform health and social care across Dorset to enable and deliver sustainable improvement in health and care outcomes through person centred, outcomes focused, preventative, co-ordinated care.

The programme is being delivered in partnership across the health and social care system in Dorset. Partner organisations include NHS Dorset CCG, Dorset County Council, Bournemouth Borough Council, The Borough of Poole, Dorset County Hospital NHS Foundation Trust, Dorset HealthCare University NHS Foundation Trust, Poole Hospital NHS Foundation Trust, the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and South Western Ambulance NHS Foundation Trust.

The Better Together Board will also oversee the Better Care Fund. The programme has five main workstreams as follows:

- **responding to need** - the 'front-end' of support such as easy to access points of contact, improved information and advice, reablement/ intermediate care, technology, accessible homes (via district councils);
- **improving effectiveness** - new ways of working for social care fieldwork services, especially for assessment and support planning processes across the three local authorities, and improved information sharing with health, supported by an integrated information and communications technologies system ;
- **integrating commissioning** - shared commissioning functions across the CCG and the three local authorities: use of resources, pooled and aligned budgets, common principles and priorities and working with providers to develop the market for care and support;
- **integrating service delivery** - integration for acute, community and primary health and social care, with enhanced community health and social care co-located services fully integrated with all primary health services and delivered by multi-disciplinary teams;
- **sharing delivery** - of local authority provided services across Bournemouth, Poole and Dorset.

Key priorities

- frail elderly and long term conditions;
- early intervention support and reablement/intermediate care;
- mental health and learning disabilities;
- urgent and emergency care .

Outcomes for patients, their carers and the health system

- total system costs reduced by 5%;
- people have independence, choice and control;
- resources are used efficiently and effectively;
- people are better able to help themselves;
- joint resource planning responds to need and local people's priorities;
- people experience better outcomes through safe, co-ordinated quality care;
- informal support maximised to care for people at home;
- a capable, sustainable motivated workforce.

Programme timeframe

- September 2013 to October 2013 - programme set up;
- November 2013 to January 2014 - programme mobilisation;
- January 2014 to 2018 - programme delivery.

BETTER CARE FUND

The Better Care Fund 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 from existing budgets.

In Dorset the Better Care Fund together with the Better Together Programme is seen as an enabler and will drive integration of health and social care services across Dorset. The financial allocations for this fund can be seen in the table overleaf.

National funding will be based on achievement of a 3.5% reduction in emergency admissions. In addition to this we also aim to see improvement in the following areas:

- admission to residential/nursing homes;
- increased effectiveness of reablement;
- reduction in delayed transfers of care;
- improved patient/services user experience;
- increase diagnosis rates for dementia.

Better Care Fund Local Allocation	**2014/15**	**2015/16**
National Funding Allocation	£1.1bn (transferred)	£3.8bn (pooled)
	£000's	**£000's**
Dorset County Council	8,869	4,113
NHS Dorset Clinical Commissioning Group		53,051
Bournemouth Borough Council	4,052	2,266
Borough of Poole	2,922	862
Total	**15,843**	**60,292**

Better Care Fund Schemes 2015/16

The table below identifies CCG funding areas as part of the Better Care Fund.

Scheme	Dorset CCG – B&P HWB	Dorset CCG – Dorset HWB	Dorset CCG - Combined
	£m	£m	£m
Integrated Equipment	2.3	2.3	4.6
Reablement	1.3	2.5	3.8
Early Help	0.2		0.2
Carers	0.6	1.1	1.7
Accessible Homes	0.2	0.7	0.9
Enhancing social care to support health	7.6	7.2	15.0
Integrated Health & Social Care Teams	12.0	15.0	27.0
TOTAL	**24.2**	**28.2**	**53.0**

URGENT CARE AND SYSTEM RESILIENCE

Programme overview

In line with new national guidance NHS Dorset CCG has established the Dorset System Resilience Group (Emergency Care Network), through which, and working in partnership across primary, secondary and community care services we will deliver enhanced urgent care with an emphasis on prevention of avoidable admission. This work will be aligned to the work of the Clinical Service Review, Better Together and Better Care Fund Programme.

The Dorset System Resilience Group has developed two key strands of work as follows:

- further development and delivery of the Organisational Resilience and Capacity Plan, initially supported by a dedicated Project Management Team;
- implementation of the Urgent Care Strategy, which is supported by a two year action plan.

Central to the delivery of these strands of work will be joint partnership programmes established and developed by three geographically based Health and Social Care Clusters that will support the effective allocation and use of non-recurrent funds to enable seasonal pressures to be managed, and to provide opportunities to pilot innovation.

Key priorities

The Urgent Care Strategy has identified six high impact areas that require a multi-agency approach to ensure delivery:

- **case finding and care co-ordination**: offering targeted case management and care co-ordinators for high risk patients through frailty assessments and implementing anticipatory care plans for over 75s shared across all care sectors;
- **in-reach into care homes**: develop a focused and co-ordinated approach to systemic support and in reach into care homes;
- **Emergency Department attendance avoidance programme**: managing minor injuries and illness more effectively in primary care/secondary care through better workforce integration and service model changes;
- **ambulance service conveyance reduction:** undertake diagnostic work to identify high impact changes that will increase see and treat rates and reduce conveyances;
- **hospital at home:** shared care services between outreach secondary care advanced practitioners and community intermediate care service to support higher acuity patients in crisis;
- **care overnight**: expansion across the patch of the Dorset County Council pilot that provides night visiting, linking it with primary care OOH's and night nursing.

Outcomes for patients, their carers and the health system

- patients feel safe, supported and in control;
- reduced amount of time people spend (avoidably) in hospital through integrated care;
- enhanced commissioning and planning capacity to build successful strategies, plans and delivery capability;
- integrated services;
- reduced levels of inappropriate demand;
- reduced accident and emergency admissions.

Programme timeframe

2014/15

- develop and agree a Dorset Organisational Resilience and Capacity Plan;
- establish a Dorset System Resilience Group and its associated sub –groups including three Health and Social Care Clusters;
- allocate winter pressure funding and establish effectiveness of schemes;
- establish a Project Management Office for System Resilience.

2015 to 2018

- implementation of the two year Urgent Care Strategy action plan;
- revision of the Dorset Organisational Resilience and Capacity Plan;
- develop and implement effective winter pressure schemes;
- consider the outcomes of the Clinical Service Review recommendations.

PRIMARY CARE DEVELOPMENT

In our strategy we have identified the need to transform primary care as without change and support it will not be fit for purpose or sustainable.
We have established joint commissioning arrangements with NHS England and will work closely with partners in our Joint Primary Care Committee to support and drive forward the future strategy for general practice to ensure we are able to deliver:

- proactive, coordinated care;
- holistic, person centred care;
- fast, responsive access to care;
- health promoting care;
- consistently high quality care.

To do this we will:

- develop a primary care development plan to focus on:
  - developing new models of out of hospital care at the local level;
  - supporting collaborative organisational models in primary care to enhance access and promote service integration.;
  - developing a more comprehensive contractual framework to align funding and incentives more closely with the role of primary care in out of hospital care;
  - improving quality and address variation in primary care provision;
  - improving recruitment and develop the clinical workforce;
  - promoting innovation in service delivery and ways of working;
  - premises;
- implementing programme of care to support the management of frail elderly and complex patients, building on the over 75s schemes;
- implement schemes identified within the Prime Ministers challenge fund;
- improve general practice IT in line with our Information Plan (see pages 34-35).

IMPROVING QUALITY

Quality and safety is at the heart of what we do and has quite rightly been a matter of significant public debate in recent years and as such is key in our strategic planning.

The national inquiries surrounding Mid Staffordshire Hospitals Trust and Winterbourne View in South Gloucestershire have brought into focus the need for staff at all levels to change behaviours, systems and processes so that safety and quality are the organising principles of health and care services. All reports have reinforced that quality is about our behaviours and attitudes and the need to address this to ensure high quality care for all.

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, use of contractual levers, and through the implementation of quality improvement plans.

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.

In our commitment to ensuring safe, high quality services during 2015/16 we will continue to focus on:

- improving quality and outcomes as measured through the NHS Outcomes Framework;
- improving patient safety;
- implementation of the '6Cs' and Compassion in Practice;
- roll out of 'Seven Day' services across health providers;
- use of medicines- antibiotics;
- safeguarding adults and children.

Details of our priorities can be seen in our Quality section on pages 22-28.

MEMBERSHIP DEVELOPMENT AND ENGAGEMENT

NHS Dorset CCG is committed to ensuring our members have the support they require to develop as clinical and Governing Body leaders and to support the development of our member GP practices.

The CCG has an Organisational Development Framework and Implementation Plan 2014/15 to 2015/16 which was designed to respond flexibly to the needs of the organisation, and at the same time demonstrate assurance against the framework of excellence and formal assurance domains and is the basis upon which we identified and shaped the work needed to enable delivery of the 2015/2016 corporate objectives.

Over the last 12 months we have refocused our approach to membership development, engagement and communication. We will continue to work with members to understand the approaches that best suit them.

The Clinical Services Review has provided us with an opportunity to test our organisational resilience, responsiveness and capability and the experience and insight we have learnt from this will be used to progress our organisational development activities in the future.

During 2015/16 we will build on what we have achieved in 2014/15 and continue to develop and embed our role as confident and consistent leaders, enabling us to build stronger and more meaningful relationships with partners, stakeholders and our membership. Key priorities are:

- Governing Body development and clinical succession planning;
- review and alignment of CCG development events, to the commissioning cycle, enabling membership, locality and commissioning support development;
- leadership and management development which enhances succession planning and is based on role modelling our values and behaviours;
- continue to develop our engagement and communications approach with our members.

Further priorities for organisation development, engagement and communications can be seen on page30.

Improving Health and Reducing Inequalities

The CCG is working closely with both Dorset and Bournemouth and Poole Health and Wellbeing Boards to tackle the wider health issues to improve health and reduce inequalities that exist across Dorset.

The CCG are members of the Health and Wellbeing Boards Commissioning Intelligence Group which includes membership from local authority, public health, voluntary sector. This role of the group is to develop the Joint Strategic Needs Assessment which informs both the Health and Wellbeing Strategies and the CCGs strategies and plans.

During 2014/15 our localities and CCPs have been closely working with partners to deliver joint priorities set out in the Health and Wellbeing Strategies such as CVD, dementia, diabetes. Examples of initiatives are:

- improve the identification of high risk families and reduce their risk factors familial hypercholesterolemia;
- implement the National Awareness and Early Diagnosis Initiative;
- Dementia Friendly Wimborne initiative;
- Exercise on Referral programmes for people at risk of circulatory disease;
- co commissioning smoking cessation, including targeting smoking in pregnancy;
- supported Public Health England through supporting public health campaigns e.g. screening, flu.
- malignant melanoma and skin cancer prevention project.

During 2015/16 we will continue to work closely with both Health and Wellbeing Boards and Public Health Dorset to further understand the needs of our population through the work of the Joint Health and Wellbeing Commissioning Intelligence Group and develop plans to tackle the causes of ill health (prevention programmes) and to reduce inequalities.

Equality Delivery System 2

We are committed to ensuring that we reduce health inequalities and that we have the needs of our communities at the heart of our commissioning functions. We recognise that people access services and need support in a range of different ways. Our challenge is to understand these communities, engage effectively with them and commission services to meet their local needs.

The CCG has adopted and is working towards implementation of the NHS Equality Delivery System (EDS 2) and the NHS Workforce Race Equality Scorecard. In line with EDS2 guidelines, the CCG has completed the annual review process, this can found at: http://www.dorsetccg.nhs.uk/Dorset%20CCG%20Equality%20and%20Diversity%20Report%202014-15.pdf

Key Priorities for 2015/16:

- procurement of Primary Care Diabetes Services;
- smoking cessation programmes, including smoking in pregnancy;
- implementation of the findings from the Kings Fund Cardiology review;
- implementation of schemes identified within the Olympic Legacy Fund to improve physical and mental health of people across Dorset targeting areas where inequalities are most evident and support vulnerable and marginalised communities;
- reprocurement of the Weymouth Community walk-in centre (Darzi centre);
- implement action plans which have been developed for implementation of EDS 2 throughout 2015/16;
- continue to work with partners and stakeholder groups to improve how we engage with them to reduce inequalities;
- further embed equality and diversity into day to day working, ensuring that we are taking a pro-active approach to commissioning and support services;
- continue to provide updates to directors on organisational workforce scorecard which includes measures in the NHS Workforce Race Equality standard.

SYSTEM WIDE PARTNERSHIP

The large-scale system change in health and social care is complex and challenging and driving such change takes strategic, collaborative leadership, built on a compelling vision for the future.

Eighteen months ago the system leaders agreed a clear commitment to develop a more integrated care approach to redesign the model of health and social care in Dorset. In doing this we have established the Better Together Sponsor Board (aligning health and social care).

Through our CSR we have a Chief Executive Sponsor Group with membership from all the Chief Executive Officers from each provider organisation and Local Authorities in Dorset, as well as establishing a Clinical Reference Group to lead the review with membership including Medical Directors, Directors of Nursing and GPs. Representatives are:

- NHS Dorset CCG;
- Bournemouth Borough Council;
- Borough of Poole;
- Dorset County Council;
- Dorset County Hospital NHS Foundation Trust;
- Dorset HealthCare University NHS Foundation Trust;
- Poole General Hospital NHS Foundation Trust;
- Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust;
- South Western Ambulance NHS Foundation Trust;
- NHS England- Wessex Sub Region.

The challenge that all partners recognise is that aligning the programmes' priorities with the needs and interests of the agencies will not always be easy. However all partners are committed to the shared goal, through the common interest, in transforming the system to ensure its sustainability.

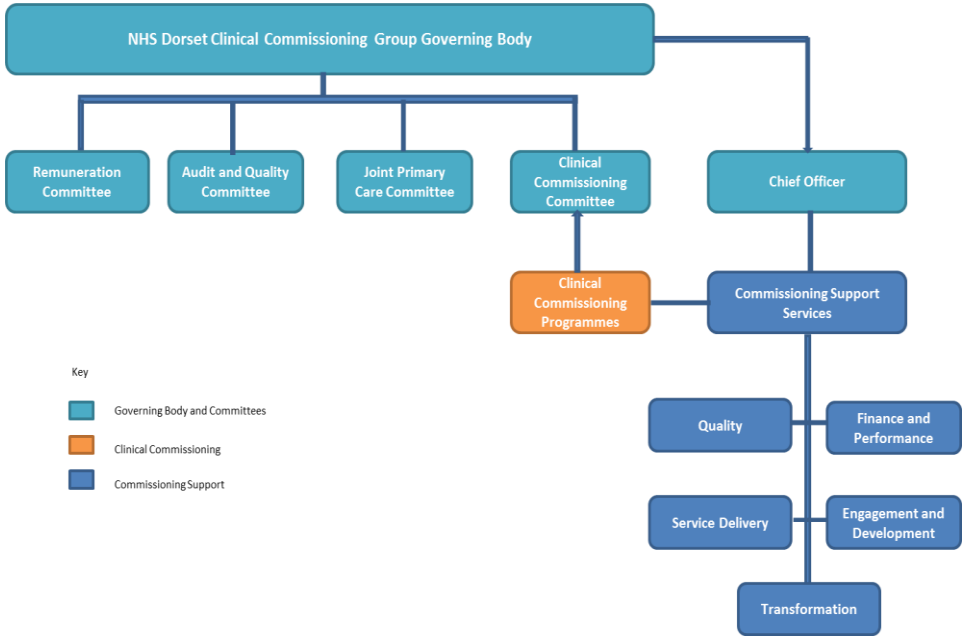
Our programmes have dedicated resource identified in terms of clinical and managerial leadership, and project support from the respective organisations. Each programme has its own detailed project plans and monitoring process in place.

CCG Governance arrangements

The diagram shows the relationship between the CCG Governing Body, its committees and our commissioning support services.

CCG 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 to both Health and Wellbeing Boards, Joint Commissioning Boards and Better Together Board. Details of the governance for clinical services review can be seen in **Appendix 2.**

CLINICAL COMMISSIONING PRIORITIES

During 2014/15 we aligned the workforce and priorities of our Clinical Commissioning Programmes to that of the four Clinical Working Groups to provide clinical leadership and management support of the system wide review of clinical services.

- Maternity and Paediatrics;
- Long Term Conditions and Frail Elderly;
- Planned and Specialist Care;
- Urgent and Emergency Care.

The priorities for delivery during 2015/16 aligned to the four Clinical Working Groups, but not subject to the CSR review formal process as agreed prior to and outsides CSR, can be seen in the tables below. These priorities support the delivery of the 5 NHS Outcomes Domains, the seven outcome measures and the NHS Constitution Standards (see **Appendix 3**)

MATERNITY AND PAEDIATRICS CLINICAL WORKING GROUP	**Supports delivery of:**						
Priority Project	**CCP Specific Priority**	**National**	**CSR**	**Better Together**	**Systems Resilience**	**Primary Care**	**Health and Wellbeing Board**
Implement the review of looked after children (LAC) health pathways including appointing a designated nurse, who will be appointed by the Quality Directorate	Maternity, Reproductive and Family Health	Y	Y				
Joint commissioning programmes to include: (a) Develop and implement attention deficit hyperactivity disorder/autistic spectrum disorder pathway b) Implementation of the Special Educational Needs (SEN)Act 2014 statutory requirements c) Continuation of the Review programme for children and adolescent mental health and Learning Disabilities services	Maternity, Reproductive and Family Health	Y	Y				Y
Implement the local assisted conception policy and guidance in line with national policy and guidance	Maternity, Reproductive and Family Health		Y				
Redesign of Termination of pregnancy services (TBC CSR)	Maternity, Reproductive and Family Health	Y	Y				
Review and redesign of children's audiology services	Maternity, Reproductive and Family Health	Y					

LONG TERM CONDITIONS AND FRAIL ELDERLY CLINICAL WORKING GROUP	Supports delivery of:						
Priority Project	**CCP Specific Priority**	**National**	**CSR**	**Better Together**	**Systems Resilience**	**Primary Care**	**Health and Wellbeing Board**
Evaluate the outcome and implications of the Kings Fund cardiology Review	Cardiovascular Disease		Y				
Respiratory- fully evaluate the impact of the primary care Chronic Obstructive Pulmonary Disease pathway (complete April 2016)	General Medical	Y	Y		Y		

PLANNED AND SPECIALIST CLINICAL WORKING GROUP	Supports delivery of:						
Priority Project	**CCP Specific Priority**	**National**	**CSR**	**Better Together**	**Systems Resilience**	**Primary Care**	**Health and Wellbeing Board**
Review of Physiotherapy Services	Musculoskeletal						
Review fracture neck of femur pathway and time to surgery	Musculoskeletal						
Redesign of referral management following completion of 2013/14 review	Cancer and End of Life						
Implement neurology service specification (Wessex mental health and dementia neurological conditions strategic clinical network project area)	General Medical		Y		Y		

URGENT AND EMERGENCY CLINICAL WORKING GROUP	Supports delivery of:						
Priority Project	**CCP Specific Priority**	**National**	**CSR**	**Better Together**	**Systems Resilience**	**Primary Care**	**Health and Wellbeing Board**
Develop, agree and implement local health and social care wide capacity management system	Coordinated Care				Y		
Review and implement Operational Resilience Capacity Plan , including clearly identified schemes	Coordinated Care	Y	Y	Y	Y	Y	

Mental Health and Learning Disabilities

The vision of the Mental Health and Learning Disabilities programme is "to value mental health equally with physical health to achieve Parity of Esteem and to provide equitable services across Dorset for people with learning disabilities and mental health conditions."

We are committed to delivering the ambitions and targets set out in the Five Year Forward View into Action. Detailed information on our current performance and the actions we are taking and priority projects to deliver the ambition are set out within this section.

Mental Health Access

Improving Access to Psychological Therapies: The new access time target is to receive treatment within 6 weeks for 75% of people referred to the Improving Access to Psychological Therapies programme, with 95% of people being treated within 18 weeks. **Currently** the CCG is delivering 98.7% within 28 days (Jan) for referral to assessment and 91.2% from first treatment to follow up within 28 days. As required under the forward planning guidance, the CCG has requested, through the Service Delivery Improvement Plan in the contract, that and action plan with trajectory is delivered within 3 months of receipt of national definition of the requirements.

Early Intervention in Psychosis: The new target is for treatment to be given within 2 weeks for more than 50% of people experiencing a first episode of psychosis. **Currently** 95% of people referred to the EIS receive treatment within 5 days from referral (contract reporting). As required under the forward planning guidance, the CCG has requested, through the SDIP in the contract, that an action plan with trajectory is delivered within 3 months of receipt of national definition of the requirements.

Dementia

The CCG dementia diagnosis rate is currently third in Wessex, fourth in the South of England and 94th in England.

The Memory Support and Advisory Service (MSAS) was commissioned from the Alzheimer's Society jointly with all three local authorities and the CCG and provides both pre and post diagnostic support to people with memory concerns and their carers across the whole of Dorset. This was launched in September 2014, and it has reported receiving over 1500 referrals in its first four months of operation.

The CCG has been working with Dr Alistair Burns' national team and the Wessex Strategic Clinical Network to develop and launch local guidance to GPs to enable them to diagnose dementia effectively, where appropriate, across Dorset. The CCG is also working with the Strategic Clinical Network on a toolkit for GPs to diagnose dementia in care homes, which is scheduled to be piloted in Wessex in Quarter 1 2015/16.

We have developed a dementia diagnosis and care improvement plan which sets out clear actions to support the achievement of diagnosis rates.

Learning Disabilities: Keeping people closer to home and out of hospital

The CCG commissions Community Learning Disability Teams and an Intensive Support Team to help to support people to live as independently as possible in their own local community. The Joint Commissioning Board for Learning Disabilities is currently scoping the options to commission an intensive residential nursing care service to assist further in delivering care to people closer to their homes and out of hospital.

Parity of Esteem

The CCG have been working with the Strategic Clinical Network to help to deliver Parity of Esteem. These are:

- developed a **local health passport** to prompt better joining up of physical health and health improvement issues in people with mental health conditions;
- assessing smoking rates in the population who have a serious mental illness to identify how best to offer cessation programmes for this cohort of clients;
- additionally the CCG has been leading the development of the Dorset Mental Health **Crisis Care Concordat:** 16 partners have been working together and have developed a cohesive action plan for 2015/16;
- we have also been working with partners to deliver a Street Triage Pilot to ensure S136 detentions are necessary and to reduce detentions in police cells.

The CSR has included discussion on mental health in each of its working groups including:

- delivering of out of hospital care for people living with anxiety and depression;
- improving mental health support and assessment particularly in acute hospitals including emergency departments;
- improving psychological support for people living with long term conditions in the community.

Mental Health and Learning Disabilities Priorities

The table below summaries the priorities for mental health and learning disabilities programme for delivery during 2015/16.

MENTAL HEALTH	**Supports delivery of:**						
Priority Project	**CCP Specific Priority**	**National**	**CSR**	**Better Together**	**Systems Resilience**	**Primary Care**	**Health and Wellbeing Board**
Implementation of dementia diagnosis and care improvement plan	Mental Health and Learning Disabilities	Y					Y
Implementation of the Joint Crisis Concordat action plan	Mental Health and Learning Disabilities	Y					
Memory Advisory and Support Service: Alzheimer's Society Contract	Mental Health and Learning Disabilities	Y		Y			Y
Review and redesign the functional mental health acute care pathway	Mental Health and Learning Disabilities	Y			y		
Street Triage : outcome from pilot (due June 2015)	Mental Health and Learning Disabilities	Y		Y			
Psychiatric Liaison Services	Mental Health and Learning Disabilities	Y	Y		Y		
Learning Disabilities: implementation of **Confidential inquiry into premature deaths of people with learning disabilities** (CIPOLD) recommendations	Mental Health and Learning Disabilities	y	Y	y			
Parity of Esteem	Mental Health and Learning Disabilities	Y	Y				Y

FINANCIAL OVERVIEW

NHS Dorset CCG has been recognised as under-funded and the 2015/16 growth award recognises this as Dorset moves towards our fair share of resources. Despite this good news it is recognised that this will not address the longer term financial gap that is predicted.

Our recurrent resource allocation for 2015/16 is £961.3m, the responsibility for commissioning Social Care Grant of £15.8m is transferring from NHS England to the CCG. Running costs allocations have been reduced by 10% and Dorset CCG will operate within a revised running cost allocation of £16.8m. The opening budget for 2015/16 will also include non-recurrent funding of £10m.

CCGs are required to plan for a surplus which is very challenging considering the pressures within the provider sector. NHS Dorset CCG has planned a surplus target at £15.2m, which is an increase on last years of £14.8m, equating to 1.5% of the CCG combined recurrent programme and running cost resource limit.

The CCG will pool £53m of health budgets with Local Authorities as part of the Better Care Fund in 2015/16 to create a total pooled budget of £60.2m.

The emphasis in 2015/16 will need to be one of continued financial control along with a focus to support the CCG to commission healthcare services for the future and deliver the outcomes necessary to deliver our strategic objectives. This will include providing non recurrent funding to support the implementation of the Clinical Services Review to support a more sustainable health and social care economy in the future.

The financial risk rating for 2015/16 and beyond is seen as high risk for the Dorset health economy, even though we have an excellent track record of achieving our financial duties. We operate in an environment where there is increasing demand for services, provider sustainability and pressures on continuing healthcare, which requires the support of the localities to ensure our finances, remain robust for this financial year and beyond.

Opening budget 2015/16 £1,019m

Acute services £513m

Mental health and learning disability services £109m

Community health services £79m

Continuing care services £79m

Better care fund £53m

Primary care services £26m

Prescribing £115m

Operating plan requirements £5m

Running costs £17m

Other commissioning £8m

Surplus £15m

SUPPORTING CLINICAL COMMISSIONING

COMMISSIONING SUPPORT SERVICES

NHS Dorset CCG has internal commissioning support services that support clinical commissioning and CCG development and assurance. The commissioning support function is organised within four directorates.

Directorate	Function
Quality	• quality; • information governance; • safeguarding; • patients safety and risk; • medicines management.
Service Delivery	• support and delivery of clinical commissioning projects; • continuing health care; • locality commissioning (primary care); • individual patient treatments; • patient contact centre; • personal health budgets.
Finance and Performance	• financial planning & management accounts; • financial accounts; • contracting and provider management; • business intelligence; • procurement; • information management and technology; • GP IT.
Engagement and Development	• Strategic planning; • CCG Assurance; • engagement and communications; • organisational development.

The commissioning cycle

In addition to our four directorates we have established a Clinical Services Review Programme Management Office (PMO) led by our Director of Transformation. The PMO will oversee and lead the CSR supported by management consultants working alongside a dedicated team from our internal commissioning support services (CSS)

The following section sets out the priorities for delivery for the commissioning support functions. It includes enablers and how NHS Dorset CCG will monitor performance and manage risks to deliver its strategy and delivery plan.

COMMISSIONING SUPPORT – Quality

The quality team supports NHS Dorset CCG to drive continuous improvement in services. The general definition of quality used by the NHS comes from Lord Darzi's NHS Next Stage Review, who defined quality as a combination of three factors: patient experience, patient safety and clinical effectiveness. The team is responsible for quality assurance and quality improvement, including the areas of patient safety and risk, infection prevention and control, safeguarding, information governance and medicines management.

Key priorities for delivery are:

Through the implementation of the CCG's Quality Framework we will ensure the following programmes of work are enacted during 2015/16:

Respond to National Publications and Inspections

- the findings from CQC inspections and intelligent monitoring reports will be used to inform the CCG of quality of care in provider organisations, ensuring any improvement actions are taken; learning from where care is good or outstanding;
- we will continue to monitor that the recommendations from the Francis, Berwick and Winterbourne View Reports are followed within all local health providers as part of routine contract monitoring and for ourselves as commissioners, through monitoring by the professional practice leads; This will be achieved by monitoring staffing levels and staff feedback, being open, the duty of candour and taking action when standards are not being met;
- we encourage a culture of transparency, openness and candour across the health system, to ensure that staff, patients and carers feel listened to and safe and secure when raising concerns and that we learn from patient safety incidents and 'never events' to prevent them from happening again; the process for reviewing serious incidents ensures that themes and trends are identified and shared with all providers;
- we will monitor the levels of incident reporting in provider organisations, encouraging high levels of reporting of incidents with "no harm" and "near misses", and use this information as an indication of a culture that promotes openness and honesty. The ambition will be for provider organisations to be amongst the top 25% of Trusts in the country for reporting to the National Reporting and Learning System (NRLS) whilst maintaining low levels of harm;
- we will work with NHS England and Local Authorities to continue to transform care for people with learning disabilities, improving the system of care; the Clinical Services Review will incorporate plans to develop out of hospital services for all patient groups and conditions including those with learning disabilities who experience crisis;
- people with a learning disability who are in crisis and receiving care in an inpatient facility will have their care plan reviewed regularly to ensure that they are moved to a suitable facility out of hospital as soon as possible, with a commissioning intention to develop a local short stay assessment unit;
- we will work with providers to embed the practice of clear clinical accountability with a named doctor responsible for a patient's care.

Patient Safety

- all local providers have signed up to the "Sign up to safety" campaign and are linked in with the Patient Safety Collaborative Programme. Each provider organisation will develop key areas of work as part of the sign up to safety campaign, examples of improvement areas include reduction in harm associated with pressure ulcers and falls, improving communication in relation to discharge from hospital and leadership development;
- as commissioners we will take an active part in the Patient Safety Collaborative and support provider organisations to develop improvement programmes through the "Sign up to Safety" campaign

which will include Sepsis. Key performance indicators will be developed which will include requirements for early detection and treatment by screening and early detection of sepsis on admission, and initiation of antibiotics within one hour of presentation, achieved through the implementation of a sepsis care bundle or pathway within the Emergency Departments;

- we will ensure all relevant providers implement the improvement standards regarding Acute Kidney Injury (AKI) which will include the introduction of the AKI algorithm to ensure people at risk are consistently assessed, ensuring that the triggers within the algorithm are integrated within pathology reporting systems, appropriate treatment is given and timely and appropriate communication is made to primary care to prevent further associated illness or hospital readmission. This area of improvement work will be applied across the health economy including community and mental health services;
- we will work with our providers and use contractual levers available to ensure that patients are treated in a safe environment, with an emphasis on zero tolerance of avoidable harm and ensuring that care is of the highest standard;
- we will ensure that systems are in place to measure and understand harm that occurs in healthcare services, and work with all agencies to improve safety;
- the Safety Thermometer will be used in all provider organisations to measure and reduce the level of harm; in addition there is an ambition to achieve zero preventable hospital acquired grade 3 and 4 pressure ulcers;
- we will continue to work towards reducing the number of other Health Care Associated Infections (HCAIs) and remain committed to a zero tolerance approach, with an ambition to achieve zero MRSA bacteraemia in acute hospitals.

Patient Experience

- we will work with providers to put mechanisms in place to systematically gather patient and carer feedback from the Friends and Family Test, complaints and other feedback sources including social media. Providers will be expected to analyse and present a summary of the feedback on a quarterly basis, identify any themes and trends and outlining improvement actions they will take as a result. The Friends and Family Test for staff will be included within the feedback analysis. The ambition will be for all providers to increase positive feedback;
- we will benchmark Friends and Family Test scores across providers and share these results;
- we will continue to use 'real-time' feedback from our patients and carers made directly to the CCG via a number of routes, including visits to clinical areas and patient involvement networks and forums. We will build on this to reduce poor experience of people who receive care and treatment from a range of providers.

Compassion in Practice

- we are committed to the full implementation of the "6Cs" and Compassion in Practice; ensuring that providers regularly monitor and publish staffing levels, ward leaders are given supervisory time to lead and that there is roll out of the indicators to measure patient experience and reduction in harms, as identified in earlier section of this report;
- we will support the roll out of the principles of "6Cs" to staff groups other than nurses within provider and commissioning organisations.

Safeguarding

- as a CCG we will continue to work closely with the Local Authorities to improve safeguarding of children and adults within Dorset;
- we will work closely with partner agencies to support the Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM) and honour based

crime agendas. This work will be overseen by the Safeguarding Boards of which we are active members;

- the successful commissioning of the multi-agency safeguarding hub (MASH) has been completed and it will be operational from 1 April 2015;
- there is ongoing training planned for Primary Care staff in both safeguarding children and adults;
- the CCG contributes to all Serious Case Reviews and will work with partners to implement changes identified through these reviews. Key areas of work include promotion of safe sleeping for babies and assessment of mental capacity for vulnerable adults;
- we have appointed a Mental Capacity Act (MCA) facilitator who is linking with partners and providers to improve the awareness of the MCA. Following a successful bid to NHS England the CCG is planning safeguarding and MCA training for General Practices and we will support and monitor providers on their compliance with MCA training to ensure all professionals are aware of their responsibilities;
- we have also appointed a GP who will lead on areas of work in relation to the MCA and PREVENT*, with a particular responsibility for raising awareness and training both for staff in commissioned services and the public;
- we will meet the legal duties of the NHS Safeguarding Accountability and Assurance Framework and will ensure provider compliance through the contractual process. Safeguarding consideration (including capacity) is considered as part of procurement and contracting processes. This will include ensuring providers have identified named safeguarding and MCA leads, safeguarding policies and training, safe recruitment practices and engagement with multi-agency safeguarding forums;

**PREVENT is a part of the government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism.*

- we will engage with partners to deliver the **PREVENT** agenda and will continue as a member of both the Contest Board and Pan-Dorset Prevent Group;
- workshops to raise awareness of PREVENT (WRAP) training are being built into safeguarding training and there are monitoring requirements for all providers. There are four CCG staff who are accredited WRAP trainers and the CCG is a key partner in the Channel Process and associated safeguarding plans. The CCG is developing a PREVENT policy for staff and Independent contractors;
- we will continue to implement the recommendations of the **Caldicott Review** and ensure the application of the recommendations in provider organisations and within the CCG, ensuring that data is shared when justified, aligned to the Caldicott principles.

Research and Innovation

The CCG actively supports research and has a strong culture of leading innovation, for example funding and leading a system wide Innovation Group, which has been identified by the Academic Health Science Networks. During 2015/16 we will:

- support research and innovation through continued adoption of measures in "Innovation Health and Wealth" and active promotion of primary care research;
- work with the Academic Health Science Network to promote research in practice, including board member sponsorship of the Dementia Programme.

Additional priorities for delivery are:

- **roll out of 'Seven Day'** services across health providers to ensure that providers meet the ten clinical standards;
- we are working towards **integration of services** across the health and social care system through the Better Together Programme;

- we wish to gain more in depth understanding of **provider staff satisfaction and** how to improve this in order to improve patient experience; in addition we will monitor workforce information in relation to training, absence and staff turnover rates and ensure that providers routinely undertake staff and patient dependency audits and take action to address any staffing shortfalls, we will do this through:
    - all main providers are reporting results of the staff friends and family test and results are available through NHS Choices. The 14/15 contract required implementation of staff FFT only so limited measurable improvement data is available. Main providers also produced action plans in response to the annual NHS Staff survey, with the aim of improving scores for overall engagement. Most action plans also include areas of focus on the bottom five results for the trusts. All trusts have implemented elements of values based recruitment as a method to improve retention and satisfaction for new starters.
    - CCG assurance visits now include questions to explore staff experience in providers such as; What is it like to work here? How is staff morale? Are there any areas where the quality of care for patients could be improved? Do you have access to clinical supervision? Awareness of policies such as safeguarding risk and incident reporting, being open, complaints, infection control. Comparison of findings will be possible at subsequent visits. The quality scorecard for providers will also include reporting on staff FFT results and the staff survey is mandated in the surveys schedule. It is anticipated exception reporting will be expected to describe changes in scores and represent some triangulation with patient experience results.
    - there is limited evidence of comparison and benchmarking against similar organisations although the staff survey results are presented in this format. Local providers are involved in the Better Together Programme which has workforce subgroups and the Clinical Services Review. Some trusts are also considering shared recruitment opportunities and rotational roles giving staff a broader experience and developing flexible skills.
- we will increase our focus on **improving quality within Primary Care**, working closely with NHS England on co-commissioning. We will provide support and resources to develop the Primary Care workforce.

MEDICINES MANAGEMENT PRIORITIES

Medicines priorities for 2015/16 will be to maintain the cost effective and evidence based approach to prescribing advice. This will be done in primary care prescribing through the Medicines Optimisation Group and across the health community through the pan Dorset formulary, safely managing the entry of new drugs, traffic light and shared care systems overseen by the Dorset Medicines Advisory Group.

Financial priorities will be to ensure that where possible practices are encouraged to free up funding to afford new medicines by ensuring maximised use of generics and minimise use of medicines that are either not recommended or of limited clinical value. Where a NICE technology appraisal has identified that a new and high cost drug is to be made available, ensure through audit and financial analysis that it is only being used within the NICE specified criteria.

Multidisciplinary working will be encouraged, by supporting practices to work closely with local pharmacies to identify appropriate patients who can benefit from repeat dispensing, especially in connection with electronic prescribing systems to ensure that GP time can be freed up at a time of great pressure in primary care.

Ensure that medication reviews, and reconciliation of patient medicines in the practice are done effectively, using Polypharmacy tools where appropriate and support practices and localities seeking to access additional pharmacist support, at practice and community level, working with community pharmacists to get the most from the New Medicines Service and Medicines Use Reviews.

Where additional services are being commissioned and developed, support localities to identify how improved or additional pharmacist support may help them reduce medicines related admissions and long term condition management.

Support service delivery leads in identifying how community pharmacy can be commissioned to deliver improved outcomes as part of developments in primary care. Advise on the commissioning and development of such services in localities and the whole CCG.

Respond to potential changes in primary care as practices federate or otherwise change the way in which they operate, ensuring that the prescribing budget is considered and amended accordingly.

Maintain a focus on safe medicines use, challenging high or inappropriate prescribing of medicines with known safety or abuse potential. Medicines for particular focus in 2015/16 are use of long term anti-emetics, excess opioid use, particularly short acting preparations and other drugs now recognised to have abuse potential such as Pregabalin.

Benchmarking within the CCG and across the sub region and NHS England using the Medicines Optimisation Dashboard, addressing areas where the CCG is an outlier. Areas of focus include promoting use of repeat dispensing systems, improving uptake of NICE approved drugs where there is an improved outcome for patient care and addressing areas of high prescribing such as use of laxatives.

Work with NHS England colleagues in Controlled Drugs monitoring and safety and on any transitions to CCG responsibility that may arise as part of organisational changes.

Antibiotic Stewardship

The safe and appropriate use of antibiotics is monitored and benchmarked across practices within the CCG and across the sub region of NHS England. In addition, annual audits and awareness campaigns have been undertaken within the CCG.

The results of the 2014/15 audits, especially data on indications for Cephalosporins and Quinolones should provide useful information upon which to monitor future prescribing.

In addition for 2015/16 the medicines team will promote the use of the Target Toolkit and associated supporting materials across Dorset. This will include a focus on conditions rather than just individual antibiotic agents with the aim of engaging more GPs.

The audits provided by Target on Urinary Tract Infections and Acute Sore Throat will be promoted to practices. Implementation of the Target Toolkit would be expected to have a wider benefit in antibiotic stewardship than just on the audited conditions.

The medicines team is also seeking to engage Dr. Michael Moore (RCGP National Clinical Champion for Antimicrobial Stewardship) to assist us in launching this by supporting initial teaching sessions and encouraging practices to lead on this themselves.

Use of the Target toolkit will align closely with the standards set by the quality premium and the standards will be promoted by Medicines Team at practice visits.

In secondary care it is hoped to engage the local antibiotic pharmacists and microbiologists in an anti-microbial working group with secondary and primary care representatives which will facilitate sharing of information across the interface. This should allow additional guidance to be developed for conditions not covered by current HIOW guidelines.

The medicines team have indicated to the producers of the current HIOW antibiotic guidelines that we would like to have Dorset included in any review and re-issue.

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

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 2015/16 will include the national and local schemes of:

National CQUIN Schemes

- Acute Kidney Injury;
- Sepsis;
- Dementia and Delerium;
- Mental Health;
- Urgent and Emergency care;

Local CQUIN Schemes

- Mental Health and Learning Disabilities;
- Admissions Avoidance;
- Discharges;
- Cancer.

QUALITY PREMIUMS

National Quality Premium Indicators

- reducing potential years of lives lost through causes considered amenable to healthcare;
- urgent and emergency care:
    - Avoidable emergency admissions;
    - Delayed transfers of care which are an NHS responsibility;
    - Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.
- mental health:
    - Reduction in the number of patients attending an A&E department for a mental health-related needs who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.
- improving antibiotic prescribing in primary and secondary care.

Local Quality Premium Indicators

- Estimated diagnosis rate for people with dementia;
- Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement and rehabilitation services.

COMMISSIONING SUPPORT – service delivery

The service delivery function of the organisation is responsible for supporting the localities, clinical working groups and transformational programmes.

Within the programmes they lead on service review and design, ensuring that communication and engagement, innovation, quality and financial and clinical sustainability are considered and embedded within commissioning. In addition to this, the service delivery function is responsible for contract setting, performance management and procurement of services; personalisation, continuing healthcare (CHC); individual patient treatment requests and the patient contact centre.

The priorities of the service delivery team can be seen within the clinical commissioning priorities section of the delivery plan.

In addition to these we will continue to commission services to enable people to be independent and manage their own care through a continued focus on:

- personal health budgets for CHC;
- implementation of technologies;
- supporting carers through partnership working with social care;
- continue to support self-management through commissioning of My Health My Way.

COMMISSIONING SUPPORT – engagement and development

The engagement and development directorate is responsible for three core functions:

- planning and assurance;
- communications and engagement;
- organisational development.

The priorities for the directorate can be seen in the following sections.

STRATEGIC PLANNING AND PRIORITISATION

The strategic planning and prioritisation functions of the organisation support clinical commissioning by ensuring that the organisation, localities and the clinical commissioning programmes understand and have access to health needs analysis information relating to the people in Dorset. In addition the team works across directorates and with partner organisations to facilitate and enable the wider 'commissioning intelligence' perspective to be considered when prioritising how and where NHS Dorset CCG should focus its resources. This wider perspective includes working with Public Health colleagues, using insights from stakeholder audiences, feedback from patients and by monitoring the quality and equity of the services being provided and the outcomes that they deliver.

Key priorities for delivery are:

- enhance existing strategic management and planning systems and processes, including the joint development of the Dorset Commissioning Intelligence Group and development of NHS Dorset's strategic planning and prioritisation framework;
- review and refresh the CCG's strategy in line with the outcomes of the Clinical Services Review;
- working across the CCG and with partners to develop and implement business continuity plans, emergency planning rotas, incident plans and provider assurance and support multiagency working;
- delivery of the organisation's Annual Report and Accounts.

CCG AND CSS ASSURANCE

The assurance function works across the organisation to support, develop and coordinate the CCG's assurance processes. This includes working with commissioning support directorates to develop and implement the required reporting processes and the facilitation of information required for the quarterly checkpoint assurance meetings related to the domains of CCG Assurance and the internal quarterly and annual CSS Assurance process.

Key priorities for delivery are:

- continue to work across the CCG to review and implement interventions and local processes to support CCG Assurance;
- facilitate the checkpoint reviews for the CCG;
- work with directorates to put in place necessary reporting/ development processes as required;
- review and implement required changes to the CSS assurance process for 2015/16;
- design and develop the CSS annual report including 360 CSS Stakeholder survey.

COMMUNICATIONS AND ENGAGEMENT – Engaging Communities

The engagement and communications team provides effective and professional advice and support to NHS Dorset CCG at a corporate and programme level. The team ensures patient, public, stakeholder and staff views and issues are anticipated, heard and managed consistently for the best outcomes for the organisation.

We are committed to involving people in our commissioning processes and decisions. We have very clear statutory duties with regard to individual and public participation and these are embedded within the way we work. Involving our stakeholders and communicating effectively will be critical to our success and is at the heart of everything we do.

We have in place an Engagement and Communications Framework and detailed implementation plans which set out in more detail how we will meet our statutory duties and how we will be adopting good practice in engagement to support the CCG in becoming an excellent clinical commissioning organisation.

Key priorities for delivery are:

- supporting the Clinical Services Review engagement and communications activity, in particular consultation during summer 2015;
- proactively supporting our membership enabling them to engage in the work and decision making of the CCG;
- continued development of health involvement networks and patient participation groups, including locality engagement;
- undertaking a communications review to ensure that NHS Dorset CCG provides high quality communications both internally and externally;
- continue to work with diverse groups to understand how best to communicate and engage them in commissioning decisions;
- development of proactive and robust media management plans.

ORGANISATIONAL DEVELOPMENT

The organisational development team provides internal organisational development advice, guidance and support for NHS Dorset CCG staff including the clinical and Governing Body leadership and the development of its member GP practices. In addition the team provides strategic human resource advice and guidance both within the organisation as well as working collaboratively with professional colleagues across the wider health and social system.

The team supports the clinical commissioning and transformational programmes by providing workforce planning and impact assessments for service reviews and clinical pathway redesigns.

Key priorities for delivery are:

- continuing to develop and embed our role as confident and consistent leaders, enabling us to build stronger and more meaningful relationships with partners, stakeholders and our membership;
- leadership of the CCG transition, ensuring that we remain fit for purpose and also to flexibly meet the ongoing needs of the organisation;
- Governing Body development and clinical succession planning;
- review and alignment of CCG development events, to the commissioning cycle, enabling membership, locality and commissioning support development;
- leadership and management development which enhances succession planning and is based on role modelling our values and behaviours;
- supporting and enabling CCG and CSS assurance (capacity and capability of the Governing Body and commissioning support workforce to meet and where possible exceed expectations);
- understanding and supporting the wellbeing of our workforce;
- maintain oversight of workforce assurance through working in partnership and collaborating with providers and understanding the impact of the existing workforce to deliver change and transformation.

STAFF SATISFACTION

CCG Staff

The organisational development team provides guidance and support to enable the CCG to create a positive working environment where staff feel involved, are motivated in their roles and are able to contribute to the delivery of the CCG's strategy and objectives in line with the NHS Constitution. Ultimately if staff have an enriching work experience this will lead to greater levels of staff satisfaction.

The team measures the levels of staff satisfaction on a monthly basis through the internal workforce scorecard, as and when basis through internal surveys and feedback questionnaires, and through the annual staff survey.

Key priorities to ensure staff satisfaction are:

- developing a culture which recognises and values the contributions that everyone makes;
- ensuring staff have a defined role with clear responsibilities and accountabilities;
- creating a work environment, both physical and cultural, that is conducive to staff satisfaction, supports their wellbeing and meets the needs of staff;
- developing a culture which engages and involves staff through a variety of mechanisms;
- creating an organisation which involves staff in key decisions which affect their work;
- developing an environment which encourages internal development and progression.

COMMISSIONING SUPPORT - finance and performance

FINANCE

Commissioners are expected to make sound financial investments to ensure sustainable development and value for money. Excellent financial skills and clinical resource management will enable the management of the financial risks involved in commissioning and to take a proactive rather than reactive approach to financial management.

The key skills of the team are:

- professional financial management;
- business-case modelling;
- financial impact and risk assessment;
- financial planning;
- programme budgeting;
- processes and knowledge requirements of the complex world of NHS finance.

Key priorities for delivery are:

- customer satisfaction with financial support service to clinical programmes;
- support greater working with localities;
- compliance with Department of Health statutory duties;
- achieve the financial targets set;
- regularly report and monitor the financial performance of the CCG;
- support strategic requirements including CSR, Systems Resilience and Better Together;
- cash management - ensure all undisputed commissioning invoices are paid within 30 days;
- compliance with standing financial instructions;
- financial training for clinicians and managers.

PROCUREMENT

Procurement and market management support the delivery of commissioning priorities and facilitate the agreement of strong, secure contracts which ensure services meet the health needs of the population and the priorities of the organisation.

The service supports NHS Dorset CCG, clinical teams and other support functions during the planning and design of services. The team has skills in project management and provides the facilitating role for the accreditation, tendering, evaluation and negotiation with potential providers. They also ensure robust performance and reporting arrangements are included in the final contract to support the performance monitoring of providers.

Key priorities for delivery are:

- support the delivery of the CCG delivery plan through a structured procurement work plan;
- interpret and implement the requirements of Section 75 of the Health and Social Care Act;
- continue to provide educational and support programmes for:
  - GPs as commissioners;
  - localities;
  - procurement for review, design and delivery;
- continue to work with the CCPs/CRGs to understand and develop the provider market;
- integrate and align best practice procedures for procurement alongside other commissioning support services.

CONTRACTING AND PROVIDER MANAGEMENT

The provider and contract management team supports the organisation to implement effective and robust contracts with providers of health care. They hold providers to account for delivery of these services and ensure that improvements are delivered against the outcomes which have been agreed with the commissioner.

NHS Dorset CCG uses the NHS contract for all contracts with providers and ensures all national terms and conditions, fines and sanctions are applied to provider organisations. Fines and performance are tracked every month via the formal contract management process and these are supported by the CCG's internal support services from the contracting, business intelligence and contracting functions.

Contracts are in the main set on a full payment by results basis but with in-year risk sharing to ensure financial stability across Dorset for both providers and commissioners.

The formal contract query process is used when required to manage providers and will apply sanctions where necessary. However in the interest of partnership working the CCG and providers make every effort to avoid the use of formal processes if performance can be improved without the need for contract or financial consequences.

NHS Dorset CCG manages its contracts with Trusts outside of Dorset by using either contracts with support services supplied from either NHS South Commissioning Support Unit (for providers in the central southern region) or from Optum (for contracts with London providers). NHS Dorset CCG support services recognises that to deliver the best value for the CCG there is a requirement to outsource contract management for contracts such as these to those best placed to manage the providers.

NHS Dorset CCG has a strong track record of meeting the national deadlines for signing contracts and it is testament to this that the CCG is usually one of the first to achieve contract signature and has the most contracts signed when compared across the southern region.

Using the support of the business intelligence and finance functions they will:

- provide comparative analysis of provider cost and performance to help NHS Dorset CCG to achieve measurable improvement in the quality of healthcare, while controlling the overall costs to the system through more sophisticated contract management;

- develop the systems and processes to enable access to real time information and feedback about the organisations which supply services, the economics of the providers, and other benchmarks that reveal impacts upon the provision of services.

Provider management operates contract governance arrangements and clear accountabilities for leadership on contract negotiation and management.

BUSINESS INTELLIGENCE

Good business intelligence services ensure that the right information is available at the right time to support clinical insight. This enables NHS Dorset CCG to make effective commissioning decisions for patients. Data is an essential and valuable organisational resource; critical to the management of services, budgets, forward planning and to the timely identification of provider and service issues.

The management and interpretation of nationally evolving requirements relating to system security and information governance will continue to dominate the complex and evolving data sharing environment. Such changes will continue to influence and shape the delivery and effectiveness of business intelligence services throughout 2015/16 and beyond.

Key priorities for delivery are:

- continue to work with clinicians closely and proactively as part of a locality wide business intelligence resource;
- further development of key business intelligence systems and resources to enable local level reporting, analysis and interpretation;
- development of business intelligence support to primary care to support co-commissioning within the CCG;
- increased emphasis on patient centric systems and management of data and reporting functions with specific attention given to the evolving national requirements around data sharing and use;
- deployment of systems, developed with reference to customer requirements and engagement, that support and add value to clinical decision making;
- increased emphasis on benchmarking clinical quality and performance indicators across providers, including across primary care providers;
- focus on the further development of a full suite of automated business intelligence resources that reflect customer requirements.

Dorset is part of the Wessex Area Team acute sector activity modelling project. This project feeds into the Dorset Clinical Services Review. In addition to this project, Dorset undertakes a series of modelling assumptions within acute sector contracts each year that feed into the activity planning process co-ordinated by NHS England. In particular this process ensures that changes in demand which impact on providers can be built into Trust contracts via activity and financial baselines and that this will then triangulate with plans supplied to Monitor and Trust contracts. This process also takes into account any developments or service reconfiguration agreed by the CCG as part of the regular commissioning cycle - in this case priorities set by CCPs are translated into activity and finance profiles and fed into contracts via the contract variation process.

INFORMATION MANAGEMENT AND TECHNOLOGIES (IM&T)

NHS Dorset CCG's Information Plan sets a vision for information management and technology across the organisation and reflects our mission to support people in Dorset to lead healthier lives by using IM&T to help achieve its aims and values. The plan reflects local requirements driven by improvements in the quality of care, patient health and care outcomes, the reduction of inequalities and increased productivity and efficiency.

The CCG IM&T plan is being updated to reflect 'Personalised Health and Care 2020' which was published in November 2014 and sets out the national direction for using data and technology to transform outcome for patients and citizens. The key workstreams are:

- enable me to make the right health and care choices – citizens to have full access to their care records and access to an expanding set of NHS accredited health and care apps and digital information services;
- give care professionals and carers access to all the data, information and knowledge they need – real-time digital information on a person's health

and care by 2020 for all NHS-funded services, and comprehensive data on the outcomes and value of services to support improvement and sustainability;

- make the quality of care transparent – publish comparative information on all publicly funded health and care services, including the results of treatment and what patients and carers say;
- build and sustain public trust – ensure citizens are confident about sharing their data to improve care and health outcomes;
- bring forward life-saving treatments and support innovation and growth – make England a leading digital health economy in the world and develop new resources to support research and maximize the benefits of new medicines and treatments, particularly in light of breakthroughs in genomic science to combat long-term conditions including cancer, mental health services and tackling infectious diseases;
- support care professionals to make the best use of data and technology – in future all members of the health, care and social care workforce must have the knowledge and skills to embrace the opportunities of information;
- assure best value for taxpayers – ensure that current and future investments in technology reduce the cost and improve the value of health services and support delivery of better health and care regardless of setting.

In addition to the main work streams above, specific actions and commitments are made in the national strategy:

- expand national system including EPS, e-referral and NHS Choices. National apps will be developed and the NHS Spine Service will be expanded. It is expected that there will be more IT training and support for GPs;
- data standards and messaging for integrated records will be developed, CCGs and practices will be assessed using a Clinical Digital Maturity Index, Information Governance and better data sharing with care agencies is required;
- transparency and publication of data is a key theme running throughout the strategy;
- security of data is required as is informed choices by patients on sharing data. There is an emphasis on the use of data for research and development;
- training and development of staff is required which will be led by national bodies. CCGs will be expected to ensure value for money in their informatics expenditure.

The workstreams above separate into a series of projects that are either related to improving CCG IT or improving primary care IT.

CCG IT WORKSTREAMS

Following completion of the consolidation of PCT IT into a single CCG IT Infrastructure, CCG IT workstreams focus on developing CCG IT to support integrated mobile working within a secure and reliable infrastructure. Key workstreams include:

- development of the physical infrastructure and network links between sites, rationalisation of IT on disparate bases and consolidation of services on key HQ bases;
- implementation of modern integrated IP based telephony following the successful tendering in 2014-15;
- development of collaboration tools for remote working in a office-independent setting, including mobile working initiatives;
- improvement in management and resilience of CCG systems.

PRIMARY CARE IT WORKSTREAMS

Funding for primary care IT has increased and combined with the capital funding from NHS England has allowed for a series of ambitious plans in the following areas:

- Dorset Care Record - The CCG has worked with the local authority on a matched funded £5m technology bid to develop a Dorset Care Record.

The programme is led under the Better Together banner with input from the Dorset heads of IT group. The plans are aligned with national strategies and are closely related to developments in the GP Systems of Choice Programme that will improve integration between GP clinical systems;

- GP practice infrastructure - Phase 2 of the server/switches infrastructure plans are underway and will complete in 2015 to make primary care IT systems faster and more reliable;
- a new GP IT support contract has been tendered and implemented and will be operational during 2015-16, with benefits to support resilience, disaster recovery and improved IT response times;
- to support mobile working and integrated care, a WiFi programme has been tendered and will be implemented in each GP practice during 2015. This will allow NHS workers from many local NHS organisations to more readily access WiFi in practices and support mobile GP working;
- Primary care IT developments - a series of developmental programmes around national system deployment such as Electronic Prescription Service, GP2GP, Summary Care Record are being rolled out with increasing compliance across the patch. Smartcard services are being provided for the Area Team along with Information Governance and mail for primary care contractors.

PAPERLESS NHS

The CCG is committed to working with partners to achieve a paperless NHS, in doing this through our contracts and our IT strategy (as overleaf) we will work towards achieving the following national standards:

- electronic discharge summaries are in place by October 2015;
- 80% of GP referrals being sent electronically to providers by 31st March 2016;
- 60% of GP prescriptions being sent electronically to pharmacies by 31st March 2016.

MONITORING PERFORMANCE

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

The team monitors the quality standards and outcomes set out in 'The Five Year Forward View' and NHS Outcomes Framework, including the elements within the CCG Quality Premium. Close working with the Finance and Provider Management Teams ensures a joined up approach to ensuring NHS England and CCG performance goals are achieved. The team will be focussing on:

- 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. These will be 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;
- any risk to delivery will be managed through existing structures and using appropriate contract controls and levers with providers.;
- the CCG being required to provide assurance to NHS England on six domains, working closely with the Wessex Area Team as required;
- supporting the Clinical Services Review in achieving its aims.

MANAGING RISK

The CCG is committed to minimising risks to which it is exposed, strategically and corporately. The overriding aim is to reduce the potential for loss of services due to adverse events, financial management or performance and quality management of commissioned services that could ultimately be of detriment to the population the CCG serves.

In order to achieve this aim, risk management has become part of the culture of the organisation, and become a primary concern of all staff and stakeholders. The Risk Management Strategy was approved and endorsed by the Governing Body in December 2012 ready for use in April 2013 to reflect the CCG's risk management requirements.

The Risk Management Strategy:

- sets out the organisation's objective to identify, treat and mitigate risk;
- defines the role and objectives of the CCG's committees and groups. It describes the supporting strategies, policies and procedures that determine the management and ownership of risk and the management of situations in which control failure leads to material realisation of risks;
- specifies the way in which risk issues are to be considered at each level of planning, ranging from the corporate objectives set out in the CCG's Delivery Plan to the individual objectives within Directorates;
- specifies risk assessment and identification processes for new and existing activities and the resultant risk action plans and how these are captured within the Corporate Risk Register for the organisation;
- standardises and clarifies the terminology of risk management and establishes clear, consistent and effective risk scoring systems;
- explains the Governing Body Assurance Framework and assesses the risk and the impact of failure, identifies the control mechanisms to monitor these objectives and clarifies the assurances that are present to review and monitor the implementation of objectives;
- explains the risk scoring system that enables the organisation to impartially assess risk and identify high risk areas.

Assurance is provided through the Governing Body Assurance Framework which is received at every meeting. In addition there is devolved responsibility to the Audit and Quality Committee who receive the full organisation Assurance Framework on a quarterly basis in addition to the full Corporate Risk Register. The Assurance Framework receives an annual audit with the last one providing 'significant assurance'. The assurance processes of the organisation are annually reviewed via the Annual Governance Statement which is signed by the Chief Officer.

Work has now been completed to redesign the Governing Body Assurance Framework which has resulted in it being more streamlined, focussing on the key risk areas in relation to the strategic objectives. The previous version of the Assurance Framework has now become the Corporate Risk Register and will continue to be a supporting document to the new assurance framework. This work was approved by the Governing Body in November 2014.

KEY DELIVERY RISKS AND MITIGATING ACTIONS

RISK	SEVERITY	LIKELIHOOD	MITIGATION
Organisational self-interest- ineffective partnership working resulting in ineffective integration of services.	H	M	Robust clinical commissioning programmes in place with appropriate communications networks, partners and stakeholders. Development of joint priorities and action plans.
NHS providers sustainability - impacting on services delivery and implementation of service changes.	H	H	Work with providers to ensure safe, effective and efficient implementation of services. Continued monitoring and review of contracts.
Impact on NHS providers, particularly secondary care in transferring money to the Better Care Fund, and diverting from front line NHS services.	H	M	CCG to align contractual spend against pooled fund.
Increase in prescribing growth.	M	M	Robust monitoring of prescribing spend for primary care in place. Implementation of formulary and NICE TAs will support budgetary control and demonstrate adherence to NHS Constitution. Medicines input into pathway development linking to CCPs.
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.
Increase in Continuing Health Care (CHC).	H	M	Robust management of CHC and monitoring of CHC contracts in place.
Failure to achieve QIPP target.	M	M	Robust clinical commissioning programmes in place. Work with providers to ensure safe, effective and efficient implementation of services.
Public, patient, stakeholder challenge and judicial review.	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.
New health system and commissioning arrangements as well as new officers in place which will take time to embed.	M	M	Develop strong relationships and links with NHS England, Local Area Teams, and specialist commissioners, clinical senates and Local Education and Training Board.
Change of political direction could take the focus from delivery of the transformational programmes.	M	M	Maintain strong links with partners and providers to ensure service delivery is not impacted by changes in policy.
Failure of internal Commissioning Support capacity to deliver commissioning requirements of CCG.	M	M	Robust performance monitoring of internal commissioning support against locally defined key performance indicators to enable identification of any cause for concern.
Failure of outsourced services to deliver against anticipated expectations.	M	M	Contract monitoring in place to identify any cause for concern and taking appropriate action.

HOW WE WILL KNOW WE HAVE DELIVERED OUR PLAN?

NHS England have identified 5 domains which flow from the Government's Mandate to NHS England and the NHS Outcomes Framework. These five domains describe the outcomes, which NHS England expects to see CCGs support them in delivering. These outcomes have also been translated into 7 specific measurable ambitions, which will be critical indicators of success. To understand our ambition we have assessed our current performance against these outcome ambitions at both CCG and local authority level; the following section details our current performance and ambitions outcomes.

Current Performance

DOMAIN	INDICATOR	ORGANISATION	PERIOD	PERFORMANCE LEVEL (LATEST)
1	**Securing additional years of life**: Potential Year of Life Lost (PYLL) from causes considered amenable to healthcare - persons of all ages Directly Standardised rate per 100,000 population	Dorset CCG	2013	Achieving second lowest quintile performance
		Dorset CC	2013	Achieving lowest decile performance
		Poole UA	2013	Achieving second lowest quintile performance
		Bournemouth UA	2013	Achieving second highest quintile performance
2	**Increase the quality of life for people with LTC**: Health related quality of life for people with LTC Total EQ-5Q per 100 people with LTC	Dorset CCG	2013/14	Achieving second highest quintile performance
		Dorset CC	2013/14	Achieving second highest quintile performance
		Poole UA	2013/14	Achieving second highest quintile performance
		Bournemouth UA	2013/14	Achieving mid tier performance
3	**Reduce the amount of time people spend unnecessarily spend in hospital**: Composite of all avoidable emergency admissions Indirectly Standardised per 100,000 population	Dorset CCG	2013/14	Achieving lowest quintile performance
	Reduce the amount of time people spend unnecessarily spend in hospital: Unplanned hospitalisation for chronic amulatory care sensitive conditions Indirectly Standardised per 100,000 population	Dorset CC	2013/14	Achieving lowest quintile performance
		Poole UA	2013/14	Achieving mid tier performance
		Bournemouth UA	2013/14	Achieving mid tier performance
	Reduce the amount of time people spend unnecessarily spend in hospital: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s Indirectly Standardised per 100,000 population	Dorset CC	2013/14	Achieving mid tier performance
		Poole UA	2013/14	Achieving second highest quintile performance
		Bournemouth UA	2013/14	Achieving second highest quintile performance
	Reduce the amount of time people spend unnecessarily spend in hospital: Emergency admissions for acute conditions that should not usually requires hospital admission Indirectly Standardised per 100,000 population	Dorset CC	2013/14	Achieving lowest decile performance
		Poole UA	2013/14	Achieving second lowest quintile performance
		Bournemouth UA	2013/14	Achieving second lowest quintile performance
	Reduce the amount of time people spend unnecessarily spend in hospital: Emergency admissions for children with lower respiratory tract infections Indirectly Standardised per 100,000 population	Dorset CC	2013/14	Achieving mid tier performance
		Poole UA	2013/14	Achieving highest quintile performance
		Bournemouth UA	2013/14	Achieving mid tier performance
4	**Reduce the number of people reporting very bad care in hospitals**: Patient experience of hospital care - average number of negative responses per 100 patients Negative responses per 100 patients, weighted, crude rate	Dorset CCG	2013	Achieving lowest quintile performance
	Reduce the number of people reporting very bad primary care (GP, Out of Hours and Dentistry): Patient experience of primary care - average number of negative responses per 100 patients Negative responses per 100 patients, weighted, crude rate	Dorset CCG	2013/14	Achieving second lowest quintile performance

Outcome Ambition Trajectories

The table below sets out the outcome ambition trajectories Appendix 2 identifies how the priorities set out within this delivery plan will support the delivery of these outcome measures.

Domain	7 Outcome Ambitions	Baseline Measure	Target 2014/15	Target 2018/19
Domain 1	Securing additional years of life for the people of England with treatable physical and mental health programmes National Measure: Potential years of life lost from conditions considered amendable to healthcare.	1691.7 (per 100,000 population)	1685.0 (per 100,000 population)	1650.0 (per 100,000 population)
Domain 2	Improving the health related quality of life of the 15million + people with one or more LTC, including mental health problems National Measure: Health related quality of life for people with long term conditions	74.5 (Average EQ-5D Score)	74.75 (Average EQ-5D Score)	76.0 (Average EQ-5D Score)
Domain 3	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital National Measure: Emergency Admissions Composite Indicator rate per 100,000 population	1659.9 per 100,000 population)	1577.0 per 100,000 population)	1500.0 per 100,000 population)
	Increasing the proportion of older people living independently at home following discharge from hospital • Bournemouth and Poole Health & Wellbeing		84.8%	(15/16 Plan) 86.5%
	• Dorset County Council	76.3%	90.3%	91.0%
	• Borough of Poole Council	78.9%		
	• Bournemouth Borough Council	74.5%		
Domain 4	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care National Measure: The Proportion of people reporting poor patient experience of inpatient care	136.4	134.0	130.0
	Increasing the number of people with mental and physical conditions having a positive experience of care outside hospital in general practice and in the community National Measure: The Proportion of people reporting poor patient experience of General Practice and Out of Hours Services	4.0	3.95	3.75
Domain 5	Making significant progress towards eliminating avoidable deaths in our hospital caused by problems in care National Measure: Hospital Deaths attributed to problems in care (indicator under development) however links C.Diff, MRSA and VTE all of which have nationally set trajectories included NHS Standard contract.	Indicator under development	Indicator under development	Indicator under development

APPENDICIES

Appendix 1: Clinical Services Review – Need to Changes

Appendix 2: CSR Governance

Appendix 3: Alignment of Priority Projects against Domains

Dorset's Clinical Services Review
shaping your local NHS

APPENDIX 1
Clinical Services Review – Need to Change

4 February 2014

NHS
Dorset
Clinical Commissioning Group

Your vision • Your voice • Your NHS

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.

Dorset Clinical Commissioning Group Governing Body:

Dr Forbes Watson, *CCG Chair*

Dr Paul French, *Locality Chair for East Bournemouth*

Dr Richard Jenkinson, *Locality Chair for Christchurch*

Dr Blair Millar, *Locality Chair for Dorset West*

Dr Andy Rutland, *Locality Chair for Poole Bay*

Dr Jenny Bubb, *Locality Chair for Mid Dorset*

Dr Rob Childs, *Locality Chair for North Dorset*

Dr Colin Davidson, *Locality Chair for East Dorset*

Dr Karen Kirkham, *Locality Chair for Weymouth and Portland*

Dr Tom Knight, *Locality Chair for North Bournemouth*

Dr Chris McCall, *Locality Chair for Poole North / Assistant Clinical CCG Chair*

Dr Patrick Seal, *Locality Chair for Poole Central*

Dr David Haines, *Locality Chair for Purbeck*

Dr Peter Blick, *Locality Chair for Central Bournemouth*

Mary Monnington, *Registered Nurse Member*

Dr Chris Burton, *Secondary Care Consultant Member*

Teresa Hensman, *Lay Member: Audit and Quality Chair*

David Jenkins, *Lay Member: Deputy CCG Chair / Public Engagement Member*

Tim Goodson, *Chief Officer*

Paul Vater, *Chief Financial Officer*

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

Contents

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.

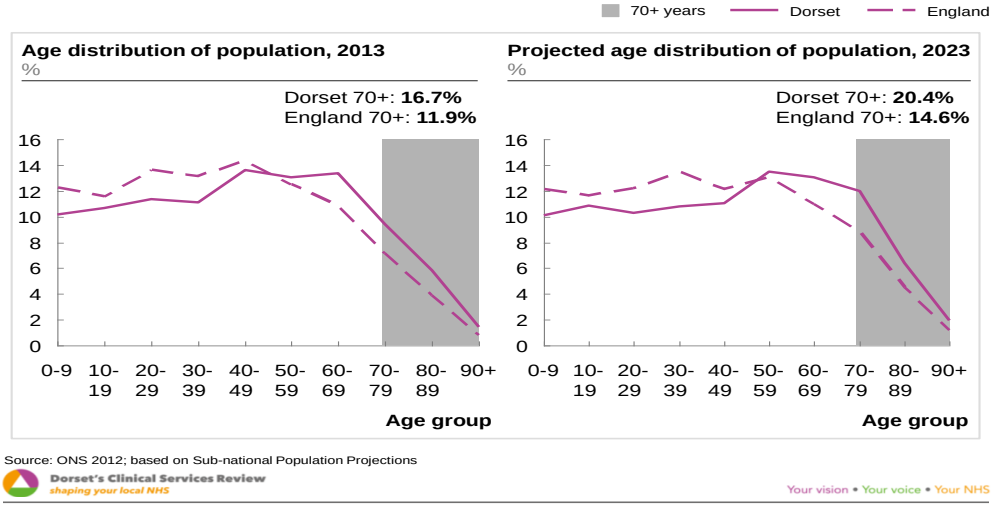
3. OUR HEALTH NEEDS ARE CHANGING

3.1 Demographic and socioeconomic profile

The population of Dorset[3] – 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 conditions[4]. 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 areas[5]; for men in Bournemouth the gap is 10 years[6]. 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 be[7].

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 CHD[9].

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 time[10]. For out of hospital settings, these factors would result in an increase in GP contacts[11] by 26% and community care referrals and first contacts[12] 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.

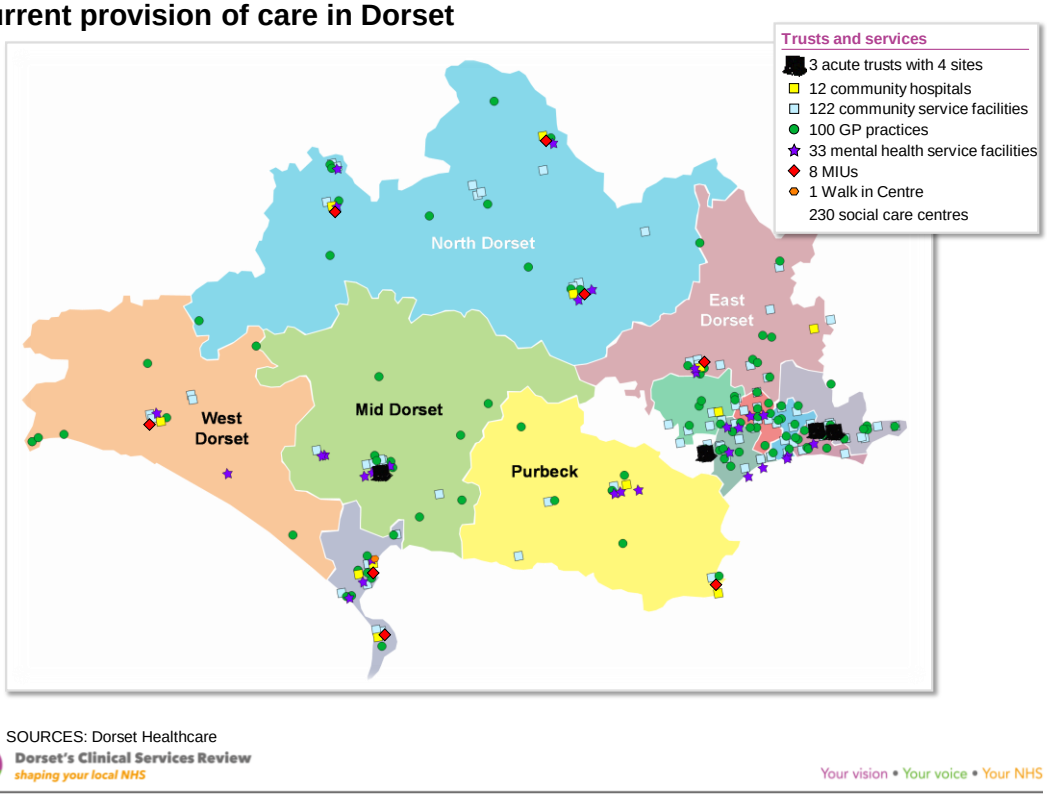
More specifically they would like to see:

- 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 to 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



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

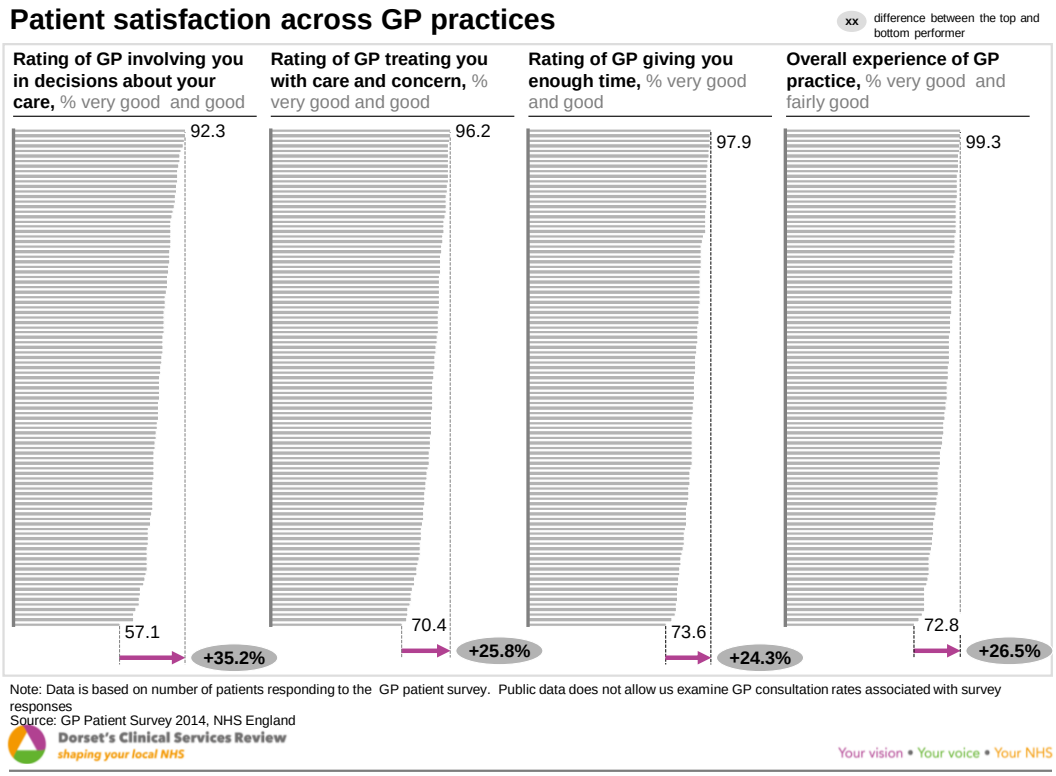
Across Dorset, there are around 642 GPs working from 100 practices across 13 localities. Practices vary significantly in size, from single-handed GP practices to practices with 12 GPs working from one site. The number of people registered per GP (adjusted to take into account that some work part time) 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 practice[14] – see graphic below. This was echoed by the key findings from the "Big Ask" (as outlined above).



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 average[15]. 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 treatments[16]. This can result in a number of people having higher rates of blood sugar than they should[8], 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 experience[17]. 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 Group[18] 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 elderly[19].

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 care[20]
- 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) services[21] 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:

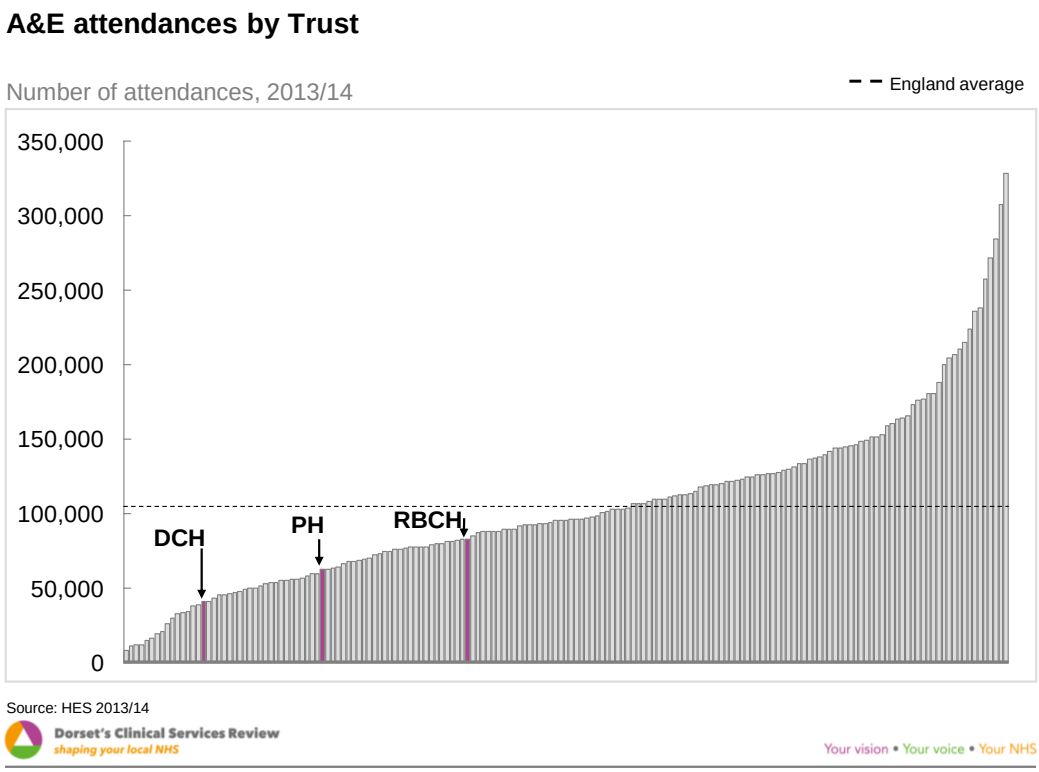
- Emergency care – accident and emergency (A&E) departments, and emergency admissions to hospital
- Planned and specialist care for example outpatients, diagnostic tests and planned (or elective) surgery
- Maternity (including obstetric) care and paediatrics (children's care).

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 across the three acute trusts have increased over the past few years, in line with other parts of the country[22]. 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.

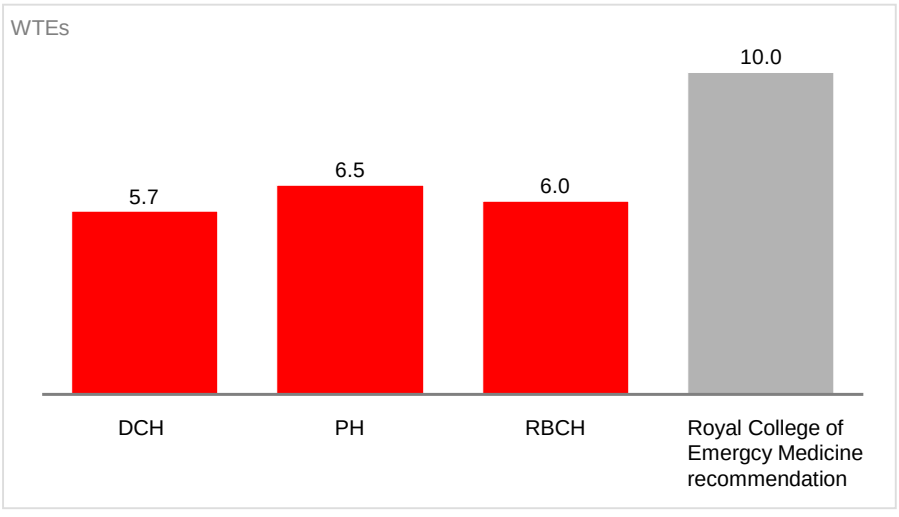
This is not good for patients as the current model of A&E departments does not enable doctors and nurses to understand an individual's health condition and background (they do not have access to patients' GP records) and does not provide an opportunity to make sure that various preventative measures (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 services[23] (e.g., formal calculation of risk of peri-operative morality, 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

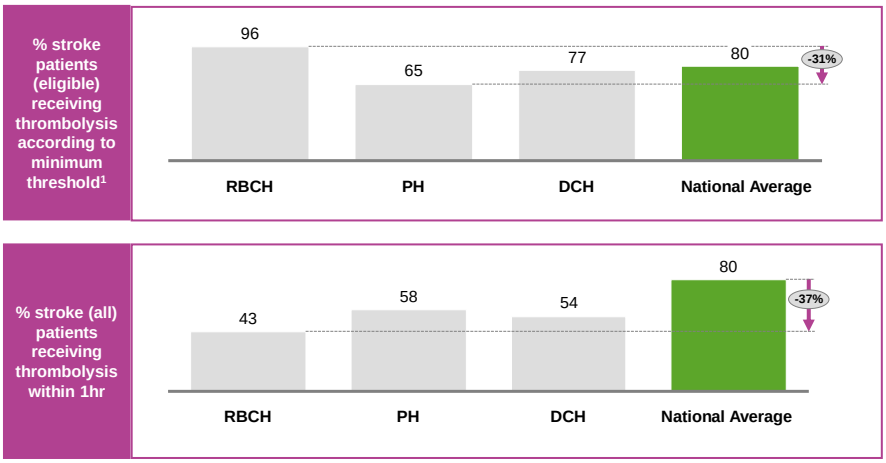


Source: Workforce data from the Trusts (January 2015); Royal College of Emergency Medicine

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 country[27]. 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 Dorset[27].

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 Hospitals[24].

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 homes[25]. 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 weeks[28].

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 county[29]– 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 diseases[30].

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 report[31] 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.

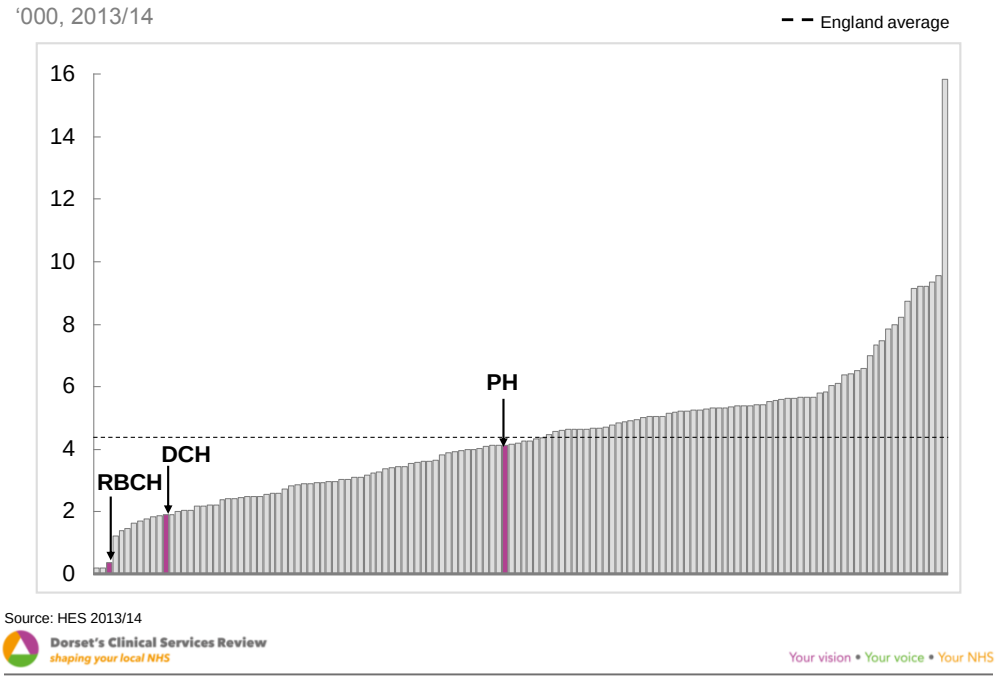
(c) Maternity, Obstetric and Paediatric care

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 10[32]). 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 admissions[23]. 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 hours[33] 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 Wales[34].

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 average[35].
- 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 transport[36].
- 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 Authority[37]). 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% respectively[38]. 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

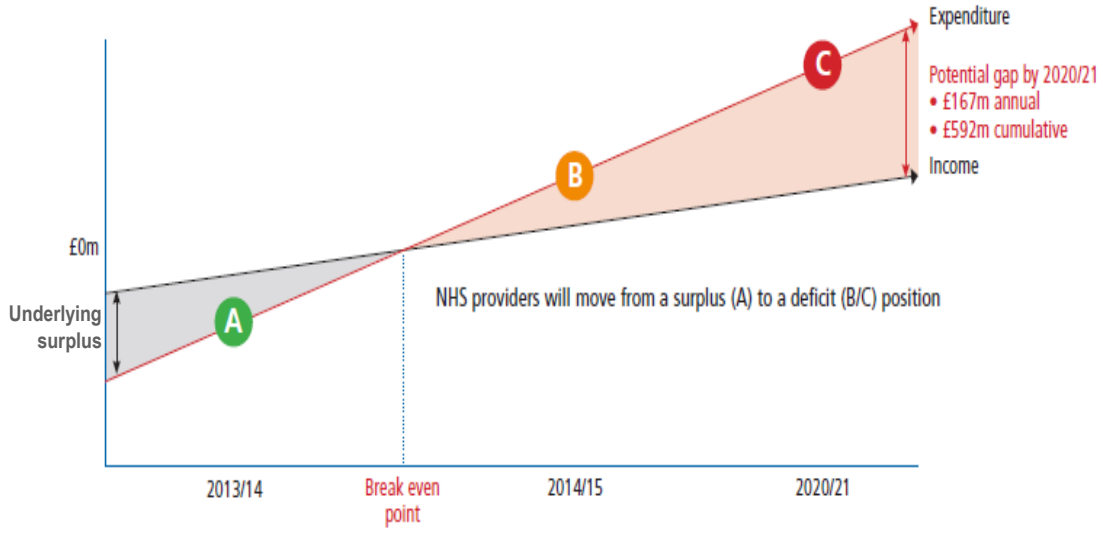
wanted to spend our limited resources on them, they would not be able to gain sufficient experience to maintain their specialist skills in the current model of care.

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

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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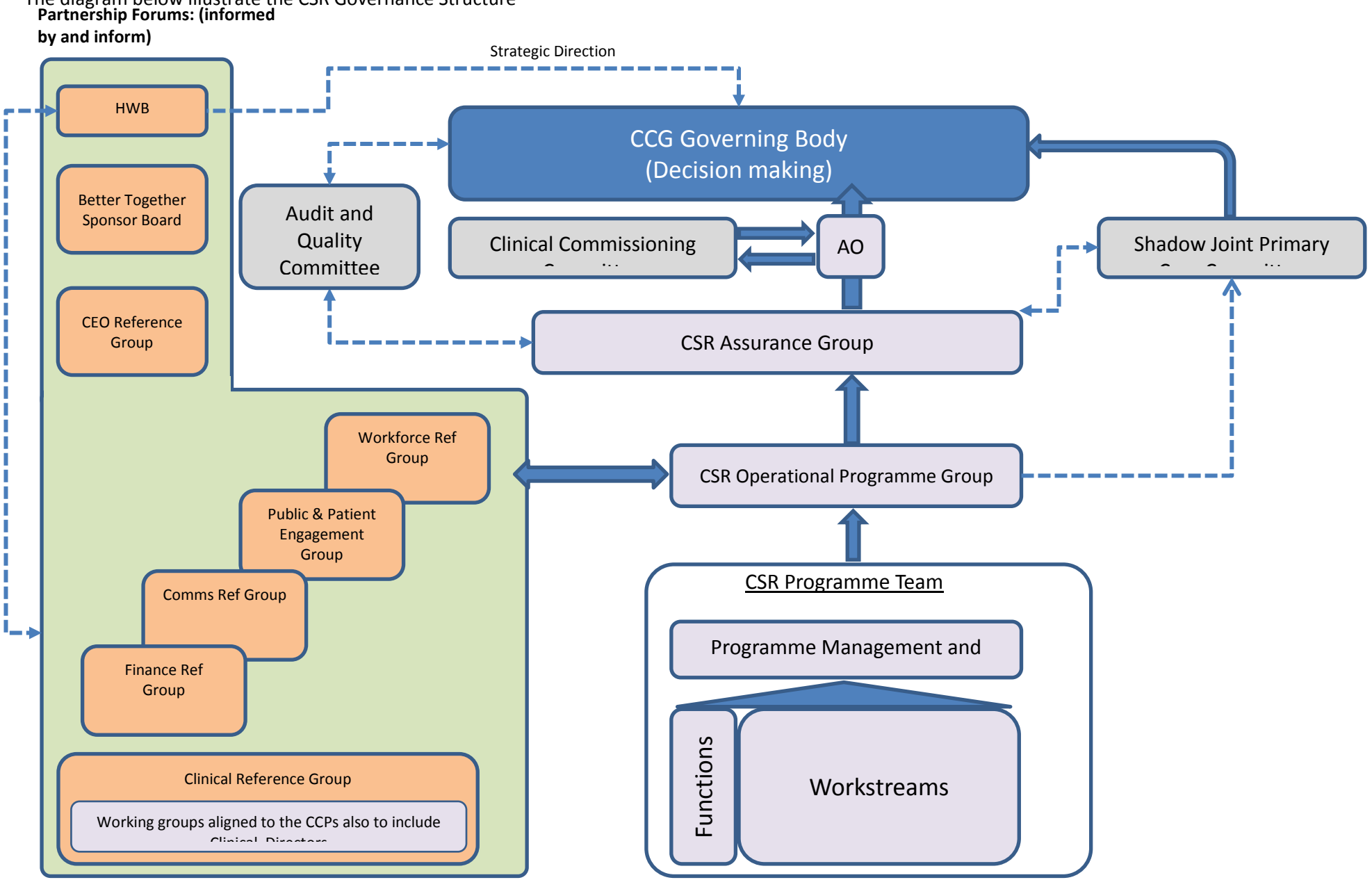
Appendix 2- CSR Governance

The diagram below illustrate the CSR Governance Structure



Appendix 3- Alignment of Priority Projects against Domains

The following section details the projects identified within the refreshed Two Year Delivery Plan which supports delivery of the 5 Domains and Seven Outcome Ambition Measures.

Domain 1: Preventing People From Dying Prematurely
Outcome Ambition: Securing additional years of life for the people of England with treatable physical and mental health programmes
Projects Supporting Delivery of Ambitions
• Procurement of Primary Care Diabetes Services; • Smoking cessation programmes, including smoking in pregnancy (in partnership with Public Health Dorset); • Implementation of the Kings Fund Cardiology Review; • Reprocurement of the Weymouth Community Walk In Centre (Darzi Centre); • Continuation of the review programme for children and adolescent mental health and learning disabilities services; • Review of smoking rates in the population who have a serious mental illness to identify how best to older cessation programmes; • Development of a local health passport to prompt between joining up of physical and health improvement issues in people with mental health conditions; • Redesign of referral management for cancer services; • Early detection of cancer programmes including endoscopy services.

Domain 2: Enhancing the Quality of Life for People with Long Term Conditions
Outcome Ambition: Improving health related quality of life of the 15million+ people with one or more LTC, including mental health problems
Projects Supporting Delivery of Ambitions
• Procurement of Primary Care Diabetes Services; • Targeted case management and care co-ordinators for high risk patients; • Anticipatory care plans for over 75's shared across all care sectors; • Implementation of programme of care to support the management of frail elderly and complex patients, building on over 75's schemes; • Implementation of the neurology service specification; • Implementation of Services Delivery Improvement Plans for IAPT 6 week access targets; • Pilot local guidance on diagnosing dementia both in primary care and within care homes (in conjunction with Strategic Clinical Network); • Continued implementation of the memory advisory and support service; • Continue to work with partners and strategic clinical networks to achieve parity of esteem; • Supporting carers through partnership working with social care through the Joint Carers Programme, supported through the Better Care Fund.

Domain 3: Helping People to Recover form Ill Health of Following Injury
Outcome Ambition: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital;
Projects Supporting Delivery of Ambitions
• Review of fracture neck of femur pathway and time to surgery; • Learning Disabilities- scope the options to commission an intensive residential nursing care services to support delivering care to people closer to their home and out of hospital; • Psychiatric liaison; • Review and redesign the functional mental health acute care pathway. Priorities delivered in partnership with Better Together programme and Implementation of the Urgent Care Strategy: • Implementation of Integrated Teams; • Early intervention support and reablement; • In reach into care homes; • Emergency department attendance avoidance programme; • Hospital at home- shared care services between outreach secondary care advanced practitioners and community intermediate care services; • Expansion of the care overnight pilot providing night visiting, linking with primary care out of hours and night nursing.

Domain 3: Helping People to Recover from Ill Health Following Injury
Outcome Ambition: Increasing the proportion of older people living independently at home following discharge from hospital
Projects Supporting Delivery of Ambitions
• Continued implementation of personal health budgets for CHC; • Continued implementation of technologies; • Supporting carers through partnership working with social care through the Joint Carers Programme, supported through the Better Care Fund; • Implementation of Services Delivery Improvement Plans for IAPT 6 week access targets. Priorities delivered in partnership with Better Together programme and Implementation of the Urgent Care Strategy: • Implementation of Integrated Teams; • Early intervention support and reablement; • In reach into care homes; • Hospital at home- shared care services between outreach secondary care advanced practitioners and community intermediate care services; • Expansion of the care over night pilot providing night visiting, linking with primary care out of hours and night nursing.

Domain 4: Ensuring People have a Positive Experience of Care
Outcome Ambition: Increasing the number of people with mental and physical health conditions having a positive experience of hospital care
Projects Supporting Delivery of Ambitions
• Work with providers to systematically gather patient and carer feedback from the FFT, complaints and other feedback sources; • Benchmark FFT scores across providers and share results; • Continue to use 'real-time' feedback from patients and carers from a wide range of sources; • Continued implementation of Compassion in Practice and '6C's; • Continue with programme of unannounced visits to all local providers to assess the Quality and Safety of care and to independently seek the feedback of patients; • Gain more in depth understanding of staff satisfaction and how to improve this in order to improve the patient experience; • Continue to work closely with LA to improve safeguarding of children and adults; • Multiagency safeguarding hub operational from 1 April 2015; • Work with partners to implement the finding from serious case reviews; • Continued focus on Mental Capacity Act and PREVENT

Domain 4: Ensuring People have a Positive Experience of Care
Outcome Ambition: Increasing the number of people with mental and physical conditions having a positive experience of care outside of hospital in general practice and in the community
Projects Supporting Delivery of Ambitions
• Work with providers to systematically gather patient and carer feedback from the FFT, complaints and other feedback sources; • Benchmark FFT scores across providers and share results; • Continue to use 'real-time' feedback from patients and carers from a wide range of sources; • Continued implementation of Compassion in Practice and '6C's; • Continue to use the GP intelligence gathering system; • Gain more in depth understanding of staff satisfaction and how to improve this in order to improve the patient experience; • Work with NHS England and LA to transform care for people with learning disabilities; improving the system of care; • Increase focus on improving quality within primary care, working closely with NHS England on co-commissioning; • Provide support and resources to develop primary care workforce; • Continue to work closely with LA to improve safeguarding of children and adults; • Multiagency safeguarding hub operational from 1 April 2015; • Training planning for primary care staff in both safeguarding children and adults; • Work with partners to implement the finding from serious case reviews; • Continued focus on Mental Capacity Act and PREVENT

Domain 5: Treating and Caring for People in a Safe Environment and Protecting them from Avoidable Harm
Outcome Ambition: Making a significant progress towards eliminating avoidable deaths in our hospital caused by problems in care
Projects Supporting Delivery of Ambitions
• Implementation of national and local CQUIN schemes; • Roll out of seven day services across health providers to ensure that providers meet the ten clinical standards; • Continue to monitor levels of incident reporting, aiming for providers to be in the top 25% of Trusts in the country for reporting to the NRLS whilst maintaining low levels of harm; • Work with providers to embed the practice of clear clinical accountability with a named doctor responsible for patients care; • Support provider organisation through the 'Sign up to Safety' campaign, which will include sepsis; • Ensure provider s implement the improvement standards regarding Acute Kidney Injury; • Work with providers and use contractual leaver available to ensure that patients are treated in a safe environment, with an emphasis on zero tolerance of avoidable harm and ensuring that care is of the highest standards; • Ensure system are in place to measure and understand harm that occur in health care services; • Continue to use the Safety Thermometer to measure and reduce the level of harm; • Work towards reducing the number of Health Care Associated Infections.