DRAFT 21.10.16

Our Dorset

Sustainability and Transformation Plan for local health and care

Name of footprint: Dorset Number of footprint: 41 Region: South

NHS England: Sustainability and Transformation Plans

In 2014 NHS England published the Five Year Forward View to provide a clear picture of the scale of change that local health and care systems need to deliver by 2020/21.

New planning guidance requires all local systems in England to create a Sustainability and Transformation Plan setting out how they will address a list of national priorities for 2016/17, as well as longer-term challenges[1]. This document, Our Dorset, is our Sustainability and Transformation Plan.

Detailed information about how Dorset is responding to the national 'must-do' priorities and key questions from NHS England are set out in each of our local NHS organisations' annual operating plans for 2016/17 (see Our Dorset Appendix document).

Our Dorset health and care system is working together to deliver our five-year plan.

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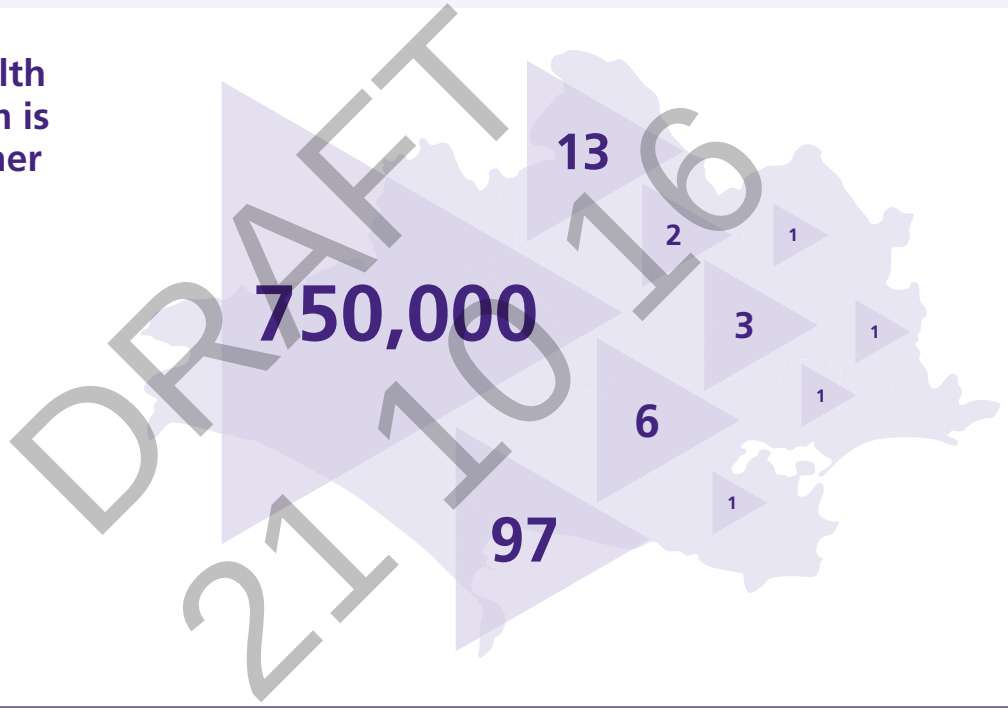

Over **750,000** people
97 GP practices
13 community hospitals
3 district general hospitals
2 unitary local authorities
1 county council

6 district councils
1 community and mental health provider
1 ambulance trust
1 clinical commissioning group

The local system is also supported by services provided by a range of private and voluntary sector organisations.

[1] Delivering the Forward View: NHS planning guidance 2016/17 - 2020/21 (December 2015)

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Foreword

Our Dorset sets out our ambitious five-year plan for radically transforming health and care in our area to achieve better health outcomes for local people, with higher quality care that's financed in a sustainable way.

We've written this document for NHS England, as part of their requirement for each area to submit a Sustainability and Transformation Plan. It is also for everyone who lives in Dorset and everyone who works in health and care in Dorset – because we want to change so our local people benefit from a stronger, more successful and sustainable health and care system.

By focusing more closely on what, when and how local children and adults require health and care we have moved our thinking beyond how we currently deliver services, and the organisational boundaries about who delivers what.

This is important if we are to truly succeed at building a system that works for everyone across our county.

We already have a successful track record and strong commitment to collaborative working across our health and care organisations, so that we act as one integrated health and care system. The last two years have seen increasingly effective partnership working between our area's GPs and primary care teams, the three local district general hospitals, our community and mental health service provider, the ambulance service, Dorset's three local authorities, patient representatives and many others. It is this approach that has enabled us to build a plan of this scale and ambition – and puts us in an excellent position to deliver it.

We are ambitious for Dorset, but big ideas will not be enough to realise our goal. We have to be clear about what needs to happen by when. That is why this plan is grounded in the practical reality of making change happen.

The road ahead is not without significant challenges. We have to change quickly and we have to involve and inform more than 30,000 staff and over 750,000 local people. We need to continue to deliver high quality services at the same time as working to transform the system. We will have to make some difficult decisions that will affect the way things are currently done. But we are committed to making the changes that will enable us to fulfil our duty to deliver the best possible health outcomes and the highest possible standard of services within the budgets we have available.

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Executive Summary

Our Dorset has been shaped by the views of clinicians, staff and local people and developed by leaders from across our health and social care system.

Together, we have a successful track record and strong commitment to collaborative working across our organisations, so that we act as one integrated system. This has been fundamental to our ability to build a plan of this scale and ambition – and puts us in an excellent position to deliver it.

Our vision

We want to change our system to provide services to meet the needs of local people and deliver better outcomes. This means our plan has been built around the needs of the children and adults who live here - the current population of over 750,000, as well as the additional 50,000 people we expect to serve by 2023 and those people from outside of Dorset that use the same services.

Our ambition is to see every person in Dorset stay healthy for longer and feel more confident and supported in managing their own health. We want everyone to have an equal standard of care regardless of who they are and where they live, delivered by health and care professionals with the appropriate skills. More of our services will be provided closer to home, with improved access seven days a week. We will have the highest level of hospital-based services for when people need them. This is how we can improve health outcomes and local people's experience of health and care services.

Our challenges

We must overcome three significant challenges if we are to achieve our vision for health and care in Dorset:

Health and well-being gap

Much of our expected population growth will happen amongst the oldest with corresponding increases in long-term conditions. This will result in an increased demand for our health and care services. We also have unacceptable inequalities between the health and life expectancy of different groups of people in Dorset, including those with mental health problems. To improve the health and well-being of our current and future population we have to change.

Care and quality gap

There is too much variation in the quality of our health and care services. We do not always have enough staff with the right skills in the right place at the right time. Finding or accessing relevant patient information is also more difficult than it needs to be. In most cases our local services are good, but we have some areas of care that do not meet the national quality standards. To improve the care and quality of the services we provide we have to change.

Finance and efficiency gap

If we carry on as we are now, we forecast that in five years our health services will have an annual shortage of £229 million a year, this includes a shortfall of £20 million on NHS England specialised services. Our local authorities also face a significant drop in income, and together our nine councils will have to save over £70 million over the next four years. As our funding cannot keep pace with growth in demands and costs, and to get the most from the money we do have, we have to change.

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Our plan

Our plan sets out how we will achieve our vision over the next five years. We have taken a 'whole system' approach to addressing issues that impact on people's well-being and the development of health inequalities. We have also used a 'needs based' approach to identify categories of need that reflect how children and adults' requirement for health and care varies over the course of their lives.

We plan to deliver three programmes of work over the next five years and beyond, with each programme contributing individually and collectively to close the gaps we have identified in health and well-being, care and quality, and finance and efficiency.

Our three programmes of work

1 the Prevention at Scale programme will help people to stay healthy and avoid getting unwell

2 the Integrated Community Services programme will support individuals who are unwell, by providing high quality care at home and in community settings

3 the One Acute Network programme will help those who need the most specialist health and care support, through a single acute care system across the whole county

Supported by two enabling programmes:

- the Leading and Working Differently programme focuses on giving the health and care workforce the skills and expertise needed to deliver new models of care in an integrated health and care system
- the Digitally-Enabled Dorset programme will increase the use of technology in the health and care system, to support new approaches to service delivery

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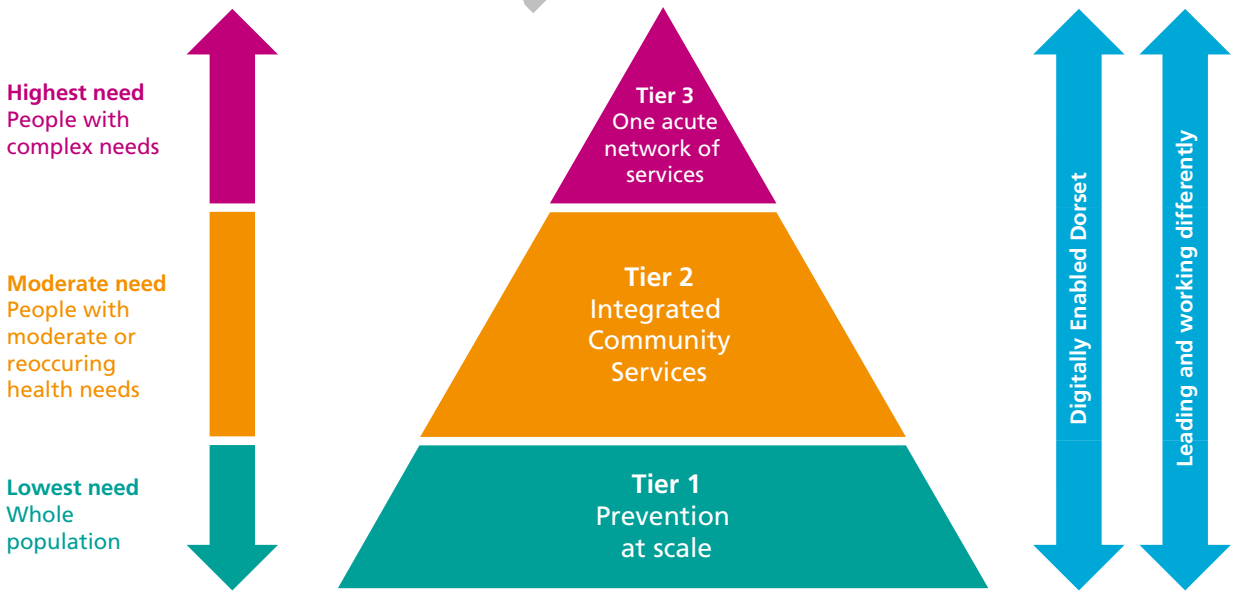
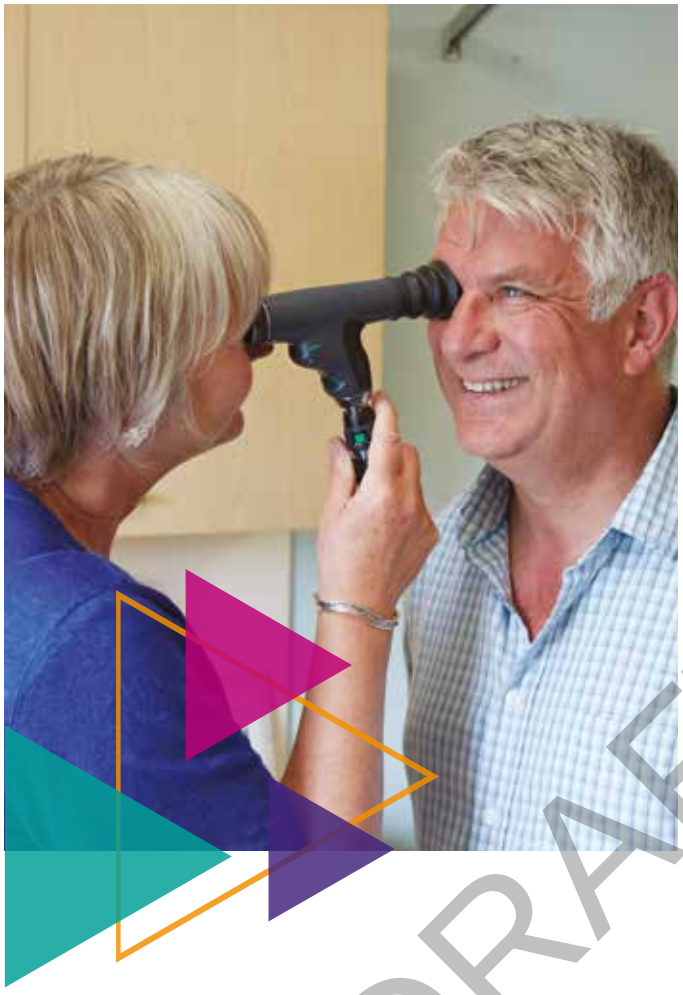
We have developed our integrated programmes of work to radically transform our health and care system to address the differing needs of our population.





The critical decisions we are looking to make

Our three key programmes of work will require us to make critical decisions around the following:

- the resourcing and co-ordination of our systematic approach to prevention at scale
- the organisation of our primary care services into larger groupings
- the reconfiguration of our community hospitals to provide more integrated services at scale
- the reconfiguration of our three acute hospitals in order to deliver the highest quality of emergency and planned care

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What this means for local people

Delivery of our plan will see us provide local children and adults with:

- improved health outcomes
- better patient experience
- same standard of care across all health and care settings
- more care provided closer to home
- more information, advice and support to help people to stay well
- more choice about when and where to receive treatment
- less travelling time to attend appointments

How national support would help

We are in a strong position, but national expert advice and investment would enable us to move faster to deliver the changes we are aiming for. In particular, we would like assistance to review and strengthen our patient benefit case for the Competition and Market Authority alongside legal, workforce and change management support. We will need access to sustainability and transformational funding along with endorsement of our case to secure the capital to undertake the acute hospital and community services reconfiguration and information technology investment. Given the scale of the transformation we are proposing we also hope to be given political support before and during the forthcoming periods of transition so we can achieve our ambitions.

Our vision

Our vision is simple but effective: we want to change our system to provide services to meet the needs of local people and deliver better outcomes.

Local needs will be at the centre of all that we do across the whole health and care system. Health and care services and resources will be organised in the best possible way to meet the requirements of local people, rather than around existing organisational structures or facilities.

We will take a broad view of health and care needs, with a focus on prevention as well as treating ill-health. We will support people to stay well even from before they are born and take into account the broader factors that affect individuals' well-being.

We will extend health and care services far beyond doctor's surgeries and hospitals, into people's homes and our communities – the places where it is needed most. When people need hospital based specialist care we want this provided from centres of excellence.

We want all children and adults in Dorset to:

- stay healthy for longer
- feel more confident and supported in managing their own health
- have an equal standard of care regardless of who they are and where they live
- have a more joined up, seamless experience of all services
- be treated by a health and care professional with the appropriate skills to deliver high quality care
- have more control over their own care
- have more access to services seven days a week
- have more services delivered closer to home
- have access to the highest level of hospital based services when they need them

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Radical change

The health and care system in Dorset that we have in 2016 is not designed in a way that can support these ambitions. That's why we're embarking on this programme of radical change.

Our local challenges

We have identified three main challenges that we must address if we want to achieve our vision for health and care in Dorset:

Health and well-being gap

Variation in the health and well-being outcomes of different people across Dorset

Care and quality gap

Differences in the quality of care received by people across our area and shortcoming in reaching national standards

Finance and efficiency gap

The increasing pressure on resources within the system, with shortages of some staff and the prospect of insufficient funds to maintain our health and care system in the way it currently operates

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How these challenges affect local people

All of the problems we have identified have a direct effect on local people. Examples include:

- having to see different doctors, nurses and other professionals and repeat their story each time
- not being able to see a GP at the times they would like
- having to travel for tests and appointments in different places
- having tests repeated because results are not available where they should be
- not meeting NHS Constitutional standards such as being seen in A&E within the 4 hour waiting time target and national waiting times for cancer referrals and treatment within 31 and 62 days
- not being discharged from hospital in a timely way
- not being able to access additional care at home when needed
- not always being able to access good quality care homes when needed
- getting different messages and advice from the professionals that they see

Our understanding of local challenges draws on a substantial analysis of Dorset's health services conducted in the winter of 2014/15 and ongoing scrutiny of a wide range of clinical quality and safety data, clinical audit measures, patient and carer experience feedback and finances. We continue to update and deepen our understanding of the range and depth of challenges we face across our health and care system so that our plans are firmly focused on delivering positive change.

Health and well-being gap

By 2023, the population of Dorset will have increased from around 750,000 to over 800,000, with much of the growth happening among older people. Increased longevity brings new challenges to health and care systems, because as we grow older more of us develop long-term conditions such as diabetes and dementia.

People in Dorset generally live healthier and longer lives compared to the average for England, but this is not evenly spread across our population – the data reveals unacceptable inequalities between different groups. We must reduce the gap between the health of the poorest and richest. There is a particularly wide health gap for men living in Bournemouth, where those living in more prosperous areas can expect to live for 11 years longer than those living in the most deprived areas. Whilst there has been no change in the numbers of people who die early from heart disease in Poole and rural Dorset in the last five years, there has been a rise in Bournemouth and this is at a time when numbers are falling nationally. We think this variation is unacceptable.

Many factors play a part in creating this gap. The prosperity of an area is one factor. Lifestyle factors are another big reason why people may have more ill health. Based on current trends, obesity will become an even more widespread problem by 2020, by which time we think 1 in 10 local people could have diabetes and 1 in 8 could have heart disease.

There is a difference of up to 20 years in the life expectancy of people with mental health problems. We want everyone in Dorset to receive the same high quality of care, regardless of where they live, what health condition they have, or any other personal characteristic. We also know that people who act as carers are at high risk of experiencing worse health outcomes, having their employment or education disrupted and becoming socially isolated, which in turn impacts on their role as a carer.

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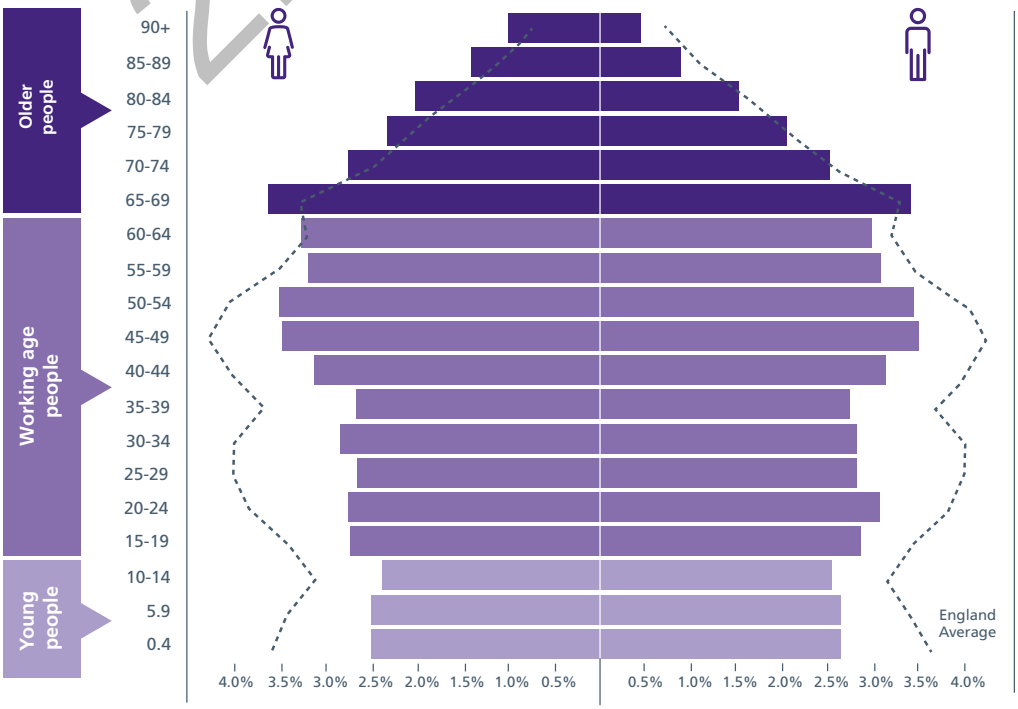
Dorset has more older people and less working age and young people when compared to the England average



Care and quality gap

In Dorset we are proud that recent Care Quality Commission inspections of local organisations have identified areas of good practice, despite the pressures in our system. However, they have also highlighted areas where we need to improve: areas where there is too much variation in the quality of services; where the standards being achieved do not meet the targets that we expect; where there are not enough appropriately-skilled staff where and when they are needed; and where finding or accessing relevant patient information is more difficult than it needs to be.

National quality standards are rightly high, and they are continuing to rise. In most cases our services are good, but in others the evidence shows we need to do more to meet these standards consistently. For example, when people are admitted as an emergency to hospital, they may end up staying longer than they need. Dorset is among the five worst-performing areas in England for delays in getting people home. For older people in particular, a longer stay in hospital increases the risk of falls, infection, increasing confusion and pressure ulcers.

There are unacceptable variations in the quality of care across Dorset. For example, patients with diabetes at some GP practices are more likely to have better control of their condition, meaning they are less likely to develop further problems such as heart disease. Similarly, there are variations in immunisation rates and dental care among children who are in the care of each our three local authorities. We want everyone to have the highest quality of care no matter who they are or where they live, and whenever their health need arises.

Better care for all

We want everyone to have the highest quality of care no matter who they are or where they live, and whenever their health need arises.

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Finance and efficiency gap

The NHS in England will have a national shortage of £22 billion by 2020/21. In Dorset we forecast that in five years our health services will have a shortage of £229 million a year, this includes a shortfall of £20 million on NHS England specialised services, if we carry on as we are now. Our local authorities face a significant drop in income that sees a requirement to have to save over £70 million over the next four years.

As our funding cannot keep pace with growth in demands and costs, and to get the most from the money we do have, we face a significant challenge of needing to bring our system back into financial balance. This means we have to be more efficient; we need to organise and deliver our services in different ways to provide health and care that meets our changing needs; and we need to invest more money in prevention.

Together the NHS and local authorities in Dorset spend over £2.5 billion on public services (health spend £1.4 billion, local government £1.1 billion), and we need to be sure that we use our resources including our workforce, technology and buildings, in a way that brings the greatest benefit to local people. More than 30,000 people work within our local health and social care system. The way that services are currently organised means that we don't always have staff with the right skills where and when they are needed. We have gaps in some staff groups, particularly in domiciliary care, nursing staff and GPs.

We have made savings and have been working more efficiently. Our health providers have all saved around 2% to 4% each year and local authorities have also made significant savings. However, given the scale of the financial gap, carrying on as we are is not an option. To achieve our vision, we need to make significant changes.

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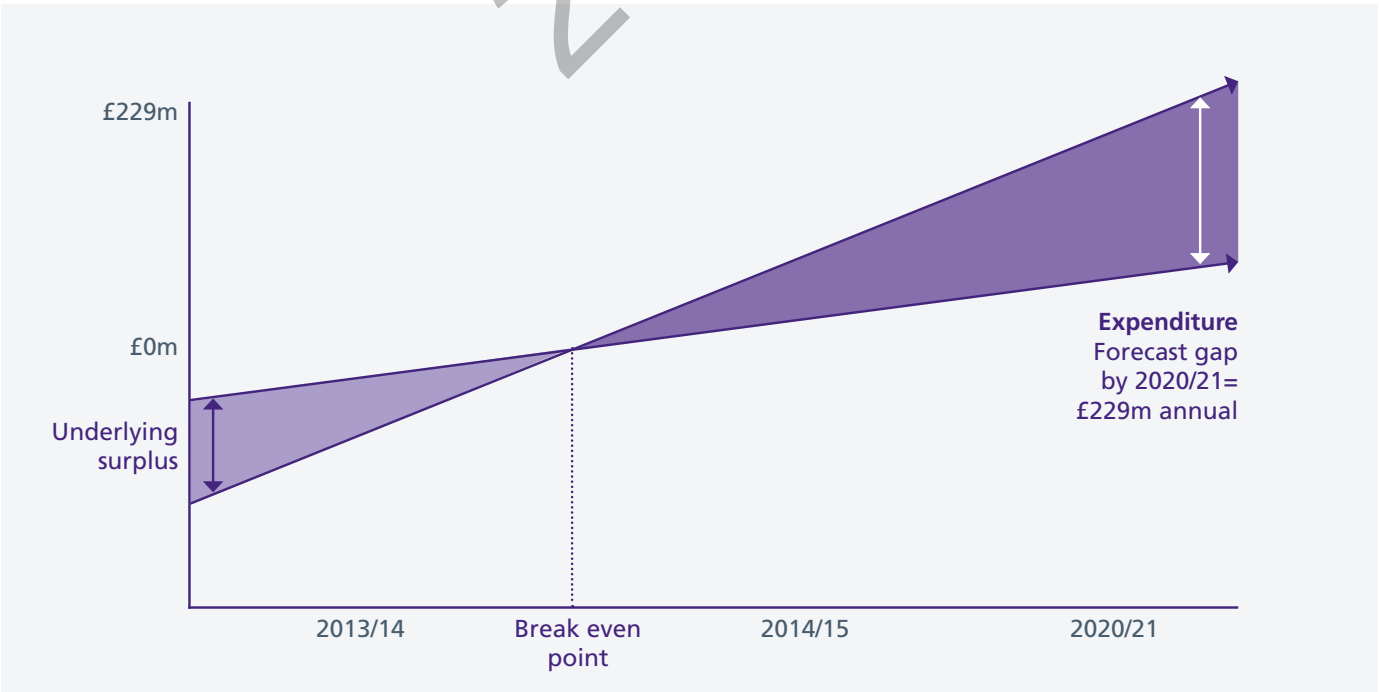
Financial impact of doing nothing in Dorset



Our plans

Delivering our vision demands ambitious plans that are bold in scope and grounded in evidence and local insight.

Our plans are underpinned by two approaches to understanding health and care: the effect that different factors in people's lives have on their health and well-being, and the different levels of need experienced across local populations.

The wider determinants of health

We recognise that there are many complex and often interrelated factors that influence people's health and care needs. These factors include the quality of housing people live in, the ability to find employment and how well schools are performing. Our plans take into account these wider determinants of health and we are working with local authorities, the voluntary sector and other partners to take a 'whole system approach' to addressing issues that impact on well-being and create health inequalities.

A needs-based approach

People experience varying health and care needs over the course of their lives. We have to be able to design and deliver high quality, safe and sustainable services that address the full range of health and care needs, including minor illnesses and injuries, long-term conditions, planned care, unexpected urgent and emergency requirements and end of life care. By thinking about local children and adults as having categories of need, which is also known as 'risk stratification' or 'population segmentation', we can make sure we are providing what is required. This understanding allows us to think differently about how we organise our services, workforce and finances to support each segment of the population.

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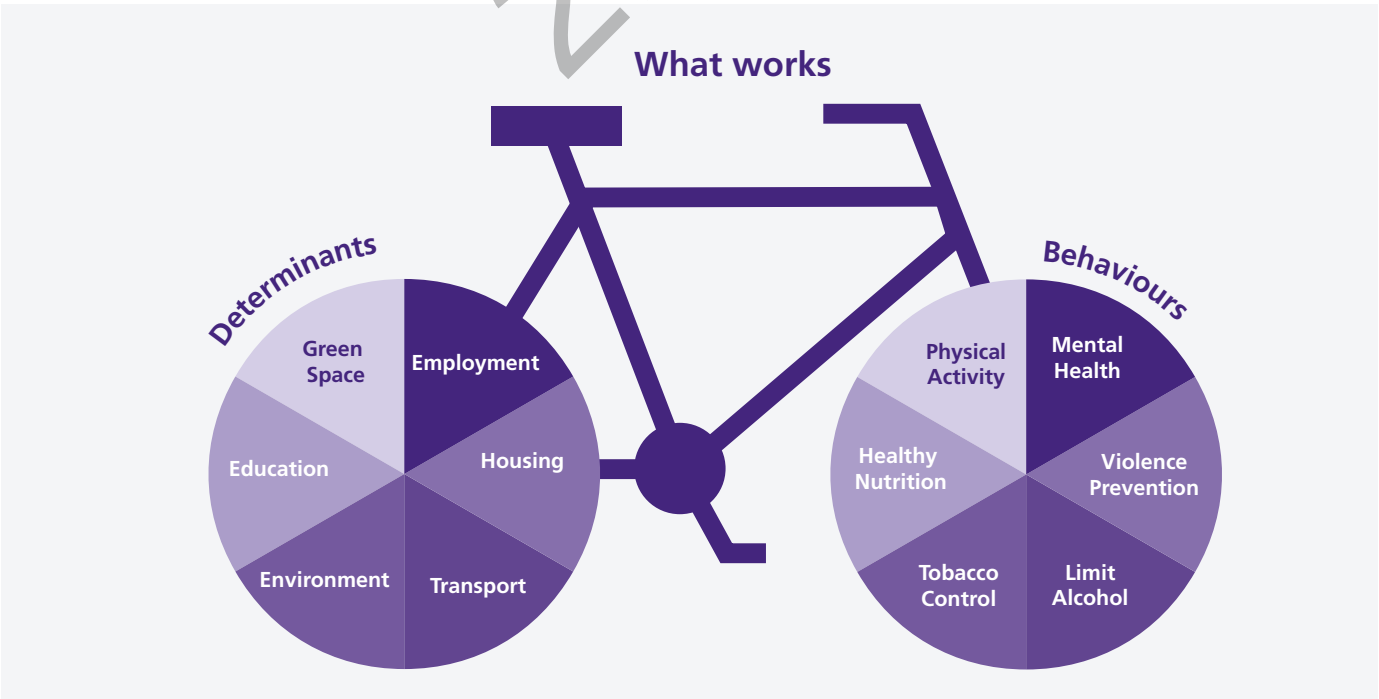
Determinants of health



A needs-based approach to our integrated programmes of work

We have three interconnected programmes of work to drive forward changes to our services in order that we better meet the differing health and care needs of local children and adults.

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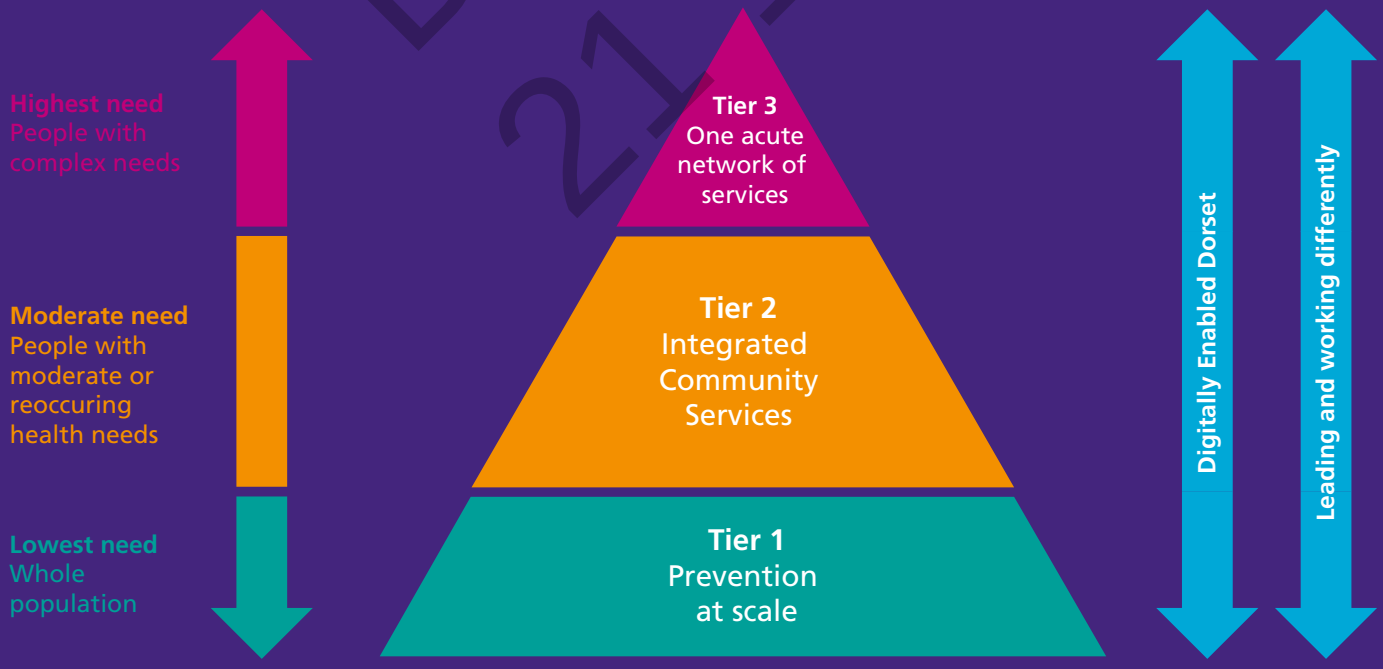

Our programmes of work

We have identified three programmes of work that are already underway, which we will continue to develop and accelerate to enable us to realise our vision for health and care in Dorset over the next five years.

Each programme contributes individually and collectively to close the gaps we have identified in health and well-being, care and quality, and finance and efficiency, to produce a truly integrated system that meets the needs of all our population. There is already a great deal of exciting work going on within these areas that we can learn from and build on.

1 Our Prevention at Scale programme will help people to stay healthy and avoid getting unwell.

2 Our Integrated Community Services programme will support individuals who are unwell, by providing high quality care at home and in community settings.

3 Our One Acute Network programme will help those who need the most specialist health and care support, through a single acute care system across the whole county.

To realise these ambitions we have two fundamental enabling programmes.

- Our **Leading and Working Differently** programme focuses on giving the health and care workforce the skills and expertise needed to deliver new models of care in an integrated health and care system.
- Our **Digitally-Enabled Dorset** programme will harness the power of technology and support digital innovation across the health and care system, to support new approaches to service delivery.

Our plans for these two workstreams are outlined in the Our Dorset Appendix document.

Local Government

In developing our plans we have been mindful of the evolving government landscape. The Government has set out the legal framework within which local authorities and the public, business and community sector partners can develop and deliver devolution opportunities. As part of the devolution proposals, the structure of councils across Dorset is under review and it may lead to local government reorganisation during the lifespan of this plan. These proposals have been prepared in a context where local authorities in the area will be losing all Government Revenue Support Grant funding over the next five years and, in some cases, by 2019.

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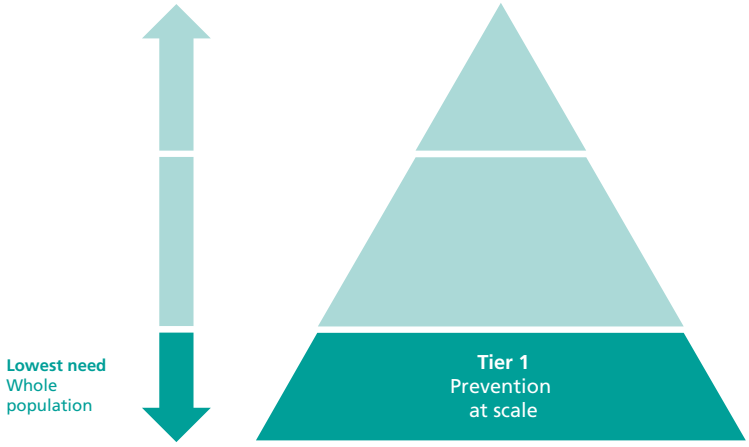
Programme 1
Prevention at Scale

The Prevention at Scale programme forms the foundation of our plans and underpins all of the work we will do. Prevention work also runs through the upper tiers of the triangle – our Integrated Community Services and One Acute Network programmes.



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Prevention is not a new idea, but with more people developing long term conditions our approach to prevention is now as much about promoting health and well-being as it is about preventing disease. We are committed to working in partnership to tackle the wider determinants of health – the complex and often interrelated factors that influence people's mental and physical well-being, and in the longer term impact on their health and care needs. Our programme also aims to help individuals take control of their own well-being and make healthy choices that will keep them well for longer. As we plan and deliver services we will consider what effects we can have on health of all our population.

Our two Health and Well-being Boards will be central to this work and are currently refreshing their Joint Health and Well-being Strategies to align with this plan. These will go out for consultation with the public later in 2016. They will provide a common framework and language so that all our partners from across health and social care, the voluntary sector and the independent sector, can understand how they can contribute to this work.

We are focusing on the following major and growing influences on the health and well-being of our population:

- heart disease and diabetes contribute the most to health inequalities in Dorset, and we know that early deaths from these causes are increasing in some areas. Many of the actions we take to reduce the impacts of heart disease start early - in pregnancy and early life. They will also reduce the impacts of cancer and dementia, and will help to give the next generation a healthy start in life
- musculoskeletal and mental health problems as they have a major influence on the quality of life for a large number of local people from childhood to the end of life
- alcohol misuse – the ill effects of this rapidly increasing problem affect all parts of our society, and impact on all public services. We will take a comprehensive co-ordinated approach to reduce alcohol's harm

A comprehensive approach to prevention

Our Prevention at Scale programme will use these focus areas to take a comprehensive approach to prevention including a focus on promoting health and well-being and the wider determinants of health, as well as building on best practice in primary, secondary and tertiary levels of prevention.

We will also build this approach into the Integrated Community Services and One Acute Network programmes.

Promoting health and well-being and the wider determinants of health

Local authorities in Dorset are already delivering a range of initiatives that are designed to tackle the wider determinants of health. We will build on the experiences and successes of these initiatives as we develop plans for the Prevention at Scale programme of work. Examples of work already being done include:

Supporting children to grow and families to thrive: Through the Joint Commissioning Partnership Board for Children, a Pan Dorset Emotional Well-being and Mental Health Strategy for Children and Young People has been developed. It emphasises the need for a focus on mental health and emotional well-being and improved early access to support across a broad spectrum of need. More use will be made of schools and early years settings to provide low level support. Parents will be helped to become more self-reliant and build the emotional resilience of their family. We will also ensure improved partnership working to identify vulnerable families and children who need extra assistance.

Creating job opportunities and access to affordable housing: Dorset's local authorities have formed a single local economic partnership and produced a county-wide strategic plan that focuses on building skills, developing the local economy, increasing job opportunities and access to affordable housing. Bournemouth University and Arts University Bournemouth play a key part in and contribute to the growing creative and digital sector in Bournemouth.

Revitalising communities: Each local authority is leading projects to address housing needs, job opportunities, community facilities and cultural attractions in areas identified as being in need of regeneration. These areas include Boscombe, West Howe, Bourne Valley and Melcombe Regis.

Improving the quality of homes occupied by vulnerable people: Older, less energy-efficient houses can be difficult to keep warm and cold homes are linked with health problems such as respiratory disease, circulatory problems and increased risk of poor mental health. The Dorset Healthy Homes programme is a collaboration across the district, borough and unitary authorities in Bournemouth, Poole and Dorset, which aims to improve the quality of homes occupied by vulnerable people. The ambition is to deliver improvements to around 150 homes each year over the next three years.

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NHS Five Year Forward View

"The future health of millions of children, the sustainability of the NHS and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health."

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Encouraging active travel: Dorset local authorities have a good history of working together on sustainable transport projects, including the Local Transport Plan which highlights the importance of shifting commuter behaviour away from cars and towards healthier alternatives such as walking or cycling. The most recent plans include the Dorset-wide Partnerships for Active Travel initiative, which aims to promote walking and cycling as alternatives to car journeys, among businesses, employees, apprentices, job seekers and students. There are direct economic benefits arising from switching to active travel (estimated to exceed £4 million over 10 years); there are also likely to be further health and well-being benefits from a reduction in future risk of developing chronic diseases like cardiovascular disease, as well as effects on air quality by reducing the number of miles travelled by car.

Primary prevention - staying healthy

Primary prevention is about helping people who are currently well to make these changes in their lives that will help them stay healthy for longer. We will:

- extend our *LiveWell* Dorset service to provide more people with help to quit smoking, cut down on alcohol, exercise more, lose weight and eat more healthily. The service is currently being evaluated so that our planned expansion will be refined to ensure it reaches more people, particularly in more disadvantaged areas, and that it works to support people to make the changes they want to their lives
- deliver training and advice in 2016/17 via *LiveWell* to help employers and voluntary organisations reach their employees and the communities they serve with tailored health and well-being advice and support

- extend our work training teachers and staff across educational settings in Mental Health First Aid and Five Ways to Well-being so they are better able to support pupils' emotional health and well-being

Secondary prevention - staying well

Secondary prevention focuses on supporting people who have already developed a health problem such as high blood pressure or diabetes. It focuses on detecting these problems at an early stage and making sure that they are well controlled so that the person stays well. An important part of this is supporting people in developing the confidence, knowledge and skills to manage their condition. We will:

- extend the number of people receiving personalised support from our *My Health My Way* initiative to be able to self-manage their long-term conditions. We will also work closely with primary care to ensure patients are invited in regularly for check-ups and that a more proactive approach is taken for people who do not attend appointments
- develop a 'patient portal' within the Dorset Care Record, as part of our 2020 Digital vision (see page 37). This will provide people with access to better information and decision making support around how to self care. The portal will also provide people with access to their health records and link the information held by the *My Health My Way* and the *My Life, My Care*
- ensure our health and care practitioners provide timely and high quality support to help people to consistently control their blood sugar, blood pressure and cholesterol, especially for people who have diabetes. This will help to address the variations in health and well-being outcomes across our area, reduce the likelihood of patients developing further problems and needing hospital based care

Tertiary prevention - staying independent

The third type of prevention focuses on individuals who have more complicated or severe health problems. Tertiary prevention aims to make sure that their condition has as little impact as possible on their quality of life. We will:

- continue to support people to find the help they may need to live independently at home with our *My Life, My Care* service
- continue to provide short-term intensive support to help people get back home after a hospital stay, as part of our integrated community services programme (see page 21)
- provide more timely access to information and advice to carers to help those they care for, as well as support to help them to maintain their own well-being. The 2011 census identified that we have 82,900 unpaid carers providing invaluable support to people at home

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What our Prevention at Scale programme means for local people

Focusing on promoting health and well-being across the whole system will lead to a wide range of positive health outcomes for local people:

- with improved housing conditions, fewer people will become unwell with lung problems and fewer people will die early from chronic lung problems or heart disease
- a focus on walking and cycling in local transport planning will mean a small increase in physical activity for most people, that overall will add up to fewer deaths from heart disease
- community-based obesity prevention work that brings together different approaches to help people eat well will mean fewer people become obese and therefore fewer people will go on to develop diabetes. Places where this approach has been tried have also found that people have a more positive outlook on life, which may mean they are less prone to mental health problems
- more children and young people growing, developing and achieving their potential

It will help people to stay healthy by making positive healthy choices:

- reduced levels of smoking will lead to less heart disease, lung problems, cancer and dementia
- by becoming more physically active, eating healthily and moving towards a more healthy weight, people will be less likely to develop diabetes, heart disease and mobility problems
- fewer people drinking more than is healthy for them will result in fewer people admitted to hospital for alcohol related problems including stomach or liver problems

It will help people who already have a health problems to stay well by:

- detecting more health problems at an early stage
- building confidence and support to help people take more control of their own care
- reducing the likelihood that they will need to go into hospital because of their condition
- creating an equal standard of care for all, with less variation in the quality experienced by advantaged and disadvantaged groups

It will help people who have more complex health problems stay independent by:

- making sure that people are discharged from hospital as soon as possible
- providing more support to carers

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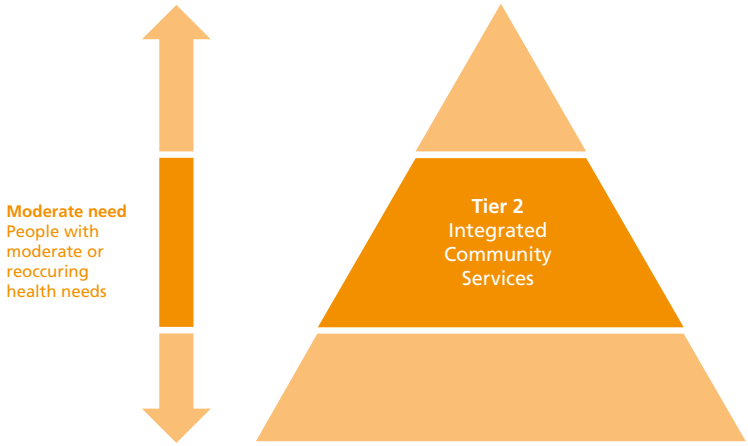
"The plans we have for prevention at scale and to empower self-care, represent an exciting opportunity to shift from a focus on the treatment of ill-health to a focus on helping people keep well for longer. This will require a clear and enduring commitment from all partners to prevention as a central theme of all their work. "

Dr David Phillips, Director of Public Health, Public Health Dorset

Programme 2
Integrated Community Services

Integrated Community Services form the middle tier of our plan. This programme will transform general practice, primary and community health and care services in Dorset, so that they are truly integrated and based on the needs of our local populations.



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Community based services will be led by multidisciplinary teams of professionals, working together to meet the needs of people of all ages who have short-term health needs, individuals with long-term conditions and those requiring specialist care for severe or complex health needs. We will deliver all of these services in a way that makes it easier for people to access care when and where they need to, with a consistent and high quality experience for patients as they move between different parts of the integrated system.

Our priorities are to:

- support people to better manage their own health, with access to appropriate information and support – we expect a 10% reduction in new outpatient attendances and a 25% reduction in follow-ups
- provide care that is based on the needs of our local population, with services delivered at the times and places people need them
- enable more people to receive care at home and in the community, and to self-manage long-term conditions, to avoid having to visit hospital or being admitted as an inpatient – we expect to reduce unplanned medical admissions by 25% and unplanned surgical admissions by 20%
- make sure our community services are able to support frail older people with long-term conditions so that more care can be delivered closer to home
- improve personalised care for people with complex needs, including individuals with learning disabilities
- adopt new technologies that will support a high quality, consistent patient experience throughout the health system, with standardised working practices and seamless communication between health and care professionals
- create integrated teams of professionals with the right skill mix (including students) in improved working environments, to support the delivery of the model of care as well as enhance skills acquisition and personal development opportunities
- make sure that our NHS buildings, resources and finances are used in a cost-efficient way, including by planning care on a larger scale to achieve cost savings

Creating a network of community services

To deliver our priorities we intend to create a network of community services hubs throughout Dorset. These services will enable people to access a wider range of health

services, from routine care to urgent and specialist care, closer to their homes.

Mixed teams of health and care professionals providing care for people who have physical and mental health needs will staff these services hubs. They will offer services for children, adults and our growing older population.

The health and care system will address a wide range of different needs of our local population, including:

- people who are mostly healthy but with some recurrent health needs, such as young children, pregnant women and people with short-term illnesses
- people at moderate risk of requiring higher sudden levels of care need, or sudden care needs, including those with long-term conditions, learning or physical disabilities, and frail older people
- people with a very high risk of a deterioration in their health, who require regular supervision and support, including people at the end of life and those with multiple health and social care needs

The services will include:

- routine care including traditional primary care, screening, baby clinics and checks, contraception services and prevention advice
- rapid same-day access to GP-led urgent care, with on-site diagnostic testing including imaging and x-rays
- self-management support for patients with long-term conditions
- outpatient appointments
- urgent and unplanned care
- secondary care consultations and minor procedures
- rehabilitation and services to support recovery after periods of ill-health
- specialist care and support for people with complex needs, including 24/7 crisis support to help people receive the urgent care they need without going into hospital

Community service hubs: Many of these services will be delivered through our proposed community service hubs. Some of the hubs will also offer community beds so that when appropriate, people can receive care locally instead of being admitted to an acute hospital. These community beds will also be used to provide rehabilitation after an acute stay, and to support people at the end of life.

We have modelled the level of demand we expect for each of the core services that would be provided, and considered the facilities

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We will establish a network of community service hubs each providing a range of health and care services

1 Routine care

2 Rapid same-day access

3 Self-management support

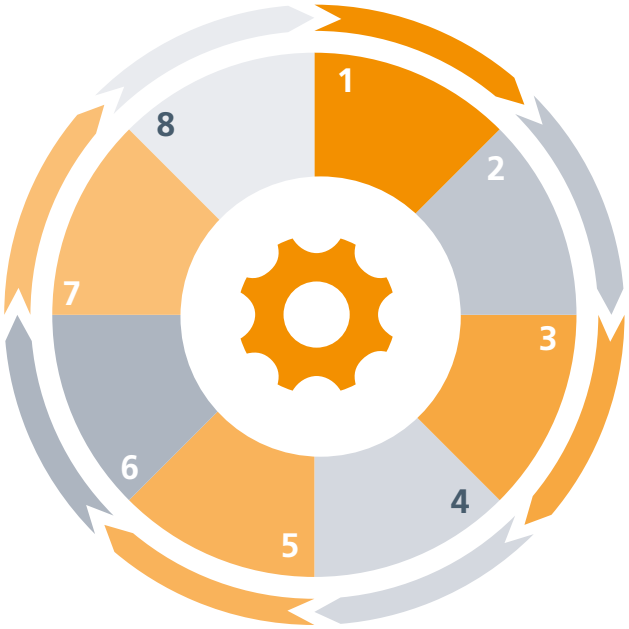
4 Outpatient appointments

5 Urgent and unplanned care

6 Secondary care consultations

7 Rehabilitation

8 Specialist care and support



that would be required on each site, such as the number of consultation, treatment and therapy rooms. We have identified a minimum population catchment required for each hub, which will ensure use of the facilities for a minimum of 8 hours a day, 5 days a week, with some services being provided 14 hours a day for 7 days a week, and use the workforce efficiently. Our plans for expanded integrated teams could deliver more and better services from a fewer number of sites than the 13 community hospitals with beds and over 130 primary care sites that currently operate across Dorset.

We have reviewed our existing community hospital estate to identify options for locating the proposed community hubs. The options involve consolidating services on some existing sites and repurposing or development of some buildings to make better use of resources. We have taken into account criteria such as quality of care, access to care, affordability and value for money, workforce, deliverability and research and development.

Following this review, our proposals are to have 12 sites across Dorset; seven community hubs with beds which will have a wide range of facilities including outpatients and diagnostics. We will also have an additional five hubs without beds which will have a range of outpatient services, co-location of staff and could be used by a range of other local community resources.

Dorset CCG's proposals for creating three centres of excellence (page 30), which include a major planned care hospital with an urgent care centre support our options for integrated community services, as this site will also provide community beds.

During 2016/17 we will continue to test out our plans and seek assurance from local and national regulators. These plans will be part of our public consultation in late 2016. When a final decision is taken and implementation begins, we expect that the services provided within the hubs, where appropriate, will be jointly commissioned by the NHS and local authorities.

An integrated workforce: We know that we already have most of the health workforce that we need to deliver community care in these new ways, but we have yet to understand the gaps in the social care workforce. We expect there will be a need for some recruitment, changes in the skill mix across staff groups and new ways of working, such as developing nursing and allied health professional roles across community and primary care services, including community pharmacy and pharmacists in a range of settings.

We will reorganise health and social care staff into teams with a greater diversity of skills and expertise, so that they are better able to respond to specific health needs in community settings.

For more information about our plans for the workforce see page 36.

Transforming General Practice

General practice is the fundamental building block for the delivery of health services. "Should General practice fail, the NHS will fail" (Stevens 2016); ensuring long-term sustainability of General Practice is therefore critical.

Our analysis to date suggests that if we continue with the current 97 GP practices delivering care in over 130 sites this will over-stretch our workforce and finances; a challenge compounded by the workforce crisis and our local ageing population.

The ongoing engagement with GPs to develop the Primary Care Commissioning Strategy has identified the key barriers to sustainability of General Practice: workload and workforce and this has shaped our thinking around enablers to overcome these barriers: adequate resourcing to facilitate transformation (financial and workforce), common health record (with appropriate information governance arrangements) to minimise duplication and improve efficiency, reducing unnecessary workload and improved responsivity of social care.

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Our plan permits an opportunity to consider at a practice, locality and county-wide level the short, medium and long term stages to enable transformation and thereby establish sustainability.

Our Primary Care Commissioning Strategy determines how general practice within Dorset will seek to evolve given the current challenges and to reflect the General Practice Forward View[2], in particular to address workload and workforce whilst seeking to address the STP aims.

The strategy outlines our vision for delivery of community based care and identifies the opportunities for how general practice could work at scale to strengthen delivery of the three key aims of our plan:

1. prevention at scale
2. integrated community services
3. appropriate use of acute services

A reduction in the number of GP sites and development of community hubs will allow more services to be consistently and more efficiently delivered across the county for more hours of the day and days of the week. However, there is no 'one size fits all' approach to how general practice should best be organised, and we recognise that we will need to further invest and develop our estate for delivery now, while we plan for future transformation. The solution depends upon the needs of the local population and our additional modelling work and on-going discussions across primary care will help to determine the right approach for each area within Dorset.

Community hubs are expected to be supported by strengthened networks of GP practices, offering patients a wider range of universal and more specialist services, including urgent care seven days a week.

The RCGP Ambassador and Local medical committee have indicated their support for our approach and continue to be involved in the consultation.

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Transforming community based urgent and emergency care

Our plan is to further strengthen the urgent care integrated advice and assessment service (see page 27) to create one clinical pathway that provides timely access to the most appropriate service. This will ensure Dorset is best placed to meet the NHS England Commissioning Standards for Integrated Urgent Care by 2018[3]. We also want to develop a high quality and consistent trauma care pathway that will support the proposed model of care for the One Acute Network (see page 29). Enhancing the provision of community based urgent and emergency care is essential if we are to reduce inappropriate attendance at A&E, reduce hospital admissions and deliver care closer to home.

Transforming mental health services

We are committed to tackling mental health with the same energy and priority as we have tackled physical illness in order to deliver 'parity of esteem' in line with the Five Year Forward View for Mental Health[4]. Our vision (see page 8) applies equally to people with mental health problems and learning disabilities.

We want to see more being done to prevent the development of mental health problems, and early intervention across primary care and other services to NICE standards and national

[2] NHS England General Practice Forward View (April 2016)
[3] Commissioning Standards for Integrated Urgent Care (September 2015)
[4] The Five Year Forward View for Mental Health (February 2016)

"The community teams have very capable expert staff in them. What they haven't had previously is a way to access medical expertise and that means that managing complex patients often involved referring patients to different services. By making myself available to those teams easier, and often informally, they can continue to manage those patients and I can support the patients at home where necessary. And the patient has to do much less moving around of the healthcare system."

Dr Riaz Dharamshi, Geriatrician, Dorset HealthCare University NHS Foundation Trust

targets so that people get timely access to the help that they need. We want our integrated community services to support as many people as possible to stay independent and to provide appropriate health and care closer to home.

We also want to improve the linkages with our acute services and raise the quality of the care that is provided at a time of crisis, including for people with anxiety and depression as a result of pain, living with a long-term condition or following an acute physical health event, as well as those living with dementia.

To help to achieve our ambition, in 2015 we began a Mental Health Acute Care Pathway Review to understand how services such as inpatient assessment and treatment, psychiatric liaison, crisis response and home treatment, street triage and community mental health teams need to change.

In line with 'Implementing the Five Year Forward View for Mental Health', the co-produced Acute Care Pathway review has developed options for:

- the delivery of safe spaces
- further development of peer support workers
- improving choice and access options for people with the aim of preventing crises and
- enabling people to self-refer into some services when they feel that they need support.

We are also looking at the future demand for acute inpatient beds to ensure these are fit for the future, sustainable, safe and best placed for people to access within 33 miles from their place of residence.

The first phase of the review was to gather views[5] from local people, carers, staff, the voluntary sector as well as our health, social care and public service partners. We gathered over 3350 pieces of feedback. We are now in the second phase, describing and shortlisting options for new models of care. The options were approved by Dorset CCG Governing Body in October 2016 before public consultation in early 2017.

The new model will reflect best practice and national guidance, and will be focused on improving patient outcomes. It will also take account of the work of the Integrated Community Service and One Acute Network programmes.

When a final decision is made in 2017, implementation will begin and will include close partnership working with the third sector.

We have also started a Dementia Services Review jointly with our local authority partners this year, in support of our commitment to the 2020 NHS Mandate goals for dementia care. This will include looking closely at how to improve the time it takes to access a diagnostic assessment and post diagnostic support, our inpatient services and specialist dementia intermediate care. We expect to identify opportunities to deliver more services to reduce social isolation that could be provided from the proposed community hubs. We will also be working with technology partners as part of our local digital vision 2020 to trial innovative new ways of working.

In 2017 we will start a review of the complex care and recovery pathway of people with

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[5] ACP Mental Health Acute Care Pathway – View seeking evaluation, full report, Bournemouth University MRG (October 2015)

For more information about the existing integrated workforce at Bridport Community Hospital and the Integrated advice and assessment centre watch this video www.youtube.com/watch?v=KHWWudtgaaU

mental health problems, to include supported housing and employment. We aim to ensure that people are not held in restrictive settings for longer than they need to be. This will require ongoing support across the system in supported housing and employment services as these are critical to prevention of mental health problems and the promotion of recovery.

As part of the national Transforming Care Programme we are progressing our plans to ensure that people who have the most complex needs have appropriate and personalised care and support. This will ensure we can reduce the numbers of people who are placed in specialist hospital provision outside Dorset. Our three local authorities and Dorset CCG are also developing The Big Plan, a joint commissioning strategy for people with a learning disability which will be implemented from April 2017.

Integrated community services: the impact to date

Important foundations have already been laid towards realising our integrated community services vision, which will help us to increase the scale and pace at which we can deliver our ambitious plan.

Our existing Weymouth and Portland Integrated Care Hub has the potential to act as a blueprint for the rest of Dorset. The hub covers a network of nine local GP practices whom together service 74,000 people. It operates 8am to 6pm seven days a week, and brings together a wide range of health and social care coordinators working as one integrated team. It includes GPs with enhanced skills to manage chronic and acute illnesses, community nurses, social workers, an old people's mental health worker, a community rehabilitation team nurse, a community matron, a paramedic and an in-reach nurse. Working collaboratively enables the team to identify and respond to people at the highest risk of needing more health and care with the aim of providing support in the community and reducing the need for an admission to an acute hospital. The staff use anticipatory care plans and frailty registers, and have close links to local practices to strengthen care planning. The hub also has access to local 'step-up' community beds. In its first four months the hub has had 500 referrals and the improved care pathways means only 32 people have needed to be admitted to Dorset County Hospital. Staff also report feeling more satisfied and motivated.

The modelling work we are undertaking to identify the options on where to locate our community hubs will also be informed by the existing work to locate services together in areas such as Blandford, Bridport, Shaftesbury and Sherborne. These examples demonstrate the benefits we can realise by using our estate more effectively and supporting services and teams to work more closely together to meet patient need.

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An illustrative example of a Dorset Vanguard Programme which looks to have a mixed team of health and care professionals, as well as volunteers and peer supporters, to provide care that is centred around local people's physical and mental health care needs.

- GP
- Community centre with shared space
- Social workers & other support agencies (food, transport, services)
- Volunteers & peer supporters
- Health monitoring tools

An integrated workforce: the impact to date

The Better Together Partnership (Better Care Fund) has supported the integration of 13 health and social care teams. They have helped deliver better management of frail and older people through robust multi-agency care management arrangements. They have also enabled earlier discharge from hospital, increased intensive rehabilitation and reablement for patients such as those who have had a stroke, and improved end of care.

At Bridport Community Hospital this is an integrated health and social care team working together to support the most vulnerable local people. Our plan is to create similar integrated health and care teams that reflect local need across the whole of Dorset.

GP services: the impact to date

Launched within the last six months, the Local Dorset Vanguard programme has provided CCG funding and additional planning support to six GP federations covering all of Dorset, to help them think how they can work differently to provide care to local people that meets their needs seven days a week. Some of our GP practices have chosen to work together across bigger localities and combine primary care services with community, social care, voluntary and acute care services to plan to deliver services in a range of ways, such as working through networks or being co-located within hubs. Other practices are still developing their plans. We are working to agree a standard integrated locality model that allows the flexibility to ensure the provision is appropriate for local need. The funding and planning support from the Local Dorset Vanguard programme is helping to accelerate plans.

Community based urgent and emergency care: the impact to date

We have established a standalone urgent care integrated advice and assessment centre that handles enquiries from across the county 24 hours a day, seven days a week. It is operated by the ambulance service and sits alongside the 999-call centre, NHS 111 control centre and GP out of hours services. It also operates as a 'single point of access' through which all health and care professionals can organise follow-up appointments for individuals in need. By having up to date details of what services are available at every hour of the day the hub can ensure local people are supported to access the right care at the right time. Since April we have also introduced a new Dorset-wide labour line that is available directly through NHS 111 and provides support for women in labour or who have concerns about their pregnancy.

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Mental health services: the impact to date

Since 2013 there has been important work taking place to ensure there is more equitable treatment and outcomes for people with mental health problems.

To improve prevention and increase emotional resilience more mental health well-being education is being delivered in educational settings with training support for teachers (see page 17). We also have in place Child and Adolescent Mental Health Service liaison roles as part of our psychiatric liaison service.

Our Dorset talking therapy service, Steps to Well-being, is consistently delivering high recovery rates that are above the national target.

In 2013 acute mental health services changed in line with national models and developments, which meant that there was a reduction in inpatient bed numbers accompanied by development of crisis and home treatment services as an alternative to hospital admission; and the additional investment made to establish a recovery house to provide an alternative choice of place of care for people in crisis.

In winter 2016 a female Psychiatric Intensive Care Unit will be opened in the county, as currently local people have to travel out of the area. We have also worked in partnership with 16 organisations on the development and on-going delivery of the Dorset Crisis Care Concordat.

We have commissioned the Alzheimer's Society to deliver an innovative pre and post diagnostic support service for people who are concerned about their memory. Dorset HealthCare Mental Health acute wards for adults of working age and psychiatric intensive care unit is one of only two Trusts in the country to be awarded outstanding for acute inpatient mental health services.

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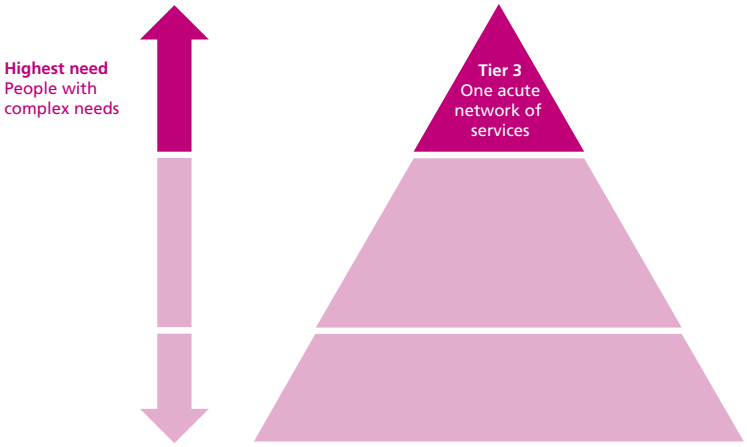
What our Integrated Community Services programme means for local people

- More choice about when and where to receive treatment
- Less travelling time to attend appointments
- Less time waiting for appointments, diagnostic tests and test results
- Improved health outcomes, with more opportunities to be cared for at home and in the community rather than in a hospital setting
- Better patient experience, with the same high standard of care across all health and care settings and effective sharing of information between health professionals
- Support to return home after a stay in hospital, or closer to home, as quickly as possible
- Easier access to health records and information about their treatment

Integrated community services will benefit everyone in Dorset, but there will be particular benefits for older people, who make up a large and growing proportion of our population (see page 10). Making a wider range of health and care services available closer to home will help people to stay in their own homes for longer; avoid unnecessary hospital stays which can lead to additional health problems and a loss of independence; and regain independence following a stay in hospital with the help of home-based support and the use of technology.

Programme 3
One Acute Network of Services

One Acute Network is the top tier of our plan. This programme will transform acute services in Dorset so that they meet the complex and specialist needs of our local population.



The network will assign specialist roles to each of our three district general hospitals and create a single skilled network of clinicians who will provide a consistent, high quality experience for patients.

Our priorities are to:

- establish centres of excellence for patients who need hospital based services
- develop a Major Emergency Hospital to provide more urgent and emergency care 24 hours a day, seven days a week where evidence shows it makes a difference to clinical outcomes, including across major trauma, hyper acute cardiac, stroke, emergency surgery
- develop a Major Planned Care Hospital to provide high quality and timely care for planned (elective) and day case surgery
- maintain a Planned Care and Emergency Hospital to provide urgent and emergency alongside planned and specialist care
- establish single acute networks for services such as cancer, heart disease and stroke, so that consistent services are provided for people across Dorset
- support integrated community services to treat where appropriate more people out of hospital and reduce the need for an inpatient stay, including the provision of more urgent and emergency care
- invest over £100 million in refurbishments and enhancements, including a new maternity and paediatric unit in east Dorset
- provide an integrated frailty service and improved mental health care, working closely with the Integrated Community Services and supporting the Mental Health Acute Care Pathway review (see page 25)
- deliver a range of primary and community services from our acute hospital sites
- adopt new technologies that will support a high quality, consistent patient experience throughout the health system, with standardised working practices and seamless communication between health professionals
- join our workforce across Dorset into a single network working together to support the delivery of more 24/7 services across our hospitals and the Integrated Community Service programme, as well as enhance skills acquisition and career and personal development opportunities

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Creating three centres of excellence

Our plan is to reconfigure the organisation of our existing three district general hospitals into three centres of excellence with better defined and more specialist roles, to enable them to deliver rapid, high quality healthcare as part of one collaborative network.

We want to:

- establish a Major Emergency Hospital in the east of the county at Poole Hospital or Royal Bournemouth Hospital, to provide more specialist emergency services for the whole of Dorset, with hyper-acute specialist services provided at the region's tertiary centre, University Hospital Southampton
- establish a Major Planned Care Hospital in the east of the county at Poole Hospital or Royal Bournemouth Hospital, to provide higher quality elective services and a 24/7 Urgent Care Centre (as part of Dorset's A&E Network)
- maintain planned and emergency services at Dorset County Hospital in the west of the county

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

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

As a result of the proposed One Acute Network we expect the bed capacity in Dorset to reduce to around an estimated 1,570 beds, from a level of 1,810 in 2013/14. The major change will result from shifting beds to the planned Major Emergency Hospital and a reduced number being required at the Major Planned Hospital. Population changes would have increased demand for beds to an estimated 2,465.

Our plan aims to achieve a 25% reduction in unplanned medical admission by improving the management of urgent and emergency cases and people with long term conditions, and 20% reduction in unplanned surgical admissions through the Integrated Community Services programme.

During 2016/17 we will continue to test our plans for reconfiguration. We will aim to hold a public consultation in late 2016 and seek assurance from our local and national regulators.

Dorset CCG's governing body will not make a final decision on the site-specific locations until 2017, following the completion of the assurance and public consultation process. We expect the implementation of the early stages to begin in 2017 and continue over a number of years.

An integrated workforce

We want our workforce to work across hospital sites and beyond organisational boundaries in a single Dorset wide network of skilled professionals. Our plan is to improve the leadership and organisation of our workforce so that there will be a single culture and aligned behaviours. This will help to ensure that local people receive a more consistent experience of our health and care services. By working more closely together, we can plan and deliver a single clinical pathway across the county for each specialty rather than having variation because different types of services are provided by different hospitals. A single network, supported by an enhanced use of technology (see our Digitally-Enabled Dorset programme plan on page 37) will also allow our clinicians to share their skills and expertise more effectively.

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Detailed modelling has taken place, alongside an assessment against the six evaluation criteria of quality of care, access to care, affordability and value for money, workforce, deliverability and other issues such as research and development. As a result, Dorset CCG is planning to consult the public on two options for reconfiguring Poole Hospital and Royal Bournemouth Hospital. Dorset CCG's preferred arrangement is Option B.

	Dorset County Hospital	Poole Hospital	Royal Bournemouth Hospital
Option A	Planned Care and Emergency Hospital with A&E services	Major Emergency Hospital with A&E services	Major Planned Hospital with Urgent Care Centre (as part of Dorset A&E Network)
Option B	Planned Care and Emergency Hospital with A&E services	Major Planned Hospital with Urgent Care Centre (as part of Dorset A&E Network)	Major Emergency Hospital with A&E services

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Transforming cancer services

A key element of our plans for establishing One Acute Network is to deliver improved outcomes for cancer patients by delivering locally the Achieving World Class Cancer national strategy and the Wessex Strategic Vision for cancer services. By working more closely with all our partners we will be able to address the fragmentation of the current care pathway so that patients experience a seamless service. Working in partnership with the Wessex Cancer Alliance there will be a significant opportunity to strengthen and support our local work, in particular around research and clinical trials, as well as prevention.

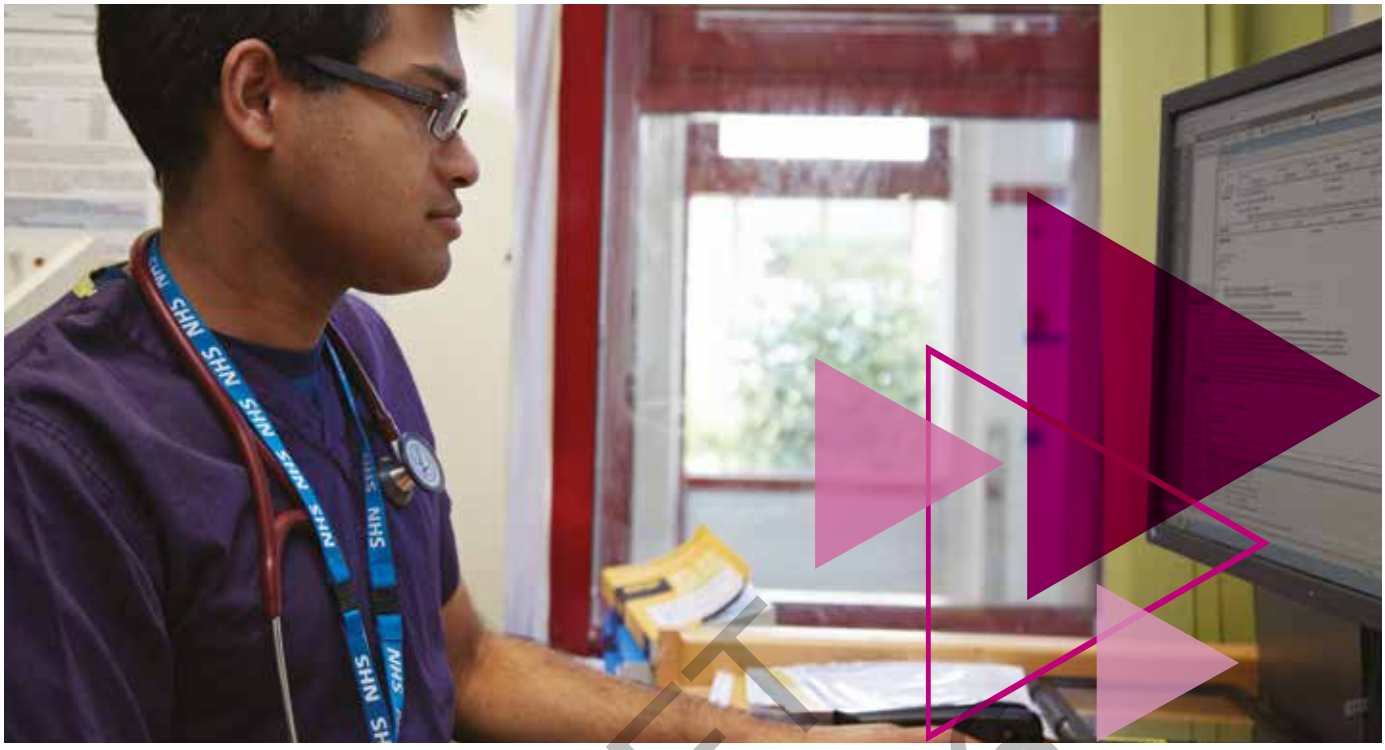
Transforming maternity and paediatric services

We have ambitious plans to improve the maternity and paediatric services that are delivered in our acute hospitals and in the community. We intend to offer a larger and higher quality range of services in the community to reduce the need for local people to have to attend hospital. This will include the development of a Dorset-wide children's community nursing service. For pregnant women we will increase the provision of midwife-led care across the county, which will enable more women to be able to choose a home birth, and create a single team of midwives, health visitors and nurses.

One network

"We want to support our workforce to work across hospital sites and beyond organisational boundaries in a single Dorset wide network of skilled professionals."

Paula Shobbrook, Director of Nursing, Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust



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We will reorganise hospital based care by implementing the Royal College review recommendation to consider '*by exploring the integration of services between Dorset County Hospital and Yeovil District Hospital such that there could be one site delivering consultant led obstetric care and one site with a midwifery led unit*'. If the feasibility of this is not agreed within the next six months, we follow the recommendation of the independent Royal College review[6] for a Dorset-wide network. If implemented, this will see us move to a midwifery led unit and paediatric assessment unit at Dorset County Hospital with a high-risk obstetric unit and consultant delivered paediatric inpatient site at the Major Emergency Hospital in the east of the county.

One acute network: the impact to date

We have two aligned work streams to develop and deliver our transformation plan for the One Acute Network:

- the Clinical Services Review being led by Dorset CCG
- the One NHS in Dorset Acute Vanguard programme being led by our three acute provider foundation trusts

Clinical Services Review

In 2014, the Clinical Services Review was started to help us to identify a future model of care to better meet the needs of our local population. The project has been managed by Dorset CCG with leadership from a representative group of senior clinicians, nurses, allied health professionals and our health and care system's chief executive, chair and lead councillors.

The work to date has been shaped by the regular and active involvement and engagement of hundreds of clinicians working in primary care, acute, community, mental health and children's services, voluntary sector organisations, our workforce and local people. Alongside input from our Patient, Carer and Public Engagement Group, Supporting Stronger Voices and Health Involvement Network. It has also been subject to valuable scrutiny and assurance from NHS England,

[6] Royal College of Paediatrics and Child Health Invited Reviews Programme - Design Review, Dorset CCG (April 2016)

29,000

Pieces of feedback used to inform our Need to Change.

525

Attendees at our public meetings to help design the models of care.

100

Different forums, meetings and events to inform and engage thousands of local people including staff.

12

Meetings with our Clinical Services Review Patient, Carer and Public Engagement Group of representatives.

3,900

Members of our Health Involvement Network and 150 representatives of Supporting Stronger Voices have received regular information and been involved.

18

Meetings with our Pan-Dorset Engagement Leads Forum to plan and deliver a consistent approach to communications and public involvement across our health and care system.

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Wessex Clinical Senate and our local Joint Overview and Scrutiny Committee, as well as the independent advice of a Royal College Review that we commissioned to examine our maternity and paediatric services.

This collaborative approach has enabled the programme to make significant progress towards making both our One Acute Network and Integrated Community Services programmes a reality. We have:

- analysed current and future demand for our services alongside our existing supply, to identify the challenges Dorset currently faces – our health and well-being, care and quality and finance and efficiency gaps are outlined in Need to Change[7] , which involved examining over 29,000 pieces of feedback from the public[8]
- reviewed evidence on good practice and considered service reconfigurations in other parts of the NHS and internationally, to help shape our ambitions
- considered the services offered outside of Dorset, such as specialist services delivered from Southampton, patient flows into Dorset from surrounding counties such as Hampshire, and Dorset patients receiving services from non-Dorset hospitals including Yeovil and Salisbury
- designed the model of care for One Acute Network as detailed on pages 29-32 and Integrated Community Services as detailed on pages 21-28
- produced detailed finance, activity and workforce modelling to explore the feasibility of the model of care
- undertaken extensive communications and engagement activity with the general public, patients and carers (see box above)

[7] Dorset CCG Clinical Services Review Need to Change (January 2014)
[8] Reference The Big Ask and Bournemouth University report

Having obtained Stage 1 assurance in 2015, and Stage 2 assurance in summer 2016, Dorset CCG are now seeking the support from NHS England's Investment Committee.

Alongside this we have been working closely with the Wessex Clinical Senate to address their detailed valuable independent feedback.

In late 2016 the CCG intends to hold a public consultation to obtain views of local people on our plans, including the site-specific reconfiguration options for our acute and community hospitals. Once the consultation and assurance has been complete, Dorset CCG's Governing Body will then make a decision in 2017. We expect to phase in the implementation of the plans over five years with the early stages beginning in 2017.

One NHS in Dorset Acute Vanguard programme

One NHS in Dorset is an early adopter site as part of NHS England's National Acute Care Collaboration Vanguard Programme. It is focused on delivering the workforce and organisational cultural and behavioural changes to have a single network of clinical services across Dorset providing higher standards of care in a more consistent way, irrespective of where local people live and what service they access. By driving more effective leadership and organisation of our workforce it is therefore the vital mechanism to accelerate the implementation of our new models of care, and it can proceed at pace before, during and beyond the external scrutiny of our site specific reconfiguration plans.

We have recently set out the timetable for the delivery of this programme of work and this includes:

2016

- Agreeing the priority activities which will include determining where to realign with other existing or planned activity.
- Agreeing the contracting and financial forms with the CCG along with the framework for the joint partnership decision.
- Completing the common IT strategy and workforce strategy and implementation plan.

2017 - 2020

- New joint partnership will be embedded and delivery locations will be organised in line with the Dorset Clinical Services Review.
- Implementation will have been undertaken and a significant contribution made to improved patient outcomes, clinical and financial sustainability.

The intention is to support the development of one or more Accountable Care Partnerships who will manage and deliver integrated health and social care to patients across Dorset. This will enable us to incentivise patient outcomes and support a collaborative approach across organisational boundaries.

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One NHS in Dorset

The nine acute hospital based services that have been identified as the priorities for our Acute Vanguard programme.

- Cardiology
- Imaging
- IT and other transaction related services
- Non-surgical cancer services
- Ophthalmology
- Paediatrics
- Pathology
- Stroke
- Women's health

"These are exciting plans for Dorset's hospitals that will ensure we have the most modern, high quality and safe hospital based health services for local people. By having more consultant-led care the evidence shows that patient outcomes will be improved. A more consistent quality of service will be enabled by teams working together in a single clinical network. This will also help staff to develop their skills, share best practice and feel more supported."

Dr Robert Talbot, Medical Director, Poole Hospital, NHS Foundation Trust

Acute Hospital@Home

The Dorset County Hospital *Acute Hospital@Home* service has been delivered as a pilot in west Dorset to provide aspects of inpatient care in patient's own homes, to reduce the need for additional admission to hospital. The service operates 7.30am to 11pm seven days a week, with access to the admitting medical and surgical teams outside these hours. By working as part of an integrated team and improving communication with primary and community care teams (including the use of an electronic discharge summary), *Acute Hospital@Home* is helping to ensure frail and older people as well as those with long-term conditions are provided with safe, high quality care that does not require them to travel. To date there has been an increase in referrals to wider community teams and positive patient feedback, the intention is to extend the service and embed this work within the Integrated Community Services programme.

What our One Acute Network programme means for local people

- Improved health outcomes, including more lives saved by having more care provided 24/7 by consultants.
- Better patient experience, with the same high standard of care for people across the county and more effective sharing of information and health records between health professionals.
- Less waiting time for access to urgent and emergency care and planned care operations.
- Reduction in cancelled planned care operations because of emergency care needing to take priority.
- Less travelling time to attend appointments as more diagnostic tests, outpatient appointments and rehabilitation will be provided closer to home in community settings.
- More support to return home after a stay in hospital as quickly as possible.

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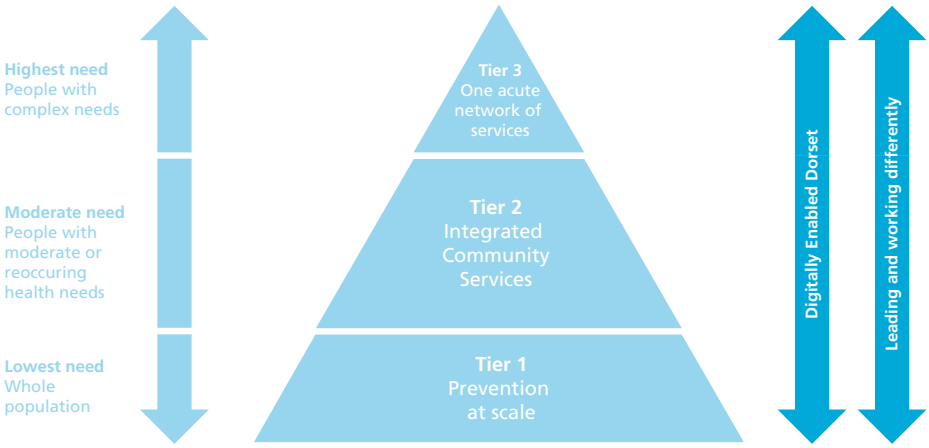
Two enabling programmes of work

Our Leading and Working Differently and Digitally-Enabled Dorset programmes are fundamental enablers to realising our ambitions to radically transform Dorset's health and care system.



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Enabling programme 1
Leading and working differently

We will organise our workforce of over 30,000 people more effectively, so they are better able to deliver high quality, safe, timely, accessible and sustainable health and care services.

This will require closer working between and across teams to deliver an integrated seamless service, and to maintain and develop professional skills.

Our plans for our workforce will help to establish Dorset as an exciting place to work, so that we can attract the highest calibre of staff into our local communities. We intend to create more innovative roles, and develop clear development pathways and placement opportunities across primary, secondary and social care for a range of professions working closely with our education providers.

This work will be delivered by implementing our Leading and Working Differently Strategy that has been created with director level leadership from across Dorset's health and social care organisations together along with Health Education Wessex and Thames Valley and Wessex Leadership Academy, the deanery, Skills for Care and the Wessex and Regional Workforce Strategic Board for Nursing and Midwifery. We will also build on the work of our established Primary Care Workforce Centre and our recruitment campaign www.doorwaytodorset.nhs.uk

We have a single integrated leadership team who have already been working together for two years and includes lead cabinet members (including the portfolio holders who chair the Health and Well-being Boards), NHS non-executive chairs and chief officers (including the pan-Dorset Director of Public Health). We will continue to develop the capability of this team to work across organisational boundaries and lead the transformation of our system. We expect this to lead to more partnerships within and between organisations and meaningful relationships that are capable of sustaining collaboration alongside competition. To oversee delivery of Our Dorset we have also agreed to move towards having an aligned system wide programme management approach.

To make these major service changes we will support the development of Accountable Care Partnerships. These build on existing partnerships between health, social care and voluntary organisations in particular localities, and will shift the focus to delivering the best outcomes for patients regardless of organisational boundaries.

We are planning to develop Accountable Care Partnerships in Dorset which may reflect the outcome of the current Local Government Review.

Practical, early wins for each of the Accountable Care Partnerships in the coming year include implementing a single, integrated hospital discharge team, improving integrated care at the end of life and developing integrated care pathways and developing real-time care capacity management systems to help reduce unnecessary delays as people move from one care setting to another.

Enabling programme 2
Digitally-Enabled Dorset

We intend to harness the power of technology and support digital innovation by rolling out the plans in our Digital Vision 2020 strategy for a Digitally-Enabled Dorset.

This will see us align the digital strategies of local health and care providers into a single digital plan for our area. We will implement the Dorset Care Record, a unified record of local people's interaction with services, with a priority focus on clinical record integration and record sharing between health and social care practitioners. This will improve safety and care for patients, by giving professionals more timely access to the right information to inform their decision-making.

We will also provide more information and support, along with expanded access to telehealth and innovative technologies to enable local people to better manage their own health.

This digital plan is being developed and delivered by our established Dorset Informatics Group made up of senior clinical, social care and technical leaders including Chief Information Officers and clinical leaders.

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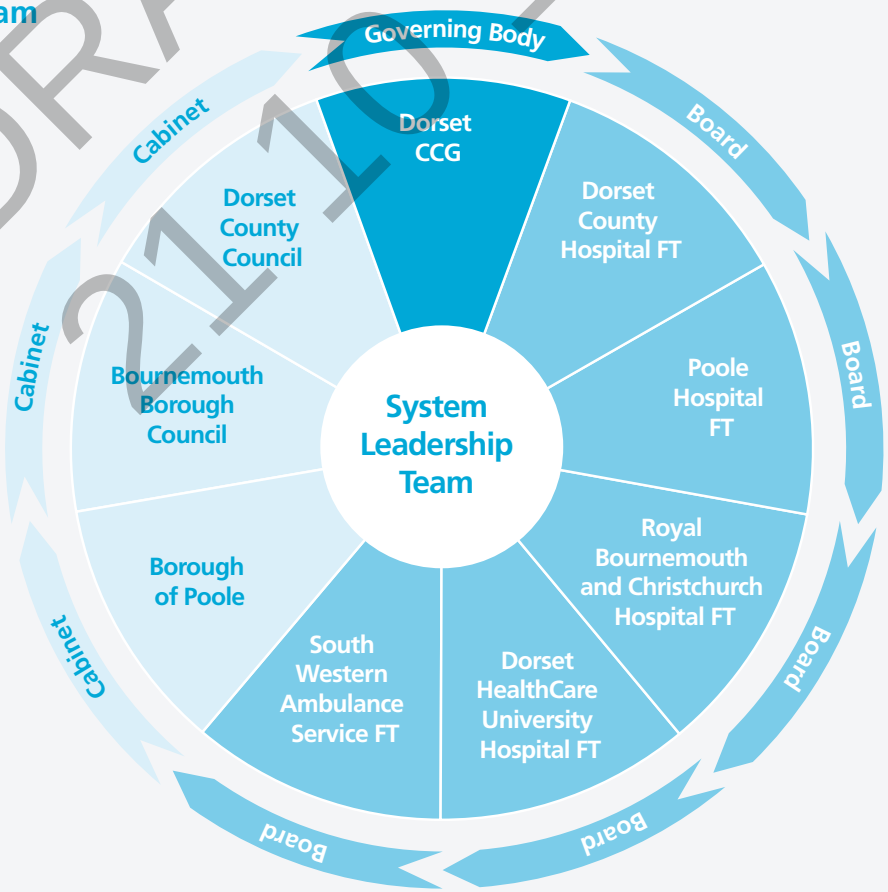
Our System Leadership Team



The governance arrangements for the programme are provided in the Appendix, page 5.

A sustainable approach to funding

Delivering improvements to our health and care system at a time of increased demand but with a lower growth in resources demands a sustainable approach to funding. This underpins all of our programmes of work.

Dorset health economy	£m
The scale of our financial challenge	**229**
Our solution: How we will jointly achieve our ambitions	
• Managing demand together	83
• Provider system efficiencies	100
• Re-investment in community services	-16
• Health system stretch target	34
• Nationally managed programmes	28
• Dorset Sustainability and Transformation Plan	229

The scale of our financial challenge has been derived from the 2016/17 planned outturn position with our solutions derived for the period 2017/18 to 2020/21 inclusive.

In March 2016 we calculated that a 'do nothing' scenario would create an annual financial gap in the local health system by 2020/21 of £158 million, with a further £32 million shortfall on NHS England specialised services. Over the summer we have updated our figures based on the latest guidance and modelling and taken into account the total financial position of our NHS providers in Dorset. As a result of this our annual financial gap over the five year period 2016/17 to 2020/21 has increased to £229 million. This includes a shortfall of £20 million on specialised services.

Meanwhile, local authorities in our footprint have identified a funding gap of over £70 million in the same period and of this, the potential amount attributable to social care is £37 million. This is in addition to a further £13 million of savings on social care already planned for the period. We are continuing to model the impact that our NHS transformation programmes will have on services provided by our local authority and the risks associated with this.

We have undertaken financial modelling work to calculate the impact of implementing our plan and to determine that we can close the health economy financial challenge gap by working together to jointly deliver the Dorset Sustainability and Transformation Plan.

Managing demand together: £83 million

Through working together as one Dorset health system:

- **NHS RightCare – Reducing unwarranted variation to improve peoples health: £28 million**
  Every health economy in England is expected to embed the NHS RightCare approach at the heart of their transformation programmes. It is a programme committed to improving people's health and outcomes. It makes sure that the right person has the right care, in the right place, at the right time, making the best use of available resources. We will implement this as part of our ongoing work in order to contribute **£28 million.**
- **Secondary prevention and active management: £27 million**
  Through our Prevention at Scale and Integrated Community Service programmes we expect to invest more in community and home care services, improve secondary prevention and active management and develop enhanced management of long term conditions. As a result of this we expect to reduce the demands on our hospitals to the value of **£27 million.**

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- **Outpatients: £8 million**
  We have identified many opportunities to modernise and develop outpatient services. Some outpatient appointments may no longer be required, some may be delivered through alternative delivery models, some may be delivered by different staff skill mix and some may be delivered closer to the person's home –which is the cornerstone to our Integrated Community Service programme. Overall, this could contribute up to **£8 million.**

- **Specialised services; £20 million**
  By working jointly with NHS England we will jointly identify an appropriate plan for specialised services, which would be expected to directly offset the estimated shortfall of **£20 million** against these services. This will include business as usual efficiencies at approximately 1% and transformational activities for the remainder supported by the production of an outline vision for specialised services delivered within Dorset.

Provider efficiencies: £100 million

- **Cost improvement plans across all four NHS foundation trusts: £81 million**
  Our local providers have agreed to contribute at least 2% savings on their existing cost base, supported by the national Lord Carter work programme. This would see the delivery of more appropriate services with better outcomes for less money by maximising effectiveness across the workforce and in areas such as supplies, information technology and estates. During the current year plans are already underway to deliver within the 2016/17 financial framework, with a further contribution of **£81 million** required across the remaining four year period 2017/18 to 2020/21. The Acute Care Collaboration (Vanguard) has ambitious plans for strengthening Dorset clinical networks, pathology services and efficiencies associated with business support services, which will be key to how this scale of ambition is delivered.

- **Acute hospital reconfiguration; £19 million**
  Once the proposed acute hospital reconfiguration is fully operational (2020/21), it is estimated that this will contribute annual efficiencies of over **£19 million** each year. Our clinically-led discussions set out that this would be achieved through a 30% increased efficiency associated with having all planned services on one site, and a 20% increased efficiency from bringing our emergency services together.

  This ambitious acute transition programme requires capital investment of between £148 million and £189 million in order to improve the existing hospital estate and to create new wards and units where required, for the Major Emergency Hospital and Major Planned Care Hospital in the east of the county. This capital investment would be spread be over a five year period with the savings contribution only realised at the end of the transition period.

  This investment decision is subject to public consultation under the Dorset clinical services review, and would require a full business case.

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Re-investment in community services: -£16 million

As part of our Dorset health economy plan to develop community services, we would re-invest community provider savings made as part of the above cost improvement plans in developing community services. This is an essential part of delivering our Integrated Community Services plans for integrated community teams and community hubs.

Health system stretch target: £34 million

We jointly expect to be able to significantly expand and develop Dorset-wide working in clinical and non-clinical areas from 2018/19 onwards. There is scope to utilise our resources and estate much more efficiently by working as one NHS in Dorset, enabled by our 'Digitally Enabled Dorset' and 'Leading and Working Differently' programmes. In addition as a system we are looking to work differently to mitigate expected growth in demand. These plans are still being developed in order to determine the programmes of work to deliver the required contribution.

Included within this to close the gap is the use of £2m per year from the historic built up commissioner surplus above the nationally required 1%.

Nationally managed programmes: £28 million

- **Sustainability and Transformation Fund; £53 million**
  As part of the confirmed national NHS funding allocation to 2020/21, a sustainability and transformation fund (STF) has been earmarked. Whilst there is limited detail as to how this will be distributed over the final two years 2019-21, the Dorset system has been advised indicative non-recurrent allocations for the next two years 2017-19 of £18.9 million per annum. By 2020/21 it has been assumed that the Dorset health system would receive £53 million recurrently as a contribution to achieving financial sustainability for health services across Dorset and support investment in nationally sponsored programmes.
- **National programmes; -£25 million**
  In closing the financial gap through the other programme areas identified above it has enabled us to protect the transformational element of the STF fund, noted above, we have estimated a

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The recent publication of the STP indicative allocations has suggested that Dorset should receive a £53 million sustainability and transformation fund by 2020/21.

programme delivery cost of £25 million. These programme areas support the delivery of the five year forward view to close the care and quality gap including prevention, childhood obesity, diabetes, dementia, cancer, GP access and national maternity review areas.

There are two programmes that underpin our savings plans, Integrated Community Services and Prevention at Scale, which are looked at here in slightly more detail.

Integrated Community Services programme reconfiguration

We are at an early stage of determining the financial implications of the model of Care for the Integrated Community Services programme. We know that workforce costs make up around 70% of our local revenue costs. We need to deliver care in new ways, our workforce will need to be reorganised to deliver services in the right place and with the appropriate skill set. The finance working group will be reviewing the proposed options for how the public sector estate across Dorset could be better organised to deliver community services by considering value for money, capital requirements, feasibility and deliverability.

There will be a transition period where we need to run some services in tandem, while we train staff and develop new care pathways that will require temporary additional running costs and investment in parts of our estate. Our plans will ensure that the funding of services will reflect patients' need, to ensure that the whole Dorset system will remain in financial balance.

We expect to be investing in our ICS programmes and for the programme to enable savings to be released in the other programmes we have identified above

Prevention at Scale

There are additional expected finance and efficiency improvements that will be delivered by addressing the wider determinants of health, undertaking:

- Smoking prevention programmes in schools can return as much as £15 for every £1 spent, as can anti-bullying interventions.
- Getting one more child to walk or cycle to school could pay back as much as £768 or £539 respectively in health benefits, NHS costs, productivity gains and reductions in air pollution and congestion.
- Housing interventions to keep people warm, safe and free from cold and damp could save the NHS £70 over 10 years for every £1 spent.
- Every £1 spent on befriending services saves £3.75 in reduced mental health spending and improvements in health.
- Every prevented visit to an NHS service results in a saving: £31 for a GP visit, £114 for an A&E attendance and £3283 for an inpatient stay in hospital.

We will be continuing to refine and check our assumptions and savings plan based on national funding allocations and efficiency requirements, while also closely monitoring how our plans are delivering the required savings. Overall, we will spend more in 2020/21 when compared with current levels but we will be ensuring more efficient use of our available resources to meet the needs of our population.

Given the leadership we have in place and our changing culture we are confident that these finance and efficiency interventions will see us deliver a financially balanced health system, alongside improvements in quality and safety for all those who use Dorset's health and care services.

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The national support we need

We are proud of Our Dorset and the scale of our ambitions to deliver a transformed health and care system focused on meeting the needs of our local population. We have a vision that we all support; a plan that we all agree will close gaps in health and well-being, care and quality, and finance and efficiency gaps; and some immediate priorities that we are all focused on delivering. We are all committed to working hard and at pace to realise our plans over the next five years.

Our Dorset already has important foundations in place. Crucially, there is a positive relationship between the organisations across our health and care system and we have a track record of working together to devise and deliver services. Recently strengthened leadership and governance arrangements will help us to accelerate the delivery of our plans. Our Clinical Services Review and Acute Vanguard programmes mean we are not at a standing start: much of the analysis and modelling work is complete and we are quickly moving towards the implementation phases. We can also build on existing good practice such as the Weymouth and Portland Hub, the integrated health and care teams operating in a number of community hospitals and the Acute@Home service.

We are in a strong position, but national support and investment would enable us to move faster to deliver the changes we are aiming for.

Expert advice and support

Receiving national expert support and assistance around patient benefits would strengthen our plan. While our modelling work has indicated how our proposals will benefit local people, we will be working with strict national regulations around maintaining patient choice and quality standards when hospitals are reconfigured. We would like assistance to review and strengthen our patient benefit case so that it is likely to be supported by NHS Improvement and the Competition and Market Authority.

As part of our Acute Vanguard programme, we would like legal expertise to help determine the format and structure of the 'vehicle' that will be established to deliver our single clinical network and workforce. Support with shaping workforce models, building skills and developing our training plans would also help to ensure we grow the right workforce to meet our future care models.

Our local authorities are seeking peer support to understand the approach of other health and care systems and to share the learning, particularly from those who are have been early adopters of new ways of working. We would welcome national support to help us set reasonable expectations about the scope and pace of partnership working, as well as assistance to develop appropriate outcome measures.

We would like support from our local MPs and elected members for our plans, particularly around best use of our estate and our site-specific reconfiguration plans. National support could help local politicians to feel they can confidently back the need for change and proposed plans for the Dorset health and care system. This will be particularly important before and during the forthcoming periods of transition as we embed the changes.

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Our specialised services are commissioned nationally by NHS England using national guidance and service specifications across a geographical footprint that is different to the area covered by our Dorset health and care organisations that have developed our plan. While we have been working with NHS England on the commissioning of these services it has been difficult to identify the specific plans and opportunities that address the needs of our local population. Assistance from NHS England to define the health and well-being, care and quality and finance and efficiency gaps within these specialist services would be welcomed.

Investment support

There are important elements of our plan that require financial investment, especially to deliver the proposed reconfiguration of our acute hospitals. If following public consultation and national scrutiny we progress with the site-specific option, from 2018 we are going to need between £147 and £189 million spread over five years or more. These capital estimates are based on national best practice and we anticipate that actual build costs could be 20-30% cheaper. The £19 million cost savings come from the reconfigured hospitals will mean that the capital investment pays for itself in four to seven years depending on the final costs.

This investment will be required in tranches over a five-year period as we extend and enhance our hospitals. For instance we would propose to develop our joint pathology capacity first at an initial cost of around £11 million.

We will also require investment in our community hospitals and primary care estate, to make sure our estate is appropriate for the planned community hubs and improved integrated community care services. As part of our ICS plan, current modelling suggests that this can be funded from existing capital allocation.

We would like national support for our capital requirement of our acute plans, to help with obtaining assurance from the investment committee so that we are in a position to bid for transformation funding and that our Foundation Trusts are successful in their application to the Independent Trust Financing Facility.

To date, our Acute Vanguard programme has received approximately 10% of the original funding request. This is going to make it difficult for the leadership and workforce across our hospitals to allocate the time to develop the clinical networks we need. The Health Foundation and The King's Fund state that transformation on the scale we have outlined will require a period of double running. To be able to deliver our plan at pace we will need the £10million Acute Vanguard funding that has already been committed. We also recognise that additional transitional funding in the region of £6 million will be required to cover double running/ non recurrent costs, across all our programmes during the five year period (this has not been built into the financial modelling).

We are confident that investment now will help to realise the estimated financial saving and other patient benefits of the the Dorset Sustainability and Transformation Plan.

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[9] Making change possible: a Transformation Fund for the NHS. The Health Foundation and The King's Fund Research report (July 2015)

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Bournemouth Borough Council

Dorset County Council

NHS Dorset Clinical Commissioning Group

Dorset County Hospital NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

Borough of Poole

Poole Hospital NHS Foundation Trust

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

South Western Ambulance Service NHS Foundation Trust