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INTRODUCTION

Welcome to our 2017/18 to 2018/19 GP Forward View Delivery Plan (GPFV), which builds on the work we have already begun to sustain and transform General Practice in Dorset. Our Plan is designed to enable delivery of our commissioning plans for Primary Care and sets out what we need to do over the next few years to meet the scale of challenges we face.

The last twelve months have seen us continue to grow and develop to take on the challenges of fully delegated authority for Primary Care commissioning from NHS England. We are confident to face the challenges ahead and have the experience to make some potentially major decisions about healthcare in the local area to achieve our ambition.

We have a strong commitment to collaborative working across our health and care system, acting as one integrated health and care system. This has enabled us to work together as the Dorset Sustainability and Transformation Plan (STP) footprint (see appendix 1) and to develop ‘Our Dorset’ STP which puts us in an excellent position for delivery. Our Dorset Primary Care Commissioning Strategy informs the direction of travel for GP practices. This Delivery Plan combines the ambitions of our Primary Care Commissioning Strategy and the General Practice Forward View (GPFV) into one comprehensive implementation plan across 2016 – 2020/21.

Our Plan responds to and has been informed by:

- ‘Our Dorset’ Sustainability Transformation Plan (STP)
- Dorset Primary Care Commissioning Strategy 2016 – 20/2021
- The Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy
- The NHS Constitution; and NHS Right Care ‘Commissioning for Value’

Our Plan sets out our high level ambitions and how, over the next few years, we will work with partners to:

- Sustain and transform health and care services to meet local population need (as part of the 9 must-do’s)
- Deliver the ambitions set out in our Primary Care Commissioning Strategy and Plan
- Ensure General Practice plays a central role in:
  - Improving health and wellbeing
  - Improving quality of care
  - Improving efficiency and productivity

Primary Care is an integral part of our STP to develop modern integrated community services that considers the needs of whole populations, not just the needs of the highest risk or most costly patients.

Our Plan aims to ensure incentives are aligned to support improving outcomes for whole populations, take action to offer consistent, early evidence based interventions and integrate services to address the impact of the wider local environment.

Our Plan recognises the need to ensure that robust and sustainable financial performance is maintained alongside the delivery of safe and high quality Primary Care services.

Our Plan is underpinned by detailed activity and financial trajectories, supported by workforce and digital plans. Performance will be managed through the Dorset CCG’s governance structures and as a system through the Systems Leadership Team.
This map defines the current Dorset CCG Locality boundaries. In 2017 the General Practice Transformation Groups will be developing blueprints which will clearly reflect local needs and demonstrate how new care models will be delivered in local communities.
Our vision for General Practice is that it will continue to be the foundation of the health system, maintaining its position as the leaders of Primary Care, retaining its identity and registered list. It will build on these strengths and past successes by working in larger groups to achieve sustainability, as part of Primary and Community teams across a range of sites, delivering care with improved quality, outcomes and access, while recognising the importance of continuity of care and building long term relationships with patients (Pereira Gray et al, 2016). We intend to do this by using the national and local tools we have at our disposal to support and work with our practices to find the best model for individual local areas and provider landscapes. Within this, we will need to reflect the requirements of the NHS Operational Planning and Contracting Guidance 2017-2019, (NHS England, 2016).

People are living longer, with often multiple long term conditions. Focusing on individual episodes of disease specific care is not an efficient way for us to be working, nor does it make the best use of the public money we have available to us in Dorset.

By 2020/21 it is our ambition to have all our practices working in collaboration at increased scale with consistent quality and improved outcomes throughout Dorset.

The ambition for the future GP model is that it will provide integrated care based on population need and will work as part of Multi-Disciplinary Teams (MDTs) across Primary and Community Services, using a network of GP practices and/or Primary Care and Community Service Hubs.

Enablers such as Workforce, Estates, Technology and Investment, recognise the real importance to modernise how we commission. We will consider emerging options such as PACS (Primary and Acute Care System) and MCP (Multi-specialty Community Provider); more work is needed locally to understand what these could mean for Dorset.

Some initial work has begun to think about what this could mean for our 13 localities, which will inform the development of local blueprints. These will be produced using local intelligence and feedback from the local engagement. We will work with groups of practices and local stakeholders in 2017 to develop these local blueprints to ensure our plans put patients at the centre of care. There will be a second phase of practice engagement and we will use the local and national enablers we have at our disposal. Local planning should ensure access to high quality patient care is maintained and new care model design enables person centred care planning;
KEY ACHIEVEMENTS IN 2016-17

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

• Health and wellbeing
• Care and quality
• Finance and efficiency

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

• Worked across the system to develop ‘Our Dorset’ STP, and have established the System Leadership Team and system wide programme
• Production of a comprehensive consultation plan and consultation document, which have received good practice accreditation from the Consultation Institute
• Continued to engage with our stakeholders to inform them about our plans for the future of Dorset’s health and care services as illustrated below

For Primary Care we have:

• Developed a Primary Care Commissioning Strategy and Delivery Plan (fully aligned to GPFV)
• Refreshed our local estates strategy and submitted estates and technology planning recommendations
• Accelerated plans to transform Primary Care, Integrating Community and Primary Care Services to deliver new care models
• Implemented the Weymouth Urgent Care Centre and Weymouth and Portland Integrated Care Hub
• Implemented integrated teams and developed community hubs in Bridport and Christchurch
• Improved antibiotic prescribing rates in Primary Care and achieved nationals measures
• Developed our Primary Care Workforce Centre and Doorway to Dorset recruitment campaign
• Work with partners across health and care to understand and develop plans for the estate within Dorset
• Developed plans to transform the infrastructure to facilitate at-scale working and technology enabled care delivery

<table>
<thead>
<tr>
<th>29,000</th>
<th>525</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pieces of feedback used to inform our Need to Change.</td>
<td>Attendees at our public meetings to help design the models of care.</td>
<td>Different forums, meetings and events to inform and engage thousands of local people including staff.</td>
</tr>
<tr>
<td>12</td>
<td>3,900</td>
<td>18</td>
</tr>
<tr>
<td>Meetings with our Clinical Services Review Patient, Carer and Public Engagement Group of representatives.</td>
<td>Members of our Health Involvement Network and 150 representatives of Supporting Voices have received regular information and been involved.</td>
<td>Meetings with our Pen-Dorset Engagement Leads Forum to plan and deliver a consistent approach to communications and public involvement across our health and care system.</td>
</tr>
</tbody>
</table>
The demand for GP appointments has doubled in the previous decade. 97% of GPs reported bureaucracy and ‘box ticking’ had increased since 2012, while nine out of ten GPs felt this took them away from spending time attending to patients’ needs. Eight out of ten reported target chasing had reduced routine available appointments to patients (BMJ, July 2014).

GPs are facing rising patient demand, particularly from an ageing population with complex health conditions, physical and mental health presentations:

- The population served by General Practice in Dorset is set to rise by as much as 50,000 in the next 10 years
- The number of people aged over 65 in Dorset is currently 185,715, (24.3% of the total population). This figure is expected to grow to 278,573 (32.1% of the total population) by 2040

**Workforce** - In response to the GPFV plan we have set our ambitions for the future of General Practice in Dorset. We will strengthen the General Practice workforce through new incentives for training, recruitment, retention and return to practice. We need to develop new roles in Primary Care including practice-based mental health therapists, practice clinical pharmacists, physician assistants and care navigators.

**Workload** – We will reduce the burden of reporting and bureaucracy and release more time for clinicians to see and treat patients. We need to encourage collaborations of General Practices serving local communities, putting plans in place which will increase the resilience of local services and lead to improvements in care quality. We need to reduce unnecessary demand on General Practice through working with patients to help them make informed decisions about how best to use local services and working with practices to introduce enhanced care navigation. GPs working as part of a more joined up Primary Care workforce will be able devote the greatest amount of time to quality and health improvement for patients and local communities.

**Infrastructure** - We will accelerate investment and support for infrastructure improvements including minor improvements and major development to support new care models including technology enhancing care and at-scale delivery of General Practice and Integrated Primary and Community Services (IPCS).

**Care Redesign** – We will work with groups of General Practices working at scale to improve access and implement new care models to meet local population need. We will invest in Primary Care, take positive action to address inequalities and unwarranted variation, increase supported self-care and seek to empower patients to be able to lead healthier lives.
## OUR AMBITIONS

**Milestones to be completed by 2018/19**

**Transformation and Investment**

Ambition: Invest £3 per head population over 2 years with 40% population having access to at scale working by 2018/19

<table>
<thead>
<tr>
<th>Trajectories for General Practice funding</th>
<th>2017-18</th>
<th>2018-19</th>
<th>By 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase General Practice funding by at least the % increase in core CCG allocations to fund core Primary Care contract changes</td>
<td>2.14%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Transformation funding commitment (£M)**

<table>
<thead>
<tr>
<th>2017-18</th>
<th>2018-19</th>
<th>By 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>£1.1</td>
<td>£1.3</td>
<td></td>
</tr>
</tbody>
</table>

Develop General Practice at scale and commission integrated models of care that support the different needs of the population.

Work with communities of General Practice to develop local blueprints which include local population need, relevant patient demographics, and the configuration of Practice and community sites with a focus on those facing the greatest health needs, health inequalities and poorest health outcomes.

Engaging and working collaboratively with local people and communities to develop plans.

**Leading and Working Differently**

Ambition: Give the health and care workforce the skills and expertise needed to deliver new models of care in an integrated health and care system.

Ensure the development and implementation of a learning and development plan aligned to the organisational needs analysis to deliver transformational leadership and enhance staff personal effectiveness.

Expansion of physician associates, medical assistants and physiotherapists within General Practice.

Introduce practice based Mental Health Therapists.

Use of online consultation to improve patient access and support capacity management.

Increase focus on self-care and use of first point of contact for example Musculoskeletal Physio therapists.

**Outcome Based Commissioning**

Ambition: Commissioning and Contracting arrangements will enable General Practice and the wider health system to collaborate and deliver at scale.

Begin to procure services for patients at population level in 18/19 and achieve 100% of outcome based locally commissioned enhanced services by 2020/21.

Work across organisational boundaries to meet the needs of the population - 80% of Practices working collaboratively to provide enhanced services at scale by 2020/21.

Meet local health needs through whole system pathways.

Joint commissioning of local enhanced services to be patient centered opportunity not disease specific.

**Care Models**

Ambition: To have all our Practices working in collaboration at increased scale By 2020/21.

<table>
<thead>
<tr>
<th>Trajectories (20,000 population groups for rural localities and 30,000 for urban)</th>
<th>2017-18</th>
<th>2018-19</th>
<th>By 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>40%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Implementation of the integrated community services new care models to reflect local care needs.

Effective, equitable and efficient services across Dorset.

To have evidence based local proposals / blueprints co-designed and agreed by localities.

Single point of access for response to crises - immediate support for patients who deteriorate in the community.

Integrate community pharmacy and other agencies within care pathways.
Our Ambitions

Milestones to be completed by 2018/19

Prevention at scale

Ambition: Improved patient experience, empowering people to take control of their own health.

Align with the STP ensuring Public Health elements are integrated with Primary Care Models and Prevention working with localities to develop models of care which facilitates improved health and well-being.

Empowering people to help them stay healthy, well by continuing to commission self-care programmes and enhancing digital options (see digital

Implement a range of programmes to support health and wellbeing, building on progress made in 2016

Implement diabetes models of care through a phased programme

Contribute to the developing multi-sector, multifaceted physical activity programme

Reduction in deaths from preventable causes working in partnership with local communities

Our Workforce

Ambition: Develop a sustainable General Practice model which is attractive to work in.

Trajectories for population coverage with skill mix teams and new roles e.g. pharmacy and MSK

2017-18 2018-19 By 2021

20% 40% 100%

Deliver workforce development plans to address General Practice resilience which includes actions to ensure GPs are operating at the top of their license.

Consider and progress opportunities to expand multidisciplinary team and greater integration across community services to optimise out of hospital care.

Development of skill-mixed teams for delivery of new models of care including locality based, and networks of pharmacists supporting practices

Initiatives to attract, recruit and retain General Practice workforce

Right Care - making time for care

Ambition: Improve outcomes and reduce unwarranted variation for areas we are outliers.

Design a rolling Annual Programme of Quality Improvement and set specific standards to address variation and improve outcomes through implementing the Time for Care Programme

Reduction in variation of Chronic Obstructive Pulmonary Disease (COPD) / Atrial Fibrillation (AF) across Dorset

Build on the uptake of the PINCER tool in Practices to support high risk medication reviews, and promote safe medication use using poly-pharmacy tools and new prescribing data

Reduction in referral to acute hospitals for two identified outliers (MSK and Cardiovascular/Diabetes)

Develop GP access to consultant advice

Practice Learning and development - Training to improve decision / support for outlier areas

Improving Access to Care

Ambition: Service Users will be able to access relevant Primary Medical care when and where they need it.

Trajectories - Increasing consultations by 45 minutes per 1000 population

2018-19 By March 2019

50% 100%

There will be sufficient level of access to meet fluctuating demand – local access models to reflect local need

Address inequality in access between population groups

Additional General Practice appointments from 18:30-20:30

Additional General Practice appointments at weekends to meet local needs (to be provided on a hub / working at scale model)

Increase General Practice Capacity by commissioning a minimum of 45 min consultation per 1000 population

Improve transfer of care ensuring appropriate access

Use technology to enable access and delivery of care
Milestones to be completed by 2018/19

GP Development

**Ambition to improve capacity management across all Practices**
Releasing Time In General Practice - link national programme to ensure Practices take up training
Maximise approaches to self-care and care planning

**Online Consultation – access for patient to remote consultations**

**Trajectories - full population overage by 2021**

<table>
<thead>
<tr>
<th>Year</th>
<th>2017-18</th>
<th>2018-19</th>
<th>By 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>40%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Encourage self-care/ management through use of E-consultation and GP Web based software and telehealth and assisted technologies
Consolidate outcome from existing pilots to inform Dorset wide procurement

**Training Care Navigators/Medical Assistants**

**Trajectories – Practice coverage**

<table>
<thead>
<tr>
<th>Year</th>
<th>2017-18</th>
<th>2018-19</th>
<th>By 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>50%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Work with GP Clinicians to develop the model for the roll out across Localities
50% of Dorset population will have access to Navigator/Medical Assistants by end of year 2

**Technology Enabling Care**

**Ambition: A paperless health system**

Shared care records
Implementing the Dorset Care Record and Digital Dorset
Implementation of transfer of care documents- acute to Primary Care (17/18) acute setting to social care (18/19)
Implementation of a single pathology laboratory information management system
Joining medicines records across care settings
Implementation of transfer of care documents – Acute to Primary Care
Roll out online consultation systems
Promote joint working with local pharmacist to increase uptake of electronic repeat dispensing

**One system for Primary Care**

Creation of a single SharePoint for forms and information
Creation of a single portal for websites

**Infrastructure**

**Ambition: To have the appropriate infrastructure needed to deliver General Practice of the future with premises fit for purpose.**

Improving the Primary Care estates, working in partnership with integrated Primary and community services infrastructure development priorities and plans

8 Practice/area based feasibility studies undertaken (CCG funded)
Give General Practices options on the future of their Practice premises
Premises Improvement Grant applications sought (NHS E funded)

**Premises fit for purpose for the future**

1 ETTF pre-project costs (no capital allocation) (NHS E funded)
4 ETTF new build/significant improvement programmes undertaken (NHS E funded)

**Raising the quality of current provision of GP premises**
Use funding to maximise opportunities for transforming Primary Care estate
Raise quality of current provision of premises

**Use of technology to support collaborative working and work across organisations to support care**
Since taking on full delegation for Primary Care from NHS England in April 2016 we have been investing in developing our plans for Primary Care transformation and delivery. We have now established a Senior Clinical and Management Leadership team for the implementation of our Strategy. This group will also oversee the development and delivery of the GPFV Delivery Plan. A new Transformation programme has been developed through a Wessex Change fund agreed jointly with NHS England and has identified an initial 6 at-scale Primary Care accelerator sites, representing over 20% of the Dorset population. A Dorset Primary Care clinical lead has oversight of these plans working with 13 Locality GP Clinical Chairs. We are also working with the national GPFV team to develop these plans which include leadership for improvement with a focus on the 10 High Impact changes and leadership for transformation which will begin to develop at-scale models of General Practice delivery.

We have also established clinical leadership for General Practice Quality and Access with a focus on ‘RightCare’, looking at how we develop our commissioning framework to support our strategy and ensure we address unwarranted variation.

We propose to further accelerate work with at-scale practice groups and increase their state of readiness for this. The accelerator sites will continue to develop at-scale working supporting groups using the Vanguard learning to establish their leadership and plans for at-scale General Practice as part of local care delivery systems. The expected outcomes are:

- Clinical and business leadership for at-scale General Practice groups
- Sign-up to transformation through a Member practice statement of intent or memorandum of understanding
- Regular protected learning and development sessions
- Project management and expert facilitation of at-scale transformation plans
- Practices working together around high impact changes

All at-scale practice groups will benefit from a leadership development programme as part of our Primary Care Workforce Centre model, working closely with Health Education England and the Wessex Deanery.

We have plans in place to develop our clinical leadership and business support for at-scale General Practice to deliver the mandate commitment on access, workforce and digital transformation.

Our Investment Plans

Our local NHS faces significant financial challenges over the years ahead. Despite this we are making a commitment to investing in Primary Care, to sustain and transform the way in which care is delivered.

We are working with NHS England to better understand the national investment in GPFV delivery and how this reflects our local plans.

We are redesigning the way we commission with our localities to reflect the investment in General Practice transformational and workforce development support. We also have plans for investment and development of high impact changes and a local General Practice development programme.

We have aligned our investment plans to ensure delivery of the GPFV ambitions.
There is a requirement for General Practice funding to be increased in line with CCG core growth which is 2% for 2017/18 or £165K. The CCG is planning to invest £200K to support the Primary Care transformation agenda in 2017/18.

### OUR PLANS FOR INVESTING IN GENERAL PRACTICE

<table>
<thead>
<tr>
<th>Theme</th>
<th>Allocation Method</th>
<th>Ambition</th>
<th>Funding DM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Transformation Fund £3 per head</td>
<td>Non recurring allocation NHSE</td>
<td>Investment over 2 years from core CCG allocation to secure sustainability, stimulate development of at-scale providers and 10 non impact changes</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Reinvestment of existing funds</td>
<td>Reinvestment of existing funds</td>
<td>0.6</td>
</tr>
<tr>
<td></td>
<td>New funding 2017/18 from CCG Core</td>
<td>New investment from CCG Core</td>
<td>0.2</td>
</tr>
<tr>
<td></td>
<td>Reinvestment of existing funds</td>
<td>Redeployment of existing funds into Primary Care</td>
<td>0.1</td>
</tr>
<tr>
<td>Access (recurrent funding)</td>
<td>New funding 2017/18 as advised by NHSE within Operational Planning Guidance</td>
<td>Increase consultation capacity by 45 minutes per 1,000 registered population</td>
<td>0.5</td>
</tr>
<tr>
<td>Patient on-line consultation systems</td>
<td>New funding 2017/18 as advised by NHSE within Operational Planning Guidance</td>
<td>Transformational change at practice level to provide on-line consultations</td>
<td>0.2</td>
</tr>
<tr>
<td>(Non Recurrent)</td>
<td></td>
<td></td>
<td>0.3</td>
</tr>
<tr>
<td>Training for Care Navigators and Medical assistants for all practices (Non Recurrent)</td>
<td>New funding 2017/18 as advised by NHSE within Operational Planning Guidance</td>
<td>Part of a General Practice development programme Admin and clinical training –丧假oding (2016-17). Training care navigators and medical assistants (2017-18)</td>
<td>0.1</td>
</tr>
<tr>
<td>General Practice Resilience (Non Recurrent)</td>
<td>New funding 2017/18 as advised by NHSE within Operational Planning Guidance</td>
<td>Funds held by NHS England (Wessex) local team</td>
<td>0.2</td>
</tr>
<tr>
<td>Estates Sustainability and Transformation* (Non Recurrent)</td>
<td>New funding 2017/18 as advised by NHSE within Operational Planning Guidance</td>
<td>New funding awarded for successful bids</td>
<td>0.2</td>
</tr>
<tr>
<td>CNT</td>
<td>Funding held with NHS England</td>
<td>Nationally procured IM&amp;T systems</td>
<td>1.0</td>
</tr>
<tr>
<td>GP trainees</td>
<td>Funding held with Health Education England</td>
<td>Programmes managed by HEE</td>
<td>2.0</td>
</tr>
<tr>
<td>Public Health</td>
<td>Funding held with NHS England</td>
<td>National programmes Section 7A, supporting payments to GPs for screening &amp; immunisation services</td>
<td>5.1</td>
</tr>
<tr>
<td>Mental health therapists</td>
<td>Funding held with NHS England</td>
<td>3,000 Practice Based MH Therapists</td>
<td>5.8</td>
</tr>
<tr>
<td>Total investment in Primary Care in Dorset</td>
<td></td>
<td></td>
<td>5.5</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>19.5</td>
</tr>
</tbody>
</table>

*additional Estates Capital subject to NHS England review and due diligence of recommended programmes.
ENGAGING OUR MEMBERSHIP AND LOCAL COMMUNITY IN DEVELOPING THIS PLAN

GP Members and Teams

As part of our consultation on developing our Plan we met with our GP Members and their teams. The Clinical Leadership Team (CLT), supported by Primary Care Team Managers, presented to and discussed the draft strategy document with each of the 13 GP Localities. In addition to this, the December 2016 membership event focussed on developing this Plan, to shape the offer of support to practices and held workshops on key themes from GPFV:

- **Workload**: releasing time for care
- **Access**: increasing consultation capacity
- **Technology enabling care**: patient on-line
- **Care design**: new models

We also conducted wider engagement with all staff in practices to ensure the delivery plan has been developed collaboratively, with the launch of a survey.

As at 12 December 2016, 60% (57/96 Practices) responded to the survey and 81% (78/96) practices had representation at the membership event. This is what we heard:

Online Consulting

Online access is used across 98% of responding practices for booking appointments and repeat prescribing.

56 out of the 57 practices that responded highlighted that they don’t currently use an online consultation system but 79% would support Dorset wide or at scale group of practice roll out of an off the shelf tool e.g. GP web or AskmyGp as they have indemnity inbuilt. This would provide patient focused support at a time, place and format most suitable for them which is likely to be attractive to those patients who currently prefer to attend Out of Hours services for routine matters because it fits around other commitments.

Access

Investing in access to General Practice from 18:30 – 20:00 Monday to Friday and access at weekends, there was a clear response that this is not achievable at a practice level, with the majority looking for an ‘at scale’ offer. 36% of practices would consider an outsourced service for their patients. There is concern that a lack of staff and low recruitment levels are still going to be an issue however much money is available and that improving access cannot be to the detriment of continuity.

This was balanced with the recognition that the public want more routine appointments, with all expected services (for example, blood tests) up until 20:00 and if a person needs to see a doctor quickly, they would be happy to see a doctor (or any appropriately qualified medical professional) if it meant they did not have to wait.

Differing extended hours models may be confusing for patients. The current South West Ambulance Service Trust (SWAST) service is not local enough, a re-design of the existing SWAST service, including 111, may be better use of the money. One concern was that when the public call 111 during the day they are often being told to go to the GP – it is no longer an advisory service.

Releasing Time for Care

70% of practices that responded suggested that their reception staff signpost their patients to the most appropriate source of help. Many practices responded that this could be enhanced by specific triage training for non-clinical/reception staff. With regards to the proposed training opportunities, the vast majority of the practices see this as a positive. However, ideas around usage of the funding is varied, it requires a big commitment and backfill of roles would be needed but is was recognised that the outcome of a 10% decrease in workload would be worthwhile.

Many practices want to ensure training opportunities are equitable across the county, with a strong theme around HCA and Practice Nurse development. Other recurring themes include more GP trainees and more IT training so that Clinical Systems are used to their full potential. The processing of information is a high percentage of the workload and looking at procedures for other staff to review letters would be useful.
Care Redesign

Patients need uniformed access and quality of care everywhere, shaping resources around needs. This needs to be patient centred and include social care, with significant investment in patient education to support self-management and maintaining wellbeing.

At Scale/Transformation

The CCG should provide clarity of what is needed in and across Dorset and facilitate conversations within practices as well as between practices. We also need to develop effective ways to share best practice and idea development across groups.

Within the next five years the majority of practices saw themselves actively part of a Federation or forming strong alliances and 30% practices saw themselves merging. In terms of ‘quick wins’ which could be achieved by practices working together, there was a clear indication that ‘Support for high intensity patients with complex needs’ was a priority, followed by rapid access to MDT’s.

Rural vs urban factors give different challenges. Rural practices may be disadvantaged as it is not easy to do at scale at 30,000 patients, could we explore an alternative minimum at scale for rural locations?

Changes will be required in Local Enhanced Services (LES)/Directed Enhanced Services (DES) to support at scale working e.g. extended hours across groups of practices.

Equity of resources and services was a dominant theme, everyone needs to have a fair share of what is available and transparency is important. Finally, the vast majority of responding practices (87%) would prefer transformation support to be offered at ‘groups of practices’ rather that CCG wide or cluster wide.

*N.B. Since 12 December 2016 we have introduced a minimum of 20,000 at scale for rural communities.

In September 2016 we also met with Patient Participation and Engagement Group (PPEG) and the following table shows what we heard and how it has been reflected in our Strategy:

<table>
<thead>
<tr>
<th>What did we hear?</th>
<th>How this is reflected in our strategy:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improving Access</strong></td>
<td></td>
</tr>
<tr>
<td>A good experience of access to local NHS services is important</td>
<td>We are building on the existing high quality General Practice offer by achieving extended and improved access:</td>
</tr>
<tr>
<td></td>
<td>• Offer weekday provision of access to pre-bookable and same day appointments after 6.30pm to provide an extra hour and a half per day</td>
</tr>
<tr>
<td></td>
<td>• Commission pre-bookable same day appointments on both Saturdays and Sundays “to meet local population needs”</td>
</tr>
<tr>
<td>There is a need to strengthen access to General Practice services in local communities as part of a wider look at community services:</td>
<td>There is a commitment to support practices working together in local communities with input from improved community and specialist services, to look at how access and choice can be improved</td>
</tr>
<tr>
<td>Use of technology to help people to have easier access to care and navigate services is important</td>
<td>There will be technology enabled care across Dorset working through a Dorset Digital Roadmap and roll out of a Dorset Care record</td>
</tr>
<tr>
<td>We need co-location of Primary Care with other local services recognising its role in accessing information, advice and support in local communities – especially in rural areas</td>
<td>We are developing Local Blueprints for care delivery which will look at how public sector services can work together</td>
</tr>
<tr>
<td>Consider mobile GP services to maintain access to rural isolated communities</td>
<td>We will consider how Technology and Models of Care can help improve existing access to care with a particular focus on isolated communities</td>
</tr>
<tr>
<td><strong>Empowering Patients</strong></td>
<td></td>
</tr>
<tr>
<td>Make services more responsive to patient needs</td>
<td>We will have patient centred care planning supported by integrated teams</td>
</tr>
<tr>
<td>Recognise patients as experts in their care</td>
<td>There will be a focus on prevention and supporting people to lead healthier lives with a more holistic view of what patients need</td>
</tr>
<tr>
<td><strong>Joining up Care</strong></td>
<td></td>
</tr>
<tr>
<td>Patients want to be able to know they have a team looking after them who work with them to understand their care needs</td>
<td>We will have an integrated team-based approach to care delivery using new care models which respond to the needs of different patient groups</td>
</tr>
<tr>
<td>Make sure that General Practice is supported by teams which include mental health workers</td>
<td>We will support practices to work together in local communities to develop more skill mixed teams, working with other services to support practices</td>
</tr>
<tr>
<td><strong>Improving Quality</strong></td>
<td></td>
</tr>
<tr>
<td>Patients want the same high quality care experience no matter where they are seen</td>
<td>We will consider variation and what can be done to ensure patients receive the right care at the right time and that is responsive to their needs</td>
</tr>
<tr>
<td>There is a need to develop a new relationship with patients so that they work in partnership with health care professionals</td>
<td>There will be a focus on prevention supporting patients to be able to take control of their own health and when they need local NHS services general practice are able to support them navigate appropriate access to care. Working with patients via PPEG and PPGs</td>
</tr>
</tbody>
</table>
In response to this feedback we have developed a Primary Care support offer for Practices working collaboratively at scale:

- Named CCG senior link manager
- Protected learning and development time
- Project management support
- Facilitation Access to an expert team – local and national resources

Our programme of engagement will show how we plan to engage with our GP Members, their teams, patients, carers and the public to inform the development of the models. Part of this process will be to identify whether or not there is a need to go to formal public consultation. In this case NHS Dorset CCG would provide appropriate support.

NHS Dorset CCG has a defined engagement process, developed in line with national guidance. When reviewing, designing or planning services the CCG routinely undertakes a number of actions to facilitate meaningful engagement, ensuring the views of local people inform every stage of the commissioning cycle.

These include the following:

- Audience Analysis
- Representation
- Gathering insight
- Seeking local views
- Communication planning
- Engagement on proposed changes
- Equality impact assessment process

The CCG has a clear engagement structure to support the delivery of this process and this is illustrated pictorially below.

*PPGs = Patient Participation Groups in GP Practices
LINS = Locality Involvement Networks
HIN = Health Involvement Network of 4000 + members with an interest in health care*
By 2020/21 we will look to commission integrated models of care that support the different needs of the population in a fully joined up way. There are many forms of these Accountable Care Organisations (ACO) but the two models that will be considered are Multispeciality Community Providers (MCP) and Primary and Acute Care Systems (PACS).

Our plan is to work with local communities of General Practice to develop Local Blueprints. These planning tools will consider a number of factors including population need, relevant patient demographics, and the configuration of practice and community sites when considering the future design of Primary Care for their local population. They will be tailored to respond to local demographics – engaging local people and communities. They will consider in detail local needs with a focus on those facing the greatest health needs, health inequalities and poorest health outcomes.

Our plans for transforming primary care will not be achieved in one step. During the next two years we will work with practices, practice groups and federations to commission appropriate services at scale and to look to extend the number of services delivered at a collaborative level.

Our priorities for the use of the transformational funding are to support General Practice to move from the current position to a fully collaborative model in the next two years.

We will invest in both General Practice becoming super practices through mergers and / or support the development of General Practice federations to deliver Primary Care at scale.
Our vision for General Practice is that it will continue to be the foundation of the health system, maintaining its position as the leaders of Primary Care, retaining its identity and registered list. It will build on these strengths by working in larger groups to achieve sustainability and maintain continuity of care for patients, as part of wider Primary and Community teams, across a range of sites delivering care with improved access, quality and outcomes, as close as possible to people’s homes.

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

Our Primary Care Commissioning Strategy sets out how we will transform General Practice reflecting the General Practice Forward View and deliver the following ambitions by 2020:

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

<table>
<thead>
<tr>
<th>Milestones</th>
<th>17/18</th>
<th>18/19</th>
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<tbody>
<tr>
<td>Local blueprints</td>
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<tr>
<td>Complete Co-production of local plans to improve health in partnership with local communities, health, social and voluntary organisations.</td>
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<tr>
<td>Commence implementation of local transformation programme to enable 40% the population to be receiving GP Services from practices who are part of a collaboration, working at scale</td>
<td></td>
<td>✓</td>
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<tr>
<td>Commence Technology enabling the delivery of care through implementing the Dorset Care Record and Digital Dorset</td>
<td>✓</td>
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</tr>
<tr>
<td>Complete estates and technology transformation plans. Improving the primary care estates, working in partnership with integrated community services infrastructure development priorities and plans</td>
<td>✓</td>
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</tr>
<tr>
<td>Improve access to general practice – commence planning to provide additional consultation capacity per 1,000 population including on-line consultation systems, address inequality in access and commission additional capacity for evening and weekends reflecting local need</td>
<td>✓</td>
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<tr>
<td>Urgent primary care – develop improved care integration between GP extended care and out of hours</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Design a rolling Annual Programme of Quality Improvement and develop a set specific standards to address variation and improve outcomes</td>
<td>✓</td>
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</tr>
<tr>
<td>Commence work to address the General Practice workload challenge by local delivery of Releasing Time for Care Programmes and supporting the implementation of the 10 high impact changes</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Deliver workforce development plans to address General practice resilience, supporting the development of skill MIXED teams for delivery of new models of care</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Develop Prevention at scale – work with localities to develop models of care which facilitate supported self-care, improved health and wellbeing including training for care navigators</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Commence the organisational development of general practice to enable primary care to be equal partners in new collaborative arrangements</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Further develop commissioning of primary care to deliver care at scale</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Implementation of the integrated community services new care models to reflect local care needs</td>
<td>✓</td>
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</tbody>
</table>
During 2016/17, health and social care partners across Dorset came together to develop ‘Our Dorset’ STP, which sets out a clear vision: we want to provide services which meet the needs of local people and deliver better outcomes (http://www.dorsetccg.nhs.uk/aboutus/subsustainability.htm)

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

Our three programmes of:
1. Prevention at Scale - will help people to stay healthy and avoid getting ill
2. Integrated Community Services - will support individuals who are unwell, by providing high quality Primary Care at home and in Community settings
3. One Acute Network - will help those who need the most specialist health and care support, through a single acute care system working in partnership with Primary Care

These programmes are supported by two enabling workstreams of:

- Leading and Working Differently – which 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
- Digitally Enabled Dorset - which will increase the use of technology to support new approaches to service delivery

Delivery of our STP will be overseen through the System Leadership Team, with each organisation individually and collectively accountable.

The following section sets out our GPFV Delivery Plan, our ambitions over the next two years, and outcomes for each of five key programmes and detailed deliverables.
The ambition for the future GP model is that it will provide integrated care based on population need and will work as part of MDTs across Primary and Community Services, using a network of General practices and/or Primary Care and Community service hubs.

The GP element of these care models will be co-produced through local engagement with GP and patient communities. This will reflect local need and how best to configure services to meet local population, future demand and new ways of working. The table below shows the GP element of the current care model and what it could look like in the future, working as part of MDTs.

The cumulative impact of the pressures that General Practice is facing is resulting in a time of unprecedented change. These pressures provide a catalyst to find new ways of organising General Practice for the future in addition to ensuring that General Practice can deliver the breadth and quality of care that our population requires. The strategic programmes for Dorset provide a framework within which models can develop.

Different delivery models are emerging which share similar features or are being developed to create similar opportunities, e.g. working at scale to assist in developing teams with greater skill mix, supporting new ways of working and meeting the needs of patients.

Different delivery models will not solve the problems facing General Practice in themselves, but in some situations they may be an important step towards enabling practices to address their challenges.

The CCG, alongside General Practice, shall empower GP’s to move to new models of integrated working, recognising that there are different approaches to doing this – no one size will fit all in Dorset.
The Prevention at Scale Programme forms the foundation of all our plans and underpins all the work we will do. The role of primary care is fundamental to this in engaging local populations in leading healthier lives.

Our three programmes for Primary Care are:

• Identify unwarranted variation in services in each locality and put a programme in place to address these
• Co-production of local plans to improve health in partnership with local communities, health, social and voluntary organisations
• Offer consistent early, evidence-based support for prevention interventions

Through various collaborative programmes we aim to improve the health and wellbeing of our current and future population by reducing unacceptable difference in health and life expectancy of different groups of people in Dorset, including those with mental health problems.

Milestones to be completed by 2018/19

**Ambition: Improved patient experience, empowering people to take control of their own health.**

Align with the STP ensuring Public Health elements are integrated with Primary Care Models and Prevention working with localities to develop models of care which facilitates improved health and well-being.

Continue to develop and refine the prevention at scale implementation plans to support STP delivery

Develop and implement diabetes models of care through a phased programme

Reduction in deaths from preventable causes

**Empowering people to help them stay healthy, well by continuing to commission self-care programmes and enhancing digital options**

Develop additional pathway into ‘Live Well Dorset’

Implement a range of programmes to support health and wellbeing, building on progress made in 2016

Contribute to the developing multi-sector, multifaceted physical activity programme
Through our Integrated Primary and Community Services (IPCS) programme we will transform general practice, primary and community health and care services in Dorset so that they are truly integrated and based on the needs of the population, as illustrated below.

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

The workstreams within this programme are:

- Integrated community hubs and teams
- Primary medical services-General Practice
- Mental health
- Learning disabilities

Nine Must Do’s

This programme supports the delivery of the following must do’s:

- Implementing GP Forward View
- Implementing the Mental Health Forward View
- Implementing Right Care
- Implementing Transforming Care Partnership Plans
- New Models of Care - health and social care integration
- Improve Quality

Outcomes

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

- Improve access to integrated services within the community including general practice
- Improve outcomes for adults and children suffering from mental health illness and those with learning disabilities
- Reduce in the growth in outpatient appointments
- Reduce in the growth in non-elective medical and surgical admissions
- Reduce community hospital length of stay for step up and step down beds
- Reduce the number of delayed transfers of care across all providers

Further detail on how this programme contributes to the delivery of the outcome measures set out in the NHS Improvement and Assessment and its contribution to closing the financial gap can be seen in the finance section.

This programme is overseen by a Senior Responsible Officer – Chief Executive from Dorset HealthCare University NHS Foundation Trust, and has a dedicated Portfolio Director – Deputy Director of Service Delivery, Dorset CCG.
Through our integrated community services workstream we aim to improve people’s health and wellbeing, increase care closer to home, and improve people’s experience of services through the implementation of community based services. These will be led by multidisciplinary teams of professionals working together to meet the physical and mental health needs of people of all ages. In doing this we will reconfigure community hospitals and establish community hubs and further implement integrated community teams.

This builds on the existing hub model in Weymouth and Portland where over the last six months, for patients over 65yrs, we have seen a 4% reduction in bed use, more people discharged home after an admission, 9% reduction in minor and emergency department attendances and although there has been an increase in admission for over 65yrs, this is significantly lower than other localities in Dorset.

The hubs will provide:

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

During late 2016/17 we will consult on the site specific options for community hubs as part of the clinical services review consultation (CSR). Key deliverable during 2017/18 to 2018/19 can be seen in the table overleaf. Our community hubs are expected to be supported by strengthened networks of GP practices, offering patients wider range of services.

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<tr>
<th>Milestones</th>
<th>17/18</th>
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<tbody>
<tr>
<td><strong>Community Hubs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full business case for revenue and capital implications of IPCS model</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Complete decision making on community hub configuration post public consultation, including:</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- confirm number of community hubs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- confirm range of services and numbers of beds at each community hub with beds</td>
<td></td>
<td></td>
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<tr>
<td>- define primary care facilities for the delivery of community outpatients</td>
<td></td>
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<tr>
<td>- implement phase 1 of short term care home bed provision through development of Mitchell House in Poole</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- establish step ups beds in Dorset County Hospital, in line with proposed hub model</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Implementation phase 1 of community hubs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement phase 2 of short term care home provision expansion in Bournemouth, Christchurch and Shaftesbury (subject to consultation)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Expand rehabilitation model to seven day working, reduce community hospital length of stay from circa 32 days to 24 days step down and 3 days step up.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Implement phase 2 community hubs linking with primary and social care</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Integrated Community Teams (health and social care)</strong></td>
<td></td>
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<tr>
<td>Implement frailty framework, including risk stratification, education (linked with HEE), technologies (linked to Digital Dorset), standardised care delivery across Dorset to reach 0.5% of the population (3,830 people) in 2017/18</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Expand teams so 5% of the population (38,300 people) are supported (as above)</td>
<td>✓</td>
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</tr>
<tr>
<td>Expand teams so 15% (206,820) of the population with moderate need will receive co-ordinated signposting, advice and support, and personalised care</td>
<td>✓</td>
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</tbody>
</table>
Transforming how urgent care services are provided is a key part of our plans for Integrated Community and Primary Care Services. We want to develop a rapid response to urgent care needs with a single point of access.

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

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

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

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

We have developed a joint health and social care strategy and action plan to reduce the number of Delayed Transfers of Care (DTOC), we aim to achieve a rate of 3.5% across all providers with a further ambition to reduce to 2.5% together with a reduction in bed days lost due to delays. In addition to this, we will aim to achieve a rate of 7.5% across all community hospital sites. We will work with partners to understand the impact of social care funding changes on urgent and emergency care service delivery such as DTOC.

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

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<tr>
<th>Milestones</th>
<th>17/18</th>
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<tbody>
<tr>
<td>Determine the urgent care requirements across both community and acute sectors in line with IPCS and one acute network programme</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Subject to consultation implement new models of integrated urgent and emergency care, linked with acute care collaborative vanguard</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Continue to deliver the 5 priority areas identified within the A&amp;E delivery Board and to deliver the action plan in conjunction with health and social care partners</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Re-procurement (2017/18) and implementation (2018/19) of NHS 111 out of hours in line with Keogh and IPCS modelling</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Take on lead commissioner role for SWAST 999 for the South West region</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Develop Integrated urgent care access and advice as part of re-procurement of NHS111 and out of hours</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Progress discharge to assess model of care</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Develop trusted assessor role and integrated discharge services across Dorset</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Implement DTOC action plan to improve patient flows across health and social care and meet national standards</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Continue to implement four priority standards for seven day working as part of provider service development improvement plans</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Continue to meet national seasonal planning requirements</td>
<td>✔</td>
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</table>
OUR WORKFORCE PLAN

To enable us to transform services set out in our Primary Care Commissioning Strategy and GPFV we know we need to work more closely across different organisational boundaries for the benefit of patients and to help address our workforce challenges. We recognise we need to work collectively as a system to deliver a seamless integrated service, and to maintain and develop professional skills.

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

- Development of our leader and organisations
- Recruitment and retention of our staff
- Developing our staff
- Supporting staff through change

We will organise our workforce around General Practices working at scale to serve local communities, 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 and innovative place to work, so that we can attract the highest calibre of staff into our local communities. We intend to create more diverse training placements across Primary, Secondary and Social Care for a range of professions and work closely with Bournemouth University to establish a training academy approach. This work will be delivered by implementing our workforce action plan 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 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

In 2017 we will produce a baseline assessment of the current workforce in General Practice, the workforce demands and identify practices that are in greatest need of support. We will undertake a skills audit across General Practices to identify the top priority areas to address.
### OUR WORKFORCE PLAN

**Milestones to be completed by 2018/19**

**Ambition: Develop a sustainable General Practice model which is attractive to work in.**
- Produce workforce development plans which set out future ways of working, which includes actions to ensure GPs are operating at the top of their license.
- Develop the postgraduate schemes for doctors and nurses, ensuring the appropriate mentorship and support structure is in place.
- Develop a workforce plan for paramedics and pharmacists and other HCP roles in General Practice.
- Create work placements with HEE to enhance and improve the offer to encourage people to work in General Practice.

**Commit to, develop, fund and implement local workforce plans.**
- Develop and commission programmes to address the training needs, ensuring alignment to the hot topics and Practice learning programmes
- Ensure the development of core skills, such as statutory and mandatory training, led through the leading and working differently strategy.
- Provide leadership, programme management, facilitation and development support to Practices.

**Develop and embed initiatives to attract, recruit and retain GPs and other clinical staff.**
- Provide direct recruitment support to Practices
- Partner with Dorset Healthcare to set up a bank of medical and non-medical staff for General Practices to access and use for their temporary staffing needs.
- Set up an infrastructure for locums to use and for Practices to access.
- Support for Doctors Retainer Scheme with better training/benefits
- Design and develop a leadership programme to support the development of GPs and other professionals in practices in Dorset.

**Consider and progress opportunities to expand multidisciplinary team and greater integration across community services to optimise out of hospital care.**
- Support Practices and federations to develop multidisciplinary teams and greater integration across community services.
- Work with the community vanguard teams and transformation lead Practices to support this work.
- Provide leadership, programme management, facilitation and development support to Practices.

**Sustainable GP services for today.**
- We will support NHSE in delivering the GP Resilience programme and monitoring the outcomes.
- We will support the RCGP in providing mentoring and support to GPs.
- We will work with the PCWC & Practices to develop coaching schemes.
- We will support the LMC in raising awareness of its counselling service for GPs.
QUALITY, SAFETY AND PATIENT EXPERIENCE

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

Outcome Based Commissioning

Implementing outcomes-based commissioning will enable us to better meet the financial challenges of commissioning and deliver more personalised care for patients and service users across Dorset.

By using outcomes-based commissioning, we will work with populations to change behaviours supporting the transformation of healthcare by prioritising people, patients and population over conditions; and focusing on value and systems thinking.

In supporting this work the CCG will work closely with partners and patients across the system focusing on:

- Working with service users and providers to agree outcomes and measures
- Focusing on long-term value rather than in-year cost or throughput
- Recasting the role of commissioner as a producer of systems of care
- Stressing the importance of evidence
- Better linking commissioning intentions and service delivery through clearer, more robust contracting with providers, the use of contractual levers, and through the implementation of quality improvement plans, including

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

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

It is essential, as we deliver transformation on the scale identified within the STP and our operational plan, that we maintain a strong focus on ensuring safe, high quality services continue to be delivered. In doing this during 2017/18 –2018/19 we will:

- Improve quality and outcomes as measured through the NHS Improvement and Assessment Framework
- Continue to roll out of ‘Seven Day’ services’ across health providers, with particular focus on the four clinical priorities
- Improve the use of medicines, including antibiotics
- Work with partners to ensure the safeguarding of adults and children
- Continue to ensure good quality of services provided within Primary Care
- Continue to work with providers to implement plans to improve quality of care, aiming to achieve good or outstanding CQC ratings
- Continue to monitor the impact of staffing on quality in acute hospital settings through our contract review process; in line with the recommendations of the National Quality Board
- Continue to work with providers to reduce avoidable deaths including reviewing and publication of findings and actions taken.
QUALITY, SAFETY AND PATIENT EXPERIENCE

• Continue to improve processes and assessments, implementing best practice for NHS Continuing Health Care and Continuing Care for Children

• Continue to implement the five cost effective high impact interventions

• Implement Right Care to minimise unwarranted variations in outcomes.

Our commissioning intentions for General Practice is to commission Primary Care services that deliver efficient services equitable to local need.

To achieve the vision, we will move to a point where we commission for the health needs of a population. The endpoint in this process is about a model that dissolves the divides between organisations, releases efficiencies and allows creation of a new system of care delivery that is backed up by a new financial and business model (irrespective of existing institutional arrangements).

We will use different means available to support commissioning including the use of:

• Basket of Services to deliver equity across Dorset

• Reinvestment of Personal Medical Services (PMS) Premium

• Reviews of Local Enhanced Service (LES) / Directed Enhanced Service (DES) to commission / decommission where appropriate in line with CCG / IPCS and Primary Care Commissioning strategy

• Clinical Commissioning Local Improvement Plan (CCLIP)

All of these will be moving towards commissioning at scale.
It is well known that there are enormous variations in many aspects of healthcare and clinical work. There is also a general frustration that good practice is not adopted everywhere.

There will always be some variation in General Practice due to the complexity of variables that produce it (for example, characteristics of the individual patient, complexity of disease or unpredictability of symptoms). Such variation is reasonable and, even expected. However, the unwarranted variation in healthcare is the area for concern.

There is some variation that is the result of inconsistent practices and decision making. Reducing variation in these circumstances should be seen as one of the work areas that will strengthen Primary Care in Dorset and work towards increasing the quality and consistency of care. The research indicates that unwarranted variation yields sub-optimal clinical outcomes and significant financial burdens.

Unwarranted variation in Primary Care remains widespread within Dorset. The quality of most Primary Care is good, yet there are wide variations in performance, quality and accessibility of Primary Care across Dorset. The key driver is to improve the outcomes for all patients as part of our strategic goal for longer healthier lives. Potentially patients can benefit from:

- Reduced inappropriate hospital admissions resulting in better patient outcomes and experience for those exposed to those preventable admissions
- Less duplication of tests and diagnostics from improved systems and processes resulting in better clinical outcomes and patient experience
- More robust prescribing processes, delivering better patient safety and experience
- Improved quality of referral and more targeted referral process means increased patient safety and better clinical outcomes
- Equally this could result in a smoother experience for patients with quicker access to the right care and support
- To reduce unexpected or unwarranted variation in General Practice, we need to identify the sources and work to reduce their impact on patient care and experience

Our Ambition:

By 2020/21 it is our ambition to have improved outcomes and reduced unwarranted variation for areas we are outliers.

<table>
<thead>
<tr>
<th>Milestones to be completed by 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Right Care – making time for care</strong></td>
</tr>
<tr>
<td><strong>Ambition: Improve outcomes and reduce unwarranted variation for areas we are outliers.</strong></td>
</tr>
<tr>
<td>Design a rolling Annual Programme of Quality Improvement and set specific standards to address variation and improve outcomes through implementing the Time for Care Programme</td>
</tr>
<tr>
<td>Reduction in variation of COPD / AF across Dorset</td>
</tr>
<tr>
<td>Build on the uptake of the PINCER tool in practices to support high risk medication reviews, and promote safe medication use using poly-pharmacy tools and new prescribing data</td>
</tr>
<tr>
<td>Reducing variation in secondary prevention of Cardiovascular disease and diabetes</td>
</tr>
<tr>
<td>Reduction in referral to acute hospitals for 2 identified outliers (MSK and Cardiovascular / Diabetes)</td>
</tr>
<tr>
<td>Develop GP access to consultant advice</td>
</tr>
<tr>
<td>Protected Learning Time (PLT) Training to improve decision / support for outlier areas</td>
</tr>
</tbody>
</table>
IMPROVING ACCESS TO CARE

There is no single definition of good access to General Practice, and no one size fits all solution that all practices should implement.

Improving access is about getting supply and demand in equilibrium, which means that there is no backlog of appointments and no delay between when the demand is initiated and when the service is delivered. The gap between supply and demand not only contributes to a delay in meeting patients’ needs, but it can also be expensive and generate waste in the system.

Our ambition is to improve access to care in General Practice in Dorset to enable service users to be able to access relevant Primary Care when and where they need it and ensure there is sufficient level of access to meet fluctuating demand.

The outcome will be that the CCG will commission services 8am-8pm during the week, and at weekends, provide access to pre-bookable and same day appointments to meet local population needs. This is in addition to the extended hours enhanced service and the out of hours services.

In capacity terms General Practice will be required to provide an additional 30 minutes extra consultation capacity per 1000 population, rising to an extra 45 minutes (an additional 30 mins per week per 1,000 from 2018 rising to 45 mins per 1,000 from 2019)

We will support a phased roll-out of patient on-line access to consultations to further enhance the current on-line access for patients to practice and health information, medicines management and prescriptions, and booking appointments.

We expect to commission this on an at-scale local population basis to meet local need. This could mean:

- Groups of practices working together to address patient demand across a particular locality including offering additional bookable appointments
- Practices working with the wider health system to increase bookable General Practices appointments for an identified population

A staged approached to delivering this will be taken:

- Stage 1 - develop local blueprints to deliver integrated care and improved access
- Stage 2 - communication campaign to help patients access appropriate care
- Stage 3 - invest in developing skill mixed integrated teams including new roles - clinical pharmacy; physiotherapy; paramedics, signposting, care navigation and social prescribing
- Stage 4 - develop integrated care hubs serving natural communities around Dorset phased to align with STP plans for IPCS
- Stage 5 - accelerate new care models around same day access and commission new access models

Provision will be based on local blueprints to establish new access models with roll out across Dorset.
ONLINE CONSULTATION SYSTEMS

Recent years have seen rapid development of a number of online consultation systems for patients to connect with their General practice. Using a mobile app or online portal, patients can contact the GP. This may be a follow-up or a new consultation. The e-consultation system may be largely passive, providing a means to pass on unstructured input from the patient, or include specific prompts in response to symptoms described. It may offer advice about self-care and signposting to other sources of help, as well as the option to send information to the GP for a response.

These systems are proving to be popular with patients of all ages and they free up time for GPs, allowing them to spend more time managing complex needs. Some issues are resolved by the patient themselves, or by another member of the practice team. Others are managed by the GP entirely remotely, in about a third of the time of a traditional face to face consultation. Others still require a face to face consultation, and these are enhanced by the GP already knowing about the patient’s issue. As well as improving the service for patients, evidence to date indicates that online consultation systems can free up to 10% of GPs’ time.

Patients are offered the opportunity to consult the GP, pass messages or send queries via a web-based portal. The askmyGP system provides a series of boxes for entering details, as well as more detailed questions about specific issues where appropriate. Information submitted by patients is received in reception and directed to the appropriate member of the team, whether that is a receptionist, a member of the clerical team or a clinician. If the patient has sent a clinical query, they are able to state whether they have a preference for a specific clinician.

Benefits for Patients:
- Greater convenience, often no longer requiring time off work/caring duties
- Improves availability of appointments
- More opportunities to build knowledge, skills and confidence for self-care and development of apps to support self-care

Benefits for Practice:
- Shorter appointments (e.g. phone consultation average 50% shorter, 66% dealt with entirely on phone).
- More opportunities to support self-care with e-consultations, text message follow-ups and group consultations.

Any procurement activity would be undertaken utilising the CCG’s Procurement and Market Management policy.

Within this policy is stated that The CCG has the authority to select services to proceed to a full procurement but this will need to be in accordance to the mandatory requirements and guidance and will be in accordance with the CCG’s Contestability Framework.

The CCG will have in place a robust Conflict of Interest Policy which will ensure that the CCG’s principles are applied and when conflicts are identified, ensure a robust and secure Conflict of Interest Policy is operated with rules to apply when conflicts are identified.
### Improving Access to Care

- Address inequality in access reflecting local need by understanding demand and capacity at different times.
- Additional General Practice appointment from 18:30-20:00
- Additional General Practice appointment weekends to meet local needs (to be provided on a hub / working at scale model)
- Increase General Practice Capacity by commissioning a minimum of 45 min consultation per 1000 population
- Improve transfer of care ensuring appropriate access
- Use technology to enable access and delivery of care
- Align local and enhanced services (e.g. extended hours national enhanced service). Identify gaps in current services
- At scale delivery of access with General Practice working at scale to meet local population need
- Redirecting requirements of opening times to meet local demand
- Cross boundaries to tap into existing facilities (e.g. South Western Ambulance Service Trust (SWAST) / Community and acute Trusts / third sector)
- Reduce unnecessary demand for appointments by improving self-care and redirection
- Increase use of alternatives to one to one GP appointments such as telephone consultations / face to face groups.
- For patients who may need a follow-up appointment, develop a system where the nurse checks in with the patient by phone two weeks prior to when the follow-up appointment would have occurred. If the patient’s condition warrants a visit, the appointment can be scheduled at that time. Otherwise, an additional follow-up contact with the patient can be made by phone.
- Improve workflow and reduce waste across the health system (GP / Out of Hours)
- Add appointment slots to prevent backlog and putting off what can be done on the day
- Reduce scheduling complexity
- Ensure homeless and other socially excluded group have access General Practice
In Dorset our development programme is aimed at responding to the opportunities and challenges identified within the GPFV and building capacity for improvement.

The programme will:

• Spread the best innovations, helping all practices use the 10 High Impact Actions to release capacity
• Learn from the GP Access Fund and Vanguard sites to support mainstreaming of proven service improvements across all practices
• Fund local collaboratives to support practices to implement new ways of working
• Provide free training and coaching for clinicians and managers to support practice redesign
• Link with a National programme to stimulate update of online consultations for every practice

In turn, this will help practices lay the foundations for new models of integrated care, and play their part in delivering a sustainable and high quality NHS as part of the STP process in which General Practice has a key role.

Training and development for reception staff and care navigators will provide patients with a first point of contact, which directs them to the most appropriate source of help. Web and app-based portals can provide self-help and self-management resources as well as signposting to the most appropriate professional. Receptionists acting as care navigators can ensure that the patient is booked with the right person first time. It will have immediate effects through making workload more sustainable and releasing time for staff to spend with the patients who need it most.

Clerical staff will be given additional training and relevant protocols in order to support the GP in clinical administration tasks incoming correspondence about patients from hospitals is processed by a member of the clerical team.

We will support the growth of local networks of practice managers to address these challenges; these will promote sharing of good ideas, action learning and peer support.

Social prescribing will have longer term benefits through strengthening collaboration between practices and other organisations in the health and care system, establishing a renewed focus on patient benefit within federations, and building capacity and capability for service improvement and medical assistants.

10 High Impact Changes
### General Practice Development Programme

#### Milestones

**Releasing Time In General Practice**

Link with National programme:
- Identify first group of practices to take up training
- First wave of practices (practice staff) to undertake training
- Identify next wave of practices etc.

Good practice / local champions
- Identify practices currently operating gold standards
- Share good practice across Dorset (for example across locality, peer to peer)

**Training Care Navigators/Medical Assistants**

Training / up skilling
- All practices to be offered training in year 1
- Work with GP Clinician to develop the model for the Locality for roll out
- 50% of Dorset population will have access to Navigator/Medical Assistant by end of year 2
- Work with Bournemouth University Primary Care Workforce Centre

**Online access**

- Increase online use of repeat prescribing
- Increase access to online patient records
- Increase access to online appointment booking

**Use of online consultation for capacity management**

Link in with CCG IT group
- Consolidate outcome from existing pilots to inform Dorset wide procurement
- By end year 2 have 20% of practices using online consulting, end of year 3 - 40%
- Explore scope of use of online consultation, for example Elderly patients in Residential and Nursing

**Approaches to self-care and care planning**

- Continuing review of the over 75 projects
- Roll out of good practice Dorset wide
- Online Consultations - Encourage self-care/ management through use of E-consultation and GP Web based software and telehealth and assisted technologies

**Community Pharmacy**

Identify role of community pharmacy in Primary care working with Pharmacy team to identify the opportunities

GPs and community pharmacies to understand what role each have in Patient Care and understand areas of joint working e.g. medication reviews
TECHNOLOGY ENABLING CARE

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

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

### Milestones for completion by 2018/19

<table>
<thead>
<tr>
<th>Ambition: A paperless health system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shared care records</strong></td>
</tr>
<tr>
<td>Implementing the Dorset Care Record and Digital Dorset</td>
</tr>
<tr>
<td>Implementation of transfer of care documents - acute to Primary Care (17/18) acute setting to social care (18/19)</td>
</tr>
<tr>
<td>Implementation of a single pathology laboratory information management system</td>
</tr>
<tr>
<td>Joining medicines records across care settings</td>
</tr>
<tr>
<td>Implementation of transfer of care documents – Acute to Primary Care</td>
</tr>
<tr>
<td>Roll out online consultation system</td>
</tr>
<tr>
<td>Promote joint working with local pharmacist to increase uptake of electronic repeat dispensing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>One system for Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creation of a single SharePoint for forms and information</td>
</tr>
<tr>
<td>Creation of a single portal for websites</td>
</tr>
</tbody>
</table>
We have a well established Local Estates Forum in place to engage and involve our health and local authority partners in infrastructure development. Our aspiration is to implement a comprehensive estates enabling plan which fully aligns to our system wide plans for sustainability and transformation. This includes one public sector estate solutions to be able to respond to the health and care needs of our local communities.

Our delivery plan reflects work with NHS England to develop infrastructure transformation proposals in line with our strategy.

We are building knowledge and capacity to assist Primary Care with the transformation of their estate. We have gained early stage approvals to a number of Estates and Technology Transformation Fund (ETTF) proposals these include:

• 2 Technology schemes; one will which integrate Telehealth and Telecare services;
  - The other will enable GPs to be able to work flexibly by using mobile technology

• 2 significant GP premises improvement schemes which will ensure accommodation is fit for the future and enhance the overall patient experience.

• 2 new build proposals which will replace outdated surgeries in Wareham and Poole.

• 1 project development allocation in North Dorset to explore opportunities within this local area.

These schemes will be commence in January 2017 and to be completed March 2019.

In 2016/17 we introduced processes which enabled us to deliver Minor Improvement schemes to a value of £245,000 benefitting practices throughout Dorset. It is our intention to deliver a similar programme of support in subsequent years ensuring that the quality of practice accommodation is maintained and improved.

Once Consultation for the IPCS has concluded in 2017 Primary Care will be working collaboratively to ensure service redesign e.g. Community Hubs will includes Primary Care at Scale working.

In 2017/18 we are planning to work with practices and their local communities to undertake 8 feasibility studies with the aim of identifying a range of options which have the potential to improve primary care estate infrastructure.

<table>
<thead>
<tr>
<th>Milestones</th>
<th>17/18</th>
<th>18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Give GP practices options on the future of their practice premises</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eight practice/area based feasibility studies (CCG Funded) to include Community hubs</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td><strong>Premises fit for purpose for the future</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Four new build/significant improvement programmes undertaken (NHS E funded)</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td><strong>Exploring funding to maximise opportunities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One significant improvement award for pre-project costs (no capital allocation) (NHS E funded)</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td><strong>Raising the quality of current provision of GP premises</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premises Improvement Grant applications sought (NHS E funded)</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td><strong>Use of technology to support collaborative working and work across organisations to support care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two IT schemes</td>
<td>✔</td>
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</tr>
</tbody>
</table>
Priorities for 2017/18 and 2018/19 will be to maintain the cost effective and evidence based approach to prescribing advice within Primary Care and across the health community with the pan Dorset formulary. The medicines team will:

• Build on progress in achieving the antimicrobial measures by reducing variation in prescribing through education and audit, implementation and updating of the antimicrobial strategy to reflect national priorities.

• Support commissioning and transformation of services through horizon scanning to provide early insight of new medicines and their potential impacts

• Promote joint working with local pharmacists to increase uptake of electronic repeat dispensing

• Build on the uptake of the PINCER audit tool in practices to support high risk medication reviews, and promote safe medication use using polypharmacy tools and new prescribing data

• Promote appointment of Practice and locality based pharmacists in line with the Primary Care Commissioning Strategy, and networks of Pharmacists supporting Practices

• Maintain a focus on safe medicines use, challenging high or inappropriate prescribing of medicines with known safety or abuse potential

• Benchmark within the CCG and across the sub region and NHS England using the Medicines Optimisation Dashboard, NHS Benchmarking and Right Care addressing areas where the CCG is an outlier

• Ensure a local focus on optimisation of medicines is aligned to national priorities through use of materials such as The National Institute for Health and Care Excellence (NICE) key therapeutic topics

Quality and Outcomes

Quality and outcome measures will include:

• Clinical outcome measures
• Social outcome measures
• Patient reported outcome measures
• Patient defined outcome measures
• System perspective
• Population level outcomes

We will do this through the implementation of a work stream which will be led by the CCG and which will align to the delivery of the Integrated Community and Primary Care Services. The work stream will focus on:

• Developing the right population segmentation / patient population to focus on
• Engage with patients, clinicians and the wider system
• Creating the shared vision
• Engagement, co-development of the right outcomes
• Understanding the barriers
• System working to co-create solutions
• Changing how and what we commission to commission for outcomes
• Changing how and what we provide to deliver outcomes
• Developing adaptive accountable care systems
The CCG’s internal governance arrangements are illustrated below. The CCG provides assurance to NHS England Wessex through regular assurance meetings and also provides regular updates on its progress and performance to Health and Wellbeing Boards, Joint Commissioning Boards and System Leadership Team.

### Monitoring Performance

The CCG has a robust approach to performance management, building upon a strong base developed over previous years. Quality standards and outcomes set out in ‘The Five Year Forward View’ and NHS Improvement and Assessment Framework, including the elements within the CCG Quality Premium and financial performance are monitored and reviewed as follows:

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

To enable effective commissioning we have in place established networks and early warning mechanisms in place to minimise risk to the delivery of plans. However, where a risk to delivery is apparent we will manage this through existing structures and using appropriate contract controls and levers with providers.
As a system, to deliver our programmes, we have agreed to move towards an aligned system wide programme management approach with our programmes being led by a Senior Responsible Officer (Chief Executive from the system) supported by a Portfolio Director. The system wide governance is described in our STP (http://www.dorsetccg.nhs.uk/aboutus/substainability.htm).

We recognise that the next two years will be challenging for us across the system and as individual organisations. We have considered and assessed the potential risks to the delivery of our plans.
ASSESSING THE IMPACT OF OUR GPFV DELIVERY PLANS

As part of our operational planning we have begun to assess the impact of our plans on Primary Care and the importance of understanding the interdependencies of these plans.

<table>
<thead>
<tr>
<th>Primary Care Deliverables</th>
<th>Provider</th>
<th>Type of activity</th>
<th>Trajectory</th>
<th>Impact</th>
<th>Interdependencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement local transformation programme to enable 40% of the population to be receiving GP Services from practices who are part of a collaboration, working at scale</td>
<td>Primary Care</td>
<td>At-scale provision</td>
<td>20% increase in at-scale working across Dorset to achieve full population coverage by 2021</td>
<td>Finance and efficiency</td>
<td>Integrated community services</td>
</tr>
<tr>
<td>Technology enabling the delivery of care through implementing the Dorset Care Record and Digital Dorset</td>
<td>Primary Care</td>
<td>Technology enablement March 2017 Patient on-line consultations roll-out over 3 years. Anticipatory care planning</td>
<td>20% year on year increase in patient on-line access working across Dorset to achieve full population coverage by 2021</td>
<td>Care and quality</td>
<td>Dorset Digital Roadmap</td>
</tr>
<tr>
<td>Improve access to general practice by providing additional consultation capacity per 1,000 population including on-line consultation systems, address inequality in access and commission additional capacity for evenings and weekends reflecting local need</td>
<td>Primary Care</td>
<td>Patient consultations delivered by practices working at scale</td>
<td>Trajectory in line with investment programme from 2018 2016: 40% population coverage 2018-20 80%, 2020-20 100%</td>
<td>Care and quality</td>
<td>Transforming primary care</td>
</tr>
<tr>
<td>Design a rolling Annual Programme of Quality Improvement and set specific standards to address variation and improve outcomes through implementing the Time for Care Programme and 10 high impact changes</td>
<td>Primary Care</td>
<td>Right Care programme to reduce variation Ten high impact changes to reduce waste and improve patient experience Outcome based commissioning</td>
<td>TBA Trajectory to achieve full population coverage by 2021</td>
<td>Care and quality</td>
<td>Integrated community services</td>
</tr>
<tr>
<td>Deliver workforce development plans to address General practice resilience, supporting the development of skill mixed teams for delivery of new models of care</td>
<td>Primary Care</td>
<td>Increase skill mix of primary care workforce</td>
<td>Targets in line with STP and national ambitions</td>
<td>Care and quality</td>
<td>Workforce action plan</td>
</tr>
<tr>
<td>Prevention – work with localities to develop models of care which facilitate supported self-care, improved health and wellbeing including training for care navigators</td>
<td>Primary Care</td>
<td>Care design</td>
<td>Roll-out of new care models across all localities to achieve full population coverage by 2021</td>
<td>Health and wellbeing</td>
<td>Prevention at scale Public health strategy and investment</td>
</tr>
<tr>
<td>Support the organisational development of general practice to enable primary care to be equal partners in new collaborative arrangements</td>
<td>Primary Care</td>
<td>Provider development</td>
<td>Finance and efficiency</td>
<td>Accountability Care organisations</td>
<td></td>
</tr>
<tr>
<td>Further develop commissioning of primary care to deliver care at scale</td>
<td>Primary Care</td>
<td>New commissioning models</td>
<td>Finance and efficiency</td>
<td>Commissioning intentions</td>
<td></td>
</tr>
<tr>
<td>Implementation of the integrated community services new care models to reflect local care needs</td>
<td>Primary Care</td>
<td>Care design</td>
<td>Care and quality</td>
<td>Integrated community services planning including hubs</td>
<td></td>
</tr>
</tbody>
</table>
## RISKS AND MITIGATING ACTIONS

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

<table>
<thead>
<tr>
<th>AREA</th>
<th>RISK</th>
<th>SEVERITY</th>
<th>LIKELIHOOD</th>
<th>MITIGATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Investment</strong></td>
<td>Failure to increase investment in core Primary Care services and transformation in line with CCG core allocation.</td>
<td>M</td>
<td>M</td>
<td>Re-allocation of CCG core budget to ensure continued investment in core Primary Care services and transformation funds to meet the national ambition of £3 per head allocation between 2017-19.</td>
</tr>
<tr>
<td><strong>Workload</strong></td>
<td>Failure to implement new ways of working will have a detrimental impact into benefit realisation</td>
<td>M</td>
<td>M</td>
<td>Effective support to practices around implementation plans.</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td>Failure to attract sufficient new clinical staff.</td>
<td>H</td>
<td>H</td>
<td>Work with practices &amp; groups of practices to deliver care in new ways using a new cohort of professionals in Primary Care. Implement local General Practice Resilience Programme. Further develop Dorset Primary Care Workforce Centre, working with General Practices to develop local workforce plans.</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td>Additional funding is not released to commission additional access into general practice</td>
<td>M</td>
<td>M</td>
<td>Work with practices around existing extended hours arrangements and seek opportunities for locality/group offer</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td>Practices unable to offer additional access due to insufficient workforce</td>
<td>M</td>
<td>H</td>
<td>Work with other providers to ensure additional Primary care access is available in Dorset</td>
</tr>
<tr>
<td><strong>Infrastructure</strong></td>
<td>Failure to achieve the delivery date of March 2019 for each Estates and Technology Fund scheme.</td>
<td>H</td>
<td>M</td>
<td>Close working within the Estates Team and 4 practices. Effectively achieving the Due Diligence requirements.</td>
</tr>
<tr>
<td><strong>Care Models</strong></td>
<td>Lack of commitment to implement new models of care and systems working from key stakeholders/ organisations.</td>
<td>H</td>
<td>M</td>
<td>Clear communication with key stakeholders, however taking into consideration the delivery of the messages are appropriate for the audience;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Consultation of clear plans</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Regular partnership interactions to ensure commitment from key stakeholders</td>
</tr>
</tbody>
</table>
APPENDIX

Appendix 1
Our Dorset Sustainability Transformation Plan on a Page 43

Appendix 2
Primary Care and Supporting Prevention at scale 44
APPENDIX 1

Our Dorset’- Sustainability and Transformation Plan on a Page

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

Our programmes and priorities
Prevention at Scale – will help people to stay healthy and avoid getting unwell through:
- Tackling wider determinants of health
- Upgrading primary prevention
- Extending secondary prevention
- Supporting people to live independently

Integrated Community Services – support individuals who are unwell by providing care at home or in the community through:
- Integrating health and social care
- Developing Community Hubs*
- Ensuring sustainable Primary Care
- Developing Urgent Care*
- Transforming Mental Health and Learning Disability Services

One Acute Network – will help those who need the most specialist support through a single acute care system across Dorset
- Acute Reconfiguration*
- One NHS in Dorset (Acute Vanguard) – includes transforming:
  - Cancer
  - Maternity & Paediatrics
  - Cardiology
  - Pathology
  - Stroke
  - Imaging
  - IT & back office

* Part of the Clinical Services Review

Underpinned by our enabling programmes
Leading and Working Differently – focuses on giving the health and care workforce the skills and expertise needed to deliver new models of care. Programmes include:
- Working differently
- New ways of delivery
- Single Leadership

Digitally-Enabled Dorset – increasing the use of technology in the health and care system to support new approaches to service delivery
- Shared care record
- Intelligent working
- Self care
- Independent living
- Digital Dorset shared service
- Continuing digital operations
- Enabling technologies

Overseen through
System Leadership Team – comprises of Chief Executives, Chairs and the Director of Public Health Dorset, from across the Dorset system, as follows:
- Dorset CCG
- Dorset County Hospital NHS Foundation Trust
- Poole Hospital NHS Foundation Trust
- Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- Dorset HealthCare University NHS Foundation Trust
- Dorset County Council
- Bournemouth Borough Council
- Borough of Poole Council
- South Western Ambulance Services NHS Foundation Trust

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

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

Finance and Efficiency
- Closing the financial gap
- Reduced waiting times
- Increase in efficiency of services
- The right workforce to meet our future care needs
Primary Care and Supporting Prevention at scale

Primary prevention - Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups.

Why is it important?

More systematic primary prevention is critical in order to reduce the overall burden of disease in the population and maintain the financial sustainability of the NHS. While prevention in childhood provides the greatest benefits, it is valuable at any point in life.

It is estimated that 80 per cent of cases of heart disease, stroke and type 2 diabetes, and 40 per cent of cases of cancer could be avoided if common lifestyle risk factors were eliminated (WHO, 2005).

Common lifestyle risk factors cluster in the population (Buck and Frosini 2012), which has a dramatic effect on life expectancy (Khaw et al 2008). Addressing this clustering, and its socio-economic determinants, is likely to reduce inequalities and improve overall population health.

What is the impact?

Primary prevention is an excellent use of resources compared with many treatments. Of more than 250 studies on prevention published in 2008, almost half showed a cost of under £6,400 per quality-adjusted life year and almost 80 per cent cost less than the £30,000 threshold used by the National Institute for Health and Clinical Excellence for cost-effectiveness (van Gils et al, 2010).

More systematic primary prevention in General Practice has the potential to improve health outcomes and save costs (Health England 2009). For example, five minutes of advice in a General Practice setting to middle-aged smokers to quit smoking can increase quit rates and save £30 per person for a cost of £11 per person.

Community-level campaigns to improve health behaviours, such as No Smoking Days, have been found to be very cost-effective (£82 per life year gained) (Kotz et al, 2010).

How we will do it

Evidence-based interventions include: supporting individuals to change behaviours, for example, through brief advice during a consultation; systematic community interventions in schools to reduce childhood obesity; and regulatory actions such as controlling the density of alcohol outlets (Campbell et al, 2009).

In many areas, a strategic approach using a combination of interventions at the individual and societal level is likely to be most effective. For example, NHS Knowsley has had a major impact on smoking rates in disadvantaged communities through cross-partnership action including targeting illicit tobacco sales, reducing smoking in pregnancy, and providing drop-in clinics.

These approaches often require new ways of engaging with communities to ensure they reach those in greatest need. Social marketing techniques can improve the effectiveness of interventions by tailoring interventions to the needs of specific individuals or groups.

NHS England, acting in its new role as the single purchaser of NHS Primary Care, has an important opportunity to ensure that primary prevention is implemented systematically and at scale.

Useful resources

- Health England has developed several reports on the impact and cost-effectiveness of primary prevention and modelling tools to help local areas prioritise
- The former National Support Teams programme at the Department of Health published information on systematic approaches to primary prevention, modelling and case studies
APPENDIX 2

- Social marketing guidance, resources and toolkits for behaviour change from the National Social Marketing Centre
- NICE’s public health guidance
- NHS Midland and East Making Every Contact Count toolkit
- Institute of Public Care toolkit to help commissioners target preventative services effectively

Secondary prevention - Systematically detecting the early stages of disease and intervening before full symptoms develop – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure.

Why is it important?

Secondary prevention is based on a range of interventions that are often highly cost-effective and that, if implemented at scale, would rapidly have an impact on life expectancy.

There is substantial variation between practices in the systematic implementation of approaches towards secondary prevention – for example, use of disease registers. Only a minority of patients receive all recommended interventions.

Evidence suggests that this is an area where the ‘inverse care law’ applies and those in greatest need are least likely to receive beneficial services.

Identifying those at risk and intervening appropriately is one of the most effective ways in which GPs can reduce the widening gaps in life expectancy and health outcomes (Marmot Review, 2010).

What is the impact?

Successful secondary prevention would have a major impact on health outcomes, in terms of improvement in life expectancy and reduction in complications.

Modelling by the Department of Health (2009) has shown that systematic and scaled-up secondary prevention is a cost-effective, clinically significant and fast way to tackle inequalities in health in local areas. The National Audit Office (2010) suggests that improving cholesterol levels and hypertension control have not been adopted at a sufficient scale. If they were, they would have a significant impact on inequalities.

Cost savings are likely to accrue over the medium term, as patients are prevented from experiencing a wide range of adverse events as their life expectancy lengthens.

How we will do it

Secondary prevention largely involves the systematic application of standard, low-technology interventions. The key actions for commissioners are:

- Ensuring appropriate coverage of key secondary preventive interventions and processes including managing disease registers systematically by modelling expected versus actual prevalence and incidence, and thereby identifying practices where improvement is needed
- Systematic screening, where appropriate and known to be cost-effective
- Ensuring systematic control of hypertension, cholesterol and diabetes among clinical commissioning group’s populations
- Working systematically with local authorities and other partners to ensure secondary prevention forms part of a broader strategy on public health
• Working with community and voluntary sector groups to both develop more tailored joint strategic needs assessments and health and wellbeing strategies, and to engage with and provide services to patients who are not reached by mainstream health services

Useful resources

• London Health Observatory’s Health Inequalities Tool can be used to help commissioners understand where to focus their efforts

• The former Health Inequalities National Support Teams’ ‘how to’ guides for secondary prevention in Primary Care and related resources

• Guides to expected prevalence of diseases susceptible to secondary prevention at General Practice and local authority level from the network of Public Health Observatories

• National Institute for Health and Clinical Excellence publishes commissioning guidance and tools for various forms of secondary prevention, for example, myocardial infarction