PRIMARY CARE COMMISSIONING STRATEGY AND PLAN

2019-2024

Supporting People in Dorset to lead healthier lives
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Foreword

The aim of this Strategy is to ensure that primary care is equipped and supported to provide sustainable, accessible, pro-active and co-ordinated care close to a patient's home. This will help achieve the ambitions set out in the NHS Long Term Plan.

Dorset’s Primary Care Commissioning Strategy was first published in 2016. This has been updated to reflect our evolving priorities and plans in light of the role of primary care in our new Dorset Integrated Care System. This refreshed Strategy responds to the challenges and opportunities outlined in the NHS Long Term Plan and GP Contract reform guidance whilst strengthening our primary care commissioning to meet local population needs as a fully delegated Clinical Commissioning Group.

Since 2016 we have made significant progress towards our aims and ambitions. We recognise that we have highly skilled General Practices that provide high quality, safe care and high levels of patient satisfaction but services remain under pressure as they respond to increasingly complex patient demand, a growing population and significant workforce challenges.

Dorset has a range of health needs across its rural and urban geography, with a registered population of over 800,000 people served by our 81 General Practices now working in 18 Primary Care Networks.

Dorset has the highest percentage of elderly people in the country, an above average proportion of children, a mix of rural and dense urban populations, areas of significant deprivation and some of the most affluent areas in the UK. This complex profile of different communities brings with it a significant breadth and depth of need which impacts on primary care.

We recognise that General Practice needs to work in partnership at scale to serve the specific needs of the population for defined geographical areas. General Practice working as part of Primary Care Networks is now recognised as the building blocks for Integrated Care Systems.

In 2018, Dorset was officially recognised as one of England’s first wave of Integrated Care Systems in which all partners, including primary care, hospitals, community care, local authority and voluntary sector, agreed to work together to address our health, quality and financial challenges. For this to be successful, all parties recognise that the role of General Practice working in highly developed Primary Care Networks is a fundamental foundation stone for delivery of our Care System Strategy and ambitions for the future.

This updated Strategy details our approach to ensuring Primary Care Networks are able to flourish, building on the foundations we have put in place. Our approach is strengthened through partnership working and collaboration, as well as co-design with patients and partners. Our plans for delivery include an increasing investment in primary and community care by reshaping how we use our NHS funding in Dorset to achieve our aim of providing world class primary care within a world class Integrated Care System.

“In Dorset our aspiration is for everyone to start well, live well and age well, no matter where they live or what their circumstances are.”
Executive Summary

This Strategy sets out our high-level commissioning intentions and approach to delivering change built on our progress since 2016 with a focus on the next two years as part of our five-year plan to invest in and transform General Practice. We want to build on past successes and provide consistently outstanding services for our patients. There is a real opportunity to do this now, as part of whole system transformation as we build the Dorset Integrated Care System to reflect the ambitions set out in the NHS Long Term Plan to fully integrate community-based health care.

Primary Care Networks will form around our natural communities, serving populations of around 30,000 to 50,000 involving partnerships including local General Practices, community and voluntary service providers and local authorities including social care and Public Health.

Primary Care Networks working at scale, will focus on population health, providing both continuity of care and better access to services. These Networks will offer care on a scale which is small enough for patients who need to get the continuous and personalised care they value, but large enough to be both responsive to changes in need and more resilient to demographic, workforce and workload pressures.

A key focus of this work will be to further develop multidisciplinary teams. This will include GPs, pharmacists, nurses, allied health and care professionals, local authorities and the voluntary sector. These teams will work across primary care, community and hospital sites. How this looks will differ from area to area? Communities and patients will be involved in developing the way in which new care models will be delivered to reflect local need, especially in areas of deprivation and where the needs of rural and isolated communities need to be addressed.

Our delivery plans are progressing at pace but aligned to the state of readiness of Primary Care Networks for change. This document confirms the strategic framework for delivery based on strengthening partnerships within our Integrated Care System.

Dr Forbes Watson, Chair
Dr Karen Kirkham, Assistant Clinical Chair and Locality Lead, Weymouth and Portland
Dr Anu Dhir, Primary Care Clinical Lead
Sally Sandcraft, Director of Primary and Community Care
Jacqueline Swift, Deputy Chair and Primary Care Commissioning Committee Chair

“By 2020/21 it is our ambition to have all our primary care providers working in collaboration at increased scale functioning as part of fully developed Primary Care Networks, contributing to the delivery of Integrated Primary and Community services with consistent high quality and improved outcomes throughout Dorset”
1. Strategic Context

National
In January 2019 NHS England launched the NHS Long Term Plan to secure an NHS fit for the future. This plan makes a commitment to prioritise investment in primary and community services as part of new care models.

A five-year framework for GP Contract reform to implement the NHS Long Term Plan was published by NHS England on 31 January 2019. These reforms secure and guarantee extra investment in General Practices over the next five years to be able to tackle workforce and workload challenges and focus on making improvements to the quality and outcomes of care.

A GP Partnership Review was also published in January 2019 following a year long review. The review concludes that the partnership model still offers many strengths including providing a powerful independent advocate role for patients with accountability to local communities.

Five major changes to the NHS Service Model in the NHS Long Term Plan:
- Boost ‘out of hospital’ care with services being more joined up and coordinated, especially between primary and community health providers;
- Will reduce pressure on emergency hospital services;
- People will get more control over their own health with a focus on support tailored to meet individual need and personalised care and support;
- Support digitally enabled primary and outpatient care across the NHS;
- Be more pro-active with a greater focus on prevention and population health.

Local - ‘Our Dorset’ Vision
In Dorset our aspiration is for everyone to start well, live well and age well, no matter where they live or what their circumstances are. Dorset will be seen as a place:

- Where children will get the best start in life and as they grow be inspired to be the best they can;
- Where people will have a decent home, good job and support when they need it;
- Where older people will be valued within communities, independent, safe and take more control for their own care;
- Where everyone has a voice;
- To do business, learn and grow;
- Where Public Services work together to build thriving communities.
Care delivered in Primary Care Networks supported by integrated teams

Primary Care Networks in Dorset create the opportunity to strengthen joint working to meet local population health need, supporting local delivery of the NHS Long Term Plan by boosting out of hospital care to reduce pressure on emergency hospital services. People will be able to gain more control over their own health through personalised care and support plans and access to new technology.

Population Health Need

In the UK 18 million patients are estimated to suffer from a chronic condition, with the majority being managed in the community by primary care. Around 53% of all patients in England report having long standing health conditions. Most of their care will be delivered by primary care, either directly or with input from specialist services:

- By 2021, more than one million people are predicted to be living with dementia and by 2030 three million people will be living with or beyond cancer;
- By 2035 there are expected to be an additional 550,000 cases of diabetes and 400,000 additional cases of heart disease (CHD) in England. By 2020, around 1 in 10 of the population could have diabetes and around 1 in 8 could have CHD. The number of people with multiple long-term conditions is set to grow from 1.9 to at least 2.9 million from 2008 to 2018;
- In Dorset it is estimated that 8.8% of people aged 16 years and older are living with diabetes. The total prevalence of diabetes is expected to rise to 9.4% by 2020 and 10.4% by 2030;
- In 2010, around 30,000 people in Dorset were living up to 20 years after a cancer diagnosis. This could rise to an estimated 60,000 by 2030.

Demographics

Dorset GP Practices serve a population of around 803,000 living in sparsely distributed rural areas and within the urban conurbations of Bournemouth, Poole and Weymouth. The age profile of Dorset is older than the England average, around 17% of the population are over 70 (vs. England average of 12%). Children and young people under the age of 20 years make up for 21% of the population and account for around a quarter of a typical GP workload.

The population over 70 is expected to grow four times faster than the growth rate of the total Dorset population, and by 2023 one in every five Dorset residents will be over 70 (an increase of 30% between 2013 and 2023).

At the same time, the core working age population (20–59) is expected to decline by about 1% while children and young people below the age of 20 are expected to grow by 7%.
2. Transforming Primary and Community Care Services

Since 2016 we have made significant progress towards our aims and ambitions to ensure delivery of high quality sustainable General Practice services. We recognise that we have highly skilled General Practices that provide high quality, safe care and high levels of patient satisfaction but services remain under pressure as they respond to increasingly complex patient demand, a growing population and significant workforce challenges. We described this as a journey where primary care needs to evolve to be able to deliver modern sustainable high quality services:

Our Key Priorities are:
• A sustainable General Practice model which is attractive to work in;
• Improved work-life balance for clinicians and non-clinical staff working in primary care;
• All Practices working in Primary Care Networks;
• Integrated community and primary care multidisciplinary teams delivering new care models through increased system level investment and evaluation of the impact of this;
• Continuous improvement to the quality of GP services;
• Improve patients experience, empowering people to take control of their own health;
• Reducing the health inequality gap;
• Improve outcomes, reduce unwarranted variation and accurate disease prevalence for all areas we are outliers;
• Improve extended and consistent access to General Practice services;
• A paperless health system where patients are enabled to better access care through the use of technology.

Through our Integrated Community and Primary Care Services (ICPCS) programme our local plans have been to transform General Practice, primary and community health and care service in Dorset so that they are working at the right scale, truly integrated and based on the needs of our population. The Dorset Integrated Care System has made a significant investment in integrated working across Dorset. We have already come a long way in the last few years in integrating services and we are still shaping the future to continuously improve the health and care for the people of Dorset, to ensure a modern health and care system that focusses on outcomes, as reflected in the NHS Long Term Plan.

Over the next two years we will focus on:

• Development of Primary Care Networks (PCNs) to serve all patients in Dorset – taking a population health management approach to target care, further development of new models of care for urgent, planned and complex care;

• The Primary Care Organisational Development Framework – which sets out the way in which we will support our members in the development of practices and the emerging Primary Care Networks, ensuring there is the capacity and capability to provide sustainable primary care services in the community;

• Embed new workforce such as clinical pharmacists, social prescribing link workers, physiotherapists, physician associates and community paramedics;

• Integrated community services – continuing our system level investment to support the development of community hubs and integrated teams;

• Infrastructure planning – technology enabling care and developing the primary care and community hub estate to be able to deliver new care models
Primary Care working at scale delivered through our Primary Care Networks

When the NHS Long Term Plan was published in January 2019, the Primary Care Home (PCH) model development in Dorset formed the foundation for Localities to rapidly move towards establishing Primary Care Networks.

Key Characteristics

Key characteristics of a Primary Care Network will include:

- Delivery of an agreed model of care providing integrated community services;
- Maximising the use of resource, including workforce and estate to effectively deliver care locally;
- Collaborative leadership and relationships that are based on trust within the Network and across the Integrated Care System;
- Good governance underpinned by a network agreement;
- Clinical Leadership, including a named accountable Clinical Director.

Focus: on defined health, care and wellbeing needs of the population;

Function: develop new models of service delivery;

Funding: work together to agree how best to use available resources;

Form: what new organisational / contractual mechanisms are required.
There are 18 Primary Care Networks serving the population of Dorset:
Primary Care Network Development

Implementing the NHS Long Term Plan requires the development of effective Primary Care Networks (PCNs). To help all PCNs mature and thrive, every Integrated Care System needs to put in place high quality support.

In practice, responsibility for ensuring effective support falls to primary care leads with PCN Clinical Directors working with their wider community partners; community providers, the voluntary sector and local government.

National funding has been made available to support: (a) PCN development and (b) a specific Clinical Director development programme. The funds are intended to help PCNs make early progress against their objectives – for example supporting much closer practical collaboration between PCNs and their community partners, including preparatory activity for the forthcoming national service specifications.

How our PCNs will support delivery of the NHS Long Term Plan in Dorset

We will extend the range of primary care services available to patients by investing in integrated health and social care teams to serve each local community and by harnessing the role Pharmacy, Dental and Optometry services play across our Primary Care Networks. Primary Care Network development in Dorset creates the opportunity to strengthen joint working around population health needs and form fully integrated community-based health care teams in line with the NHS Long Term Plan:
**Boosting ‘out-of-hospital’ care** – out integrated care system has significantly invested in new integrated community and primary care teams and we plan to introduce additional roles over the next few years.

**A new integrated workforce better meeting local population needs** - The ambition to recruit more GPs and nurses continues and the ongoing challenge of retaining existing staff remains. As we continue to skill mix care teams more patients attending their general practice will have the opportunity to see an expanded team with advanced training in diagnosis and treatment in their specialist areas. This signals a fundamental change in how patients will experience general practice, expanding general practice to a broader team that is better suited to meeting patient needs.

These new care teams will include clinical pharmacists, physician associates, physiotherapists and paramedics and social prescribers. This can improve access to care, enhance patient safety and streamline patient pathways, ensuring that holistic care is delivered more efficiently, with patients being seen by the most appropriate person, who has extensive knowledge of their condition, at the right time.

**Reducing pressure on emergency hospital services** – for patients with more complex needs local Frailty teams delivering personalised care and support plans including better medicines management and community pharmacists working in Care Homes supported by therapists and other professionals in providing targeted rehabilitation care; Dementia Coordinators in each Primary Care Network to better meet local need.

“Pharmacies already take some pressures from urgent care services with Pharmacy Urgent Repeat Medicines Service delivered by 112 Pharmacies”.

**People will gain more control over their own health**, and receive more personalised care when they need it – with new care models responding to local population health need; this includes many more patients supported by better oral health care services improving prognosis and outcomes for people with cancer, diabetes, dementia and other long-term conditions; eye health services within Primary Care Networks to treat conditions such as glaucoma, cataract and low vision; pharmacy led episodic health care advice and treatment and treatments for minor illness.  Public health programmes such as Starting Well providing better targeted support in the most deprived communities; pharmacies providing support for people with long term conditions and targeted support such as Dementia Friendly Pharmacies; Eye health care services improving access to care for minor eye conditions and most vulnerable populations including those with learning disability or those who are homeless.
Digitally-enabled primary and community outpatient care – including electronic prescriptions, e-consultations and supported self-care using NHS Apps; Care navigators helping people find the services they need and social prescribing link workers giving patient choice and access to a range of community and voluntary sector services, promoting self-care and reducing the need for medical intervention.

“There are 148 Community pharmacies in Dorset, each with a registered Pharmacist on site throughout working hours to enable patients and the public to access health promotional and signposting advice, support for self-care and self-management of minor conditions as well as their prescription medicines”.

“Over 80% of the community pharmacies in Dorset have achieved Health Living Pharmacy level 1 improving the health and wellbeing of the local population and helping to reduce health inequalities including NHS Health Checks and Smoking Cessation services. Pharmacies are particularly well placed to support prevention at scale and helping patients manage their long term conditions as part of a multi-disciplinary team.”
3. Delivering our Care Model

Royal College of General Practitioners (RCGP) - The delivery of relationship-based, whole-person care will be at the heart of general practice, with GPs having more time to care for those patients with the most complex needs working with extended practice teams to provide enhanced continuity of care. New roles will complement the skills of the GP, enabling practices to better support patients to manage their conditions and to remain in good health, multidisciplinary teams will work together to provide enhanced care to patients with the most complex needs.

GPs will work at scale in collaboration with neighbouring practices to proactively improve the health outcomes of the populations they serve, enhance access, and tackle health inequalities. The values of continuity and person-centred care will be at the heart of these new collaborations.

General practice will be at the core of a revitalised, well-resourced primary and community care sector, which delivers care closer to home, improves health outcomes and supports patients to self-care and lead healthier, more independent lives.

By 2030, the traditional boundaries between primary and secondary care will have become much more blurred. More services, diagnostic tests and treatments, currently delivered in hospitals, will be provided closer to home in community settings. There will be more specialists attached to groups of practices operating at scale. As care becomes more unified across traditional health and social care boundaries, GPs will continue to be powerful and independent advocates for their patients; they will be influential system leaders who will have a strong voice at all levels of NHS decision-making.

We have adopted a care model that helps us risk stratify patients and target care based on local population need:
(1) Specialist Care and Support - our Frailty model

The vision for Dorset is that all people living with frailty have their condition recognised early and proactively managed within an integrated co-ordinated care pathway which meets the needs and expectations of the individual, their carers and advocates. Co-ordinated care defined by National Voices states:

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

There is now a contractual requirement for PCNs / groups of Practices to focus on the identification and management of patients living with frailty. Models of care have been developed in collaboration with the wider system partners to achieve this through a single point of contact for rapid response and proactive assessment often via integrated multidisciplinary teams.

Options to explore an enhanced approach for people residing in care homes are currently being implemented, often involving regular “home rounds” and wider multidisciplinary team meetings for those requiring more specialist advice or support.

(2) Rapid access to Multidisciplinary Care

Multidisciplinary care provided by local system partners has been developed to provide support to individuals with acute or deteriorating conditions. This has been achieved through a collaborative approach between General Practices and community services to identify and agree a model of care which can enable rapid access to the relevant services.

149,000 classified as Frail estimate - (split 65% mild, 26% moderate and 10% severe).
Based on eFi (electronic frailty index for North Dorset population)

Open seven days a week, the hub has three health and social care co-ordinators who take referral calls about patients from GPs, the county council’s adult social care team, Dorset County Hospital and other agencies. They help assess what kind of care is required and, liaising with duty professionals based at the hub, ensure the right support is provided as quickly as possible, in a co-ordinated way. Staff from the various partner agencies also meet every day for a ‘virtual ward round’ to discuss ongoing cases and ensure patients’ wider needs are met, not just the problem which triggered the initial referral”.

10.7% of the registered population of Dorset have 3 or more Long term conditions – 85,500 people 
Source SystmOne Query, June 2019

“District and Community Nurses are part of the clinical hub, all nurses attend MDTs with all the GPs to discuss individual patients and agree plans fitting round the patient, which results in one person, who is the right person, seeing the patient”.

www.dorsetccg.nhs.uk
(3) Proactive Care for people living with Long Term Conditions (LTCs)

The proactive management of people with LTCs, including the promotion of self-care by patients is a key priority for Dorset.

New models of care are being implemented through continued investment to support General Practice as part of integrated care teams, specifically in relation to the management of diabetes and respiratory disease. This includes the development of a new health coaching and social prescribing service for Dorset.

In line with the NHS Long Term Plan, Dorset is seeking to ensure that the parity of esteem agenda is delivered in Primary Care, to ensure that mental health is as valued as physical health conditions. Work with partners will develop new and integrated models of primary and community mental health care that supports adults with severe mental illnesses.

The role of Pharmacists and Pharmacy Technicians is increasingly being recognised as part of the multidisciplinary team and this has been supported with national and local investment in pharmacist roles in urgent care, care homes, integrated care teams and GP Practices.

(4) Routine care - Improving Access to General Practice Services (IAGPS)

Achievement of the national target in October 2018 means that all patients are now able to benefit from improved access services designed and delivered by local NHS teams. Local plans will ensure access to care is maintained and enhanced as part of any proposed changes to local service configuration. The aim is to grow and develop the workforce, modernise infrastructure and technology, and support local networks to redesign the way modern Primary Care is offered to patients.

(5) Urgent and Unplanned Care

The newly commissioned Integrated Urgent Care (IUC) Service supports the delivery of new care models across Dorset. Using a lead provider model, the IUC Service ensures the provision of urgent and unplanned care is delivered as a System, made up of the following elements: NHS 111 (both telephonic and online), a new Clinical Assessment Service (CAS), General Practice Out of Hours (GP OOH), night nursing, Single Point of Access (SPOA) and improved urgent access to General Practice services (IAGPS).
This integrated approach ensures services work together in a way that enables more patients to be appropriately reviewed and treated without going to an acute hospital. This will result in more services being offered closer to home in the community, a reduction in accident and emergency attendances and avoidable admissions.

![Red Bag Scheme]

“The Red Bag Initiative is great for closer working with nursing homes and maximizes the role of the District Nurse. All documentation stays with the patient to improve their length of admission and speedier discharge home”.

(6) End of Life

In Spring 2018, NHS England invited Dorset Integrated Care System to act as a “demonstrator site” for end of life to improve personalised care in the last year of life. The vision for Dorset is to provide choice, dignity and compassion, with co-ordinated high quality support at the right time, in the right place, for our patients, carers and their family as they approach the end of life. In order to achieve this the following core capabilities have been identified:

- We recognise when you may be in the last months of your life.
- We all understand what really matters to you and your family and focus on this together.
- You are supposed to live well in your own way, as part of your community, finding moments of joy where possible.
- You are supported to anticipate what may happen towards the end of your life. Your wishes are shared as appropriate so that you are supported through times of illness in a way which feels right to you.
- You are as comfortable as you want to be, including in the last days of your life.
- Those close to you feel supported, including after your death.

There are several initiatives which will support the delivery of New Care Models:

**Working within our Integrated Care System**

General Practice is now playing a key role with system partners to better develop services and strategies which reflect local population need. As part of this work Primary Care is supporting a population health management approach, prevention at scale and more personalised care planning as part of integrated care delivery.
A Population Health Management approach

Population Health is aimed at improving the health of an entire population. Population Health management aims to achieve this through collating and appraising data to better understand local priorities, and then planning and delivering proactive care to achieve maximum impact undertaking population segmentation and stratification to identify local ‘at risk’ groups.

What we have set out to achieve:
Within Dorset we are building on the Clinical Services Review approach to segmentation of population based upon medical need.

Our Progress and Key Successes:
Three localities have completed Wave 1 of the Population Health Management programme and focused on frailty, diabetes, COPD and also the operating model of Primary Care. Four further PCNs have been selected to complete Wave 2, due to commence in October 2019.

Our Plans for 2019-21:
This is a great opportunity to focus on the impact of the wider determinants of health, and how Intelligent Working and collaboration between health, social care and the wider society can positively impact on health of the population.
**Addressing Health Inequalities**

We are taking a whole system approach to addressing health inequality by focusing on issues which impact on peoples well-being. Our plans are underpinned by two approaches to understanding health: the effect that different factors in people’s lives have on their health and well-being and the different levels of need experienced across local populations.

We recognise there are many complex and often interrelated factors that influence people’s health including the quality of housing people live in, the ability to find employment and how well schools are performing. Our plans take into effect these wider determinants of health working with Local Authorities, the Voluntary Sector and local communities to address issues that impact on wellbeing and create health inequalities.

"We plan to deliver targeted programmes over the next 5 years which close the gaps we have identified in health and wellbeing. People experience varying health and care needs over the course of their lives, by taking a population health approach we will be able to better organise our services, workforce and finances to support each segment of the population”.

**Prevention at Scale**

Our Prevention at Scale programme is aimed at changing our system to deliver better health and wellbeing outcomes and tackle inequalities in a way that meets the different needs of all our local people.

Primary Care Networks will increasingly play a key role in prevention at scale. Key opportunities include:

- Non-medical models of care, such as the Public Health Dorset commissioned Altogether Better practice development programme and social prescribing link worker roles working with General Practices;
- Simple lifestyle advice in primary care, connecting patients with the LiveWell Dorset service for additional support;
- Building the understanding of local neighbourhoods and communities to understand how to work with partners to address wider determinants of health and their impact on health and well-being;
- Using local data and intelligence to understand how to support different groups who may have different challenges;
- Using opportunities within the new GP contract for early diagnosis of cancer, personalised care, and local action to tackle inequalities.
What we have set out to achieve:
To deliver our vision we continue to focus on four workstreams:

- **Starting Well**: effective prevention in early years and educational settings that will have a long-term impact and help children and young people to thrive;
- **Living Well**: support for healthy lifestyles, using LiveWell Dorset for the public and with staff, reducing the risk of chronic disease in later life;
- **Ageing Well**: helping those already experiencing ill-health to feel more confident and take control of their own health and related behaviours, through working closely with local services and organisations to build prevention into how they work (see personalisation);
- **Healthy Places**: maximising the potential of our local environment and communities to improve and support good health and wellbeing outcomes for our residents.

Our Progress and Key Successes:

- 200 practice champions in GP practices providing peer support and non-medical interventions
- National Diabetes Prevention Programme in every locality with over 80% of people still on the programme, most now have HbA1c tests back within the normal range.
- Promoted benefits of the Daily Mile scheme with 36 schools signed up.
- Piloted the whole school approach to improving emotional health and wellbeing with grants of £336,000 issued to 50 schools pan Dorset to promote physical activity.
- Launched a LiveWell Dorset digital platform which has had 7429 people registering.
- 1500 vulnerable Dorset residents have received help to keep their homes warm through the Healthy Homes Dorset programme.
- 100 school facing staff have received mental health first aid training

Our Plans for 2019-21:
Prevention at scale, including self-management, early help and third sector support is key to delivering the sustainability and transformation plan for local health and social care. This might be through coaching conversations, connecting people with local community based activities or helping patients to navigate and access other services, resources and support. This includes working closely with PCNs to make sure care and support is tailored to local communities, and developing the workforce and systems to support the service and its users. In particular, we plan to:

- Develop a public health nursing lifestyle and population health management approach for universal healthy child programme
- Review school projects on emotional health and wellbeing and physical activity
- Continue work with acute and community providers to embed LiveWell Dorset
- Pilot embedding smoking cessation and lifestyle support in optimal lung cancer pathway
- Improve the way we screen and give Brief Advice in primary and secondary care settings, along with roll out of the successful Alcohol Assertive Outreach Team model from Poole is a key next step to complement our existing alcohol treatment system
- Support a second cohort of practices in Collaborative Practice programme
- Review Healthy Homes model and develop options for future work
- Run four local communication campaigns to engage and empower local people including Children’s mental health and Active Ageing
- Work with GP networks to improve previous offer as part of population health management for Diabetes in East Bournemouth, COPD in Weymouth and Frailty in North Dorset.
Personalisation

Personalised care means people have choice and control over the way their care is planned and delivered. It is based on ‘what matters’ to you and your individual strengths and needs. Personalised care is fundamental to the changes the NHS is seeking to make over the coming years to deliver better health and wellbeing for individuals; better quality and experience of care that is integrated and tailored around them.

What we have set out to achieve:
Dorset is one of 21 demonstrator sites in England for personalisation.

Our Progress and Key Successes:
We expect to report 21,183 for personalised care interventions for 2018 / 19 end of year, exceeding our target of 18,378.

Our Plans for 2019-21:
- Development of a system-wide workforce training to support personalised care;
- Full mobilisation of the Health Coaching and Social Prescribing Contract, integrated with the new Link Worker investment;
- Support PCNs to develop and embed personalised care.
4. Enabling Delivery of our Strategy and Plans

In order to deliver our Strategy for primary care we continue to focus on key enablers identified in the GP Forward View Programme. We plan to continue to invest in our workforce, supporting staff and local leaders to deliver new care models, ensuring that wherever possible care is supported by a high quality infrastructure enabled by new technology.

Investing in Transformation

The introduction of the Primary Care Contract Directed Enhanced Service in addition to local investment in 2019 will see all Practices supported to transform the way they deliver care as part of Primary Care Network development plans.

General Practice Forward View Programme (GPFV)

The General Practice Forward View is a substantial package of investment to enable General Practice to work at scale making best use of new technologies. There will be development and expansion of the workforce and better premises. General Practice will work as part of a more joined up primary care workforce able to devote the greatest amount of time to quality and health improvement for patients and local communities.

• Workforce - increase growth rate through new incentives for training and recruitment coupled with a focus on retention and return to practice;
• Workload – including 10 high impact changes;
• Care redesign – models of care and new ways of working; Releasing Time for Care is at the heart of our development programme for General Practice, we will spread awareness of innovations that release time for care and facilitate local change programmes to implement them;
• Infrastructure - investment in estates and technology to accelerate the development of infrastructure to enable the improvement and expansion of joined-up out of hospital care for patients.

Workforce

As set out in the Primary Care Organisational Development Framework, effective workforce planning across primary care will give everyone a clear picture of the current resources available and future requirements by Practice, Locality and Network as these develop. Focusing attention on workforce is essential to the delivery of our care models and addressing service cost pressures. Effective workforce planning is vital to ensure appropriate levels and skills of staff are available to deliver safe, high quality care to patients and service users.
What we have set out to achieve:
A Dorset Workforce Intelligence Group was established in 2018 to develop a workforce dashboard for the system, including Primary Care. A minimum dataset for workforce across the system to inform and support workforce planning and reporting purposes has been developed, alongside a workforce data collection tool for Primary Care.

As at March 2019 the workforce reported from the National Workforce Reporting System is shown below.

<table>
<thead>
<tr>
<th>STP</th>
<th>GP FTE</th>
<th>Nurse FTE</th>
<th>Pharmacist</th>
<th>Physiotherapist</th>
<th>Physician Associates</th>
<th>Paramedic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dorset ICS 03/19</td>
<td>511.9</td>
<td>278.2</td>
<td>14.3</td>
<td>0.00</td>
<td>0.00</td>
<td>12.5</td>
</tr>
</tbody>
</table>

Our Progress and Key Successes:
- The Primary Care workforce tool was launched in June 2019 achieving a 96% return rate from GP Practices across Dorset.
- The dashboard is available to all PCNs and has started conversations on what the data is showing, to inform and enable the analysis and development of integrated workforce plans and models associated with the transformation of services.

From 2018 the ICPCS investment to Primary and Community Care has enabled expansion of the Primary Care workforce with the addition of new roles, e.g. Advanced Nurse Practitioners, Paramedics and Pharmacists. The GP contract further supports improving recruitment, retention and expansion of the Primary Care workforce through the additional roles, including physician associates, social prescribing link workers and First Contact Physiotherapists.

Our Plans for 2019-21:
A Clinical Commissioning Local Improvement Plan now includes the requirement for GP Practices to complete and submit workforce data on a quarterly basis. The data will be incorporated in the system wide dashboard to enable development of integrated workforce plans, linked to the developing models of care associated with the transformation of services.

The Plan is to continue to offer each Network support with development of a Primary Care Workforce Plan informed by:
- Baseline workforce data;
- Heatmaps (analysis of workforce recruitment and retention hotspots);
- Workforce planning redesign methodology/tools (enabling the ownership of co-design of the plans);
- Workforce development initiatives (Primary Care Workforce Centre provision).

“People see an Advance Nurse Practitioner (ANP) as the first port of call. We do the health assessment, physical examination, may prescribe treatment, refer on to secondary care just as a GP would, but you do not have to wait 2 weeks for an appointment; ANPs run the walk in and wait service every morning”.
Development of our Leaders and new ways of working

We will continue to support our Primary Care Networks to develop their leadership and tackle their workforce challenges. We are doing this in partnership with health and social care organisations across Dorset. This is set out in the Primary Care Organisational Development Framework.

Supporting Staff
We have already made significant progress to support our Primary Care Workforce in Dorset.

• A Dorset Workforce Plan was produced to help understand who our staff are, the services they work in, the numbers of staff we employ, where there are staff pressures and challenges to recruit;
• A Primary Care Workforce Centre was established, a partnership alliance between Health Education England (Wessex), NHS Dorset CCG and Bournemouth University working together to progress the education, training, workforce and research development in Primary Care in Dorset.
• We have developed a programme of workforce development to retain, recruit and develop staff and introduce new roles, we have created a communications and engagement Strategy in order to attract more people to work and live in Dorset;
• We continue to develop a range of support services including a GP passport scheme and post graduate schemes to retain our newly qualified GPs in Dorset;
• We have agreed Primary Care Network development support.

Premises and Infrastructure

The NHS Long Term Plan recognises the challenges facing General Practice and sets out a plan which continues to build capacity and resilience, thus equipping General Practice to play a pivotal role in Integrated Care Systems.

The Built Estate forms an important component of this plan. Dorset currently has 126 premises or delivery locations for General Practice. It is estimated that, in line with the national picture, 30% of Dorset Primary Care premises need significant improvement to be able to support the delivery of integrated person-centred care.
What we set out to achieve:
A minimum dataset has been developed for the built estate, and from this the premises most in need of refurbishment or replacement have been identified. A programme of both capital and revenue investment has been created – ensuring that the built estate can be appropriately transformed.

Our Progress and Key Successes:
Within Dorset Minor Capital Grants have been used effectively to deliver a large number of premises improvements – these projects have included small extensions, internal re-modelling of rooms, and refurbishment of clinical areas.

Three premises projects were allocated capital funding from the NHS England Estate and Technology Transformation Fund. All three projects focused on the development of Primary Care estate which would be capable of supporting the delivery of new models of care.


Our Plans for 2019-21:
Our plans include:
- Developing ‘placed-based’ estates plans to meet local need and technology enhanced care planning;
- Further development of the minimum dataset for the Primary Care built estate ensuring that information is presented at Network level;
- Continued use of the NHS England Minor Capital Programme;
- Completion of the three ETTF premises projects;
- Commencement of three new priority Primary Care premises projects in Central Bournemouth, North Bournemouth and Weymouth & Portland;
- Further joint working with Dorset HealthCare NHS FT to develop the Community Hub projects in Wareham, Blandford and East Bournemouth.

Technology Enabling Care
In line with the NHS Long Term Plan, online consultations are being made available to all patients as part of plans to improve access to care. This will enable patients to benefit from advice about self-care and signposting to other sources of help, as well as an option to send information to a GP for a response. These new ways for patients to access care will improve patient experience and free up time for GPs to dedicate face to face consultations for patients with more complex needs. Patients will be able to book and cancel appointments online, request repeat prescriptions and access their medical records from anywhere in the world.
**What we set out to achieve:**
Digitally Transformed Dorset has four core areas:

**Enabling Technologies (tactical support)**
- Align the current GP clinical systems integrating across Primary Care and community providers;
- Ensure that diagnostic reports and images are made available to support care decisions;
- Extend the use of online record access, SMS texting, email and virtual clinics across all services to support self-management.

**Shared Care Record Programme (strategic support)**
- Enable electronic sharing of care records where beneficial to patient care;
- Implement the Dorset Care Record, pulling together data from primary, secondary and social care.

**Intelligent Working Programme (strategic support)**
- Build a comprehensive digital intelligence network to analyse services at a system level. This work will support Population Health management in order to develop a data led approach to support the redesign of services and offers for specific population cohorts.

**Empowered Care and Access (tactical and strategic support)**
- Support the digital design for the personalised care model on the following areas:
  - supported self-management under empowered self-care and access within mental health, respiratory, diabetes, maternity, parenting, asthma and other online therapies;
- Working with Research Active Dorset in developing:
  - a service led pipeline for digital innovation and accelerated approaches to pilots exploring digital solutions in prescribed care and their impact.

**What progress have we made?**
Access to records: All sites in Dorset have enabled their systems to allow patients (upon request) to have online access to their records
- 95% of patients are now able to access the electronic prescription services.
- By July 2019, 47% of Practices had gone live with offering GP on-line consultation.
- All Practices offering and promoting electronic ordering of repeat prescriptions and electronic repeat dispensing for all patients for whom it is clinically appropriate, as a default from April 2019.

Plans are progressing to ensure:
- All patients will have the right to online consultations by March 2020 and video consultation by April 2021 with their GP practice;
- All patients will have online access to their full record, including the ability to add their own information, as the default position from April 2020, with new registrants having full online access to prospective data from April 2019;
5. Engagement

Putting local people at the centre of our discussions

It starts with the person.

Equality and Diversity
How are you giving consideration to all 9 protected characteristics and Dorset’s geography and demography?

Patient, public and staff involvement
How are you actively involving and informing local people in planning your services?

Access
How are you thinking about ‘when’, ‘where’, ‘how’ and ‘whether’ people need to travel to health and care services?

Partnerships
How are you working with other health, care and voluntary organisations and planning for continuity of care?

Information Technology (IT)
How are you considering the use of digital technology in planning people’s care?

Physical and Mental Health
How are you ensuring that both physical and mental health needs are considered in planning your services?

Prevention and Education
How will your plan support people with their self-management and help keep them well?
There are a wide range of GP Practice Patient Participation Groups (PPGs) in the county. These groups work in partnership with their practices and enable people to be involved in influencing the way that their own local health services are delivered.

A Public Engagement Group (PEG) also operates across Dorset and consists of a group of 25 local people with a rich shared life experience – it is recognised that it is not possible for individuals to be truly representative of a particular location, condition or characteristic. There is also a Health Involvement Network of over 750 people with an interest in health and care who regularly receive our Feedback Newsletter promoting opportunities to get involved in shaping health care services and a group of over 200 patients, carers and lay representatives who work as part of a Supporting Stronger Voices Forum.

In the past year, the PEG has been supporting the commissioning of Primary Care services as part of an Integrated Care System approach. This group has helped with the planning of new services such as Social Prescription, Health Coaching and a Voluntary Sector Navigation Service, a digital programme for independent self-care, a dementia care review as well as public engagement and communications planning.

You can watch a short video from the April 2019 Supporting Stronger Voices event published here: https://www.youtube.com/watch?v=nSc-VJ1TeE&feature=youtu.be

Patient surveys provide vital intelligence on patient experience of access to care and this is used to inform the way in which services develop to respond to local need.

Overall the 2019 survey found that patient experience of GP services in Dorset compares very favourably with the rest of England:

- 87% of patients describe their experience as good, compared to a national average of 83%.
- Most patients (81%) report it is easy to get through to their GP practice on the phone, compared with a much lower national average of 68%.
- Access to on-line services is slightly above the national average (79% in Dorset compared with 76% nationally) with booking appointments on-line slightly below (11% in Dorset compared with 15% nationally).

The Dorset Public Engagement Group provided feedback which informed the Primary Care Commissioning Strategy. Below is a summary of their feedback and how the refreshed Strategy will respond to this:
**What we heard?** | **How this is reflected in our Strategy** | **Relevant Section**
---|---|---
**Improving Access**
It is very important to educate the patients on what is best for them | Our care model includes more support for patients to better understand what services are available and how to access these – this includes supported self-management, care navigation and social prescribing link roles in each Primary Care Network | Delivering our care model and enabling delivery
Make sure that strategy reflects learning from the Vanguard projects | The integrated urgent care service and improving access to general practice model developed is based on the learning from Vanguard Projects |  
Workforce is a key issue and access to different professionals based on patient need | Plan to invest in skill mixed teams and new workforce roles to support Primary Care Networks to improve access to general practice services. |  
Need to reassure patients that there is information available to let them know who is available, where and when | As part of care navigation patients will have better access to local information |  
**Empowering Patients**
We need to show people what is available in GP surgeries, community hospitals and hubs | Primary care Networks will help deliver local care models and as part of this will work with local patients and public to better communicate what services are available. | Transforming primary and community Care Services
Develop local hubs with multi-disciplinary teams | Care models include investment in integrated community and primary care services and new workforce roles, these will develop in response to local need |  
This is already working well in some part of the country | Our Strategy supports all Primary Care Networks working as part of a Dorset Integrated Care System to share learning, adopt and spread best practice. |  
If patients are empowered they do not need to see their GP | The Strategy plans to develop personalised care across Dorset which better empowers patients. This will be achieved through more supported self-care as well as personal care and support plans. |  
**Joining up Care**
Patients trust their own GP and if patients are cared for by teams it will be important that patient information can be shared. | As part of developing multi-disciplinary teams a Dorset Care record will enable more joined up working with patients only having to tell their story once | Delivering our Care Model
Don’t over estimate the cost saving of a GP knowing his/her patient | The GP will still provide continuity of care for those with more complex needs. |  
**Improving Quality**
Who are the Primary Care Network Clinical Directors accountable to? | Primary Care Networks will be part of the governance for the Integrated Care System. Clinical Directors will be accountable to the system working as part of an east and west integrated and health partnership | Enabling delivery of our Strategy and Plans
Variation in the quality of care across the country | A clinical commissioning local improvement plan will provide population health data to address variations in care and clinical outcomes |  

Our Progress and Key Successes:

Phase 1: 2016
Events with GP Members and Teams and Patients, Carers and the Public.

Phase 2: 2017 – 2018
GP Members and teams; Patients, Carers and public; Local Authority and District Council; Community Trust; Acute Trust; Voluntary Sector.

Collaborative working between Practices and the CCG to further develop engagement and local proposals.

Our Plans for 2019-21:

• Ongoing engagement each year to review national and local proposals.

• Bespoke engagement, facilitation and co-design training to 80 staff across Dorset ICS to secure a ‘bank’ of frontline staff as Public Engagement Champions with specific facilitation skills to be able to co-design services with local people in a consistent meaningful way across their own and partner organisations. Primary and Community Care Team staff participated in this training programme.

Details of engagement events held, future plans and how to get involved can be found at https://www.dorsetccg.nhs.uk/involve/

“The Patient Participation Group (PPG) is part of the surgery team. It’s the door to start relationships with the surgery and key to designing new services.”
Developing primary care as part of the Integrated Care System (ICS)

During the Summer of 2019, ‘Our Dorset’ sought the view of local people on six priority areas developed in line with aspirations of the Long Term Plan. Views gathered will be used to inform the development of ‘Our Dorset’ Looking Forward Plan for health and well-being.

As part of the Integrated Care System, Dorset CCG has a clear engagement and communication process to support future changes in Primary Care service provision.

** Individuals-** services will be designed around a person to meet their individual strengths and needs so they can take more control over, and responsibility for their care

**Communities-** helping all residents get the best start in life, living well into adulthood and ageing well. With a focus on other factors that affect individual’s health and wellbeing such as employment, housing and family relationships

**Living Well-** people getting the right care, at the right time and from the right person by providing more care in the community and out of hospitals

**Wellbeing-** improving health and wellbeing outcomes for all residents so we all have equal opportunities to live well no matter where we live or what our circumstances are

**Workforce-** increase workforce training, recruitment with a focus on leadership and mental health first aid. Making public services and the wider health and care sector a great place to work and improve staff retention

**Digital Innovation-** using digital technology to deliver services in new ways giving people more and better information about health and wellbeing
6. Investing in Primary Care

Current Spend and Primary Care Delegation Growth

The pie chart below presents how the Clinical Commissioning Group plans to utilise its funds in 2019/20 in both monetary and percentage terms. The Primary Care spend of £147.8 million includes the Primary Care delegated budget from the 1 April 2019 as well as the CCG commitment for the delivery of local contracts and transformation. This includes the Enhanced Frailty contract for £3.9 million, Improving Access to GP Services funding of £4.8 million, the Clinical Commissioning Local Improving Plan of £2.1 million and the GP Contract Plus funding of £2.1 million. The CCG has also budgeted to spend an additional £126.7 million for General Practice drugs prescribed.
How is the £147.8 million spent?

The Primary Care planned spend of £147.8 million is detailed in the bar chart below. This is split by the delegated budget of £109.1 million for the delivery of Primary Medical Services and GP Practices and the CCG core funded Primary Care budget of £38.7 million, which Primary Care has been commissioned to provide services by the CCG. These are through local contract arrangements or nationally directed through the delegated ‘Direct Enhanced Services’.

What do Primary Care delegated allocations look like from year’s 2018/19 to 2023/24

Primary care allocations have been updated and published for the next five years. Displayed in the graph below, this represents an increase in allocation of £27.7 million, or 26.2%, from 2018/19 to 2023/24.
7. Delivery Plan

Our Key Priorities are:

- System level investment in integrated community and primary care teams and evaluation of the impact of this;
- A sustainable General Practice model which is attractive to work in;
- All Practices working in Primary Care Networks;
- Integrated Community and Primary Care multidisciplinary teams delivering new care models;
- Continuous improvement to the quality of GP services;
- Improve patients experience, empowering people to take control of their own health;
- Reduce health inequality gap;
- Improve outcomes, reduce unwarranted variation and accurate disease prevalence for all areas we are outliers;
- Improve extended and consistent access to General Practice services;
- A paperless health system where patients are enabled to better access care through the use of technology.

How will we measure success?

We will measure and monitor local General Practice services using an agreed set of milestones and key deliverables. These are likely to include:

Our Key Deliverables

<table>
<thead>
<tr>
<th>Milestones</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice working in Primary Care Networks as part of an Integrated Care System to deliver new care models which improve outcomes for patients.</td>
<td>☑️</td>
<td></td>
</tr>
<tr>
<td>Primary Care Networks develop in line with a maturity matrix to serve the registered population of Dorset by improving quality of care and patient experience</td>
<td></td>
<td>☑️</td>
</tr>
<tr>
<td>A Primary Care Organisational Development Framework is developed to support Member practices and Primary Care Network development</td>
<td>☑️</td>
<td></td>
</tr>
<tr>
<td>Primary Care Networks establish community leadership teams involving patients and local stakeholders</td>
<td>☑️</td>
<td></td>
</tr>
<tr>
<td>General Practice has plans in place to ensure local sustainability and resilience and enable transformation</td>
<td>☑️</td>
<td></td>
</tr>
<tr>
<td>Primary Care Networks are delivering new care models through whole system integrated workforce planning including targeted recruitment and retention programmes to meet local population need</td>
<td></td>
<td>☑️</td>
</tr>
<tr>
<td>Population health risk stratified data supports new care model delivery, local demand and capacity planning</td>
<td>☑️</td>
<td></td>
</tr>
</tbody>
</table>
**Milestones**

<table>
<thead>
<tr>
<th>Milestones</th>
<th>2019/20</th>
<th>2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Networks have an agreed focus on prevention and long term conditions management</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>A system wide comprehensive model in place to support personalised care programmes</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>General Practice Forward View investment in local programmes supporting practices working in Primary Care Networks</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Technology enabling primary care to deliver new care models including patient access to on-line services as well as a range of self-care Apps</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Local estate infrastructure plans and capital investment in primary and community care premises to deliver new ways of working, improve the quality of patient experience and outcomes of care</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

**Initiatives for Year 1 (2019 - 2020)**

Over the next year there are a number of initiatives that we will undertake with Primary Care, supporting the ICS Strategy, to start to deliver improvements:

- Developing the maturity of Primary Care Networks;
- Commissioning at-scale for population health-based outcomes;
- Delivering an Annual Programme of Quality Improvement;
- Investing in integrated care teams and improving access to General Practice services;
- Understanding local population needs, addressing inequalities in health and access to services through population health management;
- Supporting self-care and simple life style advice.
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