

PRIMARY CARE COMMISSIONING STRATEGY AND PLAN

2016 -2020/21



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It is with great pleasure that we present to you our Primary Care Commissioning Strategy. Dorset Clinical Commissioning Group (CCG) became fully delegated for Primary Care Commissioning from NHS England on 1 April 2016. This means we now hold the finance and decision making responsibilities for the way we plan and buy our GP services. (For the purpose of this document, Primary Care means General Practice, as opposed to the other three contractor groups: Pharmacy, Dentistry, Optometry).

We know from our GP survey results that patients are mostly happy with the services they receive but they have told us that there is more work to do, especially around access. We also know from the conversations we have had with our GP Members and their teams that they are under extreme pressure with an increasing workload and diminishing workforce. The CCG has recognised for some time that things need to change; there is now also national recognition via the General Practice Forward View (GPFV). This national guidance and supporting programmes, coupled with our new decision making powers, gives us a fantastic opportunity to address these difficult challenges.

Our reasons for change are simple: General Practice in its current form will find it difficult to survive, if it does not evolve. GPs and their teams have developed and adapted their individual practices well over time resulting in many great achievements; a wider reaching strategy is now required to stretch beyond the boundaries of individual practices and better address the current challenges. As we have recognised in our work for the Clinical Services Review (CSR) and Integrated Community Services (ICS), the existing health system was not designed to meet the needs of the current population. 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.

We want to celebrate the success of General Practice, which has provided real value for money. We also want to acknowledge that General Practice is facing extremely challenging times. By working together, we are confident that we can achieve a strong, sustainable and modernised integrated GP model, which is attractive to work in and where patients can consistently receive the best care, in the most appropriate place. It is our ambition to do this as part of achieving our strategic goal for longer healthier lives via a fully integrated health and social care system by 2020/21.

Dr Forbes Watson, Chair

Dr Karen Kirkham, Assistant Chair

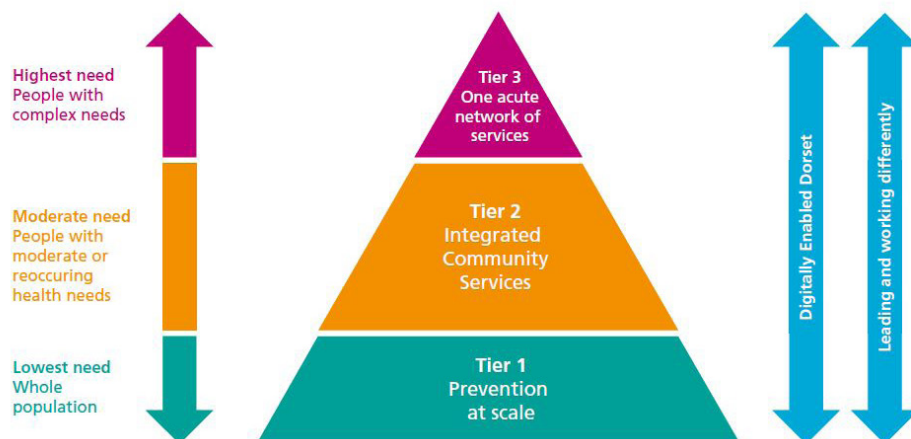
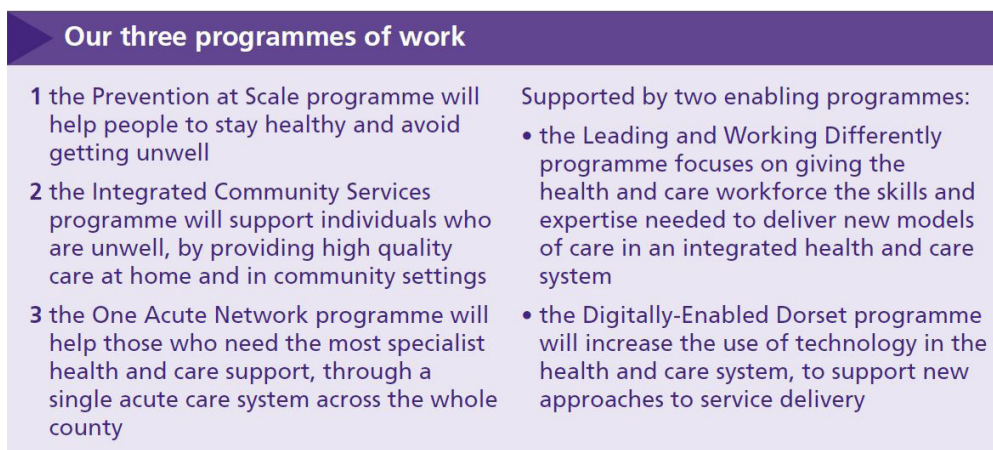
Dr Anu Dhir, Primary Care Lead

Dr Andy Rutland, Primary Care Lead

Jacqueline Swift, Primary Care Commissioning Committee Chair

EXECUTIVE SUMMARY

This Primary Care Commissioning Strategy facilitates delivery of our developing **Sustainability and Transformation Plan (STP)**. This Strategy supports delivery of Tiers one and two:



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 wider **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).



As part of our STP we are looking to make critical decisions about “... **the organisation of our primary care services into larger groupings**...”. We describe how we plan to do that in this strategy and plan.

The starting point for this is to describe our **key challenges** and how they have informed our **case for change**. We know that in order to address the issues of **vulnerability and sustainability** (workload, workforce and investment) and (unwarranted) **variation in quality, outcomes and access**, we have to do things differently. This includes starting to work across **larger population groupings**.

Some initial work has been done to start to think about what this could mean for localities, which we have presented in this document as **local blueprints**. These have been produced using local intelligence and feedback from the **local engagement** we have carried out from April to September 2016.

We would now like to work with **groups of practices** between October 2016 and March 2017, to further develop these blueprints. It is planned to do this via a **second phase of practice engagement** and use the **local and national enablers** we have at our disposal. Our thinking around **joint working** and developing the answers together with our GP Members, is in line with ‘Is bigger better? Lessons for large-scale General Practice’ (Nuffield Trust, July 2016)

As well as enablers such as **estates, technology and investment**, we recognise the real importance of the need to modernise how we commission. We start to talk about the 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.

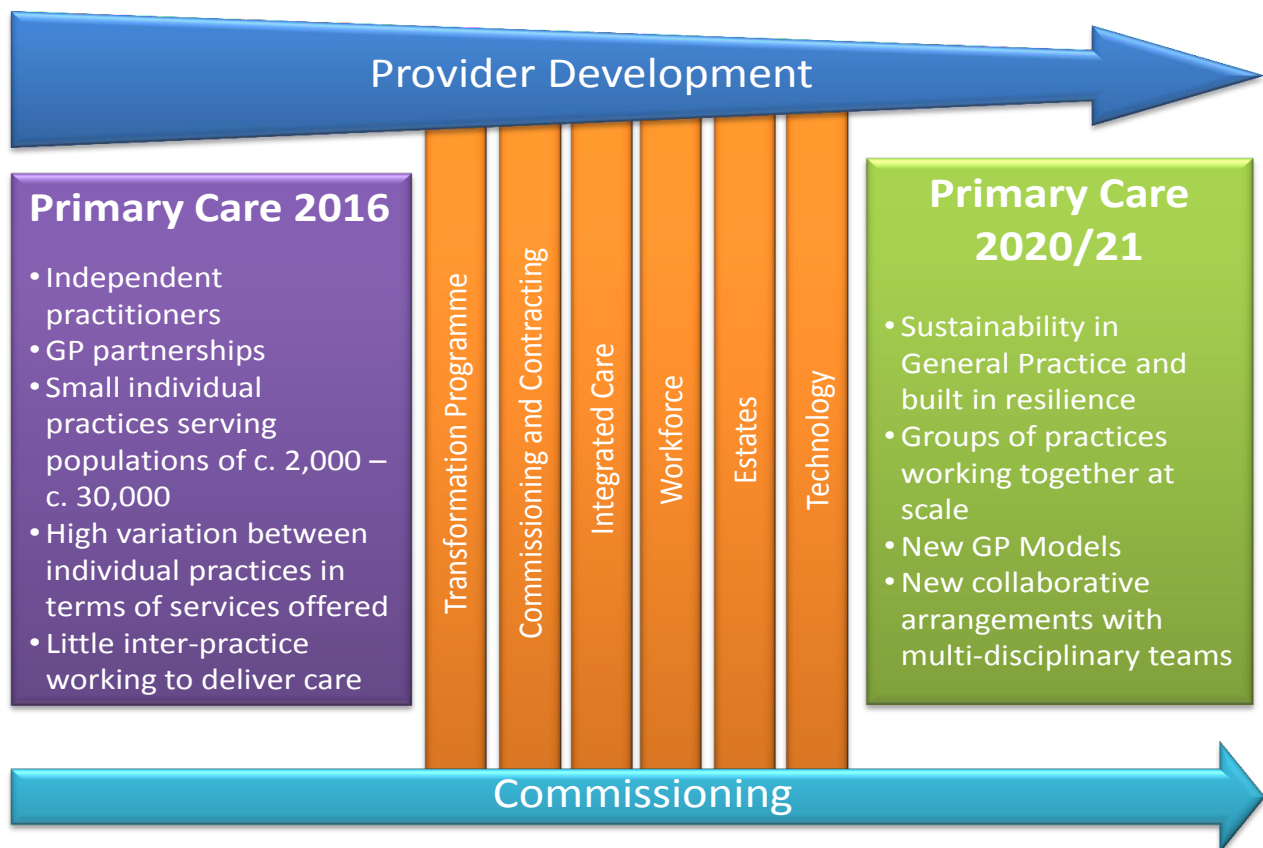
This strategy sets out our high level commissioning intentions and approach to delivering change over a 5 year period. The important **phase of co-production** begins from October 2016. We want to build on past successes and provide consistently outstanding GP services for our patients. There is a real opportunity to do this now, as part of our whole system transformation within the community services review.

This is a **five year journey**; delivery plans will progress at pace but aligned to the state of readiness of practices for change. This document sets out the strategic framework, which we are now asking our GP providers to respond to.

By 2020/21 it is our ambition to have all our practices working in collaboration at increased scale.



Primary Care Commissioning Strategy 2016-2020/21



Dorset CCG is a GP Member organisation which is now also responsible for the commissioning of General Practice Services. This Strategy therefore signals the clear commissioning intent for the future, however it also describes an element of provider development which, in line with national direction via the GP Forward View, is required to achieve sustainable GP services. Dorset CCG expects this role to reduce over time, as GP providers stabilise, strengthen and transform.



By 2020/21 it is our ambition to have:

1. Improved the **Quality** of our GP Services
2. Improved **Patient Experience**, empowering people to take control of their own health
3. Reduced the **Health Inequality Gap**
4. Improved **Outcomes**, Reduced **Unwarranted Variation** and accurate **Disease Prevalence**, for all areas we are outliers
5. All practices working **At Scale** within **Collaborations** as part of multi-disciplinary teams
6. A **Sustainable General Practice** Model, which is attractive to work in
7. Improved, Extended and Consistent **Access**
8. A **Paperless** health system

We intend to do this by:

1. Having a **Rolling Annual Programme of Quality Improvement** and Support to ensure all practices are rated at least “Good” by CQC
2. Commissioning a **System of Health Care** which removes traditional organisational boundaries, removes the need to repeat your story and where information is shared and available
3. Increase the focus on our **Prevention Agenda** and work with our partners and stakeholders to have a broader and more holistic view of the range of **Factors that Impact on Health and Wellbeing** and developing a joint plan to address them
4. Having a **Contract Management and Monitoring Process** so that every practice has access to the right information and support
5. **Working with our Member GPs and their Teams**, to move forward with different ways of collaborative working at scale whilst maintaining patient continuity. Modernise our approach to **Commissioning**
6. Using the **National and Local programmes** available to provide skills and resources to deliver financial and workforce sustainability. Continue to develop the **Primary Care Workforce Centre**
7. **Supporting our GP Practices** to become sustainable and work as part of larger groups, so that Improved, Extended and Consistent Access can be achieved
8. Delivering our **Digitaly Enabled Dorset**

CASE FOR CHANGE

Vulnerability

Currently in Dorset there are approximately 25% of practices that have a number of vulnerable factors. Many more have an element of vulnerability; practices who are not yet experiencing such extremes are often neighbours to some that are, which puts additional pressure on them if things go wrong.

Wessex Local Medical Committee (LMC) has described this as a 'Spectrum of Vulnerability':

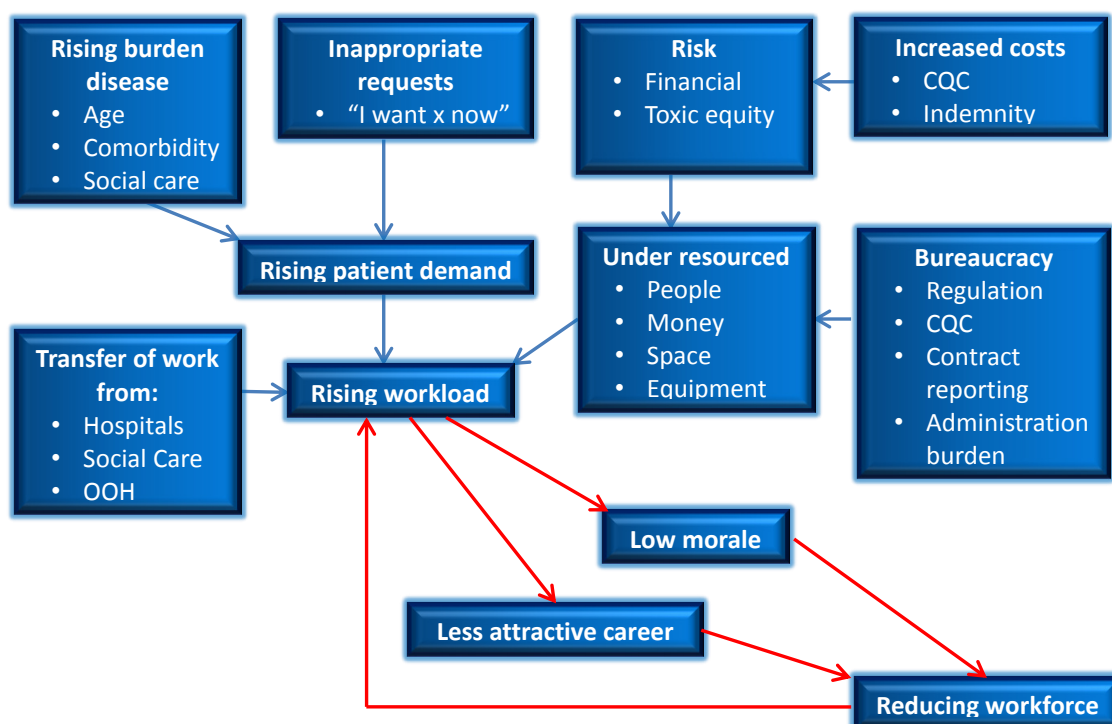
"If General Practice fails, the whole NHS fails..."

(Simon Stevens, 2016)



Wessex LMC has also identified some of the key issues which are contributing to the crisis in general practice and align with factors identified by Care Quality Commission (CQC) and Royal College of General Practitioners (RCGP), where practices have demonstrated success or not.

Causes of Vulnerability	Barriers to Change
Workforce	Premises
Workload	Indemnity
Bureaucracy	IT
Patient and System Demand	Resistance "It's not broken"
Resources / Investment	





- Over 90% of all contacts with the NHS occur in General Practice
- The demand for a GP appointment 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).

Demand

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

There are also increasing pressures on General Practice resulting from changing patterns of care, rising expectations in terms of:

- Access and range of services provided
- Changes in medical technology
- New ways of treating patients

GP workload has grown hugely, both in volume and complexity. Research by the Kings Fund shows a 15% overall increase in contacts

- 13% increase in face-to-face contacts
- 63% increase in telephone contacts (Kings Fund, May 2016)

The **main drivers** behind this vulnerability are:

Workforce

General Practice in Dorset is facing difficulties in recruiting and retaining staff. Added to this there are a significant number of GPs, Nurses and Practice Managers approaching retirement age. Staff development and succession planning are areas which need a joined up approach with other local partners.

Workload

GPs across Dorset have been telling us of the ever increasing workload. It is not only the changing patient demographic and demand which has contributed to this, but also the way the world around us has changed. The British Medical Association (BMA) reported in 2014:

- There have been significant increases in NHS activity over the past 14 years, including a 24% increase in GP consultations since 1998
- It is estimated that 340 million consultations in England are undertaken every year, this is up 40 million since 2008

Wider System Factors have compounded the situation. For example, changes in other services such as community nursing, mental health and care homes are putting additional pressure on General Practice. Communication processes with secondary care colleagues have also exacerbated GP workload.

Increase in workload has not been matched by the proportion of the NHS funding allocated to practices.

Unwarranted Variation

As described, the NHS is experiencing significant pressure and unprecedented levels of demand. Around 1.5m patients are referred for elective consultant led treatment each month. The average annual growth in GP referrals between 2009/10 and 2014/15 was 3.9%. Growth in 2015/16 compared to 2014/15 was 5.4%. For the same period, other referrals, which include consultant to consultant referrals grew by 6.7%.

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.

Unexplained variation in all aspects of clinical work and healthcare is generally unavoidable because of its complexity and the impossibility of controlling all the variables that may produce it. 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.

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 research indicates that unwarranted variation yields sub-optimal clinical outcomes and significant financial burdens.

“If all variation were bad, solutions would be easy. The difficulty is in reducing the bad variation, which reflects the limits of professional knowledge and failures in its application, while preserving the good variation that makes care patient centred. When we fail, we provide services to patients who don’t need or wouldn’t choose them while we withhold the same services from people who do or would, generally making far more costly errors of overuse than of underuse.” Mulley, AJ. (2010) Improving productivity in the NHS.BMJ

Reducing variation will also support the reduction in the financial efficiency gap we have in Dorset by ensuring that **referral management** is effective and successful in making sure that patients are seen in the right place and by the right people.

National and local context supports the development of this work with a strong case for focusing on consistent high quality services and an integrated approach focused around the patient. Dorset CCG remains committed to improving the consistency of care for its population.

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.

Premises and Infrastructure

Dorset currently has 131 delivery locations for General Practice. There is a variation in quality between some relatively new estate and a large number of smaller practices in old converted residential buildings which are not all fit for purpose.

The majority (over 70%) of practices are on the same clinical system, which is also the same system used by community services. More practices are moving to the same system as they see and appreciate the advantages of a shared clinical system. The **Dorset Care Record** (DCR) will further increase the access to information important in delivering care to the population of Dorset. There are also increasing opportunities to use digital technology to facilitate and enhance communication, not only between professionals but also between people and professionals. Before this can become a reality there is considerable work required, which we envisage happening through the Dorset Digital Road Map.

Commissioning and Contracting

Primary Care contracting is complex and currently does not lend itself to integration of services or providers. It often introduces perverse incentives to achieve the aims of the contract rather than delivering the outcomes our local population really need.

During 2015, practice engagement events took place across Dorset reinforcing the drive to improve contracting arrangements and simplify reporting as the top priority requests.

Practices reported that their ambitions to develop innovative care are inhibited due to challenges posed by contractual / payment models. Furthermore practices are potentially managing over 30 local contracts in addition to contracts from NHS England, Local Authorities and Public Health. This increases the risks of duplication, double funding and makes managing contracts difficult for both commissioners and providers.

If there is a shift to the use of **collaborations and networks of practices**, where providers are able to work on the scale required for effective integration of services and outcomes, without changes to commissioning and funding arrangements, the argument for new models of care will remain theoretical. At the heart of this approach is **population-based commissioning**, under which providers would be commissioned to deliver defined outcomes for the population they serve.

System Transformation

The three programmes of work described in the STP (page 4) will not be deliverable if General Practice fails. Care closer to home requires strong sustainable General Practice, which is not achievable if it continues to be delivered through small independent practices. Some of the workforce and workload challenges can only be addressed through working at scale, sharing workforce and resources.

STRATEGIC CONTEXT

National

The NHS Five Year Forward View (FYFV) clearly states that strong General Practice and Primary Care services are essential if we are to have a high quality and responsive NHS, fit for the future. It also contains specific, practical and funded steps to grow and develop the workforce, drive efficiencies in workload and relieve demand, modernise infrastructure and technology, and support local practices to redesign the way modern Primary Care is offered to patients.

In April 2016 NHS England launched the **General Practice Forward View (GPFV)**. Developed with Health Education England and in discussion with the Royal College of GPs (RCGP) and other GP representatives, it sets out a plan to stabilise and transform General Practice, improving services for patients and investing in new ways of providing Primary Care. At its heart is the belief that General Practice in 2020/21 will not look the same. It will be able to work at scale making best use of new technologies and increases in the workforce; so that clinicians can devote the greatest possible amount of time to quality and health improvement for patients and local communities, and be part of more joined-up local services.

The plan focuses on 5 key areas: Investment, Workforce, Workload, Infrastructure and Care Redesign.

Subsequently, NHS England has initiated a number of programmes aimed at delivering the GPFV. The **Vulnerable Practice programme (VPP)** will support a limited number of the most vulnerable practices in crisis. The **General Practice Resilience Programme (GPRP)** will help practices who are in difficulty by delivering local resources to help with practice management, recruitment issues, and capacity. The **General Practice Development Programme (GPDP)** will support practices to manage their workload differently, freeing up time for GPs and improving care for patients.

// General Practice has risen to challenges in the past and, with the support from leaders across the system, it will again. //

(NHS England 2015)

One of the '9 Must Do's' (NHS England, December 2015) for 2016/17 for every local system to deliver is:

"Develop and implement a local plan to address the sustainability and quality of General Practice."

Primary Care at Scale

Primary Care at Scale (PCaS) is a natural first step towards a accountable care provision for a population, for example via super-practices or strengthened GP federations. Emerging thinking is showing that the strategic guidance put forward in FYFV and GPFV that working in groups of at least 30,000 patients enables General Practice to:

- **Consolidate all primary medical core, extended and enhanced services**, as a way of building resilience, enabling staff development and opportunities, creating new capabilities, and realising economies (e.g. in administration)
- **Be commissioned to take on new services and funding** set out in the GPFV. These could include, as examples, the provision of additional access, delivering services from Care Hubs, undertake infrastructure investment



Local

Demographics

Dorset GP practices serve a population of around 766,000 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%). 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%.

Children and young people under the age of 20 years make up for 21% of the population and account for about a quarter of a typical GP's workload.

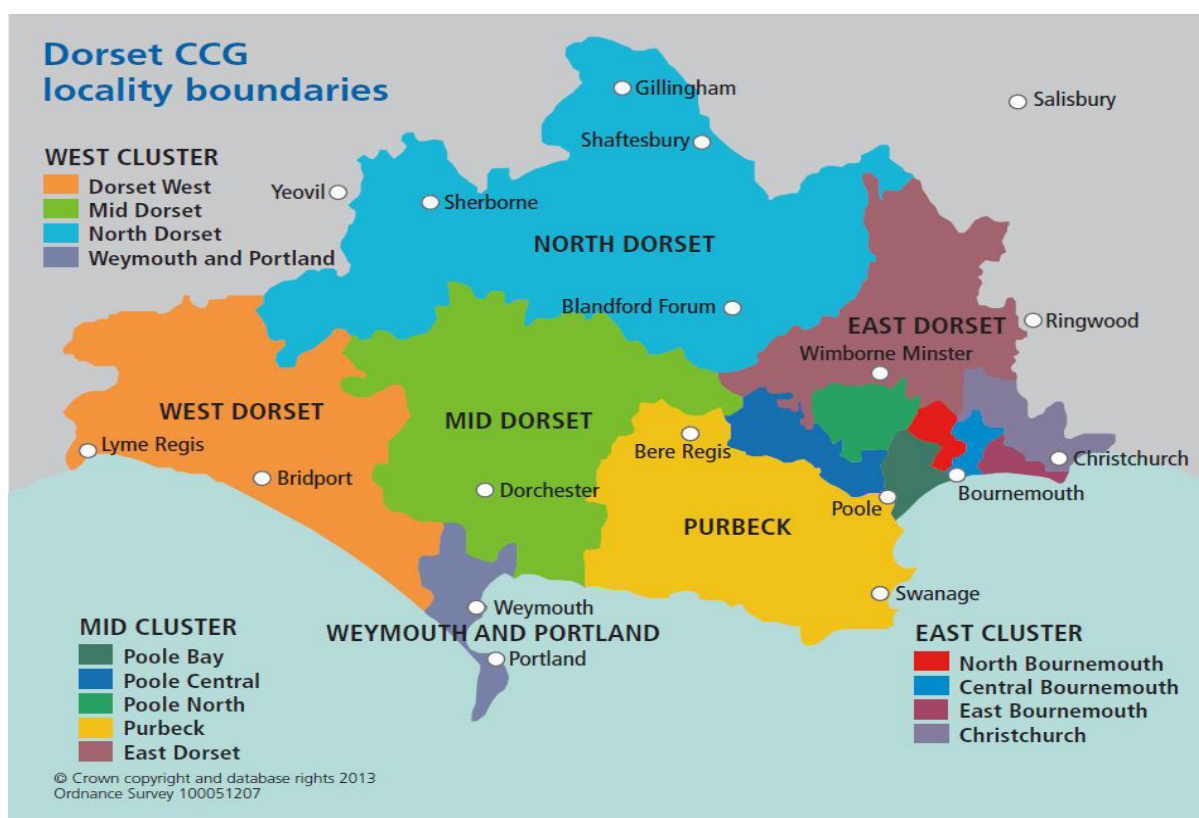
NHS Dorset CCG commissions (buys) services

from a range of other providers than General Practices including:

- Dorset County Hospital NHS Foundation Trust
- Dorset HealthCare University NHS Foundation Trust
- Poole Hospital NHS Foundation Trust
- Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- Salisbury NHS Foundation Trust
- University Hospital Southampton NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- Community and Voluntary Sector.

We have three Local Authorities, which provide social care services as follows:

- Dorset County Council
- Bournemouth Borough Council
- Borough of Poole



Population Health

- **In the UK:** 18 million patients are estimated to suffer from a **chronic condition**, with the majority being managed in the community by GPs. Around 53% of all patients in England report having long standing health conditions, many of which will be treated at some stage by GPs. Most of the 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** 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 by 2015 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
- **As of the end of 2010**, around 30,000 people in Dorset were living up to 20 years after a cancer diagnosis. This could rise to an estimated 58,300 by 2030

Other Commissioning Priorities

While developing new models for GP services, it is important to take into account changes to other areas of commissioning and how these relate to General Practice, for example:

Mental Health

The CCG 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. Services need to be commissioned that will help address the significant mortality gap for people with a

serious mental illness and to support primary care professionals to deliver primary mental health care through improving skill sets, which will enable people to be supported to recover in their communities. The CCG has a vision for more holistic care of the population and will look at how best to address the significant anxiety and depression associated with long term conditions through the multi-disciplinary community teams and further development of IAPT (Improving Access to Psychological Therapies) services. Right care, right time and right place is so important to people who require mental health support and the delivery of a more integrated approach across primary and secondary care.

Urgent Care

There are several initiatives which will impact on General Practice:

- Implementing the Commissioning Standards for Integrated Urgent Care by 2018. Nine of the twelve directly impact on Primary Care
- Implementing the A & E Improvement Plan (August 2016) including delivery of the five mandated initiatives
- Delivery of Local A & E Delivery Board responsibilities (to be newly established 1 September 2016)
- Local Initiatives

The CCG recognises how the current GP model for home visits, creates a 'spike' in ambulance demand that the **Ambulance Service** finds difficult to recover from and which can also cause a problem for Acute Trusts. Different ways of working that cause a 'smoothing out' of the demand over the day, will be explored as part of the work to develop local GP models.

Medicines, Prescribing and Pharmacy

The CCG recognises the significantly important role that Pharmacists and Community Pharmacy play in the successful running of the health system. As such, there are already a



number of pilots and models for Pharmacists working in General Practice and in wider integrated care services. Early feedback from these has shown that the pharmacists can undertake a positive role in managing prescription requests and issues, and in the review of patient medication in care homes. These pharmacists become essential members of the multidisciplinary teams managing more complex patients, their role is likely to develop further, with increasing use of pharmacist prescribers.

Future models of care to support our high intensity patients and people with long term conditions indicate a need for a substantial increase in our Pharmacy workforce. Nationally it is anticipated that there will be one practice based clinical pharmacist for each 30,000 population group. For Dorset CCG this equates to twenty five pharmacists in future posts. In order to promote this as a career option, from 2016/17 Dorset CCG and Dorset HealthCare University Foundation Trust (DHUFT) will have extended pre-registration pharmacist placements from Health Education England. This will allow pharmacy graduates to observe practice based pharmacists, CCG commissioning and prescribing advice functions and a wider exposure to community services than has previously been included in their training. This exposure should lead to practice and community based roles being an increasingly desirable career option.

In addition to the pharmacists employed in these specific primary care settings, the role of the community pharmacist is well recognised to be under-utilised at present. It is anticipated that the introduction of new models of working in the new pharmacy contract will release additional pharmacist time to be able to deliver other services such as minor ailment schemes, additional support for self-care and in the review of medicines in wider settings such as care homes. The Royal Pharmaceutical Society



(RPS), produced a report in February 2016 has presented the evidence from various schemes which demonstrates that including a pharmacist in the team with responsibility for the care of residents in care homes, reduces medicines waste and emergency hospital admissions. Such services can have a considerable impact on the workload of practices caring for patients in care homes, and most importantly improves the quality of life for residents.

The increasing role of practice based pharmacists is anticipated to reduce the workload for GPs associated with prescription management, medicines reconciliation and management of the prescribing and monitoring of medicines for those with long term conditions. Use of existing, but under-utilised technology to manage repeat prescribing with batch prescriptions, electronically transmitted to the community pharmacy will allow for a considerable reduction in GP and receptionist workload. Increasing the use of electronic prescription services and repeat dispensing will contribute to the paper free General Practice, and the efficiencies generated in community pharmacies, through receipt of electronic prescriptions will free up the pharmacists to be able to deliver additional services to support the wider healthcare community.

As extended access and models of care are transformed in line with national and local priorities, the access to pharmacy services and medication to support extended opening and changes in practice will be needed. The soon to be commissioned urgent repeat medicines service and potential minor ailments services in community pharmacy should support and help manage demand both in and out of hours. The way in which pharmacy services develop and flex will be critical to the delivery of a transformed General Practice.

Planned and Specialist

Elective care makes up the majority of general practice's day to day work (eg Ears, Nose and

Throat (ENT), Orthopaedics, Dermatology, Ophthalmology, Cancer) and this will only be impacted further by the predicted population changes in Dorset.

Development of new models of care for some services is currently being undertaken in line with the CSR and ICS which includes anticoagulant, rheumatology, dermatology and ophthalmology etc.

Pivotal to all of the Planned & Specialist work is a focus on patient self-care and prevention. In particular this is very much part of the diabetes, respiratory, musculoskeletal, cancer and dermatology work. For example working with Primary Care, methods for risk stratification of cancer patients are being developed which supports patients having appropriate care ie self-care, minimal follow ups, more regular follow ups.

Work is underway to utilise the information contained within the cancer and MSK Right Care Value packs together with local intelligence and reports such as the Joint Strategic Needs Assessment in order to ensure our plans focus on those opportunities which have the potential to provide the biggest improvements in health outcomes, resource allocation and reducing inequalities.

With new integrated models of care emerging which link with ICS there is opportunity to provide career opportunities for AHP, Nurses and GPwSIs (GP with a Special Interest) as part of the services e.g. respiratory, diabetes, ophthalmology and dermatology to ensure we develop skills and competencies across the Primary Care Team so they are better able to support people to self-care and decrease their life style choices. There is a need for appropriate primary care education/training around these to give GPs confidence in when/when not to refer and to be able to empower patients.



Children, Young People and Families

The CCG recognises the importance of improving Children's health is increasing lifelong health outcomes. Currently there is a inconsistent model of care across Dorset to respond to children and young people's care needs; GPs will support Children and Young People to have good physical and emotional health, ensuring access to more specialised services when needed. The vision is to have standardised pathways across the whole system, inclusive of primary care.

To enable sustainable health services engaging and supporting primary care professionals (GPs, practice nurses, Health Care Assistants (HCAs) etc.) will require support from colleagues in delivering increased parts of the care pathway to Women, Children and Young People with support from colleagues in their community, acute and social care, in response to person's needs. This in turn lead to reductions in acute setting (hospitals) contacts inclusive of urgent and emergency care.

Other priorities to achieve are:

- Ensuring the workforce can support prevention at scale and the development of integrated community children's health services (ICCHS). The Paediatric/Child Health service vision supports expanding the number of GP's trained in paediatrics. GP's will continue to be involved in caring for women's healthcare especially before, during and after pregnancy
- There are opportunities for GP's and other primary care professionals, to be involved throughout the maternity journey, so promoting the best start to family life for babies and children, improving health outcomes, while reducing the development of some long term conditions that could require lifetime contact from health and social care services.
- Children and young people and pregnant women are looking for fast responses in health care, by requesting the use of technology. Hence consideration of digital offers and social prescription is essential.
- Access to training/specialist advice and guidance to primary care professionals on women's, children's and neonatal healthcare is required.
- Shared patient records across health and social care, especially children's services, inclusive of community and children's and adolescent mental health (CAMHS) is needed."

Vanguard Projects

In 2015 Dorset CCG developed a distinct project that encouraged GP's to apply to be part of a programme aimed at supporting the evolving vision for integrated community services and ways of working better together. A key project focus was on developing

plans collaboratively and considering how services could be delivered at scale for the people of Dorset. In applying to be part of the programme groups were agreeing to develop their proposals and ideas collaboratively and produce a plan that captured their locally prescribed options for service models and configuration. The final proposals, submitted by the 6 ICS Vanguard Groups, were a blend of approaches, solutions, ideas and aspirations with all groups supporting the principles, as outlined by the CSR, for services and care being provided at scale, closer to a person's home and available 7 days of the week where appropriate. 3 broad themes were identified that specifically support the vision for integrated services across Dorset:

- Improving the way people work together (Integrated Hubs, co-location & co-ordination of staff, Multi-Disciplinary Teams, Virtual Wards, Anticipatory Care Plans, Risk Stratification etc)
- Diabetes (reflecting the new CCG model)
- Models for community urgent care services (including Integrated Advice & Assessment)

The CCG is currently considering how those areas can be incorporated, and aligned, with the annual delivery plans that fit within the overall context of Our Dorset Sustainability and Transformation Plan (STP), and any related governance structures.

Existing Provider Landscape

- **97 GP practices** – most independent, individually owned and managed
- **131 delivery locations**
- **Emerging GP groupings** mostly around natural local communities in 13 localities
- **Community services** serving local communities with some co-located or fully integrated with General Practice
- **Urban and Rural Models of Care** evolved in response to the distance from other care provision
- A range of **Federations** and some private providers





Phase 1

GP Members and Teams

A period of consultation with our GP Members and their teams took place between 23 June and 19 August 2016. During this period 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 Primary Care Commissioning Strategy was presented at various stages of development to the Governing Body and Membership Events.

What did we hear?

Whilst a number of local issues were raised, there were a number of common themes across the localities:

- Wide spread issues around **Recruitment and Retention** of staff. The reducing workforce needs to be addressed by developing and supporting the skill mix in Primary Care
- **Linking in other Professionals** to ensure that patients are seen by the most appropriate person in a timely way, for example close working with Pharmacists
- **Joined up Care** from community and social services needs to improve significantly
- The need for **the capacity to allow Focus on Prevention** of ill health
- The need for an improved infrastructure throughout Dorset to include a **Common IT System**, one care record and redesign of estates to support flexible working patterns
- **Direct Support** to Vulnerable practices
- Development of the role of the **Voluntary Sector** to link with Primary Care across the County

"It should not matter where you go or who you see, you should get the same quality of care."

(A Dorset patient, 2016)

Patients, carers and the public

The views of local people were central to the development of the ICS proposals. This involved:

- **2014** – analysis of 29,000 comments from Dorset-wide surveys
- **2015** – comments collected and themed at 100's of meetings, events and shows
- **2016** – in the Spring, 9 public events focussing on local views of developing health and care in the community
- **2016** – in the Summer, 2 large public events and 26 roadshow visits to test out emerging proposals with local people across Dorset
- **2014-2016** – 18 meetings of our Patient (Carer) and Public Engagement Group (PPEG) – with a strong focus on the community

In September 2016 we met with PPEG and the following table shows what we heard and how it has been reflected in our Strategy.

What did we hear?	How this is reflected in our strategy:
Improving Access	
A good experience of access to local NHS services is important	<p>We are building on the existing high quality General Practice offer by achieving extended and improved access:</p> <ul style="list-style-type: none"> • 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 • Commission pre-bookable same day appointments on both Saturdays and Sundays “to meet local population needs”
There is a need to strengthen access to General Practice services in local communities as part of a wider look at community services:	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:
Use of technology to help people to have easier access to care and navigate services is important	There will be technology enabled care across Dorset working through a Dorset Digital Roadmap and roll out of a Dorset Care record
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	We are developing Local Blueprints for care delivery which will look at how public sector services can work together
Consider mobile GP services to maintain access to rural isolated communities	We will consider how Technology and Models of Care can help improve existing access to care with a particular focus on isolated communities
Empowering Patients	
Make services more responsive to patient needs	We will have patient centred care planning supported by integrated teams
Recognise patients as experts in their care	There will be a focus on prevention and supporting people to lead healthier lives with a more holistic views of what patients need
Joining up Care	
Patients want to be able to know they have a team looking after them who work with them to understand their care needs	We will have an integrated team-based approach to care delivery using new care models which respond to the needs of different patient groups
Make sure that General Practice is supported by teams which include mental health workers	We will support practices to work together in local communities to develop more skill mixed teams, working with other services to support practices
Improving Quality	
Patients want the same high quality care experience no matter where they are seen	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
There is a need to develop a new relationship with patients so that they work in partnership with health care professionals	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



Phase 2

Rolling Programme of Engagement

Our Annual Delivery Plan (page 48) shows how we plan to continue our engagement with our GP Members and their teams, and patients, carers and the public, via a rolling programme of annual engagement.

Phase 2 is planned for October 2016 to March 2017. We plan to engage at practice level to work with groups of practices to develop the blueprints in this strategy (page 26 to page 37).

We plan to engage with local people on an on-going basis and in a variety of ways. This will include seeking views to inform our plans via:

- the PPEG – a group of 20 local people from across Dorset's geography, demography and diversity
- Patient Participation Groups (PPGs) - groups of local people at all 97 practices
- the CCGs Supporting Stronger Voices Forum – a group of over 100 patient, carer, public and lay representatives
- the CCGs Health Involvement Network - about 4000 local people with an interest in health and care.



FUTURE MODEL OF GENERAL PRACTICE

GP Model

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 across Primary and Community Services, using a **network of GP practices and / or Primary Care and community service hubs**.

The **community service hubs** proposed via the **Integrated Community Services** work are included in the Local Blueprints (see pages 27 to 37).

These hubs will provide a range of services and some will also have community beds, so

that when appropriate, people can receive care locally, instead of being admitted to (an acute) hospital. These beds will also be used to provide rehabilitation as well as end of life care.

The **community model** was developed by **risk stratifying local population need**. This allows for **service configuration** to be based around the levels of need, which have been grouped under five broad headlines. A range of **care models** emerged from considering the range of services needed to meet the levels of need.





	Current Care Models	Future Care Models
1	Hospital centred disease specific, specialist led often by GP referral	Community based teams and services in-reaching into specialist care centres. Teams bring together GP, specialists, nursing and therapy
2	Lack of capacity, often hospital led	Patient centred care planning with a named GP, health and social care co-ordination, rapid access to assessment, diagnosis, individual treatment and management plans, more responsive to intensive home based care needs, virtual ward models
3	Patient care managed by GP and Consultant by referral with care often not co-ordinated	Promoting self-management and pro-active self-care. Empowering patients and supporting carers, mobilising local community resources around groups of General practices enabled by teams working across care settings.
4	Provided by independent general practices through a patient list	Patient choice and ease of access to a local General Practice service. Local access to diagnostic and treatment services. Same high quality service offer and access for patients no matter where you live.
5	Separate GP practices provide in-hours for urgent patient need, high variation in access both in and out of hours.	Urgent in-hours care delivered at scale with access based on clinical need. Effectively streaming out the management of urgent and emergency care. Delivering care in the right place at the right time by the right care professional.

The General Practice Response to these Care Models

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 above shows the GP element of the current care model and what it could look like in the future, working as part of multi-disciplinary teams.

Prevention at Scale

Plans for **prevention at scale** involves developing a clear and consistent story of what the issues are facing our population, and highlighting actions that could be delivered at scale, with a judgement about likely effectiveness. Prevention at scale is not a separate programme, or series of commissioned interventions and activities; the challenges facing Dorset will not be solved by this approach.

For example, many of the risk factors that contribute to the development of chronic diseases like diabetes and heart disease, are so prevalent in the population that providing support to change lifestyles on an individual basis alone will not be sufficient. Further, the evidence suggests that it is the variation in how these conditions affect populations in Dorset and how they are managed and treated, that contributes to much of the observed health and wellbeing, and care and quality gaps.

For these reasons, a more **integrated approach to prevention** needs to be adopted right across the whole system, involving actions for individuals, actions for organisations, and actions for those most influential in shaping the development of places and communities. We also need to provide clarity on what we mean by prevention, including the different approaches at different stages of life and in different settings.



Rationalised Estate

In order to support new models of care delivered in local areas we require larger, more accessible, **modernised Primary Care centres**. To achieve this we need to **transform our existing General Practice estate**. Around 40% of our current estate is modern and fit for

purpose; 10% will require major investment to provide modern health care. As Primary Care transforms to deliver new systems of care, a large proportion of the existing estate is not likely to be required in its current configuration.



Past, Present, Future Working

Five years ago GP Practices were working well as individual units and although they were all members of a locality, there was little joined-up working between them. There were no real problems with recruitment of staff, including doctors and very little need for locums. General Practice was mainly GP delivered, although some practices had started to develop teams of staff with the introduction of new roles such as nurse practitioners. Many practice nurses were undertaking chronic disease monitoring as well as their more traditional roles. There was very little joint working with Social Care in response to patient care needs with many 'hand offs' between services and lack of care co-ordination.

Over the last 1-2 years things have dramatically changed for General Practice in many areas. General Practice recruitment workforce problems began to become apparent as the training schemes for new GPs were not filled and many young doctors who would have joined GP practices, decided on other careers in the hospital sector or abroad. In addition many senior GPs have retired due to the workload pressures. Over the last two years we have seen practices finding it difficult to recruit to vacancies, putting pressure on already stretched teams.

More recently, practices have seen the benefits of working closer together, as well as with other services such as the acute and community hospital trusts and social care.

Practices will be encouraged to work together in the future, planning the delivery of services by looking at what local populations need; commissioned to deliver care across the whole system in partnership with patients and the wider NHS and Social care system - one NHS workforce caring for patients in local communities.

Where this is already working, is the Westhaven Hub in Weymouth and Portland. Multi-professional teams have been developed, including GPs, community nurses and matrons, mental health workers, community rehabilitation teams and social care teams, to provide support for vulnerable and complex patients who are struggling to manage at home, or those patients that have recently been discharged from hospital. Health and social care teams in the hub provide a rapid response for patients who are frail and at risk of deterioration and/or admission. This includes people with diagnostic uncertainties, challenging symptom control and people who could avoid admission to hospital.

The team is able to fully assess patients in their own home and arrange treatment drawing on community services but also secondary care such as hospital at home. By coordinating this care via the hubs virtual ward, a service is provided that respects patients' wishes by, where possible, keeping them at home and enables management by the appropriate services. This reduces the number of times patients need to tell their story; they receive care in their own home and have access to all necessary services providing a seamless approach to care.



Introduction to the Local Blueprints

The GP Local Blueprints describe each locality profile in terms of population, current number of practices, proposed number of community sites and any particularly relevant patient demographics. In line with federations and local developments, we have paired certain populations together where it makes sense to do so: East Dorset and Poole North, Poole Central and Poole Bay respectively. Each narrative includes where the locality are in terms of readiness to, and progress made with, moving forward with New Models of Care and delivery of Primary Care at Scale.

The workforce data was sourced from HSCiC (now NHS Digital) – General and Personal Medical Services, as at 30 September 2015. The population data was sourced from National General Practice Profiles from Public Health England, correct as at 2015. The proposed ICS community hubs are shown in line with the Governing Body proposals for consultation.

The potential future number of Primary Care delivery locations has been produced by analysis based on national guidance. This guidance suggests that Care hubs (a single or network of delivery locations) serving a neighbourhood of 30,000-50,000 within an accountable care provision for a population of at least 100,000 patients, are showing significant promise in delivering Primary Care at Scale. This has provided us with a view on the potential range of the number of sites that could be required. **To test these assumptions and develop the local blueprints, we will support localities to produce their own solutions to local challenges.** Detailed analysis will be undertaken in areas such as travel and estates and consider future local changes that could impact on General Practice such as housing developments. We will also take into account the different geography across Dorset, for example the urban and rural communities. This working in partnership will

help co-produce a service design that meets local needs.

The evaluation criteria for this analysis will be as follows, which is consistent with the CSR:

1. Quality of care for all
2. Access for all
3. Affordability/value for money
4. Workforce
5. Time to deliver
6. Other (research and education)

From October 2016, further work is intended to be carried out on these GP local profiles, working closely with localities. We will seek to understand the staff employed in each practice, the variation of roles and the skills needed to deliver care to patients. We will also seek to understand the variation of staff employed across practices in Dorset, as well as nationally, learning from examples of good practice and looking for opportunities to share their success. Work will also be carried out to identify which buildings are fit for the future and where there are any issues and record future housing developments wherever significant work has been scheduled to take place over the next five years.

At this time there is an incomplete existing workforce data set, hence an inaccurate staff to patient ratio.



Central Bournemouth Primary Care Blueprint

Central Bournemouth Locality has seven GP practices across ten locations serving a registered population of approximately 67,079. 12.9% of the population are aged 65-84 years; and 2.8% of the population are aged 85 years and over (Dorset figures are 20.3% and 3.8% respectively), giving a lower than Dorset average age demographic. Bournemouth health profile has better than average rates of obesity, smoking related deaths, homelessness and long term unemployment, whilst rates of hip fractures, sexually transmitted infections and road traffic accidents are worse than average. There are small pockets of deprivation with children living in poverty and life expectancy for men lower than the England average. Life expectancy is 10.5 years lower for men and 5.6 lower for women in the most deprived areas of Bournemouth than in the least deprived.

Practices within the locality area have formed a community vanguard to work towards a co-ordinated care hub, including a frail elderly and urgent Primary Care pathway.

Localities will be supported to produce their own solutions to local challenges, working in partnership to co-produce a service design to meet local needs.

Existing Workforce

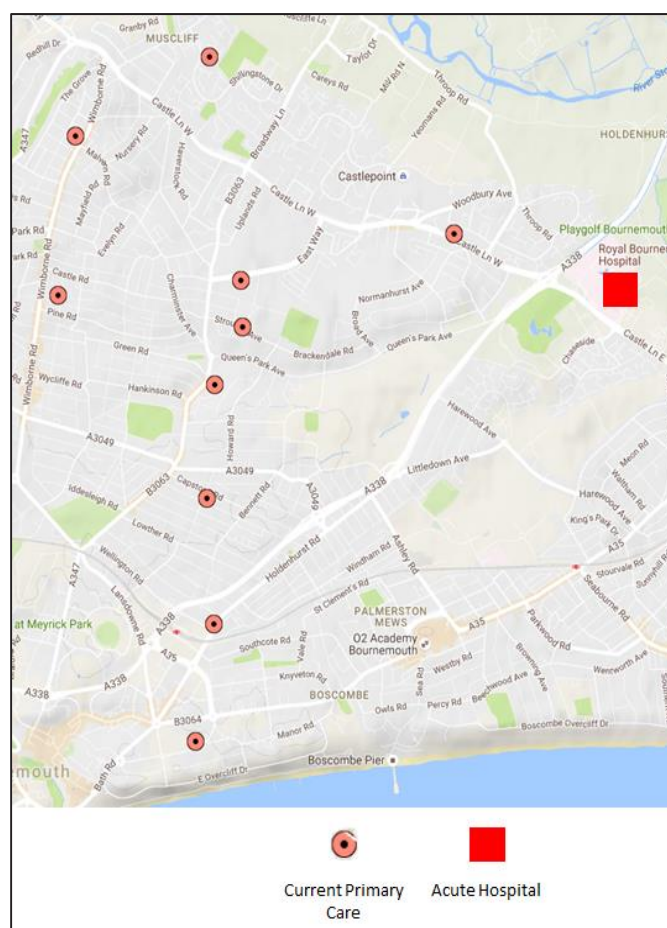
- WTE GPs: 32.9 → (0.49/1000)
- WTE NPs: 13.4 → (0.20/1000)
- WTE Administration Staff: 70.4 → (1.05/1000)

Existing Infrastructure

- There are currently 7 general practices working across 10 sites

ICS Proposals

- Access to community beds: for the Bournemouth and Christchurch area it is proposed to have access to short term care home beds with in reach support from health and care staff



Potential for Delivery of Primary care at Scale, for localities to consider

There is the potential for one or two groups of General Practices to deliver services to the population covered by this blueprint, through a reduced number of locations, possibly in the form of a community network of General Practice. This could be supported by the centralised delivery of urgent primary care by local GP's, co-ordinated delivery of routine care and services for frail older people. At scale delivery of Primary Care could potentially be delivered from 3-5 locations.

Christchurch Primary Care Blueprint

Christchurch Locality has eight GP practices across ten locations and a community hospital without community beds (specialist palliative care beds are on the site) serving a registered population of approximately 64,841. 24.2% of the population are aged 65-84 years; and 5.2% of the population are aged 85 years and over (Dorset figures are 20.3% and 3.8% respectively), giving a higher than Dorset average age demographic.

Christchurch has a number of town centre practices, along with practices that serve a semi-rural population. The Highcliffe area cares for the oldest population in England with 26.8% over 75 years of age equating to 2,660 patients out of a registered list of about 10,000. Christchurch has a better average percentage than the England average for smoking related deaths and obesity levels but new cases of malignant melanoma is worse than average. Rates of homelessness, violent crime, long-term unemployment, drug misuse, early deaths from cardiovascular disease and cancer are all better than average.

Practices in Christchurch are already working together and have formed a federation and through a community vanguard are designing new models of care for the conurbation.

Localities will be supported to produce their own solutions to local challenges, working in partnership to co-produce a service design to meet local needs.

Existing Workforce

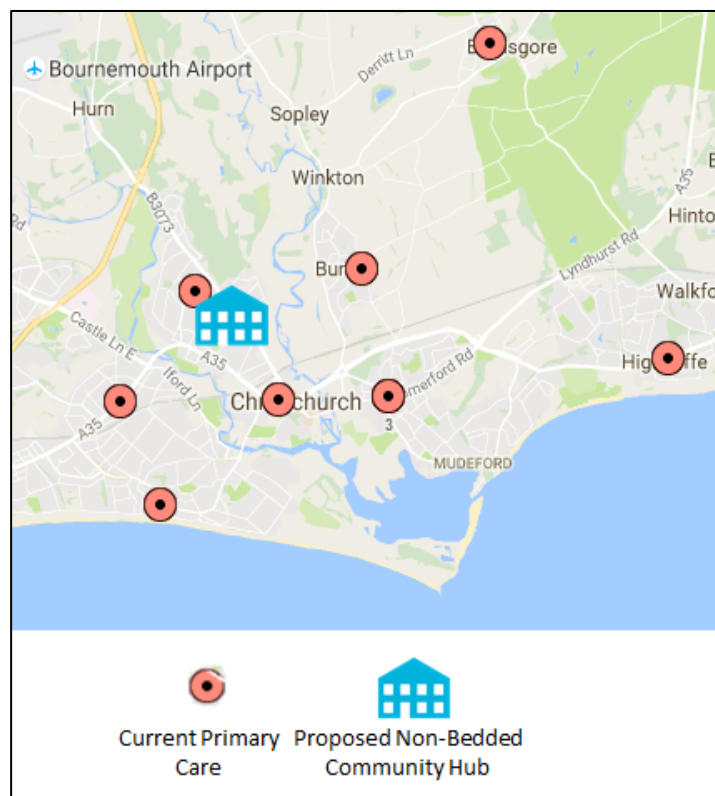
- WTE GPs: 40.4 → (0.62/1000)
- WTE NPs: 20.8 → (0.32/1000)
- WTE Administration Staff: 53.0 → (0.82/1000)

Existing Infrastructure

- There are currently 8 general practices working across 10 sites

ICS Proposals

- Number of proposed community hubs without beds: 1



Potential for Delivery of Primary care at Scale, for localities to consider

There is the potential for one or two groups of General Practices to deliver services to the population covered by this Blueprint, through a reduced number of locations, possibly in the form of a network of practices supported by services and facilities at a Christchurch Hospital Hub. The potential model could include the network of general practices delivering routine General Medical Services whilst access to urgent Primary care, diagnostics and some specialist services being delivered at a hub. At scale delivery of Primary Care could potentially be delivered from 3-5 locations.



East Bournemouth Primary Care Blueprint

East Bournemouth Locality has seven GP practices across seven sites serving a registered population of approximately 61,226. 15.4% of the population are aged 65-84 years; and 3.6% of the population are aged 85 years and over (Dorset figures are 20.3% and 3.8% respectively), giving a lower than Dorset average age demographic. The unique community services include a general palliative care team and a dementia intermediate care team. Each practice supports an over-75 scheme, predominantly around dedicated nursing care for frail older people. The area also benefits from specialist services for the homeless and other vulnerable communities. There is also a weekend walk-in centre in Boscombe providing urgent Primary Care.

Bournemouth health profile has better than average rates of obesity, smoking related deaths, homelessness and long term unemployment, whilst rates of hip fractures, sexually transmitted infections and road traffic accidents are worse than average. There are small pockets of deprivation with children living in poverty and life expectancy for men lower than the England average. Life expectancy is 10.5 years lower for men and 5.6 lower for women in the most deprived areas of Bournemouth than in the least deprived.

Practices are working closely together to design new models of care, which includes Primary Care at Scale and local access to diagnostics and treatment services.

Within the area covered by this blueprint, community services are delivered out of Shelley Road Clinic and Boscombe and Springbourne Health Centre.

Localities will be supported to produce their own solutions to local challenges, working in partnership to co-produce a service design to meet local needs.

Existing Workforce

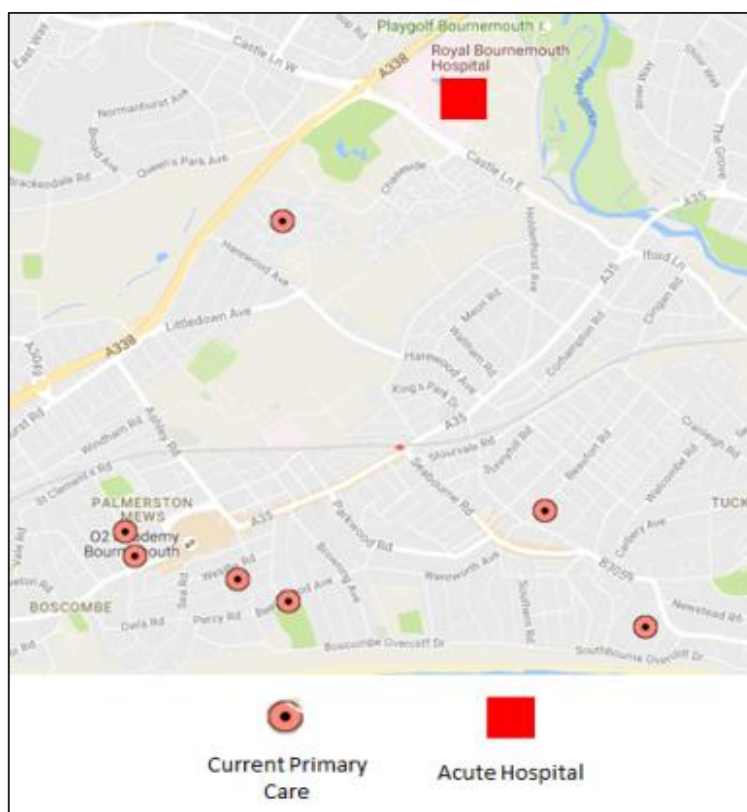
- WTE GPs: 31.1 → (0.51/1000)
- WTE NPs: 10.3 → (0.17/1000)
- WTE Administration Staff: 61.6 → (1.01/1000)

Existing Infrastructure

- There are currently 7 general practices working across 7 sites

ICS Proposals

- Access to community beds: for the Bournemouth and Christchurch area it is proposed to have access to short term care home beds with in reach support from health and care staff



Potential for Delivery of Primary Care at Scale, for localities to consider

There is potential for one or two groups of General Practices to deliver services to the population covered by this blueprint, through a reduced number of locations, possibly in the form of a network of practices supporting services and facilities at a centralised Hub. The network would also include a range of community services including community nursing utilising the frailty model of care. At scale delivery of Primary Care could be potentially be delivered from 3-5 locations.

North Bournemouth Primary Care Blueprint

North Bournemouth Locality has eight GP practices across ten locations serving a registered population of approximately 65,585. 15.7% of the population are aged 65-84 years; and 2.7% of the population are aged 86 years and over (Dorset figures are 20.3% and 3.8% respectively), giving a lower than Dorset average age demographic. The unique community services include a general palliative care team and a dementia intermediate care team.

Bournemouth health profile has better than average rates of obesity, smoking related deaths, homelessness and long term unemployment, whilst rates of hip fractures, sexually transmitted infections and road traffic accidents are worse than average. There are small pockets of deprivation with children living in poverty and life expectancy for men lower than the England average. Life expectancy is 10.5 years lower for men and 5.6 lower for women in the most deprived areas of Bournemouth than in the least deprived.

The locality has a scheme in place to support vulnerable older people to better manage their medication and reduce their risk of avoidable admissions to hospital.

Within the area covered by this blueprint, community services are delivered out of Pelhams Clinic.

Localities will be supported to produce their own solutions to local challenges, working in partnership to co-produce a service design to meet local needs.

Existing Workforce

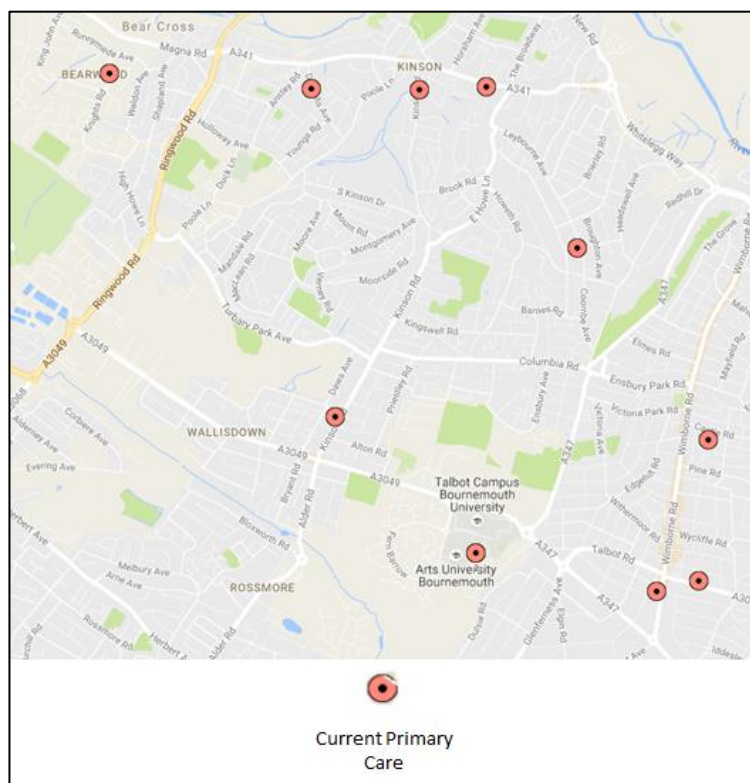
- WTE GPs: 32.0 → (0.43/1000)
- WTE NPs: 9.7 → (0.13/1000)
- WTE Administration Staff: 54.3 → (0.73/1000)

Existing Infrastructure

- There are currently 8 general practices working across 10 sites

ICS Proposals

- Access to community beds: for the Bournemouth and Christchurch area it is proposed to have access to short term care home beds with in reach support from health and care staff



Potential for Delivery of Primary Care at Scale, for localities to consider

There is the potential for one or two groups of General Practices to deliver services to the population covered by this blueprint, through a reduced number of locations, possibly in the form of a network of practices supported by services and facilities at a centralised Hub. The network would also include a range of community services and community pharmacy provision. At scale delivery of Primary Care could potentially be delivered from 3-6 locations.



East Dorset and Poole North Primary Care Blueprint

East Dorset Locality has nine GP practices across twelve locations and two Community Hospitals serving a registered population of approximately 69,534, while Poole North Locality has four GP practices across seven locations serving a registered population of approximately 52,572. 26.5% of the East Dorset population and 19.2% of the Poole North population are aged 65-84 years; 5.1% of the East Dorset population and 3.1% of the Poole North population are aged 85 years and over. (Dorset figures are 20.3% and 3.8% respectively). East Dorset has a number of semi-urban practices, along with practices that serve a semi-rural population. Poole North has a concentrated footprint of practices serving a predominantly urban registered population.

East Dorset has a better average percentage than the England average for smoking related deaths and better than average levels of adult smoking and physical activity. Rates of hip fractures, sexually transmitted infections and TB are better than average in both East Dorset and Poole North but new cases of malignant melanoma is worse than average. Rates of homelessness, violent crime, long-term unemployment, drug misuse, early deaths from cardiovascular disease and cancer are all better than average. Estimated levels of adult excess weight and physical activity are better than the England average in both localities.

Localities will be supported to produce their own solutions to local challenges, working in partnership to co-produce a service design to meet local needs.

Existing Workforce

East Dorset

- WTE GPs: 31.2 → (0.53/1000)
- WTE NPs: 11.9 → (0.20/1000)
- WTE Administration Staff: 45.8 → (0.78/1000)

Existing Workforce

Poole North

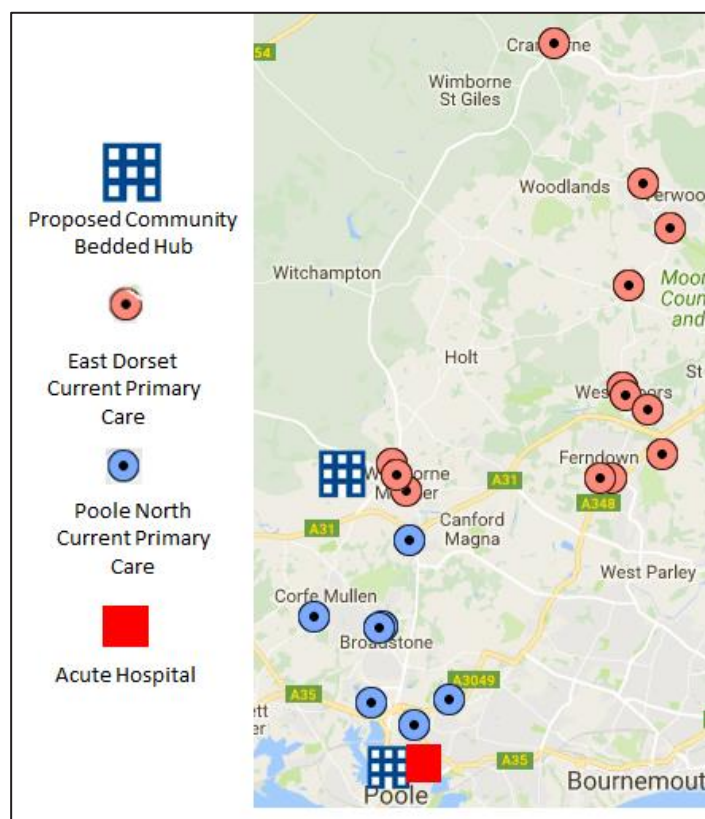
- WTE GPs: 29.8 → (0.57/1000)
- WTE NPs: 12.6 → (0.24/1000)
- WTE Administration Staff: 50.5 → (0.96/1000)

Existing Infrastructure

- There are currently 13 general practices working across 19 sites

ICS Proposals

- Number of proposed community hubs with beds: 2



Potential for Delivery of Primary care at Scale, for localities to consider

There is potential for one or two groups of General Practices to deliver services to the population covered by this blueprint, through a reduced number of locations, possible by delivering services as spokes from a Wimborne based community hub. Alternatively there is the possibility for a strengthened federative or super-practice model to deliver all primary care services and, in partnership with other local providers, all Community based services. At scale delivery of Primary Care could potentially be delivered from 5-10 locations.

Poole Central and Poole Bay Primary Care Blueprint

Poole Bay Locality has eight GP practices across nine locations serving a registered population of approximately 74,058 while Poole Central Locality has seven practices across nine locations serving a registered population of approximately 62,475. 18.6% of the Poole Bay registered population and 18.0% of the Poole Central registered population 65-84 years; 4.3% of the Poole Bay registered population and 2.9% of the Poole Central registered population are aged 85 years and over. (Dorset figures are 20.3% and 3.8% respectively), giving both localities a lower than Dorset average age demographic.

Poole Bay and Poole Central have a better average percentage than the England average for smoking related deaths and better than average levels of adult excess weight and physical activity. Rates of sexually transmitted infections and TB are better than average. Rates of homelessness, violent crime, long-term unemployment, drug misuse, early deaths from cardiovascular disease and cancer are all better than average. Estimated levels of adult excess weight and physical activity are better than the England average in both localities.

Within the area covered by this blueprint, community services are delivered out of Parkstone Health Centre, Upton Health Centre and Boots in the Dolphin Shopping Centre.

Localities will be supported to produce their own solutions to local challenges, working in partnership to co-produce a service design to meet local needs.

Existing Workforce

Poole Bay

- WTE GPs: 33.0 → (0.43/1000)
- WTE NPs: 13.7 → (0.18/1000)
- WTE Administration Staff: 67.1 → (0.88/1000)

Existing Workforce

Poole Central

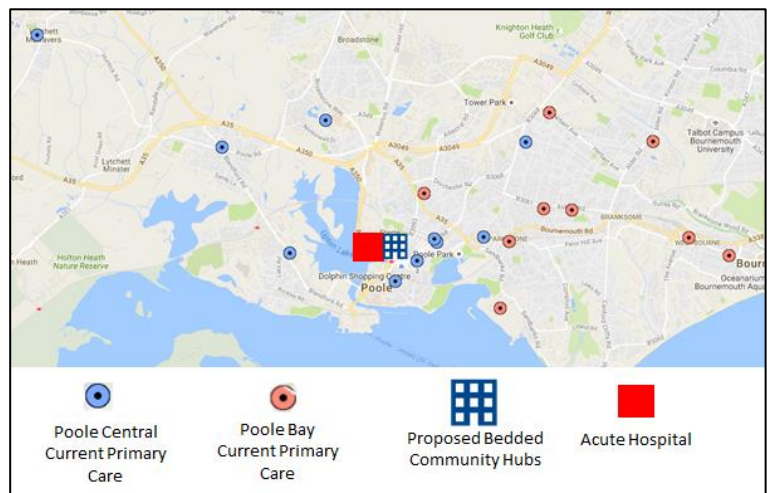
- WTE GPs: 44.1 → (0.71/1000)
- WTE NPs: 20.1 → (0.32/1000)
- WTE Administration Staff: 69.1 → (1.11/1000)

Existing Infrastructure

- There are currently 15 general practices working across 18 sites

ICS Proposals

- Number of proposed community hubs with beds: 1



Potential for Delivery of Primary care at Scale, for localities to consider

There is the potential for one or two general practice groupings to deliver Primary Care services to the population covered by this blueprint, through a reduced number of locations, possibly via a strengthened federative or super-practice model to deliver primary and community care. This could deliver all Urgent Primary Care from an Integrated Community Hub and the hub supported by a network of practices. At scale delivery of Primary Care could potentially be from 4-9 locations.



Purbeck Primary Care Blueprint

Purbeck Locality has six GP practices across six locations and two Community Hospitals serving a registered population of approximately 33,909. 23.7% of the population are aged 65-84 years; and 3.8% of the population are aged 85 years and over (Dorset figures are 20.3% and 3.8% respectively). Purbeck has a wide spread footprint with a balanced semi-rural and semi-urban registered population.

Purbeck has a better average percentage than the England average for smoking related deaths. Estimated levels of adult physical exercise are better than the England average but estimated levels of adult excess weight are worse. Rates of sexually transmitted infections and TB are better than average but new cases of malignant melanoma is worse. Rates of homelessness, violent crime, long-term unemployment, drug misuse, early deaths from cardiovascular disease and cancer are all better than average.

Localities will be supported to produce their own solutions to local challenges, working in partnership to co-produce a service design to meet local needs.

Existing Workforce

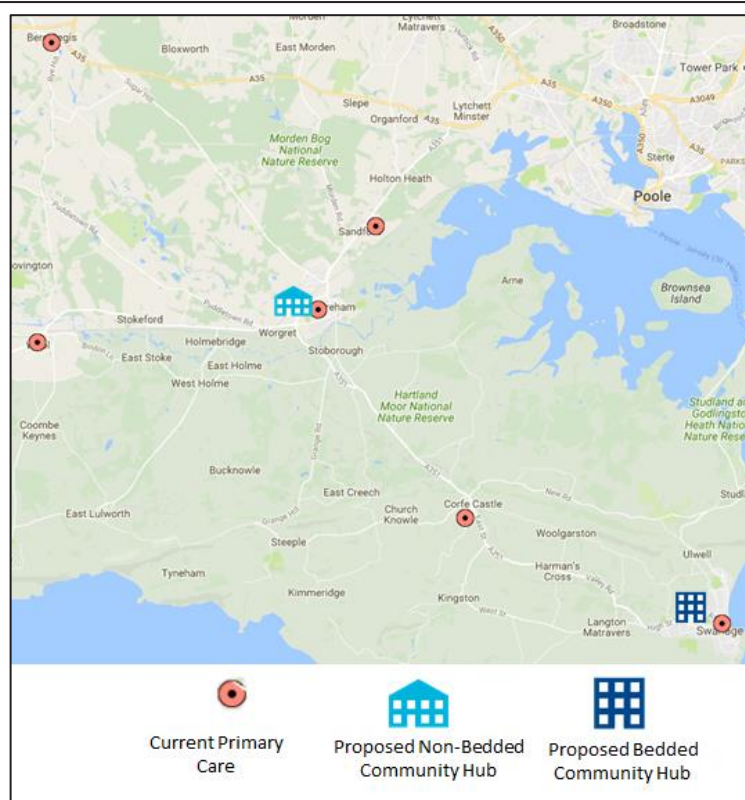
- WTE GPs: 29.6 → (0.75/1000)
- WTE NPs: 10.5 → (0.26/1000)
- WTE Administration Staff: 42.6 → (1.07/1000)

Existing Infrastructure

- There are currently 6 general practices working across 6 sites.

ICS Proposals

- Number of proposed community hubs: 2



Potential for Delivery of Primary care at Scale, for localities to consider

There is the potential for one group of General Practices to deliver services to the population covered by this blueprint and through a reduced number of locations. A number of models could be considered including all Urgent Primary Care delivered by an Integrated Community Hub and the hub supported by a network of practices. A strengthened federative or super-practice model could also be adopted to deliver primary and community care. At scale delivery of Primary Care could potentially be delivered from 2-4 locations.

Mid Dorset Primary Care Blueprint

Mid Dorset Locality has eight GP practices across eleven locations serving a registered population of approximately 43,843. 21.6% of the population are aged 65-84 years; and 3.7% of the population are aged 85 years and over (Dorset figures are 20.3% and 3.8% respectively). Mid Dorset has a balance of town centre practices, along with practices that serve a semi-rural/rural population.

Mid Dorset has a better average percentage than the England average for smoking related deaths and levels of adult obesity. Rates of sexually transmitted infections and TB are better than average but new cases of malignant melanoma is worse than average.

All of the General Practices are members of a federation and have started looking at delivery of current acute services in the community jointly with the Dorset County Hospital and Dorset Healthcare.

Localities will be supported to produce their own solutions to local challenges, working in partnership to co-produce a service design to meet local needs.

Existing Workforce

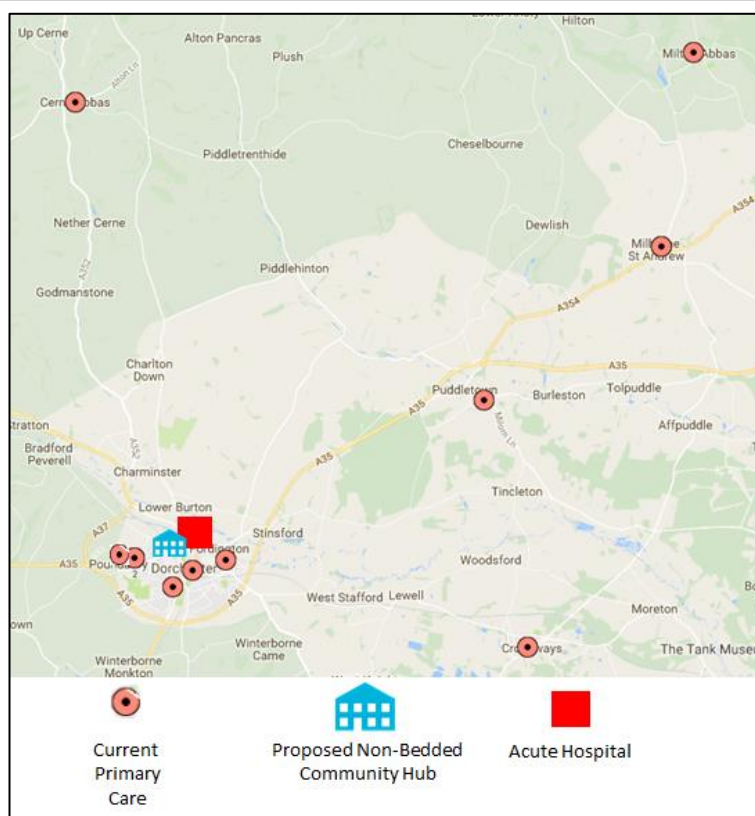
- WTE GPs: 27.9 → (0.66 / 1000)
- WTE NPs: 11.3 → (0.27 / 1000)
- WTE Administration Staff: 45.3 → (1.06 / 1000)

Existing Infrastructure

- There are currently 8 general practices working across 11 sites

ICS Proposals

- Number of proposed community hubs without beds: 1



Potential for Delivery of Primary care at Scale, for localities to consider

There is the potential for a single Primary Care collaboration to deliver all service to the population, through a reduced number of locations, possibly through the delivery of services as spokes from a Dorchester based hub. Alternatively there is the possibility for a strengthened federative or super-practice model to deliver all Primary Care services and, in partnership with other local providers, all Community based services. At scale delivery of Primary Care could potentially be delivered from 4-6 locations.



North Dorset Primary Care Blueprint

North Dorset Locality has nine GP practices across fourteen locations, two Community Hospitals with beds and one Community Hospital with no beds, serving a registered population of approximately 86,882. 21.7% of the population are aged 65-84 years; and 3.8% of the population are aged 85 years and over (Dorset figures are 20.3% and 3.8% respectively). North Dorset has a small number of semi-urban practices, along with practices that serve a rural population.

North Dorset has a better average percentage than the England average for smoking related deaths and levels of adult physical activity. Rates of sexually transmitted infections and TB are better than average but new cases of malignant melanoma is worse than average. Rates of homelessness, violent crime, long-term unemployment, drug misuse, early deaths from cardiovascular disease and cancer are all better than average.

Localities will be supported to produce their own solutions to local challenges, working in partnership to co-produce a service design to meet local needs.

Existing Workforce

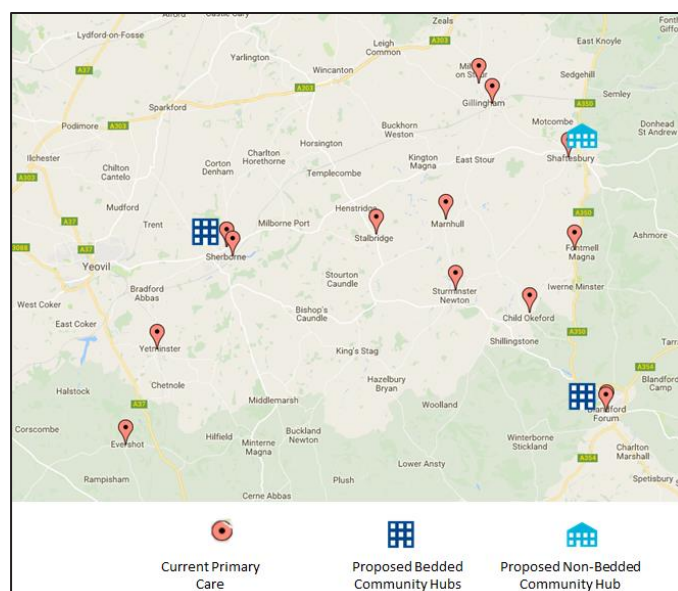
- WTE GPs: 52.1 → (0.49/1000)
- WTE NPs: 30.4 → (0.20/1000)
- WTE Administration Staff: 92.3 → (1.05/1000)

Existing Infrastructure

- There are currently 9 general practices working across 14 sites

ICS Proposals

- Number of proposed community hubs: 3



Potential for Delivery of Primary Care at Scale, for localities to consider

There is the Potential for one or two groups of General Practices to deliver services to the population covered by this blueprint, through a reduced number of locations, possibly via the co-location of Primary and Community services in a number of hub locations in North Dorset. These hubs could then be supported by a strengthened federation, super-practices or network of General Practices. At scale delivery of Primary Care could potentially be delivered from 3-8 locations.

Weymouth and Portland Primary Care Blueprint

Weymouth and Portland Locality has eight GP practices across twelve locations and two Community Hospitals serving a registered population of approximately 75,045. 20.5% of the population are aged 65-84 years; and 3.1% of the population are aged 85 years and over (Dorset figures are 20.3% and 3.8% respectively). Weymouth has a concentrated footprint of practices, some of which are town-based, with the rest serving a semi-rural population.

Weymouth and Portland have a better than average percentage than the England average for smoking related deaths. Estimated levels of physical activity are worse than the England average but estimated levels of adult smoking are better than average. The rate of sexually transmitted infections are worse than average and there are high rates of teenage pregnancies, while the rate of TB is better. The locality also has a number of deprived areas and associated mental health, drug and alcohol health issues. Obesity, particularly in children, is also a priority.

Localities will be supported to produce their own solutions to local challenges, working in partnership to co-produce a service design to meet local needs.

Existing Workforce

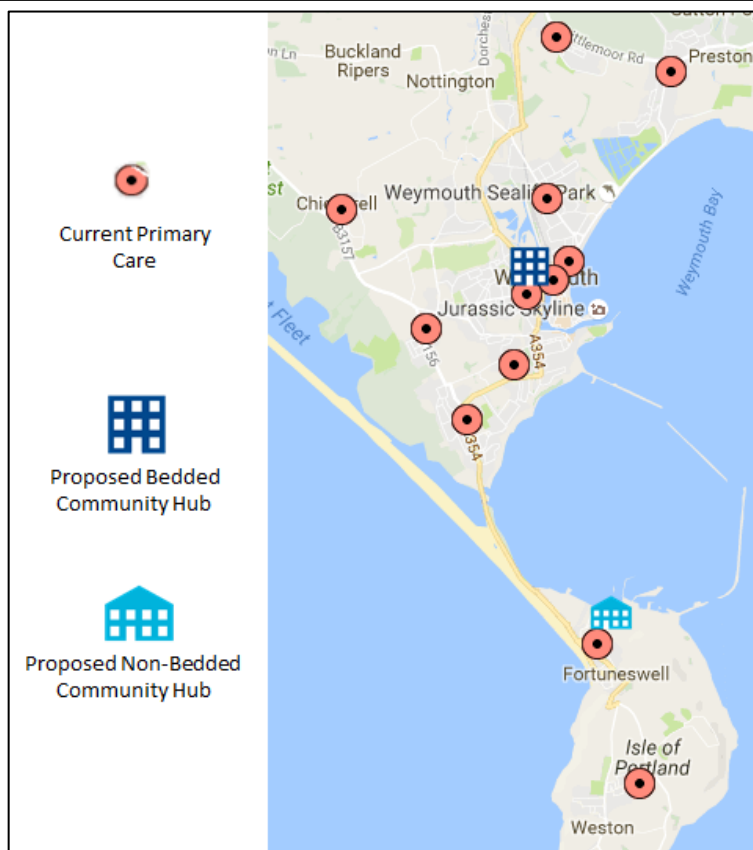
- WTE GPs: 40.4 → (0.61/1000)
- WTE NPs: 25.8 → (0.39/1000)
- WTE Administration Staff: 81.1 → (1.22/1000)

Existing Infrastructure

- There are currently 8 general practices working across 12 sites

ICS Proposals

- Number of proposed community hubs: 2



Potential for Delivery of Primary Care at Scale, for localities to consider

There is the potential for one or two groups of General Practices to deliver services to the population covered by this blueprint, through a reduced number of locations, possibly via a strengthened federative or super-practice model to deliver all Primary Care services and, in partnership with other local providers, all Community based services. This could deliver all Urgent Primary Care from an Integrated Community Hub. At scale delivery of Primary Care could potentially be delivered from 3-6 locations.



West Dorset Primary Care Blueprint

West Dorset Locality has seven GP practices across eight locations and one Community Hospital serving a registered population of approximately 41,187. 27.3% of the population are aged 65-84 years; and 4.7% of the population are aged 85 years and over (Dorset figures are 20.3% and 3.8% respectively), giving a higher than Dorset average age demographic. West Dorset has a widely spread practice footprint serving a ruralised population.

West Dorset has a better than average percentage than the England average for smoking related deaths and levels of adult. The rate of TB is better than average but rates of sexually transmitted infections and new cases of malignant melanoma are worse than average. Rates of homelessness, violent crime, long-term unemployment, drug misuse, early deaths from cardiovascular diseases and cancer are all better than average.

Localities will be supported to produce their own solutions to local challenges, working in partnership to co-produce a service design to meet local needs.

Existing Workforce

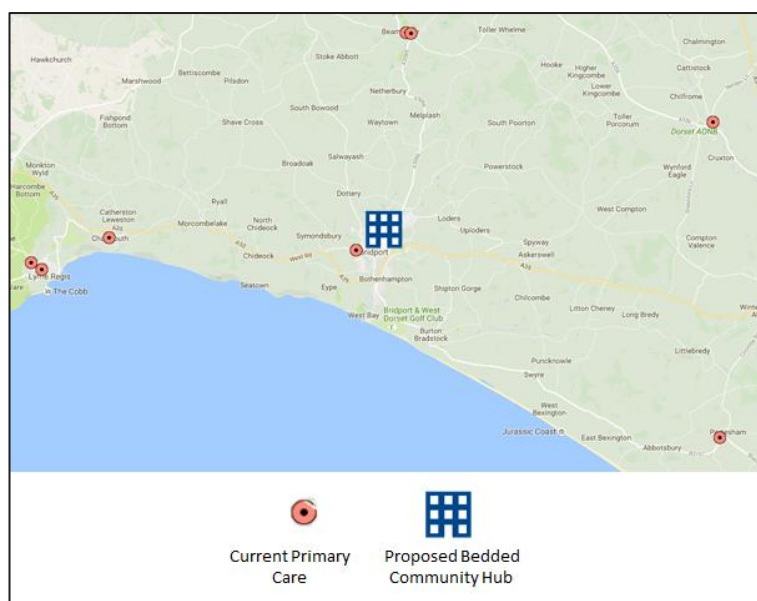
- WTE GPs: 22.0 → (0.53/1000)
- WTE NPs: 13.2 → (0.32/1000)
- WTE Administration Staff: 46.3 → (1.12/1000)

Existing Infrastructure

- There are currently 7 general practices working across 8 sites.

ICS Proposals

- Number of proposed community hubs with beds: 1



Potential for Delivery of Primary Care at Scale, for localities to consider

There is the potential for one group of General Practices to deliver services to the population covered by this blueprint, through a reduced number of locations, either via a strengthened federation, network of practices or super-practice. One possible model is to deliver all urgent primary care services from a single hub location building on the Community Hub model under development at Bridport. At scale delivery of Primary Care could potentially be delivered from 3-5 locations.

ENABLERS

// The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. //

(NHS England, 2014)

Supporting Programmes

Transformation Fund

Dorset CCG has been given the opportunity to submit a business case for a non-recurrent Transformation Fund, from NHS England Wessex. This is a local change programme to support practices that are most ready to start to work together in groups. Successful groups will lead the next stage of development of the Local Blueprints, as well as provide leadership to other practices.

GPFV Programmes

The GPFV makes a series of commitments to support General Practice. NHS England are publishing guidance documents over time to support delivery of these commitments. As described in the Strategic Context/National section (page 12), published so far are the Vulnerable Practice programme, GP Resilience Programme, and part of the GP Development Programme. We are ensuring practices have access to the right programme(s) for their individual current circumstances.

Commissioning and Contracting

To achieve the vision set out in this strategy, alongside a transformed provider landscape, 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).

However, this will not be achieved in one step, therefore while General Practices evolve into new ways of working so will our approach to commissioning.

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.

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 are being designed nationally are **MCPs & PACS**.

Multispecialty Community Provider (MCP)

An **MCP** is what it says it is - a multispecialty, community-based provider, of a new care model; a new type of integrated provider. An MCP combines the delivery of Primary Care and community-based health and care services – not just for planning and budgets. It also incorporates a much wider range of services and specialists (wherever it is best to do). This is likely to mean provision of some services currently based in hospitals, such as some outpatient clinics or care for frail older people as well as some diagnostics and day surgery; it will often mean mental as well as physical health services, and potentially social care provision together with NHS provision.

The building blocks of an MCP are the 'care hubs' of integrated teams. Each typically serves a community of around 30,000 - 50,000 people. These hubs are the practical, operational level



of any model of accountable care provision. The wider the scope of services included in the MCP, the more hubs you may need to connect together to create sufficient scale. All 14 national MCP vanguards now serve a minimum population of around 100,000.

Primary and Acute Care Systems (PACS)

Another delivery mechanism for providing integrated care to a population is by adopting a **PACS** model, now being piloted in a number of areas around the country.

This means a single organisation providing NHS list-based GP and hospital services, together with mental health and community care services. In some circumstances – such as in communities where local General Practice is under strain and GP recruitment is proving hard – hospitals could be permitted to open their own GP surgeries with registered lists. This would allow the investment powers of NHS Foundation Trusts to kick-start the expansion of new style Primary Care in areas with high health inequalities. Safeguards will be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than General Practice simply becoming a feeder for hospitals still providing care in the traditional ways.

At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget – similar to the ACOs that are emerging in Spain, the United States, Singapore, and a number of other countries (GPFV, April 2016).

Outcome Based Commissioning

To enable population based models of care, contracts could have a greater focus on outcomes at population level. Whilst performance accountability will remain to a certain degree, focus will be on the quality of life conditions we want for the identified population.

This could be achieved through working closely with commissioning partners and providers to agree a common language of what the conditions we want look like, how they can be measured and who the partners are that play a key role in delivering these outcomes. This work has already begun through the CSR and ICS programmes.

Performance accountability will be measured by looking at how Providers/ Collaborations can demonstrate that their patients are better off, how they measure if they are delivering services well and how they can demonstrate how well they are doing in addressing the most important of the measures relating to population outcomes.

Workforce

The sustainability of our General Practices in Dorset, in part, rests with the current and future supply of an available, capable and motivated workforce. Our practices are faced with challenges in recruiting staff and our practice staff are faced with increasing pressures in their working environments and may be leaving and retiring as a result. Our General Practices are filled with staff who are passionate about what they do.

We are working to support our General Practices to tackle their workforce challenges. We are doing this in partnership with health and social care organisations across Dorset. This is set out in the Leading and Working Differently Strategy which identifies 4 priority areas:

Development of our leaders and organisations

We will need to adapt as services change and organisational boundaries (to the public) merge. For our staff we must show we are doing this together and with a consistent and clear message.



Recruitment and retention of our staff

We need to work together to ensure we attract new staff whilst ensuring our existing staff stay and work in Dorset.

Developing our staff

We have great development opportunities for staff which we need to make accessible to everyone. We know that we do not always create a clear vision for career development, or always provide the opportunities for staff.

Supporting staff through change

We need to have open, honest and transparent conversations with staff, engaging and involving them in the change.

We have already made great progress to support our General Practices in Dorset.

- With funding from NHS Dorset Clinical Commissioning Group, community vanguards were established. These vanguards have brought practices together to work collaboratively in a range of ways to improve services for people locally
- A Dorset Workforce Plan was produced to help understanding who our staff are, the services they work in, the numbers of staff we employ, where there are staff pressures and challenges to recruit
- The Primary Care Workforce Centre was established, a partnership alliance between Health Education England (Wessex), NHS Dorset Clinical Commissioning Group and Bournemouth University working together to



progress the education, training, workforce and research development in primary care in Dorset. Already, we have created a website (www.doorwaytodorset.nhs.uk) to attract people to work and live in Dorset, and developed a post graduate scheme to launched in the summer of 2016 to retain our newly qualified GPs in Dorset

Estate

Dorset has 131 GP properties delivering services across Dorset. There is a wide variation in utilisation from practices 'bursting at the seams' to community estate with significant underutilisation.

We will work with all of the new practice groupings, localities and community and Local Authority partners to develop plans that will build the General Practice network to provide Primary Care at scale and to deliver new models of care. Options for investment and transformation are beginning to emerge as Local blueprints are developed – including schemes that can provide Primary Care at Scale and others which develop Primary and Community Hubs.

Over the next 5 years we will, in addition to supporting a small number of critical GP practice relocations, continue the development of these schemes utilising the **Estates & Technology Transformation Fund** in collaboration with NHS England, groups of General Practices and other sector partners.

Some surgeries in Dorset have been built specifically as a GP practice while others are converted properties dating back to pre-1970. We have some buildings that are reaching the end of their life and are not going to be suitable to provide the right type of space to enable the right care to be delivered. The current premises reimbursements for the Dorset General Practice estate is in the region of £10.7m per year and we have over 48,000 square meters of space. Some buildings are not being used to

their maximum and we are wasting money.

We need to reduce the number of buildings across primary and community estate by bringing together services under one roof, using the buildings more efficiently and increase their use over 7 days. With new practice groupings, more efficient ways in working and the use of technology, the number of buildings needed across Dorset will be reduced.

Reflecting the development of the Local Blueprints, we will be undertaking locality option appraisals looking at the current use, local population projections, cost and suitability for the future of the estate.

Technology

Harnessing the power of technology with digital innovation is a fundamental enabling programme of work that is essential is allowing us to realise our ambitions for our Prevention at Scale, Primary Care at Scale and Integrated Community Services. Dorset's Digital Vision 2020/21 strategy will:

- Provide more timely access to clear and appropriate patient records, prevention information and advice, and the means to increase self-care
- Implement the Dorset Care Record, a unified record of local people's interaction with services that will better co-ordinate care and make more efficient use of General Practice resources
- Align all of the current GP clinical systems integrating across practices and community providers
- Ensure that diagnostic reports and images are made available to support care decisions
- Ensure transfer of care documents are sent between partners promptly and efficiently

- Extend the use of online record access, SMS texting, email and virtual clinics across all services to support self-management
- Promote mobile working, with extended Wi-Fi in GP practices and across NHS premises supporting new workforce models





Finance and efficiency gap for the Dorset Health System

If we carry on as we are now, we forecast that by 2020/21 our health and care services will have an annual shortage of £158 million a year. This gap will result if we do nothing and health service provision and demand continue to expand at the same rate as the levels seen in recent years.

In this 'do nothing' scenario we would expect costs to increase by at least 4% per annum compared with an expected increase in income of only 2%. On a £1 billion budget this would be £40 million per annum. If we can avoid growing costs at the rate of 4% between now and 2020/21, this would help us close the gap of £158 million.

The changes we propose within the Clinical Services Review aim to use resources as efficiently as possible and the CCG has identified areas of focus to close the financial gap totalling £185 million.

Managing demand through the NHS's Right Care approach: £28 million

The objective of 'Right Care' is to maximise value for money within the NHS. National benchmarking information available under Right Care enables us to compare spending on health in Dorset with other areas in England that have similar population characteristics. This shows that for some operations and treatments, we spend proportionally more than other areas, even when taking into account the makeup of our population. We aim to work with doctors and other health care professionals to understand why we have this variation, and try to find more effective ways of providing care. The data suggests that we could save £28 million in this way. An Important part of this will be improving preventative care to avoid expensive treatments, which can result from conditions such as diabetes.

Secondary prevention and active management: £27 million

By investing more in community and home care, we could minimise the pressure on acute care and avoidable emergency admissions in our hospitals. We have high levels of emergency admissions within Dorset, especially at weekends. Developing alternative ways of caring for people with complex but not life threatening illness could reduce unnecessary admissions to acute hospitals. This is especially so in the case of frail, elderly people who can experience delays in returning home from hospital when medically fit to do so. This would include some of the improvements we are proposing such as step up beds in the community for people who become ill from home, community hubs and seven day services.

Outpatients: £8 million

Through advances in technology and our proposal to move over 100,000 appointments into the community, it should be possible to reduce the level of outpatient services in hospitals.

Acute efficiency savings: £73 million

NHS Hospitals are already expected to make cost improvements each year. This amount to be at least £46 million by 2020/21, and could be described as business as usual savings. The total cost improvement plans in place for 2016/17 acute hospitals in Dorset is worth £25 million.

System Reconfiguration: £30 million

All the local NHS provider trusts including Dorset Healthcare University NHS Foundation Trust (community and mental health services) have an opportunity to share services and network to a much higher level than has previously. Detailed plans are not yet available but the aim will be to match the efficiency savings of £46 million.

The three acute hospitals – Dorset County Hospitals Foundation Trust, Poole Hospitals Foundation Trust and Royal Bournemouth and Christchurch NHS Hospitals Foundation Trust – are jointly reviewing services to see if there is further potential for efficiency gains.

Priority areas within the Acute Vanguard programme are women's health, paediatrics, cardiology, stroke, ophthalmology, non-surgical cancer services, imaging, pathology and IT and payment and accounting services.

Acute reconfiguration: £19 million

The proposed options for major emergency and planned care hospitals in the east of the county would mean fewer operations cancelled fewer delays to discharge, less disruption to services and better staffing levels. This could result in savings of £30 million though additional

economies of scale, improved workforce planning and delivery of patient care at both of these sites. In future all the acute services in Dorset will work in a more integrated way.

Primary Care & Integrated Community Services

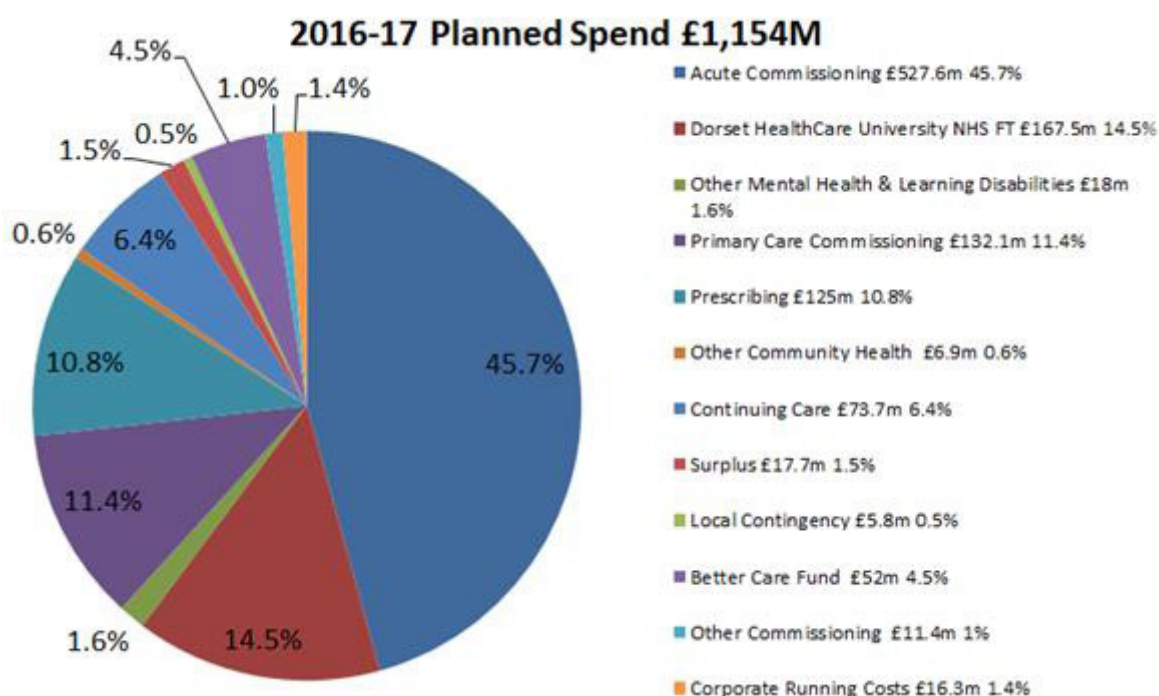
Integrated Community Services forms the middle tier of our Sustainability and Transformation plan (referred to in the Executive Summary, page 4). This programme will transform general practice, primary and community health and care services in Dorset, so that they are truly integrated and based on the needs of our local populations. The CCG has secured £500K from NHS England in 2016/17 non-recurrently to facilitate General Practice transformation and developing the vision.





Current Spend & Primary Care Delegation Growth

The following pie chart outlines how the Clinical Commissioning Group has planned to deploy its funds for 2016/17 in both monetary and percentage terms. Primary Care planned spend of £132.1 million includes both the Primary Care delegated budget from 1st April 2017 as outlined in table one and current CCG commitments for the delivery of local contracts. These local contracts include Over 75 schemes £3.9 million, Clinical Commissioning Local Improvement plan £2.3 million and the reinvestment of the PMS Premium £1.7 million Basket of Services. The CCG also spends a further £125 million for the drugs that General Practice prescribes.



How is the £132.1 million spent?

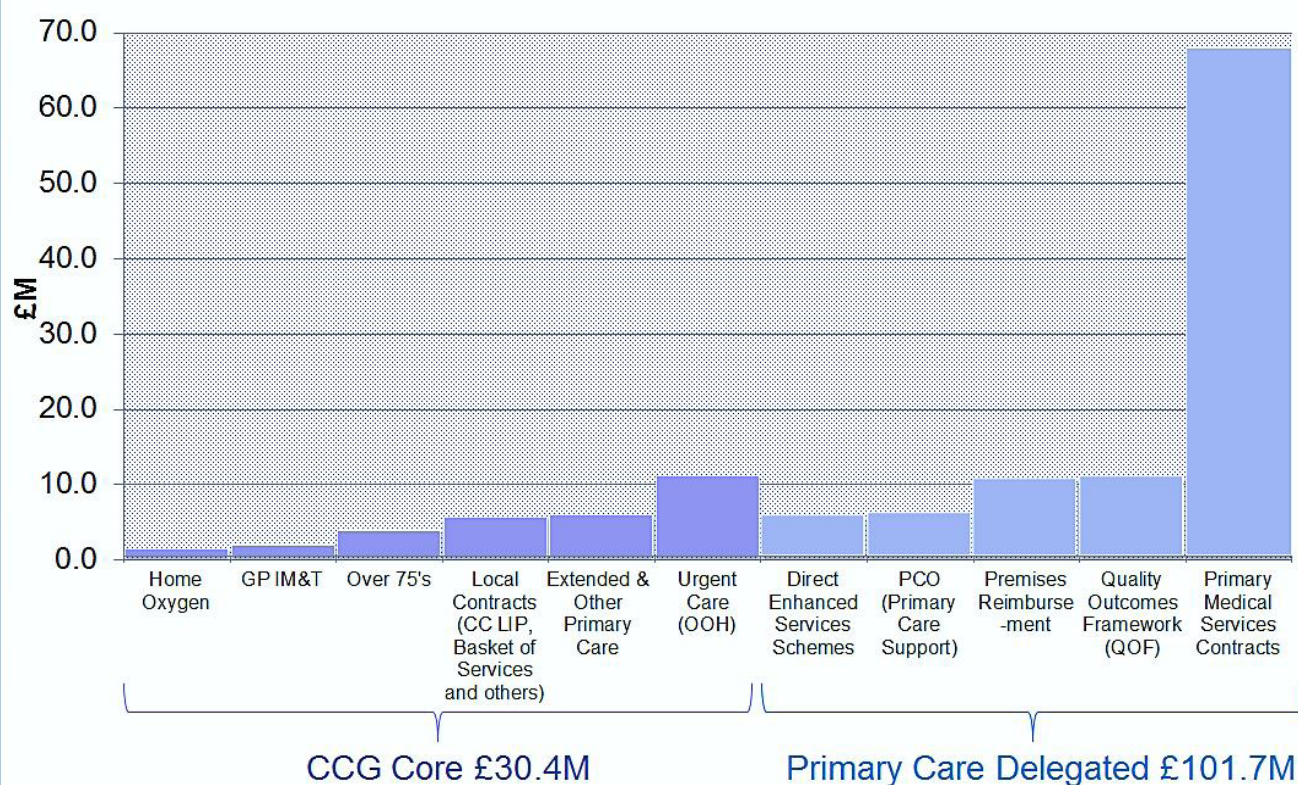
Primary Care planned spend of £132.1 million has been further analysed in the bar chart below. The primary care delegated spend of £101.7 million relates to the contracts in place with General Practice for delivery of Primary Medical Services within GP Practices. The £30.4 million relates to Primary Care services that the CCG has commissioned within Dorset. These can be through local arrangement or nationally directed through 'direct enhanced services'.

Primary Care Commissioning Bar Chart to show split of the £132.1M



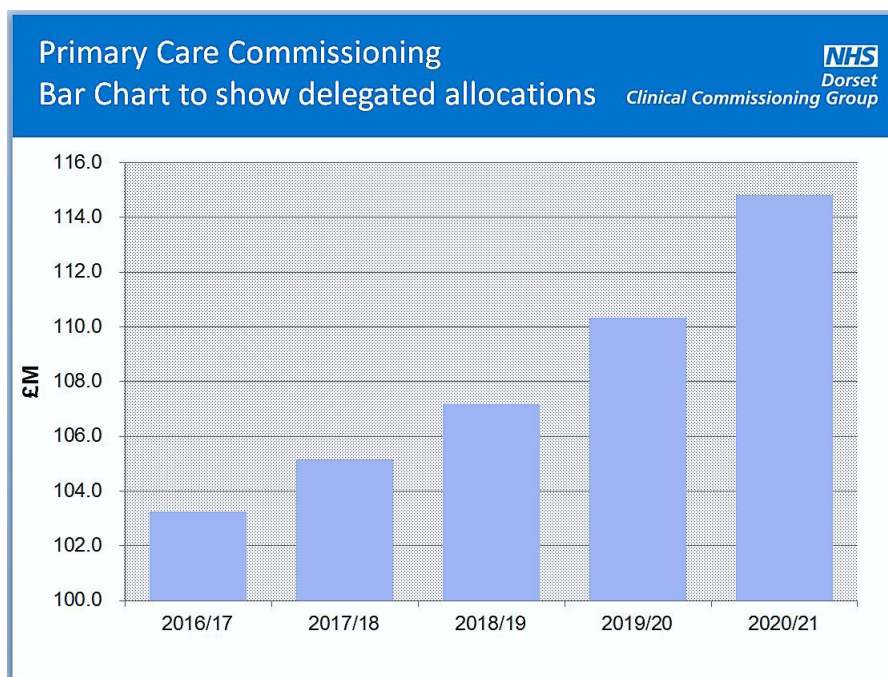
Dorset

Clinical Commissioning Group



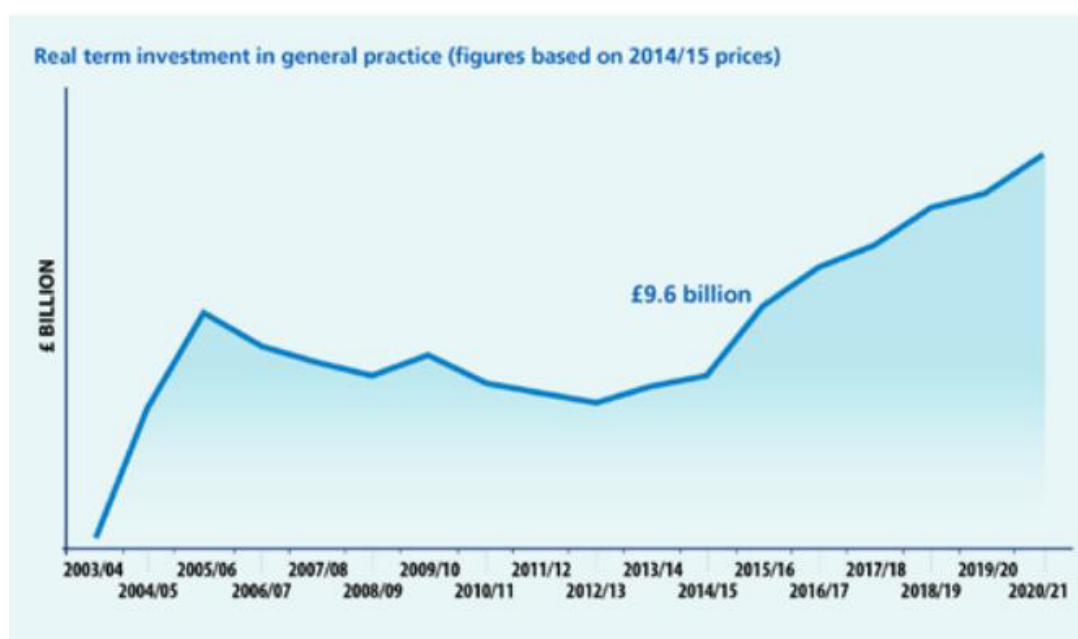
What do Primary Care allocations look like from 2016/17 to 2020/21?

Primary care allocations have been published for the next five years and are shown in the following bar chart. The funding available for Primary Care delegated budgets will rise to £115 million by 2020/21.



General Practice 5 Year Forward View

As described in (Strategic Context/ National, page 12) NHS England published the General Practice Forward View in April 2016. The forward view includes a commitment from NHS England to invest a further £2.4 billion into General Practice by 2020/21. This means that investment will rise from £9.6 billion in 2015/16 to over £12 billion by 2020/21 as shown in the graph below. This represents a 14 percent real terms increase, almost double the 8 percent real terms increase for the rest of the NHS. The specific detail on how this additional investment will be deployed at a CCG level is not currently available.



ANNUAL DELIVERY PLAN FOR YEAR 1: 2016/17

1. Rolling Programme of Engagement

Phase 1: March to September 2016 –
Complete

- **GP Members and Teams**
- **Patients, Carers and Public**

Phase 2: October 2016 to March 2017:

- GP Members and Teams
- Patients, carers and public
- Local Authority and District Councils
- Community Trusts
- Acute Trusts
- Voluntary sector

Practices and CCG to work together to further develop and operationalise the blueprints.

This will include obtaining practice level data for Estates and Workforce.

2. Initiatives for Year 1

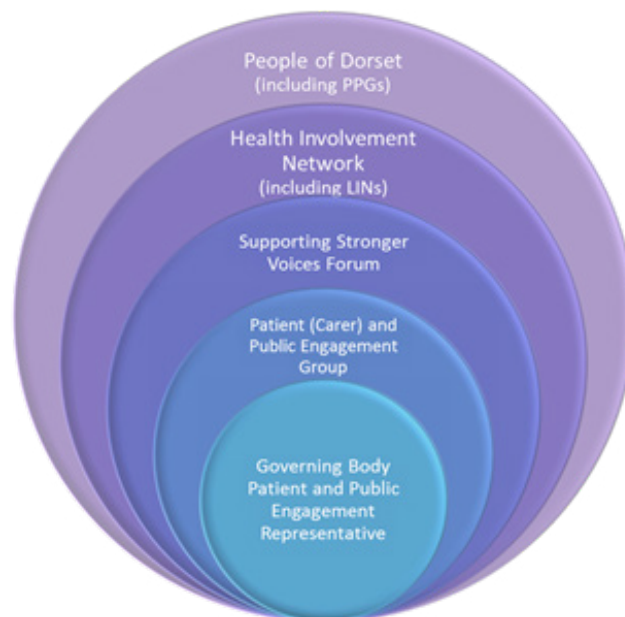
Over the first year of this strategy there are a number of initiatives that we will undertake with Primary Care, working with the ICS strategy, to start to deliver these changes:

- Design the rolling **Annual Programme of Quality** Improvement and set specific standards
- **Prevention Agenda**
- Contract Monitoring and management Process
- Locality Blueprints
- Define the outcomes required for all levels for the GP element of the ICS care models.
- Equality and Impact Assessment

3. Programmes of work to support Sustainability and Transformation

GP Forward View Programmes

- General Practice Resilience Programme (GPRP) – in partnership with practices and



We will continue to work with local people across the groups as illustrated here.

NHS England we will support practices that need to address sustainability.

- Releasing Time for Care - 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.
- Estate and Technology Transformation Programme - stronger GP services are the cornerstone of delivering a new deal for Primary Care. The GPFV has set out the importance of investment in premises and technology to enable transformation in General Practice. This programme will deliver investment to accelerate the development of infrastructure to enable the improvement and expansion of joined-up out of hospital care for patients.

Wessex Change Programme

- In Dorset, to achieve the change in organisational form required, we will support groups of practices working together to deliver Primary Care at Scale.



We will ensure we work in line with the framework for patients and public participation in Primary Care Commissioning.

We will ensure:

- The needs of under-represented and 'seldom heard' groups are particularly considered in respect of Primary Care
- Patient and public participation is considered at all stages of the commissioning cycle (planning, buying and monitoring health and care services)
- We work in partnership with NHS England as well as other Commissioners and providers to make Primary Care services joined up and effective for patients and the public
- We consider the need for – and best approach to participation depending on the situation, the population in question, and existing sources of information and insight. These sources may be national, regional or local
- We keep good records of our approach to participation including how we have assessed the legal duty to involve the public in commissioning. (NHS England commissioners are required to document their assessment of whether Section 13Q (the legal duty to involve the public in commissioning) applies using the standard form available on the NHS England intranet)
- We plan for participation – including identifying benefits (with measures of impact where appropriate) and costing participation activity. Participation plans need to be factored in to overall business planning and programme planning
- We involve people early on, not as an afterthought
- We involve people in ways that are appropriate to their needs and preferences, and provide them with the necessary information, resources and support to enable them to participate
- We work with partners in involving people, including other commissioners, providers, Patient Participation Group (PPG) networks, Healthwatch, and the voluntary and community sectors
- We feed back to those we have involved about the impact of their participation, explaining how it has influenced commissioning, and if not, why not
- We document and report on participation activities and impact for assurance and quality improvement purposes, publicising and celebrating success and sharing learning

GLOSSARY OF TERMS

ACO	Accountable Care Organisations
BMA	British Medical Association
BMJ	British Medical Journal
CCG	Clinical Commissioning Group
CCLIP	Clinical Commissioning Local Improvement Plan
CHD	Coronary Heart Disease
CLT	Clinical Leadership Team
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CSR	Clinical Services Review
DCR	Dorset Care Record
ENT	Ear, Nose and Throat
FYFV	Five Year Forward View
GP	General Practice/Practitioner
GPC	General Practitioner Committee
GPDP	General Practice Development Programme
GPFV	General Practice Forward View
GPRP	General Practice Resilience Programme
GPwSI	GP with a Specialist Interest
HCA	Health Care Assistant
HSCiC	Health and Social Care information Centre
ICS	Integrated Community Services
IM&T	Information Management and Technology
LIN	Locality Involvement Network
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LTC	Long Term Condition
MCP	Multi-speciality Community Provider
MDT	Multidisciplinary Team
NP	Nurse Practitioner
OOH	Out Of Hours
PACS	Primary and Acute Care System
PCaS	Primary Care at Scale
PCCC	Primary Care Commissioning Committee
PCO	Primary Care Organisation
PCOG	Primary Care Operational Group
PMS	Personal Medical Services
PPEG	Patient and Public Engagement Group
PPG	Patient Participation Group
PCRG	Primary Care Reference Group
QOF	Quality Outcomes Framework
RCGP	Royal College of General Practitioners
RPS	Royal Pharmaceutical Society
STP	Sustainability and Transformation Plan
SEP	Strategic Estates Plan
TB	Tuberculosis
VPP	Vulnerable Practice Programme
WTE	Whole Time Equivalent

ACKNOWLEDGEMENTS AND REFERENCES

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The patients and public of Dorset
Dorset CCG member practices
Dorset CCG Governing Body members
NHS England
Wessex Local Medical Committee
Local Pharmaceutical Committee

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