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Agenda

Dorset County Council

Meeting:	Dorset Health Scrutiny Committee
Time:	10.00 am
Date:	21 December 2016
Venue:	Council Chamber - County Hall, County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ

Ronald Coatsworth (Chairman)	Dorset County Council
Bill Batty-Smith (Vice-Chairman)	North Dorset District Council
Ros Kayes	Dorset County Council
Paul Kimber	Dorset County Council
Mike Lovell	Dorset County Council
William Trite	Dorset County Council
David Jones	Dorset County Council
Tim Morris	Purbeck District Council
Peter Shorland	West Dorset District Council
Colin Jamieson	Christchurch Borough Council
Peter Ogglesby	East Dorset District Council
Alison Reed	Weymouth and Portland Borough Council

Notes:

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- **Public Participation**

  Guidance on public participation at County Council meetings is available on request or at http://www.dorsetforyou.com/374629.

  Public Speaking

  Members of the public can ask questions and make statements at the meeting. The closing date for us to receive questions is 10.00am on 16 December 2016, and statements by midday the day before the meeting.

Debbie Ward
Chief Executive

Contact: Jason Read, Democratic Services Officer
County Hall, Dorchester, DT1 1XJ
01305 224190 - j.read@dorsetcc.gov.uk

Date of Publication:
Tuesday, 13 December 2016

1. **Apologies for Absence**

To receive any apologies for absence.

2. **Code of Conduct**

Councillors are required to comply with the requirements of the Localism Act 2011 regarding disclosable pecuniary interests.

- Check if there is an item of business on this agenda in which the member or other relevant person has a disclosable pecuniary interest.
- Check that the interest has been notified to the Monitoring Officer (in writing) and entered in the Register (if not this must be done on the form available from the clerk within 28 days).
- Disclose the interest at the meeting (in accordance with the County Council's Code of Conduct) and in the absence of a dispensation to speak and/or vote, withdraw from any consideration of the item.

The Register of Interests is available on Dorsetforyou.com and the list of disclosable pecuniary interests is set out on the reverse of the form.

3. **Minutes** 3 - 8

To confirm and sign the minutes of the meeting held on 14 November 2016.

4. **Public Participation**

   (a) Public Speaking

   (b) Petitions

5. **Draft Primary Care Commissioning Strategy and Plan** 9 - 72

To consider a report by NHS Dorset Clinical Commissioning Group.

6. **Briefings for Information / Noting** 73 - 82

7. **Questions from County Councillors**

To answer any questions received in writing by the Chief Executive by not later than 10.00am on 16 December 2016.

Dorset Health Scrutiny Committee

Minutes of the meeting held at County Hall, Colliton Park,
Dorchester, Dorset, DT1 1XJ on Monday, 14 November 2016

Present:
Ronald Coatsworth (Chairman)
Bill Batty-Smith (Vice-Chairman), Ros Kayes, Paul Kimber, Mike Lovell, William Trite,
David Jones, Tim Morris, Peter Shorland and Peter Oggelsby.

Officer Attending: Ann Harris (Health Partnerships Officer), Jason Read (Democratic Services Officer), Helen Coombes (Interim Director for Adult and Community Services) and Patrick Myers (Assistant Director - Design and Development).

Others in Attendance:
Simon Williams (Chairman of the Hughes Unit Group Supporters), Nick Johnson (Director of Strategy and Business Development, Dorset County Hospital NHS Foundation Trust), Vaughn Lewis (Clinical Director for NHS England Specialised South), Caroline Hamblett (Chief Executive Weldmar Hospicecare Trust), Sally O'Donnell (Dorset Healthcare University Foundation Trust),, Vanessa Reed (NHS Dorset Clinical Commissioning Group), Sally Sheed (NHS Dorset Clinical Commissioning Group) and Dr Phil Richards (NHS Dorset Clinical Commissioning Group).

(Notes: These minutes have been prepared by officers as a record of the meeting and of any decisions reached. They are to be considered and confirmed at the next meeting of the Cabinet to be held on **Wednesday, 21 December 2016**.)

Apologies for Absence
43 An apology was received from Alison Reed (Weymouth and Portland Borough Council).

Code of Conduct
44 There were no declarations by members of disclosable pecuniary interests under the Code of Conduct.

Minutes
45 The minutes of the meeting held on 6 September 2016 were confirmed and signed.

Public Participation
46 Public Speaking
There were no public questions received at the meeting in accordance with Standing Order 21(1).

Mr Williams (Chairman of the Hughes Unit Group Supporters), addressed the Committee in relation to specific points arising from the Care Quality Commission report. He raised concerns over RIO, the record keeping software used by Dorset County Hospital, and suggested that the system was not fit for purpose.

Petitions
There were no petitions received at the meeting in accordance with the County Council's Petition Scheme.

Dorset County Hospital Strategy
47 The Committee received a presentation by the Director of Strategy and Business Development, Dorset County Hospital NHS Foundation Trust, which outlined Dorset County Hospital's (DCH) organisational strategy.

The Strategy had been developed to take account of and align to the Dorset Clinical Services Review and the Dorset Sustainability and Transformation Plan. It was focussed around delivering the right outcomes for patients so that safe and high quality healthcare would continue to be provided as close to communities as possible. The purpose was to deliver compassionate, safe and effective healthcare.

Members raised concerns over the lack of information in the report. It was recognised that whilst the overall aims of the strategy were sensible, the Committee would need to receive specific details in order to properly scrutinise it, in particular information around travel contingencies for elderly patients in the more rural parts of the County. It was noted that the report did not contain any detail around the changes that would be made or how they would impact on the day to day service delivery. It was agreed that once the specific detail had been developed, a report would be presented to the Committee so that they may scrutinise the proposed plan.

Noted.

Safe and Sustainable Neonatal Services at Dorset County Hospital - Re-Designation.

48 The Committee considered a report by Service Specialist, Specialised Commissioning – NHS England South. The report outlined the aims of the new arrangements for Neonatal Services. It was noted that the changes outlined in the report were not a consequence of criticism of the current services. However, it was felt that the changes were required to ensure safe and sustainable delivery of those services in the future.

The report highlighted the current Neonatal Services' arrangements and outlined the background and evidence supporting the change in the level of neonatal provision at Dorset County Hospital and described the proposed options for the Neonatal service re-designation. It was noted that there were not sufficient staffing resources available to sustain the current model of service delivery.

Members were concerned that if services at Dorchester were staffed and run by midwives, the new arrangements could potentially mean any babies born at Poole Hospital would then have to remain there until they were ready to go home which would cause issues for families residing at some distance from Poole. It was clarified that there was no intention for the Dorchester unit to be midwife run and that it would continue to be staffed by neonatal nurses and covered by on call paediatric staff and consultants.

Members were also concerned about the availability of ambulances to transfer patients to Poole and the potential risks of delivery en-route. Reassurance was given that these matters had been considered and plans to mitigate risk put in place.

The Clinical Director confirmed that he would be happy to meet with the Kingfisher Ward campaign group and Members of the Committee, should they wish.

Noted.

Weldmar Hospicecare Trust Quality Account for 2015/16

49 The Committee considered a report by the Chief Executive of Weldmar Hospicecare Trust which highlighted the quality accounts for 2015/16. It was produced as a statutory requirement as Weldmar received funds from the NHS and also helped the users of the services and other stakeholders to see how they worked to improve the services provided.

The Committee received a presentation that highlighted the work that Weldmar did and the services they provided. The Chief Executive informed the Committee that the majority of feedback about their services was positive and complimentary. However it

was noted that negative feedback was rarely given as families of patients did not wish to appear ungrateful. To ensure that any and all required improvements could be made, Wedlmar were working closely with families and patients to implement improvements wherever possible.

The Committee formally congratulated Weldmar on receiving an outstanding rating from the Care Quality Commission (CQC). It was noted that it was rare to receive such a positive rating and it was a remarkable achievement that Weldmar had managed to do so.

Members raised concerns over available finances and how Weldmar could sustain services if donations and funding streams started to reduce. The Chief Executive confirmed that income had always been unreliable and Weldmar were always looking at different ways to deliver more cost effective and sustainable services.

Noted.

Dorset Healthcare University Foundation Trust CQC March 2016 inspection

50 The Committee Considered a report by Dorset Healthcare University Foundation Trust which provided an update on progress with the Quality Improvement Plans for Dorset Healthcare addressing the findings for the sixteen core services from the CQC comprehensive inspection as well as the re-inspection of seven core services in March 2016.

The Committee raised concerns over negative feedback received in regards to the current record keeping systems being used. It was clarified that the systems now in place were much better than the previous ones and clinicians found them easier to work with than any other software available. Issues had occurred in the way in which different staff used the system, but a more consistent approach was now being implemented.

Some councillors raised concerns with the criticism of Mental Health Services and in particular that they had not seen any improvement to services for several years despite concerns being raised on numerous occasions. It was clarified that interim changes had now been made to the Senior Leadership Team and all Mental Health Services had been bought back under single leadership in an effort to try and apply a consistent approach for all services.

Noted.

Joint Health Scrutiny Committee re Clinical Services Review - Update

51 The Committee considered a report by the Interim Director for Adult and Community Services which provided an update on the Joint Health Scrutiny Committee - Clinical Services Review following the last meeting of the Committee held in October.

Further meetings of the Joint Health Scrutiny Committee would need to be established towards the end of the CCG’s formal 12 week public consultation period, to formulate a response from the Committee and to review the process after the consultation had ended. In order that stakeholders’ views could be considered prior to the formulation of a response to the consultation, it was suggested that an Inquiry Day be arranged depending on the CCG timescales.

Some councillors suggested that a Task and Finish Group be established to look at the matter in further detail. The Chairman agreed to consider establishing a group at a later date, depending on the outcome of the inquiry day.

Resolved
1. That members agree to the setting up of an Inquiry Day to coincide with the public consultation to be launched by the CCG.

Continuing Healthcare

52 The Committee considered a report by NHS Dorset Clinical Commissioning Group which outlined NHS Continuing Healthcare, what is was and the patients who required these packages of care. The report highlighted budget information in addition to statistics relating to service users.

A steering group had been established to look at various different ways of improving care packages in a more cost effective and patient friendly way. The actions from the last meeting of the steering group were included in the report.

Members queried the reduction in the number of individuals receiving Continuing Healthcare funding and the appeals process. Concern was also expressed regarding delays in the process and the impact this has on families. It was noted that there has been an increase in people with very high cost packages and that work is being undertaken to look at the care market and cost of placements.

Noted.

Briefings for Information/Noting

53 The Committee considered a report by the Interim Director for Adult and Community Services which contained Dorset County Hospital's Quality Account Update, Dorset Health Scrutiny Committee's Forward Plan and the Director of Public Health's Annual Report 2016.

Noted.

URGENT ITEM - Dorset Clinical Commissioning Group's Draft Primary Care Commissioning Strategy and Plan

54 The Committee considered an urgent item that related to Dorset Clinical Commissioning Group's Draft Primary Care Commissioning Strategy and Plan.

On 6 September 2016 Dorset Health Scrutiny Committee received a report by NHS Dorset Clinical Commissioning Group regarding changes to General Practice Commissioning and Locality Working. The report outlined the changes to commissioning arrangements and the pressures on services and noted that a Primary Care Commissioning Strategy was being developed and would be presented to the Primary Care Commissioning Committee (PCCC) in October 2016. Members agreed that they would like to receive a further report regarding the Strategy at their meeting in March 2017. However, the publication of the Draft Primary Care Commissioning Strategy in October 2016 had raised concerns as to the nature and scale of changes being suggested within 'blueprints' for each Locality, in addition to concerns about the degree to which such changes had been subject to consultation and public engagement.

The CCG clarified that what had been published on the website was a draft and not a final proposal. It was made clear that no decisions had been made and no changes had yet been implemented. The draft was currently being debated by General Practitioners and the 'blueprints' in the draft were based on national standards. The draft document had been published for discussion and not decisions.

Resolved
That the Committee, considering the draft Primary Care Commissioning Strategy:-
1. Evaluates the proposed changes as a major change and thus subject to intervention by the Dorset Health Scrutiny Committee.

2. Makes the CCG aware of the Committee's deep regret and displeasure that the CCG did not itself so identify the matter as such and bring it fully to DHSC at an earlier stage.
3. Believes that the proposed changes could have a devastating effect on rural communities and in areas with a high concentration of elderly people and therefore require further and intensive scrutiny, and to provide for discussion at this meeting a plan for appropriate consultation with the public as required by the Section 242 (18) of the National Health Service Act 2006.
4. Requires therefore that the CCG provide a formal report and send a representative(s) to a special meeting of the Committee to be held within one calendar month of today's date.
5. Requires that the CCG take no irreversible decisions in this matter until after the special meeting.

Questions from County Councillors

55 No questions were asked by members under standing order 20(2).

Meeting Duration: 10.00 am - 12.45 pm.

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	21 December 2016
Officer	Sally Sandcraft, Deputy Director of Service Delivery
Subject of Report	**Primary Care Commissioning Strategy and Plan 2016 – 2020/21**
Executive Summary	This is a five year strategy to provide a framework to inform the development of local delivery models, which will be developed through working collaboratively with Practices, and engaging with local people. 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 to care. 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. This national guidance and supporting programmes, coupled with our new decision making powers, gives us a fantastic opportunity to address these difficult challenges and transform primary care.
Impact Assessment:	Equalities Impact Assessment: Yes
	Use of Evidence: NHS England General Practice Forward View April 2016

	Budget: Additional investment in primary care from CCG core allocation and further NHS England investment in access to primary care from 2018.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: The CCG operate a risk assessment process. The risks associated with General Practice are reflected in the CCG Corporate Risk Register.
	Other Implications: (Note: Please consider if any of the following issues apply: Sustainability; Property and Assets; Voluntary Organisations; Community Safety; Corporate Parenting; physical activity; or Safeguarding Children and Adults.)
Recommendation	The Committee is asked to note the contents of this report.
Reason for Recommendation	This paper is presented in response to a request from the Committee.
Appendices	Draft Primary Care Commissioning Strategy and Plan 2016 – 2020/21
Background Papers	None
Officer Contact	Name: Sally Sandcraft Tel: 01202 541468 Email: sally.sandcraft@dorsetccg.nhs.uk

Sally Sandcraft
Deputy Director of Service Delivery
5 December 2016

1. Introduction

1.1 The Draft Primary Care Commissioning Strategy and Plan is designed to be implemented over a 5 year period aligning to the GP 5 Year Forward View plan, Our Dorset Sustainability and Transformation Plan and the Dorset Integrated Community Services Strategy.

1.2 The key messages in the document are highlighted in the Executive Summary and describe a vision where General Practice continues to be the foundation of the health system, maintaining its position as the leaders of primary care, retaining its identity and registered list. To enable General Practice to build on its strengths and past successes the Strategy recognises, in line with NHS England GP Forward View, that this will only be achieved by working in new ways and in larger General Practice groups to achieve sustainability. It involves redesigning care around the health of the population, irrespective of existing institutional arrangements.

1.3 The need for General Practice to work at scale to meet local population health need does not mean that practices will have to close but it is likely that practices will increasingly work together to deliver care across local communities, pooling resources and building a shared integrated workforce. This will need to address the significant workforce challenges that practices face and mean that practices are likely to have to work in different ways in order to deliver the care their whole population needs, focussing on prevention, redesigning care and improving health and wellbeing.

1.4 This Strategy has been produced following a period of engagement between June and October 2016 with GP Members and their teams, Practice Managers, CCG clinicians and managers, patients and the Local Medical Committee. This engagement period built on previous engagement work to inform the Integrated Community Services models of which General Practice forms a key part. It has also been shared at various stages of development with the GP Membership and the Dorset CCG Governing Body.

2. Designing and Delivering Care Locally

2.1 The Strategy does not specify significant service changes for primary care, however recognises the challenges facing General Practice means that practices will need to adapt and transform to be able to deliver improved access, and sustain and improve quality services , through engaging in the delivery of new models of care.

2.2 The CCG is committed to working with localities to co-develop local blueprints that the document starts to describe and will facilitate a programme of engagement within local communities.

2.3 As ‘local blueprints’ for care are developed there may be proposals for changes to the way primary care is delivered in the local area. At this stage there would be a period of engagement with the local population or if required, subject to the level of change being proposed, formal public consultation.

2.4 We have engaged with patient representatives to inform our Strategy. We have heard how patients have different needs and different expectations. Some patients are looking for quicker access to care, perhaps where their health care needs are simpler to treat; others with more complex needs seek continuity of care and may be willing to wait longer to see the clinician of their choice. Patients also said they want to have a named health care professional and feel that this person can help them access the wider team.

2.5 The Strategy recognises the case for change, that General Practice needs to be able to respond to increasing demand – related to an ageing population and more people living with long term health conditions. This is accompanied by rising patient expectation and the responsibility to ensure the varying needs of all registered patients are supported. There is a need to work with patients to help them to access the care they need but also to encourage patients to help themselves – supporting them to access a range of help; navigate services and avoid repeated appointments for the same problem.

2.6 The Strategy supports General Practice as the cornerstone of the NHS – but recognises that General Practice is under pressure. As Simon Stevens, Chief Executive of NHS England said: “If General Practice fails the NHS fails”. There is a need for General Practice to work at scale if it is going to continue to be able to respond to need. This will make it more resilient and able to respond to the needs of local populations, addressing the challenges associated with the increasing complexity of care need (through more multi-professional team working) and the NHS workforce recruitment and retention challenges – needing to skill mix teams and bring in new roles – such as care navigators, clinical pharmacists and allied health professionals.

2.7 General Practice provider development needs to be an integral part of this Strategy, recognising that General Practitioners are independent contractors running their own businesses. In order to be able to respond to the changing needs of the community and address workforce and financial challenges they will need support to adapt. Part of this will mean a period of provider development to support practices working together to better address population health needs in local communities, to co-produce local blueprints for care and plans to transform the way care can be delivered – so that General Practice is sustainable and can continue to respond effectively to local needs.

3. Developing General Practice as part of a Future Health Care Model

3.1 We need to continue to develop General Practice to ensure patients get a good experience and good care outcomes no matter where they are registered across Dorset and that health care resources are used well.

3.2 The Strategy supports the local delivery of new care models. The proposed care models is an approach to risk stratifying need in populations and changing the way care is delivered – whilst maintaining the advantages of continuity of care provided by patients being registered with a named GP or group practice. Under the new care models teams will be developed that can better respond to the needs of different population groups – for example those wanting same day access for self-limiting conditions and those that would benefit from a multidisciplinary team supporting them with managing their long term condition.

3.3 As part of the work to implement new care models, the Strategy recognises the challenges that General Practice faces. It commits to providing a development programme (GP Forward View Delivery Plan) which strengthens the General Practice workforce, addresses workload challenges, enables General Practices to work in local communities to sustain and transform care models to better meet local needs, to invest in access to General Practice including new technology and infrastructure improvements. Many GPs own their own premises, but an increasing number are leaseholders; the Strategy needs to work with groups of General Practices to look at the best way to deliver services and with local communities to consider what this means for how services are configured and delivered to maintain access and high quality care.

3.4 Our intention is to take the Primary Care Commissioning Strategy to the CCG Governing Body in January for approval.

4. Recommendation

4.1 The Committee is asked to note the Draft Dorset Primary Care Commissioning Strategy and Plan and the next steps in the development of the local delivery models, which will be developed through working collaboratively with Practices, and engaging with local people.

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NHS
Dorset
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING STRATEGY AND PLAN

2016 -2020/21

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FOREWORD

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).

This is a five year view seeking and engagement Strategy to inform the development of proposals for future models, working collaboratively with Practices. It is not a consultation on service changes.

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 to care. 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

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EXECUTIVE SUMMARY

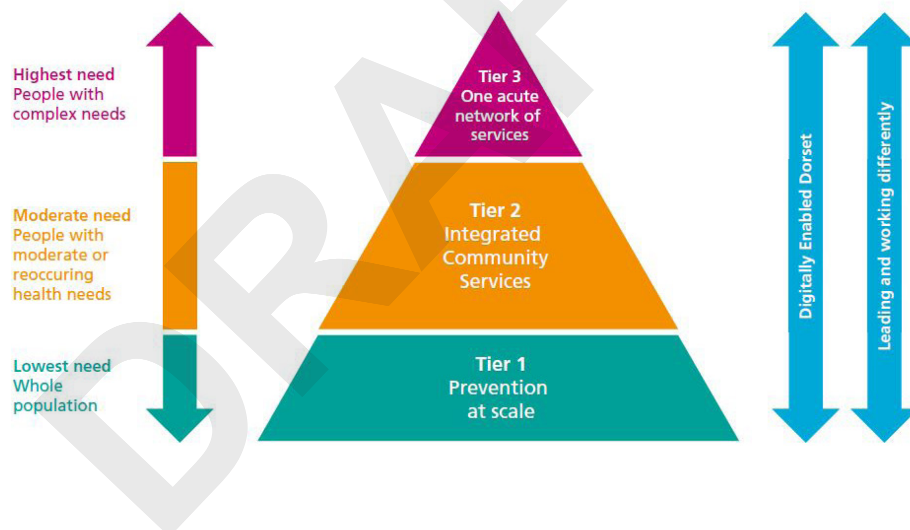
This Primary Care Commissioning Strategy facilitates delivery of our developing Sustainability and Transformation Plan (STP). This Strategy supports delivery of Tiers one and two:

Our three programmes of work

1. the Prevention at Scale programme will help people to stay healthy and avoid getting unwell
2. the Integrated Community Services programme will support individuals who are unwell, by providing high quality care at home and in community settings
3. the One Acute Network programme will help those who need the most specialist health and care support, through a single acute care system across the whole county

Supported by two enabling programmes:

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



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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 and in partnership with local voluntary and community groups 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).

Primary care is an integral part of the current drive within the Sustainability and Transformation Plan to develop modern integrated community services, that go beyond service integration and begin to consider how best to develop place-based models of care that consider the needs of whole populations, not just the needs of the highest risk or most costly patients. According to the King's Fund report on Population Health Systems, going beyond Integrated Care, the following three points are essential:

- considering the whole population's health and well-being needs, ensuring incentives are aligned to support improving outcomes for whole populations, including across organisations and budgets;
- ability to offer consistent early, evidence-based support for prevention interventions before the development of chronic diseases, including social interventions such as housing or benefits advice;
- thinking beyond integration of community health professionals to integration that considers the impact of the wider local environment, including promoting physical activity, access to green space, higher value jobs and work, and access to quality education and training opportunities.

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.

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 November 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.

General practices working in groups, at scale, will provide an opportunity to focus on population health, providing both continuity of care and better access. Where there are proposed changes to the delivery of General Practice in the future, the commission strategy will seek to work with groups of General Practices in the future, the commission strategy will seek to work with groups of General Practices to ensure continued local access to services. This may include looking at innovative new ways to deliver services in partnership with local communities especially in areas where the needs of rural and isolated communities need to be addressed.

Practices working in collaboration may begin to form practice networks to deliver care increasing joint working, developing shared teams and infrastructure, co-producing plans to improve health in partnership with local communities, health, social and voluntary organisations. How this looks will differ from area to area, communities and patients will need to be involved in developing the way in which new care models will be delivered to reflect local need.

Some initial work has been done to start to think about what this could mean for localities, which will inform the development of local blueprints. These will be produced using local intelligence and feedback from the local engagement.

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We would now like to work with groups of practices and local stakeholders between November 2016 and March 2017, to 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. Local planning should ensure access to high quality patient care is maintained and enhanced as part of any new care model design.

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 Workforce, 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 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 with consistent quality and improved outcomes throughout Dorset.

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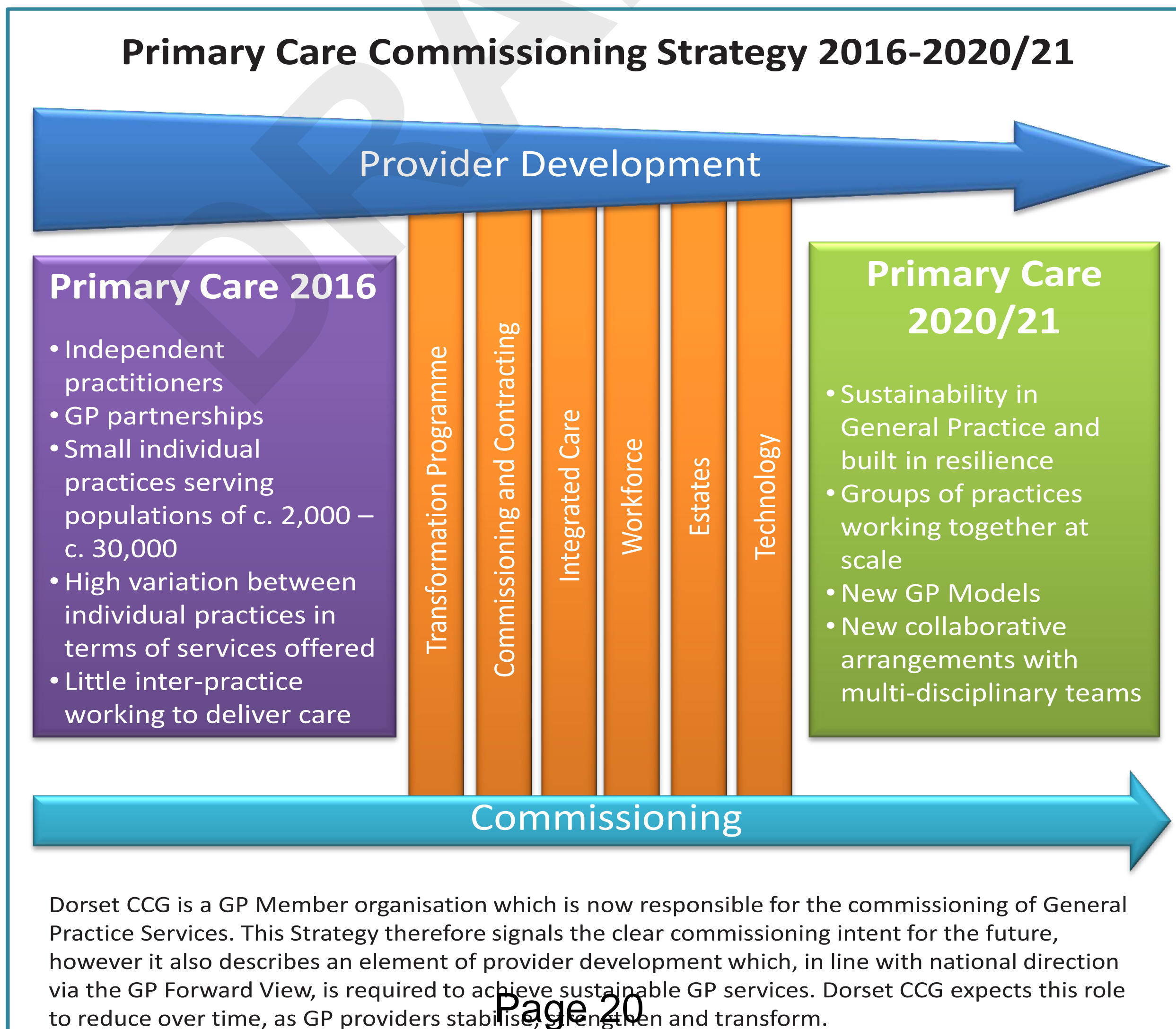

Dorset CCG is a GP Member organisation which is now responsible for the commissioning of General Practice Services. This Strategy therefore signals the clear commissioning intent for the future, however it also describes an element of provider development which, in line with national direction via the 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 tackling local factors impacting on health inequalities and health outcomes
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 Care Quality Commission (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 Well-being 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 in order to improve outcomes
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, ensuring the needs of rural, isolated and hard to reach communities are addressed
8. Delivering our Digitally Enabled Dorset

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Vulnerability

Currently in Dorset there are approximately 25% of practices that have factors that make them vulnerable. 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.

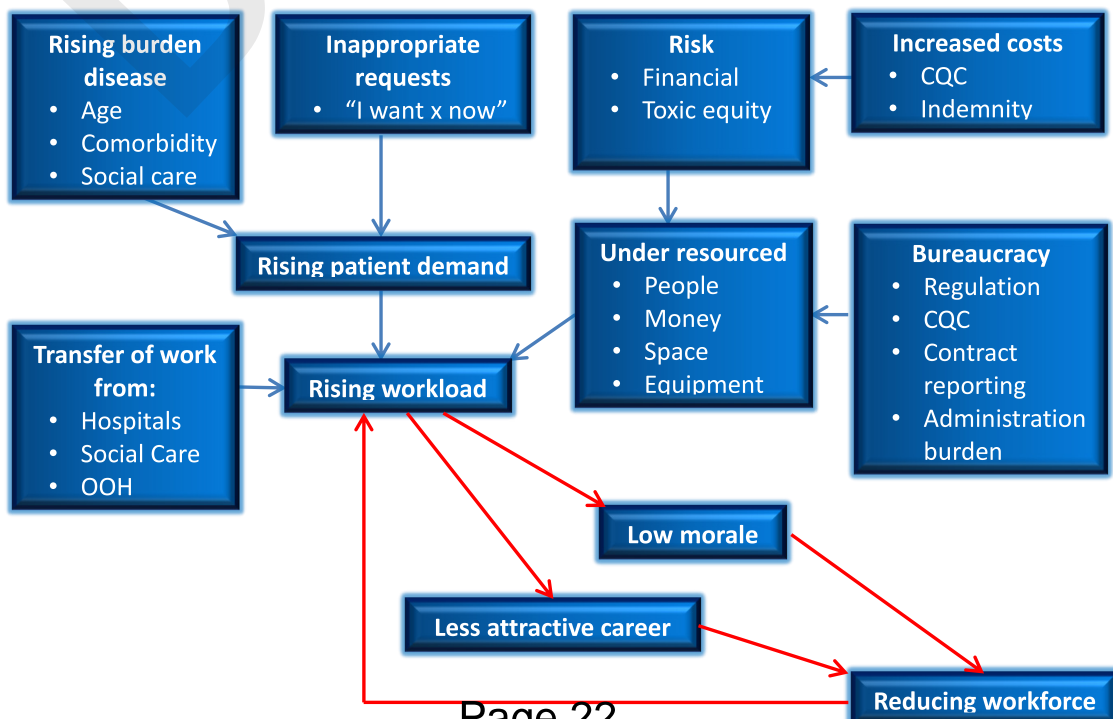
Wessex Local Medical Committee (LMC) has described this as a ‘Spectrum of Vulnerability’:

> **“If General Practice fails, the whole NHS fails…”**
>
> **(Simon Stevens, 2016)**

Demand

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	



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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
- 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)

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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.

Prevention at Scale

As plans for prevention at scale are developed, important challenges for primary care include:

- Developing models of holistic chronic disease management that recognise the different challenges in different neighbourhoods and communities of interest. Working with local communities and Public Health to understand and address local deprivation and its impact on health and well-being

- Improving outcomes reducing the observed variation in secondary prevention (i.e. management in primary care) of people with chronic conditions, particularly diabetes and cardiovascular disease

- Increasing the scale and impact of simple lifestyle advice in primary care – for example, by offering more brief interventions for physical activity and alcohol

- Exploring what alternative models of care could be deployed in different localities to reduce the observed variation in people achieving sufficient control of important parameters like blood pressure, cholesterol and blood sugar

- Recognising the challenges faced by patients living with multiple conditions in more deprived neighbourhoods in urban areas of Weymouth and Portland, Bournemouth and Poole are likely to be different to those living in rural localities, for example North Dorset.

Right Care

NHS RightCare is a key component of the Five Year Forward view, intended to support both improvement in individual patient care through personalisation of care and treatment, as well as improvements in population health with a focus on:

- **Informed and empowered patients**
- **Integrated care providers**
- **Commissioning higher value interventions and outcomes**

Its primary objective is to maximise value: the value that the patient derives from their own care and treatment, the value the whole population derives from the investment in their healthcare. RightCare is also about reducing 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. 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

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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 is a key aim to 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." Improving productivity in the NHS.BMJ (Mulley, AJ, 2010).

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.

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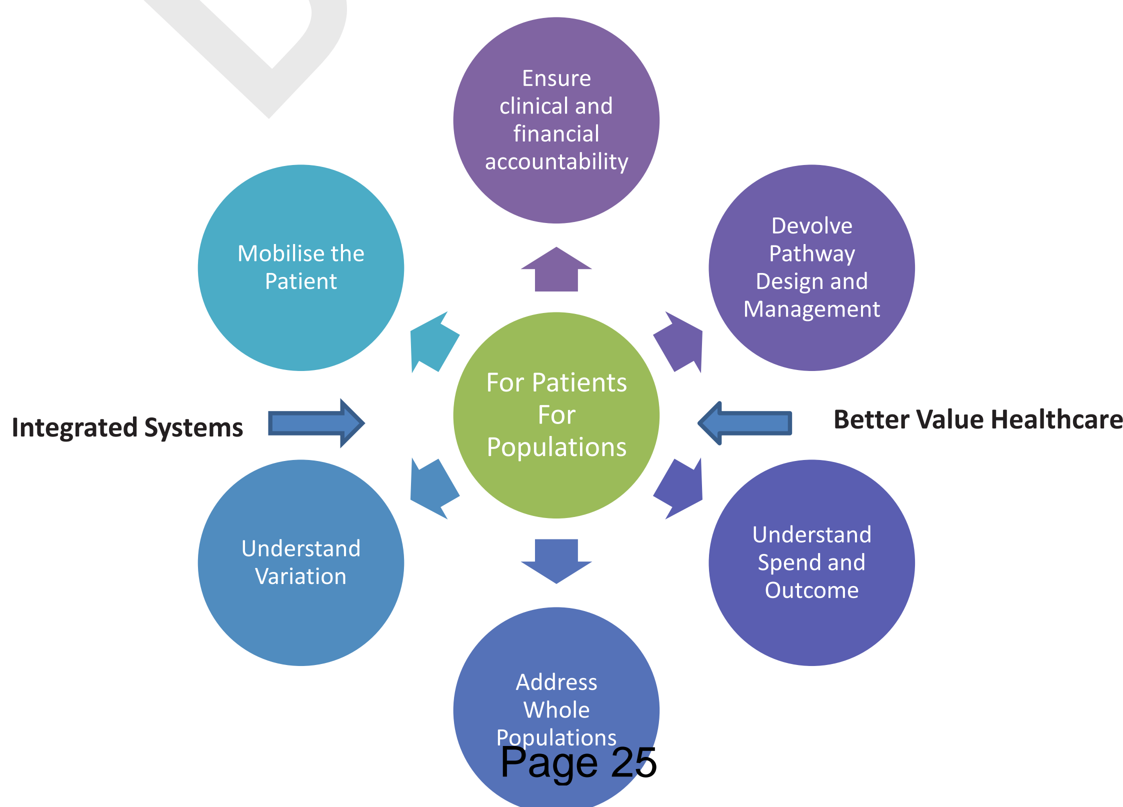
Right Care Model



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

This should result in better outcomes for patients, quicker access to the right care and support at the right time.

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

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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 quality and 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 quality 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 quality 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.

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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."

See Appendix 4 (page 56)

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

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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 main organisations supporting and developing voluntary and community groups, charities, social enterprises, co-operatives and mutuals. Between them they support approximately 2000 local groups in Dorset, they are:

- Bournemouth Council of Voluntary Services
- Dorset Community Action
- Poole Council of Voluntary Services

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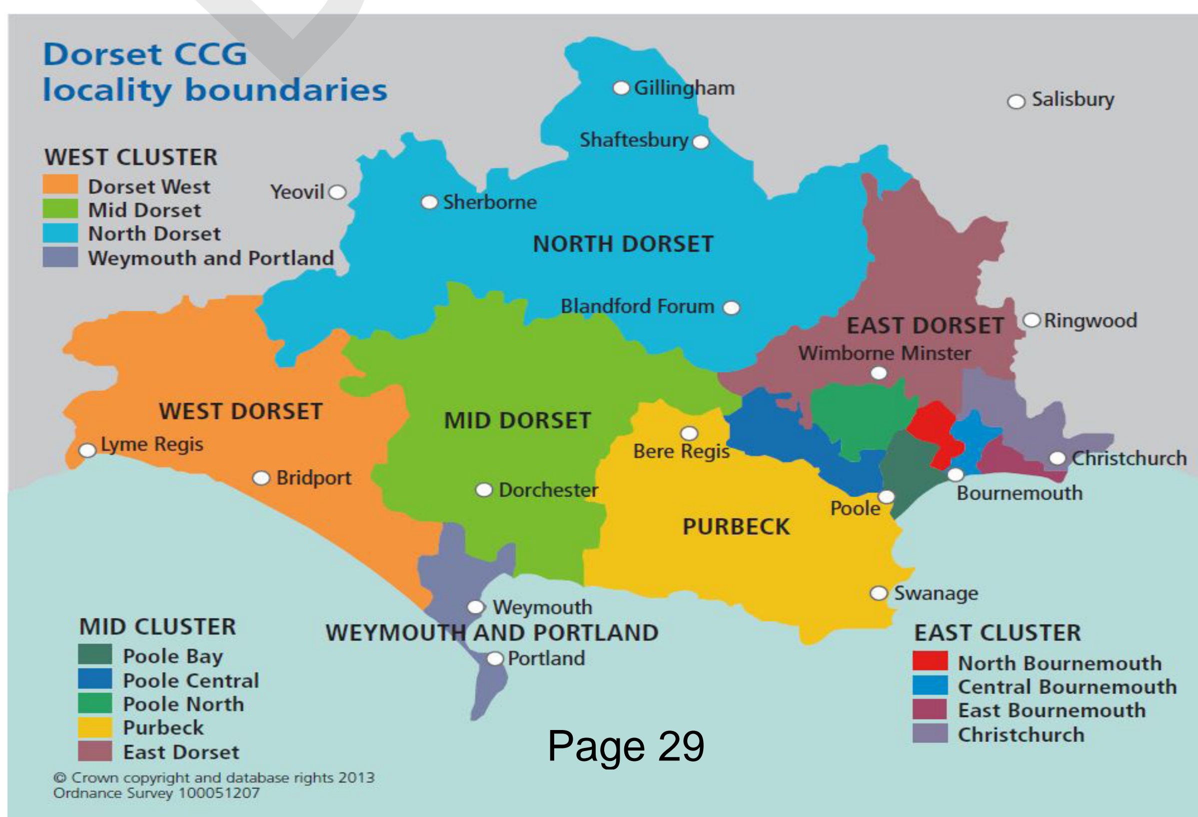

We have three Local Authorities, which provide social care services as follows:

- 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.

Dementia

The Governments Mandate 2016/17 overall 2020 goals for dementia include:

- Maintain a diagnosis rate of at least two thirds

- Increase the numbers of people receiving a dementia assessment within six weeks of a GP referral

- Improve quality of post-diagnosis treatment and support for people with dementia and their carers

- Increase numbers of Care plan reviews (face to face review of their care plan within the last 12 months)

A dementia services review is being currently being carried out. The outcome of the review and the national targets will influence General Practice future care of people with dementia and support for their carers.

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Learning Disabilities

One of the NHS' 9 must dos is to 'deliver actions set out in local plans to transform care for people with learning disabilities.' NHS England has set out a clear programme of work in Transforming care for people with learning disabilities – next steps, to improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. The NHS Operational Planning and Contracting Guidance (2017-2019) includes:

- Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population

- Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check

- Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism

The CCG is starting a project in December 2016 with General Practice to increase the quality and quantity of learning disability health checks and improve accessibility in line with the Accessible Information Standard.

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

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- 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 that presented evidence from various schemes which demonstrated 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

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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 (e.g. 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, where methods for risk stratification of cancer patients are being developed which supports patients having appropriate care i.e. 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 Allied Health Professionals (AHPs), 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.

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Children, Young People and Families

The CCG recognises the importance of improving Children's health in increasing lifelong health outcomes. Currently there is an 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 ensure health services are sustainable Health and Social Care professionals will need to work together across General Practice, Community, Acute and Social Care in response to individual patient needs. Reconfiguration of care pathways is expected to reduce the need for Urgent and Emergency care through better provision of proactive care for those in greatest need. 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, 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)

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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 (as at 1 November 2016)

- 96 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
- Community and Voluntary sector

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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.

> **"It should not matter where you go or who you see, you should get the same quality of care."**
>
> **(A Dorset patient, 2016)**

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
- Feedback from Stakeholders has informed the development of this Strategy (see Appendix 1)
- Key messages and Frequently Asked Questions documents were developed to support patient and public engagement. (see Appendix 2 and 3)

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 focusing 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.

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What did we hear?	How this is reflected in our strategy:
Improving Access	
A good experience of access to local NHS services is important	We are building on the existing high quality General Practice offer by achieving extended and improved access: • 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

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Phase 2

Phase 2 is planned for November 2016 to March 2017. Our programme of engagement will show how we plan to engage with our GP Members, their teams, patients, carers and the public to inform the development of the models. Part of this process will be to identify whether there is a need to go to formal public consultation. In this case NHS Dorset CCG would provide appropriate support.

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

These include the following:

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

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

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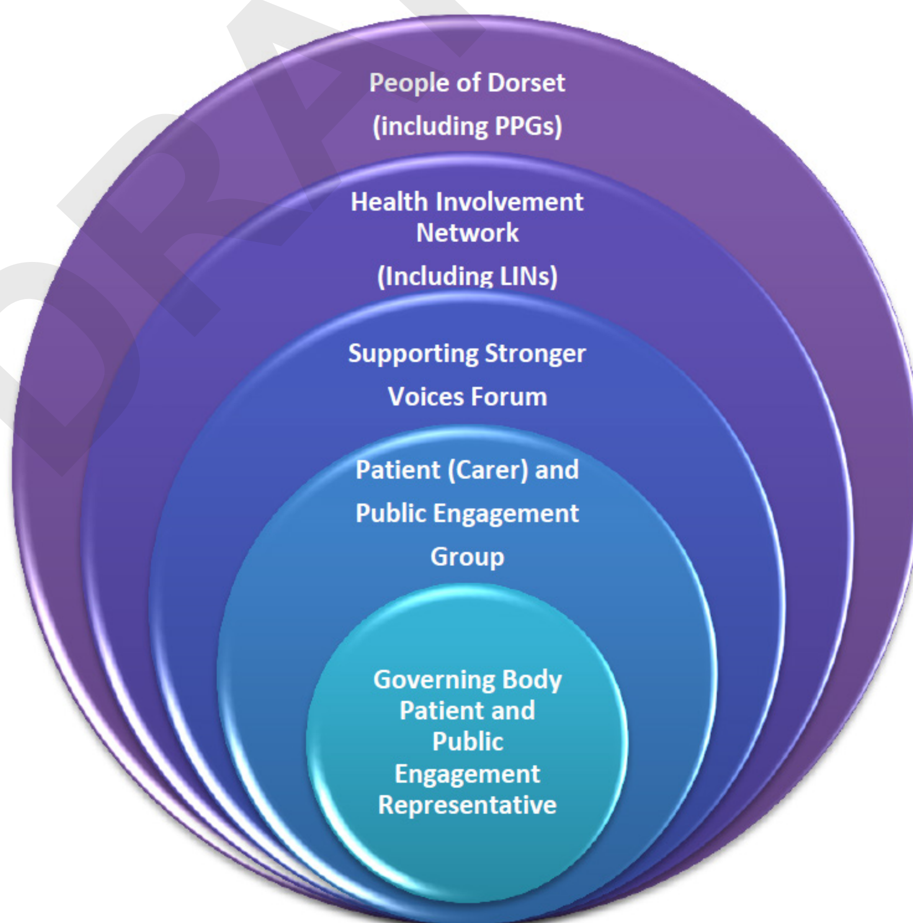

PPGs = Patient Participation Groups in GP Practices
LINS = Locality Involvement Networks
HIN = Health Involvement Network of 4000 + members with an intereset in healthcare

Our Annual Delivery Plan (page 43) shows how we will co-design a pro-active and clear engagement and communication process to support future changes in Primary Care service provision.

Primary Care services are required by the whole population; not everyone is registered with a GP and the needs of under-represented and 'seldom heard' groups need particular consideration in respect of Primary Care. More than any other part of the NHS, Primary Care has the potential to reduce health inequalities in the population.

We plan to:

- 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.
- Engage at practice level to work with groups of practices to develop the proposals for this strategy (page 30).
- Engage with local people on an on-going basis and in a variety of ways. This will include seeking views to inform our plans through:
    - The PPEG – a group of 20 local people with rich shared life experience from across Dorset's geography, demography and diversity (It is recognised that it is not possible for individuals to be truly representative of a particular location, condition or characteristic.)
    - Patient Participation Groups (PPGs) - groups of local people working with our GP practices
    - the CCG's Supporting Stronger Voices Forum – a group of over 100 patient, carer, public and lay representatives
    - The CCG's Health Involvement Network – about 4000 people with an interest in health and care
    - Healthwatch and the voluntary and community sectors
- 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
- Feedback to those we have involved about the impact of their participation, explaining how it has influenced commissioning, and if not, why not
- Document and report on participation activities and impact for assurance and quality improvement purposes, publicising and celebrating success and sharing learning

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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.

Community service hubs have been proposed via the Integrated Community Services work. 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.

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	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.

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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

In line with Social Value Act 2012 and our health inequalities duties 2012, we need to address the causes of inequality not just the symptoms. Addressing health inequalities requires action across all the social determinants of health and well-being including; housing, transport, education leisure and employment, for a fair society and healthier lives. 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 alone.

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. This is an opportunity to explore a new model of primary care that see general practice as just one element of an integrated community-led model of care. Where this has worked well elsewhere, GPs are an integral part of a holistic model of care, often incorporating not just professionals but peer supporters and voluntary sector organisations. These people are often better

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placed to deal with some of the more complex social issues connected with the reasons for primary care presentation than the disease itself. This will involve actions for individuals, actions for organisations, and actions for those most influential in shaping the development of places and communities. We need to provide clarity on what we mean by prevention, different approaches may need to be adopted at different stages of life and we need to address local factors such as deprivation and health inequalities which have a significant impact on health and wellbeing outcomes.

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.

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Developing Local Blueprints

Planning

The Local Blueprints will be developed by practices working together in each local area with support from the CCG. They can be used as a planning tool to consider a number of factors including population need, relevant patient demographics, the configuration of practice and community sites when considering the future design of Primary Care for their local population. They will be tailored to respond to local demographics – engaging local people and communities. They will consider in detail local needs with a focus on those facing the greatest health needs, health inequalities and poorest health outcomes.

Prevention

In line with Social Value Act 2012 and Our Health Inequalities Duties 2012, we need to address the causes of inequality not just the symptoms. Addressing health inequalities requires action across all the social determinants of health and well-being including; housing, transport, education leisure and employment, for a fair society and healthier lives.

Detailed population need analysis in local areas will benchmark variances in life expectancy and potential years of life lost from causes considered amenable to healthcare, explore our utilisation of green spaces and address issues such as fuel poverty.

Care Models

Local Blueprints will inform plans to deliver new care models based on population health needs and national planning guidance. Local planning should ensure access to high quality patient care is maintained and enhanced as part of any new care model design. This must include plans to address the needs of rural, isolated and hard to reach communities. National guidance suggests that Care hubs (a single or network of delivery locations) should serve a neighbourhood of 30,000-50,000. During phase 2 of the rolling plan of engagement, detailed on page 45, localities will be supported to produce their own-solutions to local challenges to implement the requirements of the GP Forward View. New care models will consider the local workforce and infrastructure requirements to deliver high quality access to care.

Any plans for local service reconfiguration will be reviewed to understand the impact on a range of indicators (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)

Transforming Care

General Practice in 2020/21 will not look the same as it does today. It will be able to work at scale making best use of new technologies. There will be development and expansion of the workforce and better premises. There will be improved signposting of patients to the most suitable service for them or where appropriate supporting them to self-care. And GPs working as part of a more joined up Primary Care workforce will be able to devote the greatest amount of time to quality and health improvement for patients and local communities.

Workforce

Working closely with localities, we will seek to understand the current workforce profile including 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 the staff employed across practices in Dorset, as well as nationally, learning from examples of good practice and looking for opportunities to share their best practice. We will work with localities

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to ensure we have an effective workforce enabled to deliver New Models of Care.

Infrastructure

There will be a focus on upgrading premises, and direct practice investment in technology to support better online patient access to care and appointment scheduling, consultation and workload management systems, and better record sharing to support team work across practices.

Work will be carried out to establish the quality of GP infrastructure, analysis of travel times and future local changes that could impact on General Practice, such as population changes and 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.

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Population Health Needs Informing New Models of Care

GP Practice Clusters

NHS
Dorset
Clinical Commissioning Group

Legend
GP Practice
Main
Branch
Clusters
East Cluster
Mid Cluster
West Cluster

Gillingham
Shaftesbury
Salisbury
Yeovil
Sherborne
WEST CLUSTER
Blandford Forum
Wimborne Minster
Ringwood
EAST CLUSTER
Bere Regis
Bridport
Lyme Regis
Dorchester
Poole
Bournemouth
Christchurch
MID CLUSTER
Swanage
Weymouth
Portland

> "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)

Improving Access to Care

GPs and practice teams provide vital services for patients, they are at the heart of our communities. But services are now under unprecedented pressure in Dorset and, as set out in the NHS Five Year Forward View, it has become clear that action is needed so we have a responsive NHS, fit for the future.

The General Practice Forward View sets out a plan to stabilise and transform General Practice. As a CCG, we will work with our colleagues at NHS England to ensure that access to General Practice remains a clear priority. We will ensure specific, practical and funded steps are in place to grow and develop 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.

Plans to improve access will ensure General Practices work together to look at population health needs and develop access to care which responds to local need. Local plans should ensure access to care is maintained and enhanced as part of any proposed changes to local service configuration.

Supporting Self-Care and Prevention

Improving patient experience and empowering people to take control of their own health is a key outcome. We will ensure:

- People with long-term conditions play an active part in determining their own care and support needs through personalised care planning
- Develop collaborative relationships between patients and professionals, shared decision-making and self-management support are at the heart of service delivery
- Working holistically to improve well-being we will promote the use of social prescription (a social, non-medical intervention), that can improve health outcomes for people with long-term conditions and reduce demands on the health system, for example; community support groups, gardening groups, walking groups or dance classes

As plans for prevention at scale are developed to help people stay healthy and avoid getting ill, Public Health Dorset has identified some of the most important challenges to help frame discussions and identify agreed actions. Important challenges for Primary Care include:

- Reducing variation in care and outcomes for people with chronic conditions, particularly diabetes and cardiovascular disease
- Increasing the scale and impact of simple lifestyle advice in primary care – for example, by offering more brief interventions for physical activity and alcohol

Use existing resources more effectively, such as:

- Telehealth (monitoring patients health

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by using electronic devices at home with readings taken and the information sent through the telephone line to a central secure data point for monitoring)

- Services to help people access a range of community activities to improve their health including personal health coaching

Supporting Programmes

Right Care work to personalise care and reduce unwarranted variation through a clinical commissioning improvement plan; in 2016/17 this will focus on improving the identification and management on COPD and CHD to in order to reduce avoidable hospital and care home admissions.

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.

General Practice Forward View Programmes (GPFV)

The GPFV makes a series of commitments to support General Practice. NHS England is publishing guidance documents over time to support delivery of these commitments. As described in the Strategic Context/National section (page 14), 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.

To help sustain and transform General Practice in Dorset a GP Forward View delivery plan will be developed. This plan will focus on supporting the General Practice workforce, addressing workload challenges, developing local plans to deliver new care models, supporting the infrastructure required to enable the transformation of care.

The plan will focus on improving outcomes for patients with better access to care, supporting self-care through improved signposting to the most appropriate services. GPs will work as part of a more joined up Primary Care workforce so they can devote more time to provide quality care for patients and health improvement for local communities.

General practices working together in their local communities will also be able to develop plans to improve patient access through new investment including new technology enabled care systems, training for staff and investment to enable better use of clinician time increasing the provision of care for those with more complex needs and easier access for patients including on-line consultations.

Releasing Time for Care

As part of local delivery of the GP Forward View programme every practice will be able to benefit from a programme to support implementation of the 10 high impact changes. These innovations will release time for clinicians to provide direct patient care as well as adding value to patient care.

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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 Accountable Care Organisations 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 work has already begun through the CSR and ICS programmes. Performance accountability will be measured by looking at how Providers 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, competent 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 will ensure that our Primary Care workforce plan links to the STP development plan which will include promoting and developing use of other health care professionals in General Practice.

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Development of our leaders and organisations

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 priority areas.

We will need to adapt as services change and organisational boundaries 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 to attract people to work and live in Dorset, and developed a post graduate scheme to be 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

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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 in 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

On-line consultations

On-line access and remote consultations will be made available to all patients as part of plans to improve access to care. This will enable patients to benefit from advice about self-care and signposting to other sources of help, as well as an option to send information to a GP for a response. These new ways for patients to access care will improve patient experience and free up time for GPs to dedicate to face to face consultations for patients with more complex needs. Patients will be able to book and cancel appointments on-line, request repeat prescriptions and access their medical records from anywhere in the world.

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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 be the 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 is 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. The aim will be to match the efficiency savings of £46 million.

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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 (refered 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.

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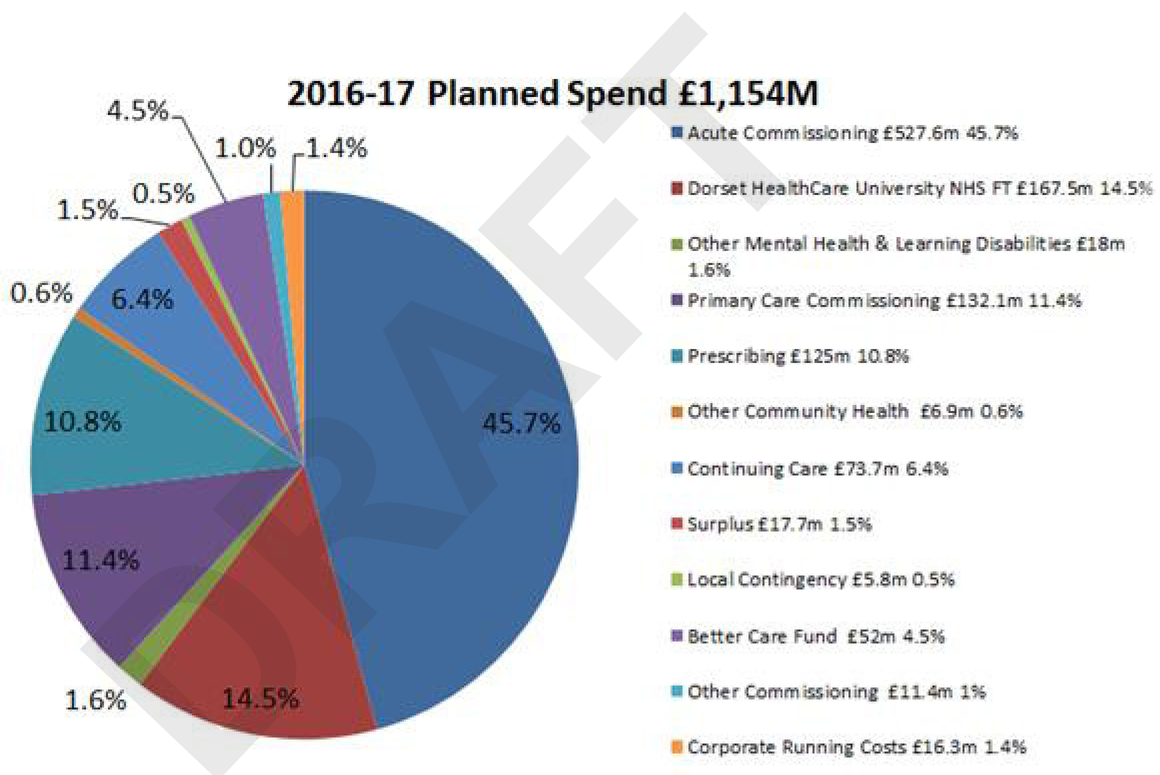
Current Spend & Primary Care Delegation Growth

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 overleaf. 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

NHS
Dorset
Clinical Commissioning Group

£M
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0

Home Oxygen
GP IM&T
Over 75's
Local Contracts (CC LIP, Basket of Services and others)
Extended & Other Primary Care
Urgent Care (OOH)
Direct Enhanced Services Schemes
PCO (Primary Care Support)
Premises Reimburse -ment
Quality Outcomes Framework (QOF)
Primary Medical Services Contracts

CCG Core £30.4M
Primary Care Delegated £101.7M

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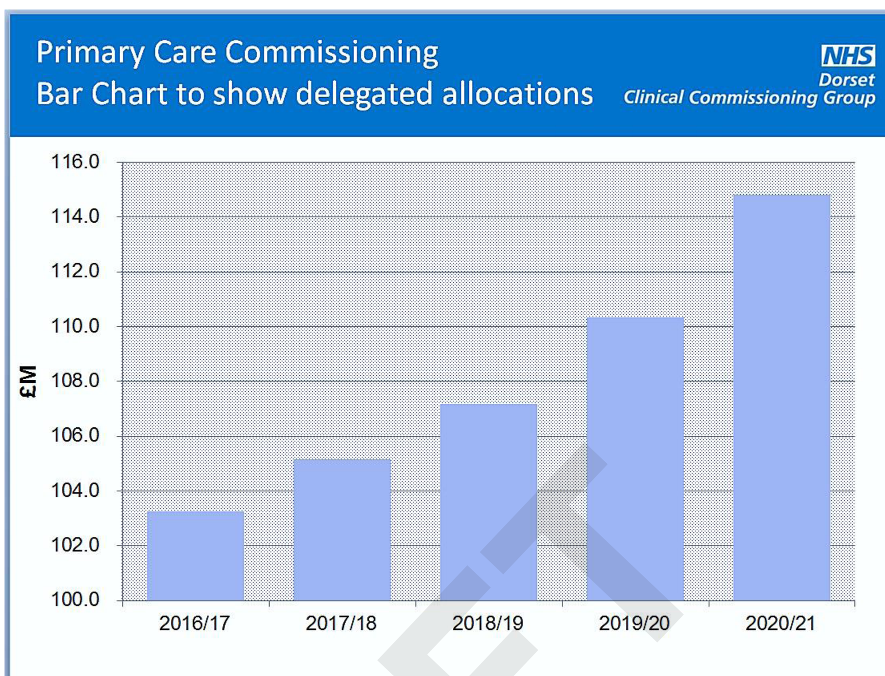
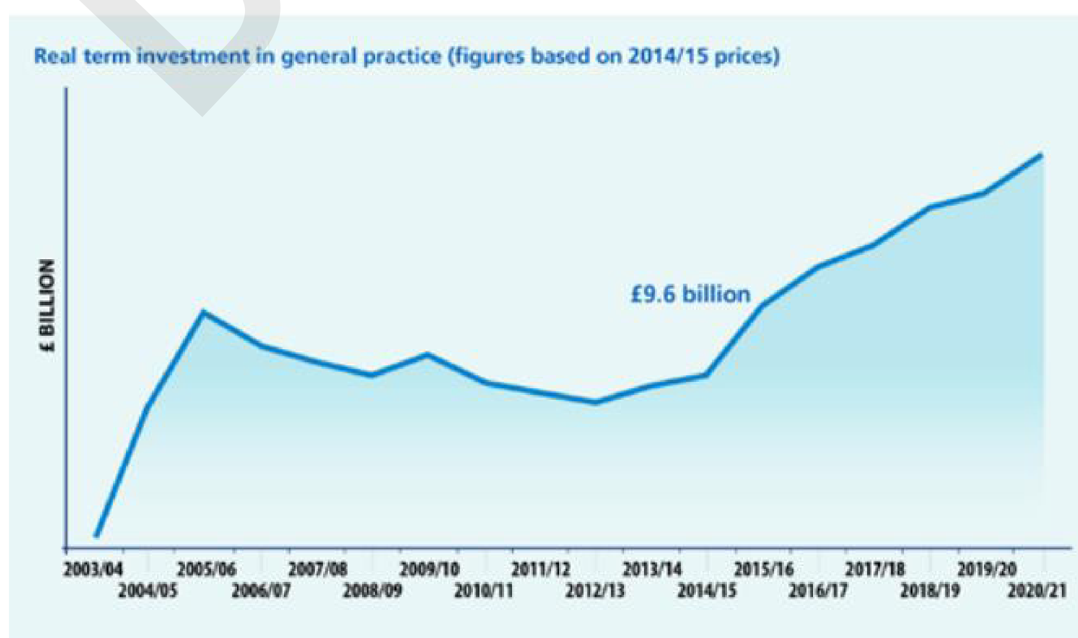
What do Primary Care allocations look like from 2016/17 to 2020/21?

Primary Care allocations have been published for the next five years and are shown in the following bar chart overleaf. 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 the Strategic Context on page 14, 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.



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Our Primary Care Commissioning Strategy sets out how we will transform General Practice reflecting the General Practice Forward View.

Our Key Priorities are:

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

Our Key Deliverables

Milestones	17/18	18/19
Implement local transformation programme to enable 40% the population to be receiving GP Services from practices who are part of a collaboration, working at scale	✓	
Technology enabling the delivery of care through implementing the Dorset Care Record and Digital Dorset	✓	
Improving the Primary Care estates, working in partnership with integrated community services infrastructure development priorities and plans		✓
Improve access to general practice by providing additional consultation capacity per 1,000 population including on-line consultation systems, address inequality in access and commission additional capacity for evening and weekends reflecting local need		✓
Design a rolling Annual Programme of Quality Improvement and set specific standards to address variation and improve outcomes through implementing the Time for Care Programme and 10 high impact changes	✓	
Deliver workforce development plans to address General Practice resilience, supporting the development of skill-mixed teams for delivery of new models of care	✓	
Prevention –work with localities to develop models of care which facilitate supported self-care, improved health and wellbeing including training for care navigators	✓	
Support the organisational development of general practice to enable Primary Care to be equal partners in new collaborative arrangements	✓	
Further develop commissioning of Primary Care to deliver care at scale		✓
Implementation of new care models to reflect local care needs		✓

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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:

Developing Locality Proposals

Design the rolling Annual Programme of Quality Improvement

Prevention - Understanding local population needs, inequalities in health and access to services, supporting self-care and simple life style advice

Contract Monitoring and management Process

Define the outcomes required for the GP element of the ICS care models.

Equality and Impact Assessment

Programmes of work to support Sustainability and Transformation

General Practice Resilience Programme (GPRP)

In partnership with practices and NHS England we will support practices that need to address sustainability. Stronger GP services are the cornerstone of delivering a new deal for Primary Care.

GP Forward View Programmes

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

- Workforce - increase growth rate through new incentives for training and recruitment coupled with a focus on retention and return to practice.

- Workload – including 10 high impact changes

- Care redesign – models of care and new ways of working; Releasing Time for Care is at the heart of our development programme for General Practice, we will spread awareness of innovations that release time for care and facilitate local change programmes to implement them.

- Infrastructure - investment in estates and technology to accelerate the development of infrastructure to enable the improvement and expansion of joined-up out of hospital care for patients.

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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.

Rolling Programme of Engagement

Phase 1: March to October 2016 – Complete

GP Members and Teams
Patients, Carers and Public

Phase 2: November 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 local proposals.

Phase 3: Ongoing engagement each year to review local proposals and action plans

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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

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ACKNOWLEDGEMENTS AND REFERENCES

Dorset CCG would like to thank the following people, groups and organisations for their input and support in developing the Primary Care Commissioning Strategy:

The Patients and Public of Dorset
Practice Patient Participation Groups (PPG's)
Dorset CCG Member Practices
Dorset CCG Governing Body Members
NHS England
Healthwatch Dorset
Bournemouth, Poole and Dorset Council for Voluntary Services
Wessex Local Medical Committees
Local Pharmaceutical Committee

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APPENDIX 1

You said, we did - Phase 1 Engagement Feedback

What we heard	How we reflected this in the Primary Care Strategy	Where this is addressed in the Primary Care Strategy document
Strategy		
How does Strategy fit with other workstreams - STP, CSR, ICS, work of Federations and Vanguards and local Government changes? Crucial that they all link.	The Dorset Primary Care Strategy forms part of our plans for Integrated Community Services –a key part of our plans for Sustainability and Transformation. Plans include support for practices working together learning from innovation and transformation programmes locally and nationally including Vanguards.	**Executive Summary**
Patient Voice		
How is the patient voice heard in developing the Strategy? How are you going to capture feedback and ensure that it is representative of the patients/people's views?	The CCG has an engagement strategy which reflects national best practice to ensure patient, carer and population voices are heard. The Strategy includes feedback received during engagement with a range of key stakeholders including General Practices, patient and community groups. Feedback captured has been used to inform the strategy and we have made an ongoing commitment to engage key stakeholders in the co-development and production of new models of care.	**Engagement and Annual delivery Plan**
Continued engagement with Voluntary and Community Sector for support with non-clinical solutions for patients	The CCG is committed to working in partnership with local communities including representatives of the community and voluntary sector, building on existing partnership working. Part of this work will consider the role of other sectors as vital to transforming the way care is delivered including best practice approaches such as the 10 high impact changes for General Practice.	
Plans for Transforming Primary Care		
CCG need to be upfront and honest about changes, particularly about potential practice closures	The CCG continues to engage with General Practices and key stakeholders to listen to local views and concerns about the plans outlined in this strategy. The CCG has no plans to close any practices. It is up to individual GP surgeries to decide whether to merge or not as they are independent contractors, we cannot force any change	**Future Model of General Practice**
Recognition of locality demographics - Vital to engage views of people and communities who experience the greatest health inequalities and the poorest health outcomes is very important.	The Strategy proposes the development of local blueprints to better understand local need and how the current configuration of services can adapt to enable delivery of new care models. It is recognised that addressing local variation in care quality and outcomes as well as working to address inequalities in health as part of Prevention will be key aspects of plans to co-design and deliver this strategy at a local level.	

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What we heard	How we reflected this in the Primary Care Strategy	Where this is addressed in the Primary Care Strategy document
	Strategy	
Practices want to be involved in development of Blueprints and pilot new ways of working	The CCG is committed to working in partnership with General Practice to develop local blueprints which begin to describe local need and how new models of care can better address these needs. As part of the CCG investment in General Practice over the next few years funding and resources will be made available to both sustain and transform the way in which care is delivered including the testing, adoption and spread of best practice and new ways of working.	**Future Model of General Practice**
	Care Models and Access to Care	
Transport links - limited public transport in rural areas, particularly affect elderly patients and those that do not drive. Bad winter weather conditions	The CCG is committed to working in partnership through the Dorset Sustainability and Transformation Plan to deliver improvements in Prevention and Integrated Care. Part of this work needs to address the wider determinants of health and access to community facilities and resources, access to local services and accessible transport is likely to play an important part in this work.	Enablers
Greater acknowledgment of the difficulties the ever increasingly elderly population will have, especially those with multiple morbidity if less access to services locally	The CCG recognises the difficulties that our older and frail population face. The CCG strategic ambition is to help all people to lead healthier lives and provide the care and support to enable this. The strategy outlines new models of Integrated Care designed to be more patient and carer centred, wrapping services around patients, targeting resources on those with greatest and most complex needs.	
Will the Strategy do enough to support 90% of NHS access via the GP and address appointment issues	The Strategy includes a commitment to developing and delivering a GP Forward View plan. This includes additional investment and support to transform access to care, targeting resources on those with the greatest need, increasing direct patient care as well as remote access to care. This plan will set milestones for improving access for patients and measures to ensure patient experience is reviewed in order to assess the success of these measures.	
Growth of service provision in Practices has flourished and is valued by patients who would want to see this continue and not diminish	The CCG knows what is valued by patients and is committed to ensuring the patient voice is heard and that patients are involved in plans for the design and delivery of local services. This Strategy makes a commitment to supporting Provider development in order to enable service providers to work in partnership to deliver new care models.	

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What we heard	How we reflected this in the Primary Care Strategy	Where this is addressed in the Primary Care Strategy document
Strategy		
Many Practices have good on-site dispensing services that are vital to rural communities	The CCG has already developed improved Prescribing and Medicines Management support for General Practices. Schemes such as introducing Clinical Pharmacy into General Practice teams will further enhance this commitment to better supporting patients. The way in which medicines are prescribed, dispensed, used and reviewed will form part of local plans for new care models. Local accessibility and the needs of rural communities will be reflected in these plans.	Enablers
People want continuity of good care and not all necessarily mind who provides it as long as there is good continuity re their notes – IT is vitally important – and the practices need computer systems/IT which support this going forward	This Strategy places the importance of patient centred care and care continuity at its heart. Central to this will be the development of Integrated Care teams so that patients have named Care professionals co-ordinating their care. Plans will be supported by a Dorset Digital Roadmap which aims to transform the way care is delivered increasing care access, care continuity and care integration.	
Need quality presented locally – in a rural county the most important thing is access to services, few people would go elsewhere as they want access to access a high quality service locally	This Strategy recognises the importance of services being responsive to local need and the challenges faced by people living in rural communities. The CCG is committed to working in partnership with General Practice to develop local blueprints which will describe local need and how new models of care can better address these needs. As part of the CCG investment in General Practice over the next few years funding and resources will be made available to both sustain and transform the way in which care is delivered including the testing, adoption and spread of best practice and new ways of working.	
Service users want to get the best care available and will travel to get best quality care, provided transport issues are addressed	This Strategy seeks to address unwarranted variation which impacts on the care, quality and outcomes in local communities. The CCG is committed to working in partnership through the Dorset Sustainability and Transformation Plan to deliver improvements in Prevention and Integrated Care. Part of this work needs to address the wider determinants of health and access to community facilities and resources, access to local services and accessible transport is likely to play an important part in this work.	

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APPENDIX 2

Key Messages

Dorset Clinical Commissioning Group (CCG) is the organisation responsible for planning and securing healthcare in Dorset. From April 2016, we have been given additional responsibilities for the way we buy and plan general practice (GP) services.

We know from our GP survey results that patients are mostly happy with their GP services but there are areas where we need to do more work, especially around opening times and hours. We also know from our GPs and practice teams that they are under extreme pressure with increasing workloads and diminishing staff numbers.

We have recognised for some time that things need to change: and now there is national guidance, which supports the need to change in the General Practice Forward View (GPFV) document published by NHS England earlier this year. You can find this document at

www.england.nhs.uk/ourwork/gpfv

Our reasons for change are simple: General Practice in its current form will find it difficult to respond to changing needs, if it does not evolve. The existing health service was not designed to meet the needs of the current population; people are living longer and many have complex long-term conditions. GPs and their teams have developed and adapted their individual practices well over time and this has resulted in many great achievements. However, we now need a wider reaching strategy - or long-term plan - to better address current and future challenges. Along with our proposals for acute hospitals and community services in the Clinical Services Review which is about proposals for the transformation of healthcare in Dorset, (which is due to go to public consultation this autumn), this and the Primary Care Commissioning Strategy will help to deliver the overarching aims of Dorset's Sustainability and Transformation Plan (STP), over the next five years, and aims to help ensure that health and care services are built around the needs of our local population.

Our draft Primary Care Commissioning Strategy describes how we plan to ensure that every person in Dorset can get a GP appointment when they need it and that high quality GP services are available to patients wherever they live in Dorset. It explains how better patient experience could be achieved by organising GP practices into larger groups, working together more closely with other providers of health and social care services. Working in groups should make practices stronger and help them to attract and retain the GPs and staff required to meet local needs.

Patients will have their care delivered from larger, local better-equipped sites offering a wider range of options for care. This will also help to support patients who wish to take greater control of their own conditions. Models for the future provision of GP services will be developed locally with communities and GP's, reflecting the fact that the needs of the population vary across the County.

You can read our proposals for a future model of general practice in full by visiting:

The document will be available on the CCG website shortly.

If you wish to provide any feedback please email: Primary.care@dorsetccg.nhs.uk

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Frequently Asked Questions

Primary Care Commissioning Strategy and Plan

Holding statement to be used reactively for media enquiries

Primary Care faces a number of challenges in the future, and if we continue as we are doing our workforce and finances could soon become overstretched. The draft Primary Care Commissioning Strategy and Plan considers how services could be delivered differently to ensure they are safe and sustainable for the future; for example consolidation of sites or back office functions or sites.

We want to be clear that this draft version has been circulated to key stakeholders to gain their views and that no decisions have been made around closure of practices.

Is this part of the Clinical Services Review (CSR)?

No. Whilst GP services are a core part of the Integrated Community Services plan, which is part of the Clinical Services Review, The draft Primary Care Commissioning Strategy and Plan is separate. It does however although it does complement it in feeding into the Sustainability and Transformation Plan (STP).

As we have been clear about, the views that we receive during the public consultation phase of the CSR will help shape any final decisions made around the recommendations and proposals which are part of the review.

What is the Primary Care Commissioning Strategy and Plan about?

The draft Primary Care Commissioning Strategy and Plan considers how services could be delivered differently to ensure they are safe and sustainable for the future; for example consolidation of sites or back office functions or sites.

The document outlines a major stream of work which supports our **Sustainability and Transformation Plan** which is available via www.dorsetsvision.nhs.uk.

We have been engaging with our GP members and their teams, and patients over recent months to develop our thinking around the future of General Practice Services. The draft Primary Care Commissioning Strategy and Plan that has been shared has been done so to seek the views of our key stakeholders.

Is this in response to problems with GP recruitment?

The strategy does recognise that General Practice faces a number of challenges including recruitment and retention; and that this may result in practices and GP's working together and that as we work with the GPs and others in developing local plans we will engage with local people who may be affected from any specific proposals that emerge from this work.

The situation we are facing in Dorset is in line with the national picture and we are working closely with practices across the county to help them with recruitment, retention and the support of staff to enable local people to have access to the services they need.

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Nationally fewer doctors than are needed have been trained and fewer are choosing to work with the NHS which has a knock on effect for those entering General Practice and becoming GPs. Our strategy for Primary Care in Dorset will respond to the GP Forward View published by NHS England in April this year and which recognises a range of challenges, including that of recruitment and retention. The document signals the future of General practice will be for surgeries to work together to maintain high quality services and improved access.

The Clinical Services Review talks about bringing care closer to home but this looks like you are closing practices, surely this is contradictory?

General Practice is the bedrock of the NHS and we want to support GPs so they can continue to deliver care in the community through GP practices, community hubs and in peoples' own homes. There should be easy access to this care when you need it, including in the evenings and at weekends.

This would mean that more care would be delivered closer to home, reducing the need to travel.

Our Primary Care commissioning plans recognise that we need to support the general practice workforce not just to ensure we have enough GPs but also developing multi-skilled teams to take some of the pressure off GPs and better respond to patient need. Examples include clinical pharmacists to help patients better manage their medication and mental health therapists able to respond to common mental health needs.

What are you doing to fill primary care vacancies?

As a response to increasing recruitment challenges the website Doorway to Dorset - www.doorwaytodorset.nhs.uk - has also recently been launched. Rather than the traditional approach of simply listing vacancies, the site sells the benefits of living in Dorset before selling the position; detailing what the local health community can do for applicants who may choose to work there. The site also aims to centralise advertising of vacancies for general practices in the county, making it easier for those searching for positions.

Recently we have also established a Primary Care Workforce Centre, a formal partnership between Health Education England (Wessex), Dorset Clinical Commissioning Group and Bournemouth University. The Workforce Centre will play a vital role in the support, education and training of the local workforce.

Through its research the centre has identified the need to offer more variety and flexibility to attract and retain newly qualified GPs in general practice. A postgraduate scheme will be launched in the autumn which will provide GPs with an opportunity to pursue a portfolio career and gain experience in a variety of healthcare settings. More details about the scheme are available online viahttp://primarycaredorset.co.uk/get-involved/gp-postgraduate-scheme/.

You say that no decisions have been made but this looks like you are closing GP practices?

The strategy itself is not making any specific proposals to close GP practices. It does recognise that General Practice faces a number of challenges including recruitment and retention; and that this may result in practices and GP's working together and that as we work with the GPs and others in developing local plans we will engage with local people who may be affected from any specific proposals that emerge from this work.

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Primary Care faces a number of challenges in the future and our analysis work to date suggests that if we continue with the current 98 GP practices delivering care in 135 sites this will over-stretch our workforce and finances. We need to consider how things could work differently and how we can continue to ensure we are able to offer primary care services that are safe and sustainable for the future. Whilst this could include consolidation of sites or back office functions we want to be clear that no decisions have been made around closure of practices.

What happens next – will I be able to have a say on this strategy?

We welcome comments on the draft Primary Care Commissioning Strategy and Plan from stakeholders and the general public. Our Primary Care Reference Group will be considering all feedback at its meeting on 2nd November; we intend to use all of this to inform a workshop and we will be aiming to finalise our strategy and take it to our Primary Care Commissioning Committee in December for ratification.

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APPENDIX 4

9 Must Do's

The nine 'must dos' for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of General Practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	21 December 2016
Officer	Interim Director for Adult and Community Services
Subject of Report	**Briefings for information / note**
Executive Summary	The briefings presented here are primarily for information or note, but should members have questions about the content a contact point will be available. If any briefing raises issues then it may be appropriate for this item to be considered as a separate report at a future meeting of the Committee. For the current meeting the following information briefings have been prepared: • Changes to the provision of health services for individuals with Cystic Fibrosis (commissioned by NHS England) • Changes to the provision of Vascular Services (commissioned by NHS England) • Dorset Health Scrutiny Committee Forward Plan
Impact Assessment:	Equalities Impact Assessment: Not applicable: briefings provided by NHSE.
	Use of Evidence: Briefing reports, referencing wider documents and future agenda items.

	Budget: Not applicable.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk: LOW
	Other Implications: None.
Recommendation	That Members note the content of the briefing report and consider whether they wish to scrutinise the matters highlighted in more detail at a future meeting.
Reason for Recommendation	The work of the Committee contributes to the County Council's aim to help Dorset's citizens to maintain health, safety and independence.
Appendices	1. Changes to the provision of health services for individuals with Cystic Fibrosis 2. Changes to specialised Vascular Services 3. Dorset Health Scrutiny Committee Forward Plan
Background Papers	None.
Officer Contact	Name: Ann Harris, Health Partnerships Officer Tel: 01305 224388 Email: a.p.harris@dorsetcc.gov.uk

Helen Coombes
Interim Director for Adult and Community Services
December 2016

Appendix 1

Dorset County Council

Briefing for Dorset Health Scrutiny Committee
21 December 2016

Changes to the provision of health services for individuals with Cystic Fibrosis	Contact: Victoria White, Care Group Manager, Specialist Medicine University Hospitals Southampton NHS Foundation Trust e-mail: victoria.white@uhs.nhs.uk

1 Background

Cystic Fibrosis (CF) is a genetic condition affecting around 10,800 people in the UK. The gene affected by CF controls the movement of salt and water in and out of cells. People with cystic fibrosis experience a build-up of thick sticky mucus in the lungs, digestive system and other organs, causing a wide range of challenging symptoms affecting the entire body.

Services to support people with the condition are commissioned by NHS England and national specifications and standards are in place, which Trusts providing the services are expected to meet. With regard to CF, individuals have to be cared for through specialist centres treating a minimum of 100 patients with the condition; hubs with satellite centres are not recommended.

2 Current provision of services in Dorset

In recent years a two site / one centre model has been adopted to serve the population of Dorset, Bournemouth and Poole, with in-patient and out-patient services being provided at Poole Hospital under management from Southampton General Hospital, which is a regional centre of excellence for Wessex. At present Poole supports 54 patients with CF and Southampton supports a further 210 patients. In 2012 options to transfer care to Southampton were considered as the service was not meeting the national service specification, but a decision was made to maintain provision in Poole. However, whilst this collaborative arrangement has worked well, this will not be sustainable in the future and does not meet best practice guidance.

3 Changes to the provision of services in Dorset

Changes to the provision of services are now being implemented, prompted by the imminent loss of consultant cover for Poole Hospital, in addition to specialist nursing and physiotherapy vacancies. Attempts to recruit to these posts and in particular the consultant post are challenging and as of 1 February 2017 it will not be possible to continue to provide a specialist CF consultant at Poole. These changes will affect in-patients and out-patients, but it is hoped that enhanced out-patient services can be developed locally, with an increase in community-based provision. Whilst the Commissioners (NHS England) and Poole Hospital are happy with the changes, it will clearly have an impact on patients, some of whom are upset at the loss of something which is highly regarded.

At any one time, an average of 3 or 4 in-patients may be in receipt of care at Poole Hospital and an average of 10 or 12 may be in receipt of care at Southampton General. In general around 20 individual patients Dorset-wide make use of in-patient facilities over the course of a year and the length of stay can exceed two weeks. Specialist in-patient services for CF are also available at Bristol Royal Infirmary and the Royal Devon and Exeter Hospital, and some patients may choose to go there instead.

4 Next steps

The patients who will be affected by these changes are being contacted and ways in which to gather their views considered (public meetings are not an option for individuals with CF due to the risk of cross-infection).

This briefing note is presented to Members for information at short notice, due to the necessity to implement the changes to services by the time at which the consultant currently in post transfers to a new role at Southampton Hospital. If Members would like further information regarding this matter, a report can be requested from the service provider (Southampton General Hospital) for the next Committee meeting on 9 March 2017.

Appendix 2

Dorset County Council

Briefing for Dorset Health Scrutiny Committee 21 December 2016

Changes to the provision of Specialist Vascular Services	Contact: Carol Wood, Head of Communications & Engagement, NHS England South (Wessex) e-mail: carol.wood4@nhs.net

1 Background

In March 2013, the National Service Specification (NSS) for Specialised Vascular Services stated that there was strong evidence that death from planned surgery for aneurysm is "significantly less in centres with a high caseload than in hospitals that perform a lower number of procedures".

This was based on recommendations from the Vascular Society of Great Britain and Ireland POVS12[1] report in which they set out the need for hospitals to collaborate in a network to provide patients care. As part of this collaboration there is a requirement for the network to decide upon a single hospital which will provide both planned and emergency arterial vascular surgical care, and a requirement that all major arterial intervention is performed on the designated arterial site.

2 Dorset and Wiltshire Vascular Network

Establishment of the network

A Dorset and Wiltshire Vascular Network (DWVN) was established in 2010, as agreed by the then South West Strategic Health Authority and in 2012 the following arrangement for services was proposed:

	Hospital	Designation
RBH	Royal Bournemouth Hospital	Major Arterial Centre (MAC)
JGH	Jersey General Hospital	Non-Arterial Centre (NAC)
PHFT	Poole Hospital	Non-Arterial Centre (NAC)
DCH	Dorset County Hospital NHS Trust (Dorchester)	Non-Arterial Centre (NAC)
SDH	Salisbury District Hospital NHS Foundation Trust	Non-Arterial Centre (NAC)

[1] VSGBI "The Provision of Services for Patients with Vascular Disease 2012"

Following the Vascular Society report, the requirement for and need for formalisation of the DWVN was recognised, and was supported by all three Trust Management Teams with the establishment of a Steering Group to oversee implementation. As the emerging network model allowed for only one 'hub', it was agreed in December 2012 that RBH would become the arterial centre and Dorchester and Salisbury's hospitals would become 'spokes'.

In June 2012 a draft of the National Specifications, based upon the Vascular Society's recommendations, was issued. In December 2012 a Dorset and Wiltshire Vascular Network was duly recommended.

This proposed RBH as the single arterial network hub undertaking all elective arterial surgery and complex vascular interventional radiology. Salisbury and Dorchester would be spokes with weekday (0900-1700) vascular presence (including DCH renal access surgery), and elective vascular interventional radiology. This would include centralisation of the emergency rota which was then operated as a 1:7 flipping between Bournemouth and Salisbury. The proposal was approved.

The first step in creating the network, was to centralise emergency on call at RBH in December 2013. A 1:7 rota was established, including vascular surgeons from Bournemouth, Dorchester and Salisbury Hospitals. Additional related out of hours procedures were also centralised at Bournemouth.

Activity to complete the programme of reconfiguration

The Dorset and Wiltshire Vascular Network Vascular Implementation Board (VIB) was established in October 2015 to oversee completion of the transfer of major arterial services to RBH.

It was clearly recognised by the VIB that a sustainable vascular service requires a minimum of six vascular surgeons and six vascular interventional radiologists to provide 24/7 emergency vascular on call. This was the rationale for centralisation of emergency services to one site. It was also clearly recognised that to provide elective vascular services without 24/7 on site emergency vascular services was an unacceptable risk.

None of the sites on its own has a population size which would make a 1:6 rota financially viable. Equally, there would be insufficient procedures for three sites to ensure surgeons maintained their current skill base by undertaking the recommended minimum number of procedures.

The population of Dorset for 2015 is estimated at 762,400 and the Community Areas (CA) surrounding Salisbury, including Salisbury itself, have a population of around 106,000 making a total of 868,400. The population of Jersey is just over 100,000 making the total population served nearly 1m. When the higher than average percentage of people aged 65 years or over is factored in (particularly in Dorset), the population to be served is substantial.

Whilst Jersey and Poole do not have an on-site vascular surgical service, Dorchester and Salisbury do have their own vascular surgeons (two and one respectively, plus two general surgeons who continue to undertake some elective vascular procedures). Bournemouth has four vascular surgeons.

Bournemouth currently acts as a Major Arterial Centre (MAC) for emergency vascular services (centralised in 2013) for all hospitals. The Dorchester and Salisbury vascular surgeons make up a 1:7 emergency on call rota with those from Bournemouth (although one from the latter has been on long term sick leave).

The vascular surgeons based at both Dorchester and Salisbury carry out some elective surgery at Bournemouth and some at their own hospitals, with local surgeons providing informal emergency on call when elective surgery is undertaken. Salisbury also undertake Abdominal Aortic Aneurysm (AAA) screening on behalf of the network.

All AAA procedures have now been transferred to Bournemouth and it is planned that the small number of remaining major elective arterial procedures will transfer to RBH by a date to be confirmed. Work is also progressing to ensure that vascular services are available at all the Non-Arterial Centre sites to support dependent services as needed, and to allow for patients to have vascular outpatient appointments and investigations carried out at the spoke sites. For elective (planned) surgery, in line with national policy on patient choice, patients in the geography can choose to access care at other hub sites.

3 Next Steps

1) NHS Wessex has commissioned an independent expert panel to review the current vascular services configuration and proposals of the Dorset and Wiltshire Vascular Network, and to make recommendations for finalisation of reconfiguration. One objective is an assessment of the existing workforces and long term sustainability.
2) A communications and engagement workstream has been established to ensure strong public, patient, staff and clinical engagement. This group includes Dorset and Wiltshire Healthwatch. As a first step we are planning to engage with patients around what is important to them and recruit a patient reference group to support implementation of any proposals recommended by the review.
3) The numbers of patients affected by the services changes are small and we feel it is better to engage directly with patients and representative groups (diabetes UK; stroke association) about what matters to them before service changes are implemented.

Procedure:		**RBH**	**SDH**	**DCH**
Abdominal Aortic Aneurysm (AAA)	EL	21	3	6
	NEL	33		
Endovascular Aneurysm Repair (EVAR)	EL	42		
	NEL	6		
Carotid Endarterectomy (CEA)	EL	12	15	15
	NEL	15		
Bypass Procedures	EL	72	18	57
	NEL	42		3
Varicose Vein Procedures	EL	73	105	96
	NEL			
Major Amputations	EL	6		3
	NEL	48		3
Minor Amputations	EL	3	6	6
	NEL	12		21
Renal Procedures	EL	96		126

Briefings for information / note

Appendix 3

Dorset Health Scrutiny Committee – Forward Plan, March 2017

Committee: 9 March 2017			
Format	Organisation	Subject	Comments
Report	The Care Quality Commission	CQC Inspections of GP surgeries in Dorset	To look at the outcomes of local inspections and the quality of GP services
Report	NHS Dorset Clinical Commissioning Group	Primary Care Commissioning Strategy	Following reports to Committee on 6 September, 14 November and 21 December 2016
Report	Dorset County Hospital	Update re action plan following the CQC inspection carried out in March 2016	Following report to Committee on 6 September 2016
Report	NHS Dorset Clinical Commissioning Group	Non-emergency patient transport services	To provide further information re progress and performance, following report to Committee on 6 September 2016
Report	Joint Health Scrutiny Committee	Clinical Services Review – update	To provide an update regarding progress, as appropriate
Report	NHS England	Changes to services for individuals with Cystic Fibrosis	To provide an update regarding progress, following a briefing to Committee on 21 December 2016 (TBC – may be a further information briefing only)
Report	NHS England	Changes to the provision of specialist Vascular Services	To provide an update regarding progress, following a briefing to Committee on 21 December 2016 (TBC – may be a further information briefing only)
Items for information or note			
Briefing	Joint Health Scrutiny Committee	South Western Ambulance Service NHS Foundation Trust	To provide an update regarding the progress and/or outcome of the Joint Committee considering issues relating to services provided by SWASFT
Forward Plan	Dorset Health Scrutiny Committee	Forward Plan – Dates of future meetings, including planned agenda items	To raise awareness of future agenda items, meetings, workshops and seminars.

Briefings for information / note

Committee: 16 June 2017			
Format	Organisation	Subject	Comments
Report	Dorset Health Scrutiny Committee	DHSC Terms of Reference	To refresh - TBC
Report	Dorset Health Scrutiny Committee	Appointments to Committees and sub-Committees	Following any changes to membership in May 2017
Report	Dorset Health Scrutiny Committee	Annual Work Programme	To agree the Programme discussed at annual workshop
Report	Joint Health Scrutiny Committee	Clinical Services Review – update	To provide an update regarding progress, as appropriate
Items for information or note			
Briefing	Dorset Health Scrutiny Committee	Quality Accounts – commentaries from Dorset Health Scrutiny Committee	Annual report
Forward Plan	Dorset Health Scrutiny Committee	Forward Plan – Dates of future meetings, including planned agenda items	To raise awareness of future agenda items, meetings, workshops and seminars.

Committee: 4 September 2017			
Format	Organisation	Subject	Comments
Report	Joint Health Scrutiny Committee	Clinical Services Review – update	To provide an update regarding progress, as appropriate
Items for information or note			
Forward Plan	Dorset Health Scrutiny Committee	Forward Plan – Dates of future meetings, including planned agenda items	To raise awareness of future agenda items, meetings, workshops and seminars.

Briefings for information / note

Agenda planning meetings (Officers' Reference Group only)			
Date	**Venue**	**Papers required by Health Partnerships Officer**	**Papers dispatched by Democratic Services**
13 December 2016 (for Committee on 9 March 2017)	County Hall	15 February 2017	1 March 2017

Workshops and development sessions (all DHSC Members)			
Date	**Venue**	**Topic**	**Comments**
February 2017	TBC	DHSC Annual work programming workshop	To consider the Committee's priorities for the coming year
June / July 2017	TBC	DHSC induction workshop	To support newly elected Members following Council elections in May 2017

Committee dates 2017: 9 March; 16 June; 4 September; 13 November

Ann Harris, Health Partnerships Officer, December 2016
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