Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	17 October 2018
Officer	Rob Payne, Head of Primary Care, NHS Dorset Clinical Commissioning Group
Subject of Report	**Integrated Care System: Primary Care Transformation Programme Review and Evaluation**
Executive Summary	This report forms part of a wider report looking at progress in the implementation of the Integrated Care System across Dorset. The report focuses on the Primary Care Transformation Programme and provides: • A mid-point review and evaluation of progress in delivery of the Primary Care Commissioning Strategy and GPFV programme areas. • Details of the investment in sustainability and transformation of primary care and the impact of this. • Evidence of achievements and impact made against the five core transformation areas of the GPFV since the inception of the programme: Investment; Workforce; Workload; Infrastructure and Care Redesign. • Next Steps.
Impact Assessment:	Equalities Impact Assessment: Report provided by NHS Dorset CCG.

	Use of Evidence: Report provided by NHS Dorset CCG.
	Budget: Not applicable for DCC.
	Risk Assessment: Current Risk: LOW Residual Risk: LOW
	Other Implications: None.
Recommendation	That Members note the content and comment on the 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 supports the County Council's aim to help Dorset's citizens to remain safe, healthy and independent.
Appendices	1 NHS Dorset CCG: Primary Care Transformation Programme Review and Evaluation
Background Papers	None.
Officer Contact	Name: Dr Rob Payne, Head of Primary Care, NHS Dorset CCG Email: robert.payne@dorsetccg.nhs.uk

NHS Dorset Clinical Commissioning Group

NHS DORSET CLINICAL COMMISSIONING GROUP

PRIMARY CARE TRANSFORMATION PROGRAMME REVIEW & EVALUATION

1.1 The Dorset Primary Care Commissioning Strategy and GP Forward View (GPFV) Delivery Plan is designed to be implemented over a five year period aligning to the GP Five Year Forward View, Our Dorset Sustainability and Transformation Plan and the Dorset Integrated Community Services Strategy.

- This report provides:
- A mid-point review and evaluation of progress in delivery of the Primary Care Commissioning Strategy and GPFV programme areas.
- Details of the investment in sustainability and transformation of primary care and the impact of this.
- Evidence of achievements and impact made against the five core transformation areas of the GPFV since the inception of the programme: Investment; Workforce; Workload; Infrastructure and Care Redesign.
- Next Steps

2. Background

2.1 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.

2.2 Dorset CCG developed a GPFV Delivery Plan for 2017-19 approved by Directors on 19 December 2016 and NHS England in early 2017.

3. Funding

3.1 **£3 per head transformation fund** – The CCG investment to deliver at-scale General Practice sustainability and transformation is set out below:

Year	Year 1 (2016/17)	Year 2 (2017/18)	Year 3 (2018/19)
Investment	£500k	£1.1m	£1.3m
Focus of Development	Practices	Localities	Networks

3.2 This funding has enabled GPs and primary care teams to engage in the development and delivery of the local sustainability and transformation plans under the direction of the GP Locality Chair.

3.3 A large proportion of the funding has been delegated to localities to support transformation through:

- Protected Learning Time
- investment in clinical and business leadership
- project management resources
- innovation funding to allow localities to test out new ways of working.

3.4 A centrally held budget has been used to support:

- estates and infrastructure development
- workforce planning
- integrated access
- training
- community engagement
- National Association of Primary Care (NAPC) investment to support collaborative working at scale through the Primary Care Home model.

3.5 In addition, specific resource has been identified within the Primary Care Team (supported financially by NHS England) to support the overall programme implementation whilst also meeting the needs of the NHS England assurance programme of work which occurs at both a local, regional and national level.

3.6 Dorset has been in a position of readiness to benefit from other national funding programmes as a result of delivery of the local plan.

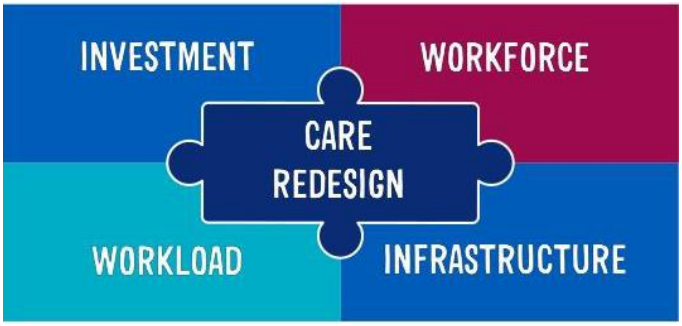
4. Evidence of Achievements and Impact

4.1 At the mid-way point through this five year programme we are starting to identify tangible outcomes and realise the benefits for primary care in Dorset. Significant progress has been made across all GPFV delivery areas.

4.2 Evidence has been drawn from the

- ***'Primary Care Outcomes Framework'***developed to monitor progress against Primary Care strategic ambitions.
- 13 Localities who continue to develop and deliver their 12 (2 localities working together) transformation and sustainability plans across all GPFV areas.
- ***12 GPFV Delivery Programmes*** that NHS Dorset CCG has implemented to support primary care transformation.
- International, national and local data also providing emergent evidence of the impact of the development of the ***Primary Care Home Model*** in supporting both national and local ambitions.

4.3 The following provides a summary of achievements and impact to date across the five areas of GP Forward View.



5. Investment

5.1 Plans are now in place to deliver the £3 per head investment in Primary Care transformation over two years to March 2019. This includes Dorset-wide initiatives such as the Primary Care Workforce Centre and Protected Learning Time for Transformation Programme teams as well as delegated budgets to support local Transformation leadership, collaboration and project management.

5.2 Planning for future investment in transformation is now underway and forms part of the discussions with NHS England in order to strengthen the role of Primary Care within the Integrated Care system. We are seeking to invest in both sustainability of General Practice, working closely with NHSE on General Practice resilience, as well as to continue to transform Primary Care to establish Primary Care Networks to serve the Dorset population.

5.3 As part of this work a review and evaluation of sustainability and transformation programme achievements over the last 18 months will be used to inform a business case for future investment. It is likely that we will be seeking to put in place a further programme of investment to 2021. This is in line with NHSE guidance for continued investment for GP Forward View delivery and transformation support for Primary Care as part of the national programme ambitions.

5.4 Specific achievements resulting from the transformation investment include:

- Development of **12 Transformation Primary Care Networks** working collaboratively to develop and deliver 12 Transformation and Sustainability Plans aligned to GPFV and with a clear focus on function.

- Strong **Leadership** and distributive leadership to drive forward the locality vision and build clinical and business capacity and capability.

- Menu of **support** and 'Team around the Primary Care Networks' to support transformation change and achieve the ambitions set out in Dorset's GPFV Delivery Plan

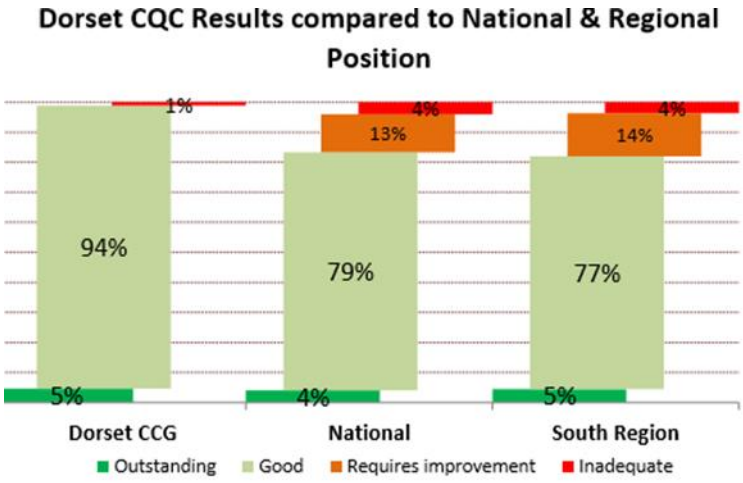
- Stakeholder **engagement** to ensure system support and integration especially in the context of the emergent ICS in Dorset.

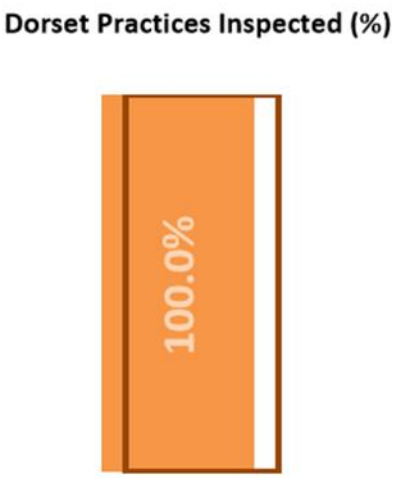
- Spectrum of Memorandums of Understanding developed at Primary Care Network level to facilitate collaborative working.

6. Impact on Improving Quality (CQC)

6.1 86 practices have had an inspection by the Care Quality Commission (CQC). The CCG has provided support to practices to improve quality and resilience through a menu of support and there has been a steady improvement in the quality and resilience of General Practice in Dorset.

6.2 As at March 2016, 19.4% of practices were rated good or outstanding by CQC. This low figure may have been as a result of not all practices being inspected. As at March 2017, this increased to 88.4% rated as good or outstanding and as at March 2018, this increased further to 99% of practices rated good or outstanding. For a comparison with regional and national averages as at March 2018, please refer to Figure 1 below.





6.3 Continued quality improvement within General Practice is being undertaken through a combined approach by the Quality and Primary Care teams undertaking joint quality and contract assurance visits. This combined with practice profiling and resilience support is aimed to keep an open and transparent environment to work with practices to ensure a proactive approach in improving quality and resilience. The ambition for 2018/19 is for Dorset to increase the number of practices rated as outstanding while maintaining the support needed to reduce risks of practices receiving less than 'good'.

7. Workforce: Achievements and Impact

7.1 Workforce profiles were completed for all localities and circulated in October 2017 to each locality for validation in order to support a Primary Care workforce baseline. Each profile included the baseline data for General Practice, identified a gap in Community Provider data and detailed the ICPCS modelling for each area.

7.2 The Workforce Redesign Lead for Primary Care was appointed in October 2017, using non-recurrent Transformation funding, to work with colleagues in Primary Care to develop the workforce profiles for Practices and localities and to inform workforce redesign to support the new models of care delivery. Updated profiles, including Community Provider data, were recirculated to localities in December 2017 with support offered for further validation of the baseline data and use of the Wessex LMC Practice Healthcheck tool to support development of local workforce plans.

7.3 As at July 2018, 58% of the localities have completed the Wessex LMC Practice Healthcheck tool to validate the baseline workforce and gain an understanding of the gap between current and the workforce recommendations by the ICPCS modelling.

7.4 In July 2018 the Workforce team gained access to the Models of Care portal, established by NHSE and the South West Academic Health Science Network. Contained within this is the General Practice Workforce Analysis Tool (WAT). Based on the information submitted to the Workforce Minimum Data Set via the Primary Care Web Tool which GP Practices complete on a quarterly

basis, the information collected is cleansed and released by NHS Digital in a flat spreadsheet (consisting of around 4million data points).

7.5 Whilst in its current published form this tool is not a resource that can be used by Practices and Workforce Managers in CCGs and STPs, the WAT will enable more accurate, timely and detailed profiles to be created on a Locality or federation level in the future. The WAT also provides us with comparisons between Dorset and the situation in similar areas as well as the national picture. This includes controlling for factors such as age of patients or relative deprivation of areas.

International GP Recruitment Programme (IGPR)

7.6 NHSE is leading on the international recruitment campaign for GPs. NHSE aims to recruit around 2,000 GPs from overseas by 2020. The overseas recruits will work alongside GPs trained in England to develop an exciting range of services away from hospitals in local community settings. Recruitment to the programme is being centrally co-ordinated and organised in phases across England. Dorset CCG submitted a bid on 28 February 2018 to be included in the programme. The Dorset bid for 33 international GP recruits is included in the national team's considerations to plan delivery based on the demand across all STPs.

Case Study

Developing Skill Mix – Clinical Pharmacists in Primary Care

East Bournemouth Locality led a successful bid to the NHSE National Clinical Pharmacist Programme to secure funding and training to support the recruitment of 3 Clinical Pharmacists. This collaborative approach across East Bournemouth and Central Bournemouth practices is now in the implementation stage and will see the three pharmacists working across all 8 practices by the end of 2018.

The three Clinical Pharmacists will work in general practice as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas. They will work with and alongside the practice teams, taking responsibility for patients with chronic diseases and undertaking clinical medication reviews to proactively manage people with complex polypharmacy, especially for the elderly, people in care homes and those with multiple comorbidities. They will provide specialist expertise in medicines use while helping to address both the public health and social care needs of a patient at the practice.

It is expected that key outcomes of this work include improving care and health outcomes for patients with improved access to care in general practice. Other benefits include:

- Supporting patients to get the best use of their medicines and identifying medicines related issues.
- Reducing potential, A&E admissions, attendances and readmissions
- Better care closer to home through home and care/residential home visits
- Expanding the general practice team to include clinical pharmacists, with their skills and knowledge. This will allow reallocation of general practice workload
- Increase GP practice capacity to see and help more members of the public
- Ensure safer prescribing and improvement in patient safety and quality of care
- Increase capacity to offer more on the day appointments and provided OOH/extended hours/on-call services.
- Improved integration with the community and hospital pharmacy teams
- Improvement in the clinical and cost-effective use of medicines.
- More efficient and effective communication between general practice and wider healthcare teams.
- Better integration with the wider healthcare systems/team's due to clinical pharmacists being key point of contact for primary and secondary care services.
- Optimisation of the patient journey through the healthcare system.
- Reduce pressure on urgent and emergency care departments by preventing avoidable admissions/readmissions.

8. Workload: High Impact Actions

8.1 Over 80% of practices are delivering two or more high impact actions.

8.2 Improvement in Managing Clinical Correspondence (MCC) is yielding significant benefits for GPs and practices. Early evidence shows a reduction in the GP workload of at least 30-40 minutes a day. If this is replicated in every practice in Dorset for every GP this means 240 hours a day or in excess of 60,000 hours a year that GPs can now spend on delivering direct patient call as well as other priorities. This innovation could deliver a £3 million time benefit to General Practice but more importantly it has started to address the increasing workload challenges that GPs today are facing.

Case Study

Implementation of Managing Clinical Correspondence by non-clinical staff

West Dorset Locality have successfully developed a centralised workflow approach to managing clinical correspondence for locality (all but one practice in the locality are signed up to MCC at scale). A Business Case is being developed whereby the locality will act as mentors for other localities to support them in their MCC development.

8.3 Practices are engaging in long-term conditions self-management support programmes including supporting a roll-out of Health coaches in GP practices which will be enhanced by a standardised Dorset model for non-clinical health coaching and social prescribing which is currently being procured. Training and education of practice staff will be made available to all surgeries either as part of the Personalised Care programme or via GPFV funding.

8.4 The General Practice Resilience Programme will provide £40 million over four years (until 2020) to support GP practices and to build resilience into the system.

8.5 The Resilience fund will deliver a wide Menu of Support to help practices become more sustainable. In 2017-18, 14 Dorset practices have benefitted from this scheme. Seven of these have completed and have action plans in place to address key areas of resilience, all of which have been approved by NHSE and the CCG.

8.6 We are now working with NHSE to plan investment in this programme for 2018-19. Agreement has been reached that the programme can support groups of General Practices working on local system resilience in partnership. The Primary Care team, working in partnership with locality groups of General Practices, are currently considering priorities for the use of this fund which is likely to include targeting locality areas currently facing the biggest resilience challenges due to planned changes in the local configuration of general practice or where there are practices facing difficulties in resilience planning.

Case Study
Supporting GP Resilience

In a change to the usual method of supporting practices facing resilience issues, NHS England provided financial support to both the practice that was facing resilience challenges and the neighbouring practice and patients affected by this.

The support was mobilised to provide:

- Detailed clinical evaluation of the issues facing the practice.
- Detailed managerial support in identifying the business challenges
- Clinical and Managerial leadership to produce an outline and detailed plan for continuing provision of Primary care to the practice patient list.

These led to an early decision that a merger of the two practices was the only real option for a controlled migration of patients and reduction in risk to both patients & the practices. The action plan listed in detail the areas that needed to be addressed and covered:

- Diagnostic & improvement
- Rapid Intervention
- Specialist Advice & Guidance
- Practice Management
- Coaching/Supervision & mentorship
- Workforce

Because of this intense and focussed support the practice successfully merger a 3,500 patient list from a very challenged practice in just a few months. Patients were risk stratified and supported thorough clinics, individual appointments or wider scale practice level engagement events.

9. Infrastructure (Estates): Achievements and Impact

9.1 **Estates and Technology Transformation Fund (ETTF) Progress -** The NHSE Estate and Technology Transformation Fund (ETTF), launched in 2015/16, is a multi-million-pound investment programme in General Practice facilities and technology. It has recently been confirmed that the programme end date has been extended from March 2019 to March 2020.

9.2 An update on the three Dorset projects is provided below:

Project 1 - New-build replacement for Wareham Health Centre:

- Revised Primary Care PID approved end of March 2018 to reflect the changing scope of the Wareham Project.
- Dorset HealthCare NHS FT (DHC) completed the Outline Business Case (OBC) for Wareham Hub in Summer 2018 and identified the preferred solution – new build on the middle school site.
- It is hoped that a single development project will be possible, ie incorporating both the ETTF funded primary care component and the Community Hub.
- A very positive ETTF project review meeting took place on 17 April 2018. Attendees included the NHSE national ETTF Programme Lead, members of both the Regional and Wessex Area NHSE teams, and CCG Primary Care representatives. Project issues and blockers were discussed in some detail and action plans agreed. CCG representatives will continue to work closely with the NHSE teams to ensure that emerging national guidelines on ETTF financial flows are applied to this complex multi-stakeholder project;
- The Full ETTF Business Case will now be developed and it is anticipated that it will be presented to this Committee in December 2018.
- Subject to approval of the Full Business Case late in 2018, the aim is to commence construction in March 2019 and to complete construction in March 2020.

Project 2 - Relocation of the Carlisle House Surgery into new leased premises:

- The combined OBC/FBC was submitted to NHSE for consideration at Panel on 23 July 2018.
- Subject to Panel approval and following the return of the tendered construction costs a final report will be presented to this committee in Autumn 2018.

- Subject to approval of the Full Business Case in early summer 2018, the aim is to commence construction in late 2018 and to complete construction in March 2019;

Project 3 - Refurbishment of the Parkstone Health Centre:

- A revised PID, created to reflect the changing scope of this project, was approved by NHSE Wessex Area team on the 1 March 2018;

- The detailed schedule of works is now being developed for agreement with the landlord (NHSPS);

- The Full Business Case is in development and it is anticipated that it will be presented to this Committee in October 2018;

- Subject to approval of the Full Business Case, the aim is to commence construction in November 2018 and to complete construction in March 2019.

9.3 **Premises Improvement Grants -** Whilst NHSE retains overall responsibility for Premises Improvement Grant Funding, the CCG's Primary Care Development team now has a robust process in place for managing the annual programme in Dorset.

9.4 In 2017/18 a total of £691,000 was allocated to 32 individual schemes in Dorset. Locally bids have been invited for funding in 2018/19 although the total amount of funding available has not yet been confirmed by NHSE.

9.5 Looking forward it is not yet clear whether this annual programme of Grant Funding will continue. It has been suggested that in future this funding will form part of the overall STP Capital Investment Plan (see below) and advice is being sought from NHSE on this.

9.6 Dorset STP Strategic Estate Plan and Capital Investment Plan - The guidance for refreshing NHS plans in 2018/19 asked all sustainability and transformation partnerships (STPs) to undertake a strategic, system-wide review of estates and develop a Capital Investment Plan.

9.7 The STP Estate Strategy needs to:

- underpin and express the STP's overarching strategy including acute, Primary Care, mental health, community, ambulance and specialist trusts;

- cover all services including acute, Primary Care, mental health, community, ambulance and specialist trusts;

- explicitly set out how it supports the STP's overarching clinical and financial strategy.

9.8 The STP's Capital Investment Plan needs to identify and explicitly prioritise the individual capital schemes, including schemes within Primary Care.

9.9 The Dorset STP Strategic Estates Group has created a prioritised schedule of all planned capital developments (system-wide) and has identified a number of priority schemes which are sufficiently well developed to allow a capital bid template to be completed. A number of capital bids have now been completed and submitted on 29 June 2018.

10. Infrastructure (Technology Enabling Care): Achievements and Impact

10.1 **GP Online Consultations -** The Primary Care team continues work with the Task and Finish group to re-examine the options for a GP Only 'GP Online Consultations' product and will procure via the NHSE Dynamic Purchasing system for practices.

10.2 In May, member practices received an update on the options for securing this support for their patients with details of framework providers discussed at the May Membership event. A Dorset procurement team including representatives from General Practice are working together with the regional NHSE team to procure a service provider. This process seeks to conclude during the summer to allow a phased implementation to commence in the autumn of 2018.

10.3 **NHS e-Referral Service (e-RS) -** A Project Board oversees assurance for this work and provides regular updates to OFRG. Our current position is:

- Utilisation continues to increase above target and in line with trajectory and quality indicators agreed for 18/19;
- A detailed Communications Plan is being implemented with Primary Care communications agreed with Wessex LMC.

10.4 **Electronic Prescription Service (EPS) - Repeat Dispensing**: Work continues to promote repeat dispensing and support has been sought from NHSE and the Academic Health Science Networks (AHSN). NHS Digital are currently working on improved resources, having employed a pharmacist lead to take the system forward. Evidence from NHSI has shown that the efficiency improvements in implementing repeat dispensing may save the system considerable funds. Advice from the NHS Digital National lead pharmacist for the programme has been sought, and new guides to implementation are planned to be sent out in the next financial year. It is planned to have a Dorset implementation group and bring together relevant stakeholders in order to re-launch when the new NHS digital resources come in. It is likely that this will include undertaking a practice suitability check before implementation.

10.5 **Patient Access to Online Services -** Dorset currently has an average of 17% of patients registered with GP Online services against a national minimum target of 10%. Locally we are aiming for 20%.

11. Care Redesign - Improving Access to General Practice Services (IAGPS): Achievements and Impact

11.1 A major component of the GPFV was the Improving Access to General Practice Services (IAGPS), which mandated the provision of services from 1830-2000 Monday to Friday and Weekends according to Local Need. In August 2017, due to its ACS aspirations, Dorset was selected to be an accelerator area for IAGPS, being set targets to achieve 50% of target population coverage by April 2018 and 100% by January 2019; this was to be delivered as part of a proof of concept phase, which would run from October 2017 through to March 2019. After a business case evaluation process, the Dorset population was split into three clusters, using existing Locality boundaries to group practices together, named East, Mid and West, with responsibility for provision being assumed a Foundation Trust in each area. The Governing Body took the further step in January 2018 of agreeing to incorporate the urgent (same-day) element of IAGPS as part of the reprocurement of Integrated Urgent Care (IUC) services. The routine (pre-bookable) element is being developed as part of locality transformation plans. The bracketed terminology from the National IAGPS guidelines was superseded by the terms urgent and routine, in order to support the concept of an integrated service, thus reducing confusion for the public. As a result of the planning guidance released by NHS England, a revised target of achieving 100% target population coverage by October 2018 was set. To date, the programme is on course to meet this target.

11.2 The first major milestone of the programme was the 50% target population coverage (measured using a calculation of clinical hours of 45 minutes per 1,000 population) for IAGPS was achieved, and surpassed, by March 2018. The actual % achievement across Dorset is shown below:

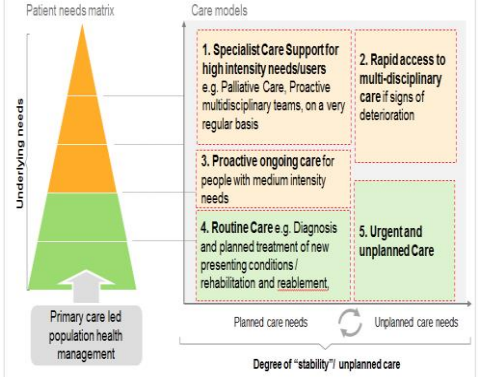
Area	25 - 31 March 2018
West Cluster (%)	109 hours (59%)
Mid Cluster (%)	112 hours (50%)
East Cluster (%)	172 hours (91%)
Dorset (%)	**393 hours (66%)**

11.3 IAGPS has arguably been perceived as the catalyst to achieving a cluster level response to CCG delivered programmes of work. The size 250k-300k population coverage is assessed to be appropriate in this context as it affords the provider the opportunity an agile and responsive model to affect a significant proportion of the population operationally as a whole without becoming so far removed that changes to service delivery become unworkable. This approach to service delivery is supported by a robust support system with colleagues (both clinical and non-clinical from primary, secondary and community sectors) in other clusters and managerial or

specialist staff at the CCG level. It could be further argued that IAGPS as a programme is a tangible example of working as an ICS, when the providers that make up the cluster groups are considered, and how they have been supported through other mutually beneficial programmes of work.

12. Care Redesign – Integrated Community and Primary Care Services (ICPCS): Achievements and Impact

12.1 **ICPCS Workforce Investment** - The case for change in community and primary care services is now well established. ICPCS workforce investment has been secured to focus on the population with complex need and enhance the proactive approach to identification and management of the most complex patients including rapid response and implementation of the frailty framework. The Outline Business Case details the workforce within each element of the model of care and the table below summarises the change in workforce and financial costs over 5 years expected as we support people with specialist care and rapid access to MDT care.



STAFF GROUP	SPECIALIST CARE FOR HIGH INTENSITY NEEDS		RAPID RESPONSE	
	WTE	£'000	WTE	£'000
GP	(13)	(1,472)	(1)	(85)
Consultant/GPSI	12	1,703	0	63
Practice Nurse	4	165	0	0
Nurse Practitioner	4	236	0	0
H&C Assistants	42	1,034	2	43
Community Nursing	47	1,812	3	119
Therapist	62	2,367	3	103
Pharmacist	16	780	0	0
TOTAL	**175**	**6,625**	**7**	**243**

12.2 It is anticipated that the locality plans will reduce:

- non elective admission and re-admissions for this population group
- occupied bed days in acute and community hospital settings
- people delayed in hospital
- the number of stranded patients in hospital settings
- the number of people requiring long term care home placements

13. Primary Care Networks

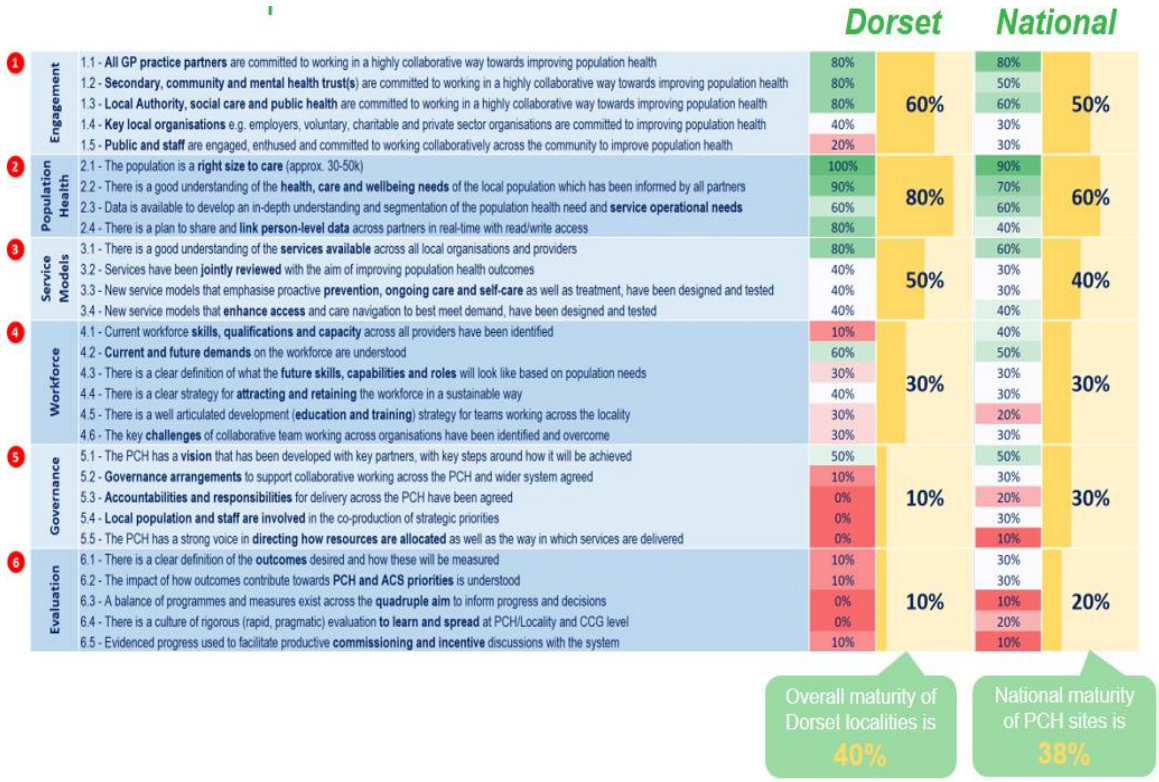
13.1 The development of **Primary Care Networks** forms part of NHS England ambitions to support General Practices working at scale (NHSE Planning Guidance, February 2018). The form and function of Primary Care Networks is currently evolving.

13.2 Primary Care Networks are expected to support person-centred care closer to home. In Dorset our planned roll-out of Primary Care Home sites will form part of this. Over time Primary Care Networks will be expected to enable an

extended range of services to be delivered in the community with a focus on population health management for physical and mental health; increased resilience to be able to better manage fluctuations in demand and capacity as well as strong engagement with local communities.

13.3 Early indications suggest better system outcomes are emerging as a result of the development of Primary Care Networks in Dorset (National Association of Primary Care NAPC). This is in line with the international emerging evidence base.

13.4 Further emerging evidence of impact can be seen in the summary Primary Care Home Development grid below. Comparing Dorset with the national picture of PCH, we are performing better than the national in terms of engagement, population health and service model development. Overall our maturity is 40% compared to the national maturity of PCH of 38%.



13.5 Next steps will be to link the development grid to the NHSE matrix to show progress towards ICS maturity at a local and aggregate level.

ICPCS Frailty

13.6 The Dorset Framework for Frailty has been developed through multi-sectorial collaboration with health and social care providers, voluntary and third sector organisations, patients and their representatives. It is endorsed by the Dorset Frailty and End of Life Care Reference Group.

13.7 The development of the framework is a response to the request for a common approach to the early recognition and identification of frailty as a long term condition, promoting early detection through case-finding, appropriate

assessment, risk stratification; and backed up by planned and coordinated care and support.

13.8 The vision is that all people living with frailty have their condition recognised early and proactively managed within an integrated coordinated care pathway which meets the needs and expectations of the individual, their carers and advocates.

13.9 The Frailty service specification forms a key part of the model of delivery of integrated community services new models of care. The specification went live from April 2018 and localities are working collaboratively to implement at locality level. Population health outcome based commissioning and system wide working is creating the environment to drive change. 65% of all Frailty plans demonstrate collaborative working with a target of 100% by March 2019.

13.10 Work throughout 2018 will support practices in delivering the model and addressing challenges / barriers to full delivery of the specification. Currently localities are at different points of the journey but all working to one specification. Plans put forward by the localities are encouraging with a large number demonstrating integrated plans to work collaboratively across primary care and other provider organisations. Primary Care Home is supporting this development including focus on integrated nursing. It is anticipated that the ICPCS plans will further encourage networking and integration to deliver outcomes.

Case Study

Locality Enhanced Frailty Service

Central Bournemouth Locality are developing and delivering an 'at scale' / collaborative frailty service model. The locality has worked together to agree a clinical and business model for a locality. The service is fully integrated with Bournemouth Hub and commenced from April 2018. Two practices in the locality share the employment of the frailty team to reduce risk (with risk sharing agreement) and have identified the development of a cluster wide venture organisation in their priorities for development.

Case Study

Weymouth & Portland Integrated Community Hub

Despite a more deprived population, Weymouth & Portland locality has achieved reductions in bed utilisation, admissions and readmissions. The Weymouth Locality Hub has a well-developed MDT approach supporting complex / frail elderly referrals through a community Virtual Ward approach (including rapid response and access to MDT). The hub has been operational for 2.5 years and is now embedded within primary, community and social care as the co-ordination and response hub supporting a number of high need patients as well as providing resilience and support to GP practices and Care Homes. Sessional clinical leadership from a Community Geriatrician, with GP Extensivist roles also providing frailty expertise and clinical leadership. Locality visiting service. ICPCS investment and development will continued to focus with this direction of travel along with a system partner focus on super stranded patients and variation between practices.

14. Care Redesign - (Right Care and Demand Management): Achievements and Impact

14.1 The Clinical Commissioning Local Improvement Plan (CCLIP) has been focusing on three areas from the nine key 'Collaborative Agreement' Specialities. These are:

- Trauma and Orthopaedics (MSK);
- Cardiology;
- Dermatology.

14.2 MSK is showing a reducing trend. In 2017-18 the volume of GP referrals reduced by 1.4% (-203), with a distinctive split between the localities, with increases predominately recorded in the East of the county. 2017/18 year-end figures show a further 14.0% reduction on 16/17, and the impact of the MSK triage service (implementation mid Oct 17) is now having a significant impact on the level of acute referrals.

Figure 6 illustrates the latest rolling 12 month figures highlighting the variation in the rate of MSK referrals to the main STP Providers (RBH, PHT & DCH) per 1000 registered list size - the highest 24.0 per 1000 in Christchurch. The rate in North Dorset is artificially low as referral activity to both Salisbury and Yeovil is not included in these STP only figures.

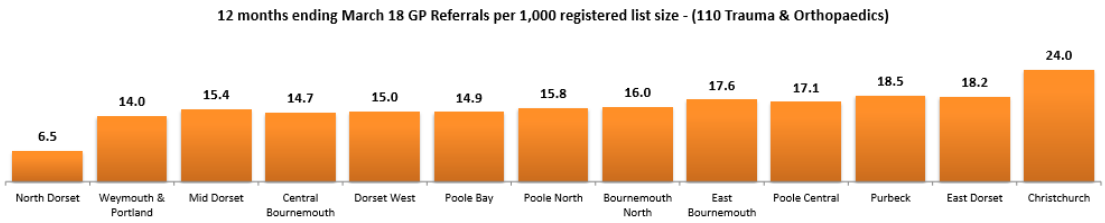


Figure 6: Variation in MSK referral rates across Localities

14.3 The MSK Right Referral Right Care group has representation from Primary Care, secondary care and the MSK triage service leads at Dorset Healthcare. This group is working together to continue to address variation. The group has identified the following project areas to take forward over the coming months:

- Developing a referral template for initial referrals from GPs into the MSK triage service (this was following a number of rejections back to the GPs from the triage service);
- Education and study days for GPs;
- Website presence for MSK triage service which can be used by both GPs and members of the public.

14.4 Cardiology is also showing a reducing trend. Last year the volume of GP referrals reduced by 1.4% (-124), with a distinctive split between the localities, with increases in the East of the county. Most notable were reductions in Dorset West (-19%) and Mid Dorset (-25%). 17/18 year-end figures indicate a further 2.5% reduction.

14.5 Latest rolling 12 month figures (Figure 7) highlight variation in the rate of Cardiology referrals per 1000 registered list size - the highest rate 17.2 per 1000 in Christchurch.

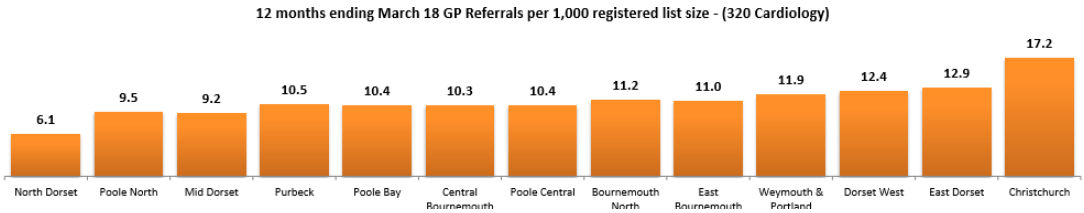


Figure 7: Variation in Cardiology referral rates across Localities

14.6 The Cardiology Right Referral Right Care group with representation from primary, secondary and community care are now focussing on:

- Creating a standard secondary care consultant outcome letter;
- Education and training;

- E-referral advice and guidance – there has been pan Dorset agreement to the E-Referral solution for cardiology;

- Direct Access to Echocardiography.

14.7 Dermatology has shown an increasing referral trend. Last year the volume of GP referrals increased by 5.2% (630), with increases recorded in all localities with the exception of Mid Dorset, North Dorset and Weymouth and Portland.

14.8 2017/18 year-end figures (Figure 8) indicate a 1.7% increase when compared to 2016/17, overall the trend has stabilised and the size of the current year to-date increase has reduced significantly over the last few months.

Profile by Locality	2015/16	2016/17	Change Actual	Change %
Bournemouth North	870	891	21	2.4%
Central Bournemouth	613	711	98	16.0%
Christchurch	1,184	1,365	181	15.3%
Dorset West	623	740	117	18.8%
East Bournemouth	1,072	1,091	19	1.8%
East Dorset	1,358	1,453	95	7.0%
Mid Dorset	685	661	-24	-3.5%
North Dorset	722	666	-56	-7.8%
Poole Bay	1,168	1,223	55	4.7%
Poole Central	1,119	1,182	63	5.6%
Poole North	860	923	63	7.3%
Purbeck	615	652	37	6.0%
Weymouth & Portland	1,095	1,070	-25	-2.3%
None	55	41	-14	-25.5%
TOTAL	12,039	12,669	630	5.2%

2016/17	2017/18	Change Actual	Change %
891	810	-81	-9.1%
711	787	76	10.7%
1,365	1,404	39	2.9%
740	752	12	1.6%
1,091	1,098	7	0.6%
1,453	1,416	-37	-2.5%
661	634	-27	-4.1%
666	599	-67	-10.1%
1,223	1,146	-77	-6.3%
1,182	1,147	-35	-3.0%
923	957	34	3.7%
652	648	-4	-0.6%
1,070	1,015	-55	-5.1%
41	26	-15	-36.6%
12,669	12,439	-230	-1.8%

Figure 8: Dermatology Profile by Locality

14.9 As part of the paper 'switch off' and to reduce the burden on Primary Care in terms of the E-Referral process there has been agreement across Dorset to implement a 'three routes in' approach to Dermatology services, as follows:

- Referral Assessment Service (RAS) - GPs will refer (including an image where possible) into the RAS service for the relevant provider who will then triage OR provide advice back to GP/ no further action;

14.10 Advice and Guidance, including tele-dermatology - GPs can now access Advice and Guidance including tele-dermatology for each acute provider;

- Fast Track - accessed through the existing Electronic Referral Service (ERS) process including an image.

14.11 The benefits of this approach will be to release capacity to reduce overall patient waits, prevent unnecessary patient appointments and provide quicker reassurance to patients without suspicious lesions.

14.12 **Tele-dermatology**: Linked to the above, work is progressing towards piloting an 'app' which GPs can use to take photos of skin lesions, send to secondary care and permanently delete photos from the mobile device used. There are currently 19 practices from across Dorset who have put forward an interest to be part of the pilot.

14.13 Discussions have taken place with the Primary Care Workforce Centre and recently identified funding for six GPs to undertake Dermatology GP with

Specialist Interest (GPSi) training, which will be a key feature of the integrated dermatology service.

14.14 The CCLIP for 2018 / 19 continues to have a requirement to focus on these areas for 2018 / 19 and embed the system wide approach to the management of demand and variation.

15. Care Redesign (Prevention at scale) – Achievements and Impact

Starting Well

15.1 Healthy lifestyle assessment is now embedded routinely within the Better Births project. Scoping is complete and the next stage is to co-produce options for implementation. Discussions are planned with Bournemouth University to include healthy lifestyle training within the midwifery curriculum for newly trained midwives

15.2 Work on building whole school approaches to health and wellbeing, with a focus on physical activity and emotional health and wellbeing is progressing well. A survey has been sent to schools about potential actions for schools, and a workshop was held to discuss next steps which will lead to production of a more detailed business case.

15.3 An intensive programme of work with health visitors and children's centres has ensured much closer working between teams, and is already having an impact on outcomes.

Living Well

15.4 The LiveWell Dorset service transitioned in-house on 1 April and the new digital platform was launched at the same time. In the first month the platform had more than 3,000 unique users, and delivered more than 50 coaching episodes via its online chat facility, and there were more than 60 requests for a call back from a coach.

15.5 The Health Checks task and finish group had its first meeting in May and has agreed some high level principles to inform the design of the future programme at locality level. Subsequent meetings will explore commissioning and contracting options, and co-production to inform how best to integrate and offer checks for people with learning disability and serious mental illness.

Ageing Well

15.6 Two pilot programmes for Escape Pain which aims to improve self-management of hip and knee pain have been run. These pilot programmes were in East Dorset and the intention is to roll out the programme across Dorset. Work is ongoing with the MSK triage service, primary care, and LiveWell Dorset to ensure that the service and referral pathway is embedded for future cohorts.

15.7 Altogether Better have now appointed a Development Manager and have confirmed the list of practices that will be engaging in the Leadership Programme for the Collaborative Practice model. Seventeen practices across

Dorset have engaged fully. Early feedback from one practice suggests there is a high degree of interest from registered patients in helping out more.

A text message to 5,000 people registered with one practice elicited 218 replies and 28 completed expressions of interest forms. Receptionist morale has improved considerably the practice reports.

15.8 Active Ageing – a project aimed at getting 55 to 65-year olds more active – is now underway, with a steering group and project manager appointed. The first engagement event with stakeholders and interested organisations has been held. North Dorset locality have expressed an interest in being involved in the pilot.

15.9 The award for the diabetes prevention programme (funded nationally) has been made to Living Well Taking Control (Health Exchange). Mobilisation of the service has commenced, working closely with the CCG and LiveWell Dorset and the service will start in 18/19.

Healthy Places

15.10 Spatial Planning – good links are being made between local planners and the Primary Care Infrastructure work. Broader developments are to be discussed at the Dorset-wide workshop planned for end June 2018.

15.11 Active travel – working alongside the Integrated Transport Planning project to include travel planning and maximising active travel in healthcare plans around access and how strategic plans for Poole and Bournemouth hospitals and hubs within GP localities are implemented.

15.12 Access to green space – A range of projects are now set up to encourage different groups of people to access their local green spaces, and these will be evaluated using the same framework to establish their impact and how well this is sustained. In Poole the projects focus on engaging young families through facilitated activities; in Dorset the projects are improving path conditions and removing barriers to public rights of way along specific routes with particular connections in mind e.g. connecting Littlemoor residents with Lorton Meadows nature reserve; in Bournemouth the project is to develop a group of volunteers (referred in by partners) with a focus on building positive mental health.

15.13 Healthy Homes – we have already upgraded over 160 homes against a target of 150 for Phase 2 and secured additional funding from the national Warm Homes Fund for specific areas of development. Key to ongoing development is better integration within GP localities to allow better targeting to vulnerable residents with specific cold-related conditions.

15.14 Public health link workers are now providing support to all Dorset localities, which includes

- use of Locality public health profiles to consider how best to target new ways of working to meet local need

- an increased healthy lifestyles offer through Livewell Dorset including digital referral, workforce development training and feedback to localities on service use and patient experience.

16. Lessons Learnt to date

- Strong and distributed leadership results in early buy in from locality practices and enables greater success moving forward.
- Recognition of a "burning platform" for change results in practices in localities being more engaged.
- Increasing patient facing clinical time improving models of care such as frailty and long term conditions management.
- A balance between addressing immediate issues, for example workload and long term change improves buy in and keeps momentum.
- Protected Learning Time (PLT) is essential to allow 'Head space' for practices.
- The value of a joint agreement (Memorandum of Understanding) cannot be underestimated in supporting a clear commitment to collaborative working.
- Making sure function drives form is essential or there is a risk of having form that does not deliver on the function.
- Recognise the value of building strong collaboration across the system to support change and buy in.
- The value of aligning incentives to accelerate change.
- Benefits of bringing together local plans to demonstrate how care can be delivered more effectively through strong system partnerships – such as that achieved in the IAGPS Cluster level working arrangements.

17. Next Steps

- Continue a co-production approach to support Dorset's Primary Care Network development working with locality transformation groups, the National Association of Primary Care (NAPC), LMC and NHS England including the National ICS support team;
- Provide locally focused support and advice around delivering new care models and frameworks for GPs to progress working at scale;
- Develop collaborative working more formally including governance and decision making processes.

- Provide support for primary care business development to strengthen leadership of Primary Care Networks.
- Continue to focus on developing resilience at practice and locality level – support improved primary care capacity and demand management.
- Increased focus on quality improvement and managing variation as a lever for change and collaboration;
- Development of Provider Leaders to strengthen leadership for Primary Care Transformation.
- Implement a Primary Care incentive framework to incentivise integrated, collaborative working and models;
- Expand the Primary Care Outcomes Framework to include other areas of the GPFV to demonstrate impact ;
- Work with ICPCS Portfolio Board, East and West IHCP to ensure primary care has a strengthened voice and is able to play a full and active role in the integrated care system.
- Further develop approaches to population health management, strengthening business intelligence support to Primary Care Networks.

18. Conclusion

18.1 This mid-point review has identified significant progress in Dorset in working towards the ambitions set out in our Primary Care Strategy and GPFV Delivery Plan.

18.2 We plan to continue to invest in primary care sustainability and transformation to further progress these delivery plans and realise our ambition as set out in our Dorset Primary Care Commissioning Strategy and GPFV Delivery Plan.

18.3 We will continue to focus on primary care provider development to establish Primary Care Networks which serve the whole Dorset population.

Rob Payne
Head of Primary Care
Dorset Clinical Commissioning Group