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1. Introduction

This document sets out the Greater Nottingham Clinical Commissioning Groups (NHS Nottingham City CCG, NHS Nottingham North and East CCG, NHS Nottingham West CCG and NHS Rushcliffe CCG) plan to transform and strengthen general practice during 2017/18-2018/19. The plan describes how the CCGs will utilise national and CCG funding to improve access and support transformation. It has been developed in response to the General Practice Forward View and the NHS Operational Planning and Contracting Guidance 2017-2019 and therefore contributes to delivery of the 9 ‘must dos’ identified in the planning guidance as demonstrated in the Operational Plans 2017-2019 for each CCG in Greater Nottingham.

The plan describes the CCG’s vision for general practice and how quality in primary care will be improved whilst also ensuring its future sustainability. It should be read in conjunction with the Nottinghamshire Sustainability and Transformation Plan 2016-2021. It is acknowledged that although the approach to delivery and the progress made to date by individual CCGs within Greater Nottingham differs in some areas, the overarching vision and aims are consistent across all CCGs and align with both the Nottinghamshire Sustainability and Transformation Plan 2016-2021 and the plan for Greater Nottingham. To reflect this, the document describes the overarching Greater Nottingham approach to primary care as well as including CCG specific chapters. To accompany this plan each CCG has developed its own delivery plan. The Primary Care Commissioning Committee of each CCG will assume responsibility for implementation and delivery.

Primary care is the foundation upon which healthcare has been provided since the NHS was established and remains one of the UK’s most important and valued public services. Primary care accounts for nine out of every ten patient contacts within the NHS and is recognised across the world as one of the most cost-effective, high quality means to deliver care. In particular, general practitioners play a crucial role in providing urgent care, coordinating and providing chronic disease management, health promotion, diagnostics and early intervention, reducing inequalities and support to patients to manage their own care.

However nationally, primary care, and general practice in particular, is currently facing significant challenges, including:

- unprecedented demand for services
- an increasing and ageing population with more complex health needs
- managing patient expectations
- workforce, workload and morale issues
- financial pressures and the requirement to deliver efficiency savings
- threats to the sustainability of general practice in its current form
- rapidly changing technology.

In October 2014 the NHS Five Year Forward View was published, setting out a clear direction for the NHS in respect of whole system integration of services and implementation of alternative care delivery models, such as accountable care organisations, multi-speciality community providers, or prime provider/primary and acute care systems.

The NHS Five Year Forward View makes explicit the need for the NHS to adapt in order to meet the challenges posed by an aging and growing population. People are living longer but not living well - often with complex health issues, sometimes because of the impact of poor lifestyle choices. The Forward View describes the need for:

- a radical upgrade in prevention and public health
- patients having greater control of their own care
- breaking down the barriers in how care is provided
- a ‘new deal’ for GPs with more investment in primary care and the stabilisation of core funding, and control of primary care budgets to CCGs to enable a shift in investment from acute to primary and community services.

In addition the Forward View confirms the central role of the NHS as caring for people with long-term conditions and also confirms the direction of travel as follows:
More care needs to be provided out-of-hospital
Services need to be integrated around the patient
Examples of best practice need to be adopted more widely
New models of in-reach support for people in care homes

To support delivery of the Forward View a new deal for general practice (the General Practice Forward View (GPFV)) was published in April 2016, which builds on existing strengths within primary care and sets out to build a firm foundation for the future, including:

- stabilising core funding for general practice
- improving access to services and supporting new ways of working
- increasing the number of GPs and other key practice staff
- providing access to funding to upgrade primary care infrastructure and the scope of services offered to patients.
- supporting practices to manage workload pressures
- redesigning models of care to ensure general practice is efficient, sustainable and able to deliver improvements in patient access and care

The NHS Operational Planning and Contracting Guidance 2017-2019 included a specific requirement for CCGs to create a plan to demonstrate how the General Practice Forward View is to be implemented locally over the next two years.

In 2016/17 NHS England and NHS Improvement described nine ‘must do’ priorities. These remain the priorities for 2017/18 and 2018/19. The 9 national ‘must dos’ are to:

1. implement agreed Sustainability and Transformation plan milestones and achieve trajectories against the STP core metrics set for 2017-2019
2. deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals.
3. ensure the sustainability of general practice by implementing the General Practice Forward View
4. deliver the four hour A&E standard, and standards for ambulance response times
5. deliver the NHS Constitution standard for referral to treatment in elective care
6. achieve cancer standards (waiting times and survival rates)
7. deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages
8. deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism
9. improve quality of care in all organisations.

The CCGs’ operational plans for 2017/18 and 2018/2019 articulate the approach to delivery against the national requirements as detailed in the aforementioned documents across a number of key areas, focussing on delivery of the nine national ‘must-dos’ and how the CCGs will support implementation of the Nottinghamshire Sustainability and Transformation Plan and the delivery of the Accountable Care System model for Greater Nottingham.

1.1. Our vision for primary care – where we want to be

The Greater Nottingham CCGs are committed to the delivery of the Nottinghamshire Sustainability and Transformation Plan which describes an overarching ambition to:

- organise care around individuals and populations – not organisations - and deliver the right type of care based on people’s needs:
  - help those who are largely well today (most of the population) stay well through prevention and health education and manage minor issues themselves in so far as it is possible
  - help those with a complex or advanced long-term condition that needs professional expertise and support to be as enabled as possible to manage their own care, to have an identified system to escalate care quickly in the event of exacerbations, and to have regular monitoring to identify changes in their health and social care needs as early as possible
• help people remain independent through prevention programmes and offering proactive rather than reactive care, with the aim of reducing avoidable demand for health and care services
• support and provide care for people at home and in the community as much as possible and ensure that hospital, care home beds, and supported housing are available for people who need them
• work in multi-disciplinary teams across organisational boundaries to deliver integrated care as simply and effectively as possible
• minimise inappropriate variations in access, quality, and cost, and deliver care and support as efficiently as possible so that we can maximise the proportion of our budget that we spend on improving health and wellbeing
• maximise the social value that health and social care can add to our communities.

The STP has three key aims: to improve the quality of care, the health and wellbeing of local people, and the finances of local services.

Primary care has a significant role to play in achieving these aims, as the single universal service from cradle to grave. As well as delivering core services general practice in Nottinghamshire will focus on improving care in all areas and at all stages, from encouraging people to

• attend screening programmes
• take up vaccinations & immunisations and health checks
• signposting people to support services
• supporting delivery of proactive care through multi-disciplinary team meetings and an MCP approach to support people to remain well for longer and retain independence

through to co-ordinating the long term management of chronic conditions and end of life care. GPs are the constant in people’s lives so are best placed to identify where care delivery can be integrated or needs to improve. In addition as commissioners in CCGs GPs also have responsibility to ensure all commissioned services are continually improving and offer value for money.

The programme of transformational change, which has been agreed by all Greater Nottingham and wider STP partners focuses on high impact and supporting themes together with a number of enablers.

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<th>High impact</th>
<th>Supporting</th>
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<td>Promote wellbeing, prevention, independence and self-care</td>
<td>Improve housing and environment</td>
<td>Future proof workforce and organisational development</td>
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<td>Strengthen primary, community, and social care and carer services</td>
<td>Strengthen acute services</td>
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<td>Simplify urgent and emergency care</td>
<td>Drive system efficiency and effectiveness</td>
<td>Maximise estates utilisation</td>
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<td>Deliver technology enabled care</td>
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<td>Ensure consistent and evidence-based pathways in planned care</td>
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Table 1. Transformational change themes and enablers

The Greater Nottingham CCGs are committed to and actively contributing to the delivery of this change programme and will continue to do so going forward. Examples of high impact initiatives that will be taken forward over the course of the next two years include:
### High impact theme | Agreed change initiatives
---|---
Strengthen primary, community and social care and carer services | Co-ordinated primary, community, mental health and social care support for people with high and emerging risk through multi-disciplinary teams (MDTs)  
Enhanced care to people in care homes through extended primary and community support
Simplify urgent and emergency care | System redesign to enable reduction of 200 beds in acute hospitals over two years in NUH that are currently occupied by people who are medically fit for discharge  
Operate single front door at ED with streaming to primary care and ambulatory care pathways, including redirecting ambulance to primary/urgent care centre  
Improve capability to discharge from ED and hospital settings
Ensure consistent and evidence-based pathways in planned care | Standardise elective care pathways with an initial focus on gastro, cardiology, ophthalmology  
Develop a new integrated multidisciplinary model for MSK, improving experience, aligning pathways and reducing duplication and waste costs  
Reduce unnecessary attendances and provide alternative ways of providing follow up care in local GP surgeries or the community where clinical appropriate

**Table 2. Transformational change: high-impact themes**

In delivering the STP, Greater Nottingham has confirmed the ambition to bring together its Vanguard and Integrated Pioneer communities, scaling and replicating innovations in best practice as appropriate (such as in support to care homes as confirmed in the high impact initiatives). Going further, the delivery unit has a stated intention to create a new integrated accountable care system (ACS) for the 700,000 population it serves. The first step in developing this ACS focused on the completion of a detailed actuarial analysis to understand where user activity and costs are in the system with the identification of the opportunities to move to person and population-centred care (i.e. reshaping the care system, with a specific focus on tailoring services to the user groups with the biggest value opportunity) to fundamentally improve quality and reduce system costs.

The primary insight from this analysis has confirmed a very significant opportunity in terms of the potential to reduce activity and spend within the acute sector (40% plus of patients potentially could receive care in a lower cost setting equating to a potential gross saving of £690m over five years). The opportunity is far greater than that identified by other benchmarking tools such as RightCare.

For community care, social care, and mental health provision, the analysis confirmed it was difficult to draw meaningful conclusions regarding their effectiveness based on the data quality and completeness. This in itself is a key conclusion, which Greater Nottingham understands to be relatively consistent with the starting point of most fragmented systems that have successfully transformed into high-performing systems.

The second stage of the process of developing the ACS focused on a period of detailed design work from July to mid-November 2016 inclusive. This design phase was supported by a transformation partner with international experience.

This design work has been aimed at confirming the care system needed to achieve a high-performing integrated system, delivering the value opportunity confirmed in the actuarial analysis, i.e. the services required and the obligations of each partner, together with the solutions the ACS would need to put in place in respect to the resource and capacity gaps. The proposed solution includes the characteristics of an integrated accountable care system and the optimal contractual framework for this system. This solution has incorporated the innovative service changes and new models of collaboration being progressed through our Vanguards and Integration Pioneers and is being aligned to our STP.

The design phase has specifically focused on an assessment against an integrated accountable care framework – which confirms the indirect enablers and integration functions needed – and is
being progressed through six design work-streams, namely patient pathways, population health, social care, IM&T, provider payment models, and ACS governance and contract design.

Greater Nottingham has confirmed that its plans for 2017/18 and beyond will be iterated in accordance with the outputs of this design work and resulting locally agreed next steps. These will be shared in the form of refreshed Vanguard Value Propositions which confirm plans to replicate and scale-up successes to date. In addition a Greater Nottingham ACS Value Proposition has been produced, with support from and submission to the New Care Models Programme and wider arm’s-length bodies stakeholders. This Greater Nottingham Value Proposition sets out three overarching models of care. These three areas have close alignment with work already being undertaken within the Greater Nottingham system; the intention of the Value Proposition is to build on and enhance the current work to enable it to be significantly more effective in terms of the results achieved within the system. These models of care promote integration of all health and social care services in a fluid and flexible menu responsive to individual need; from specialist consultant support and intensive intervention at one end of the spectrum to minimal care and advice and signposting at the other.

The three overarching models of care to be focused on are:

1. **Population health management** including admission avoidance, corresponding to the STP sections on prevention and out of hospital care. The proposed example of this within the Value Proposition is a system wide process of A&E diversion which would raise awareness of alternative care settings, better incentivise primary care providers, provide regular meaningful data for urgent and emergency care across the health and care system and allow us to better match system capacity to demand.

2. **Elective care referral management**, corresponding to the STP section on ensuring consistent and evidence-based pathways in planned care. The example of this as set out in the Value Proposition is a Referral Management Hub, or Health and Care Co-ordination Centre. This will provide a single point of access for community, mental health and social care services and will manage and co-ordinate secondary care elective referrals. The proposed model would put in place standardised criteria and process for referrals, a single point of accountability and oversight for referrals, a coherent means of coordinating referrals across providers, and a single set of referral documentation, and will have an overview of referrals as a care transition pathway.

3. **Integrated urgent and emergency care discharge management**, corresponding to the STP section on simplifying urgent and emergency care. The example of this in the Value Proposition is the proposed Integrated Discharge Unit. This will provide a single point of accountability for discharges, standardised criteria for discharge planning, more proactive discharge planning, clarity regarding assessment procedures, better communication between in and out of hospital providers, effective resourcing and meaningful data to ensure an effective discharge process.

1.2. The national and local context – where we are now

Nationally general practice is currently facing a number of challenges:

**Demographic changes:** the population is growing and people are living longer. The number of older people, and particularly those aged 85 or over, is set to rise markedly over the next few decades. In addition, the healthcare needs of the population are changing as the number of people reporting to live with a long-term condition continues to increase significantly.

**Unwarranted variation:** there are unwarranted variations (variations in the utilisation of services that cannot be explained by variation in patient illness or patient preferences) in the quality and range of services that patients receive both locally and nationally, which risk widening inequalities in health outcomes. Although patient satisfaction with general practices’ services remains high, there is increasing concern regarding patients’ experience of access to care.

**Financial pressures:** the NHS faces a projected funding gap of £30 billion by 2021/22, placing pressure on the NHS as a whole (including general practice) to maximise the use of resources and deliver efficiencies where possible.
**Workforce:** over the last 10 years the number of full time equivalent GPs has risen, but only at half the rate of other medical specialities, and not in line with population growth. There has also been a gradual increase in the number of GPs working part-time, which is creating long-term sustainability issues.

**Infrastructure:** some of the estate from which general practice is delivered is not fit for purpose and much of it is not conducive to supporting the delivery of new models of care. The uptake of and effective use of new technology is sporadic.

Locally, across Greater Nottingham, GP practices are increasingly reporting facing issues relating to workload, workforce, sustainability and premises which, if not addressed, have the potential to impact on the quality of care provided.

**Workload:** across Greater Nottingham GP practices are reporting:

- difficulty maintaining a work/life balance due to increased workload demands, with increasing workload contributed to by the diminishing workforce, and also by increasing patient demand, ageing population, and increased prevalence of long-term conditions
- higher rates of stress-related sickness
- concern about the future sustainability of general practice
- struggling to meet the competing time demands placed on them as a result of their dual role as both commissioners and providers
- difficulty coping with the increasing levels of management, administration, and bureaucracy they are required to undertake as a result of the need to engage with external agencies such as the Care Quality Commission

**Workforce:** across Greater Nottingham GP practices are reporting that they:

- are struggling to recruit both salaried GPs and partners on a permanent basis, particularly GP partners, because of national workforce issues; given the number of GPs anticipated to retire over the next 5 years, practices are concerned that this will further exacerbate existing workforce challenges and pose risks to continuity of provision locally
- are concerned that a reduction in the number of general practice trainees will result in an increased risk to workforce capacity over than next 5-10 years
- often have to manage vacancies through the use of temporary or locum GPs
- are finding it increasingly difficult to source locum medical cover for gaps in frontline general medical services provision
- are finding it challenging to maintain continuity of care and clinical quality with the need to use more temporary locum medical staff
- have concerns that financial austerity will introduce further financial challenges to sustaining frontline services

**Premises:** some of the estate from which general practice is delivered is not fit for purpose and much of it is not conducive to supporting the delivery of new models of care. The uptake of and effective use of new technology is sporadic.

Locally, practices report:

- difficulties in improving access or expanding the range of services they provide because of premises constraints
- an inability to cope with increases in their practice list sizes as a result of lack of space within their existing accommodation.
2. Model of care

The vision for primary care in Greater Nottingham aligns with and therefore supports delivery of the Nottinghamshire Sustainability and Transformation Plan. It recognises that there is a local and national necessity to optimise the general practice workforce in order to strengthen general practice and to ensure a sustainable system of care for patients and citizens. Although the specific approach may vary between CCGs the overarching approach within Greater Nottingham is to develop a delivery model based around ‘clusters’ of practices working together, supported by federations or alliances that will facilitate practices to achieve the benefits of operating at scale. Geographical clusters of GPs might maintain their independence, but will be encouraged to work closely with other primary and community care providers in a bid to flex their existing capacity co-located from estates that are fit for purpose, located centrally and easily accessible. This will result in a responsive service that delivers access to general practice services outside of core hours Monday to Friday, and on Saturdays and Sundays. This approach to collaborative working will support open dialogue, the sharing of best practice, clinical mentorship and support as well as administrative benefits such as back-office function efficiencies and clinical cover.

The aim is for multi-disciplinary teams to support these clusters in which specialist support, mental health (increase in community IAPT support), social care, and community teams will be key members. The multi-disciplinary teams will risk profile the 3-11% of patients who would benefit from support in a bid to divert their future needs away from a cycle of admission and acute support through proactive case management.

The vision is for patients to have one health and social care record that is universally used across the system, with enhanced records being adapted for more complex need. Organisational boundaries will be removed, supported through the use of care co-ordinators. Utilising technology and information patients will have the ability to book online their appointments, re-order prescriptions, and access their GP medical records. Patients will be empowered by giving them the tools to support their own self-care as well as offering more telephone advice/video consultation appointments.

This approach focusses on the prevention agenda that should result in a reduced need for complex care in future years. This will be achieved through robust risk profiling, targeted and outcome based interventions, supported through the adaption and rollout of the latest technology to support patients effectively. Social care workforce will form part of the multidisciplinary teams to assess patients pre and post admission, ensuring that those who will require hospital support are quickly managed back home with the adequate service supporting their needs. The workforce will move away from service specific care to a more generalist role and will be trained to treat the patient, not the disease, recognising that most patients may have one or more health or social care needs. In the past, over-specified contracts have had a detrimental impact on delivery, resources, and efficiencies.

Delivery of our plan will be measured in both quantitative performance indicators and qualitative outcomes and benefits, to include:

- improved patient satisfaction & improved patient outcomes
- improved access to general practice for all patients by offering a standardised urgent and routine appointment service
- more patients with complex conditions managed in general practice and supported to remain at home for as long as possible and as independently as possible and therefore reduce reliance on secondary care
- patients with the greatest clinical need identified and risk stratified and their ongoing care better co-ordinated
- improved self-management of conditions within agreed care plans
- improved achievement of ED waiting times targets and reduced waiting times for outpatients and elective admissions
- a reduction in the number of avoidable emergency admissions through systematic and proactive care management of those identified as at risk
- a reduction in secondary care elective activity
- sustained capacity for clinical leadership
- closer relationships developed locally and at scale across primary care contractors
- closer working with partners to deliver an integrated holistic care system with primary care at the core
- a year on year increased involvement of local patients and partners in the activities of the CCG and delivery of locally identified priorities.
3. Access

The Greater Nottingham CCGs are committed to improving access and reducing inequalities in terms of access to primary care. The approach to be taken by each CCG varies and is detailed in the CCG specific chapters which are included later in a later section of this plan.

However, a baseline assessment confirms the following for the 100 GP practices that constitute Greater Nottingham:

**Greater Nottingham opening hours – data as at November/December 2016**

- 40 practices have regular periods during each week when the practice is closed to patients between the hours of 8.00 and 6.30pm
- 26 practices regularly close for over 5.15 hours per week, categorised as half day closing

**Extended hours**

- **Greater Nottingham total:**
  - Of 100 Greater Nottingham practices, 60 currently provide the Extended Hours Access Enhanced Service.
  - Population coverage across Greater Nottingham for the Extended Hours DES is at 64.1% with 464,342 patients from a total population of 724,678 (April 2016 data) being able to access services outside of core hours.
  - 8 practices offer Saturday access through this service and this covers a population of 14.1%, 102,525 patients.

- **Nottingham City:**
  - 32 out of the 55 practices provide the Extended Hours Access Enhanced Service.
  - Population coverage for the Extended Hours DES is at 58.3% with 212,988 patients from a total population of 372,151 (January 2017 data) being able to access services outside of core hours.
  - As part of this commissioning arrangement 72,191 patients (19.7%) are able to access Saturday services.

- **Nottingham North & East:**
  - 11 out of the 20 practices provide the Extended Hours Access Enhanced Service.
  - Population coverage for the Extended Hours DES is at 60.2% with 90,685 patients from a total population of 151,353 (January 2017 data) being able to access services outside of core hours.
  - As part of this commissioning arrangement, 7693 patients (5.1%) are able to access Saturday services.

- **Nottingham West:**
  - 9 of the 12 practices provide the Extended Hours Access Enhanced Service.
  - The three practices not providing this service are in the Beeston, Stapleford and Bramcote areas.
  - Population coverage for the Extended Hours DES is at 80.8% with 75,908 patients from a total population of 93,976 (April 2016 data) being able to access services outside of core hours.
  - As part of this commissioning arrangement, 14,236 patients (15.1%) are able to access Saturday services.

- **Rushcliffe:**
  - 9 out of the 12 practices provide the Extended Hours Access Enhanced Service.
  - The 3 practices not providing this service are in Ruddington, Gamston and the Belvoir Health Group (Cropwell Bishop, Bingham and Cotgrave).
  - Population coverage for the Extended Hours DES is at 71.2% with 88,534 patients from a total population of 125,067 (January 2017 2016 data) being able to access services outside of core hours.
  - As part of this commissioning arrangement 8,405 patients (6.8%) are able to access Saturday services.
4. Workforce

4.1. The local system strategy for the general practice workforce

A Nottinghamshire Workforce and Organisational Development Strategy has been developed for the Nottinghamshire STP and is a statement of intent for the next five years (see Appendix 1). It is based on an assessment of the current and predicted workforce challenges across the health and care system and a collaborative, system-wide approach to re-design and development solutions.

A key foundation for developing the five year strategy has been to develop a population and place based approach to service redesign using a systems dynamics modelling tools and techniques. The model used assesses the level of ‘activity’ required (either a time limited episode of care, or the input required for on-going care), described in terms of care functions, taking into account demographic change and service transformation initiatives. It translates the future balance between care functions into an estimate of the workforce required to deliver it based on the ‘ideal’ skill mix to deliver each care function. It then compares current and future workforce requirements and provides a route map to achieve the change. The model uses skills rather than traditional roles and job titles and takes a whole system approach with no organisational boundaries.

The latest available Nottinghamshire activity assumptions were applied to assess the impact of transformation and efficiency on the Nottinghamshire system on future skill mix required to deliver health care in Nottinghamshire. We will re-run the model in the coming months as we continue to build the model and refine our assumptions.

Methodology and results of worked example

The current estimate of the combined health workforce in Nottinghamshire is c. 27,700, of which more than 21,000 are patient facing i.e. providing direct patient care. Of these around 1,300 are in primary care. The future requirements have been defined into the following areas of care; primary care, proactive care, urgent care, planned care, women and children, mental health and learning disabilities and diagnostics.

The modelling indicated that an additional 310 patient facing staff would be required in primary care in Nottinghamshire, broken down into:

- Foundation Bands 1-4, 59 additional staff
- Core Band 5, 39 additional staff
- Enhanced Bands 6-7 60 additional staff
- Advanced Band 8 and above, including GPs 153 additional staff

The change in skill mix will be required to meet the increasing number and complexity of patients being managed in primary care settings.

The resulting future skill mix projection indicates a growth in the primary and community care workforce of 24% over the next five years but with a potential £12 million savings on future pay costs across the system (as a result of skill mix, a reduction in agency costs and a reduction in the number of non-patient facing staff). Significant reductions in other areas are indicated that will contribute to closing the financial gap based on the assumption that primary and community care or self-care will increase in capacity and capability.

Delivery of the Strategic Workforce and Organisational Development Plan will be underpinned by the activity and investment plans of the Local Workforce Action Board (LWAB) and its delivery infrastructure.

Addressing capacity and capability in primary care to deliver the General Practice Forward View and the ambitions of the Nottinghamshire Sustainability and Transformation Plan is an identified priority in the system-wide workforce strategy.

There is a well-established county-wide Primary Care Strategic Advisory Group (PCSAG) that will lead on the development of collaborative delivery plans supported by a Primary Care Workforce Group (PCSET). These plans will be refined in the first quarter of 2017, in partnership with the Local Workforce Action Board, and facilitated by local workforce system leads.
The Local Workforce Action Board has initiated a system-wide project to model the general practice workforce, initially in Mid-Notts, and then across the rest of Nottinghamshire. The modelling will, in the first instance, provide a robust baseline position of the capacity in general practice. This goes further than the NHS Digital census as it counts patient facing contact in minutes by complexity and staff group.

Phase two of the project will model various scenarios, for example:

- **Demand**: Changing activity delivery approach and location – using other providers in line with the STP identified opportunities e.g. moving some activity to community pharmacy, social care and related services
- **New roles to free up capacity and skills**: Using more junior roles or introducing new roles that are not in short supply and/or are more affordable. Ensuring that patients see the most appropriate clinician
- **Reconfiguring operational services and/or rotas**: Reducing the burden of administration for clinical roles, thus freeing up patient facing time or investigating different models of triage
- **Changing patient behaviour in respect of the use of services**: A longer term strategy but likely one of the most effective if successful

The outputs of the modelling will be used across the Greater Nottingham area to inform and provide evidence to support workforce planning.

In addition Health Education England has provided a GP supply and demand tool to help inform regarding future primary care workforce requirements. Scenarios can be explored across a number of varying elements such as retirements, newly qualified GPs, international recruitment, returners, vacancies and population demand. There is also a facility to review job role substitution to close the supply/demand gap, should there be one. The Greater Nottingham CCGs will work closely with Health Education England in the near future to fully understand how this model can inform workforce plans

**Expand GP workforce capacity**

Across Nottinghamshire there are two GP training schemes - Nottingham and Mansfield. Historically Nottingham has been oversubscribed and Mansfield undersubscribed. Attrition rates are not monitored by HEE, however it is known that a significant number of trainees are lost out of areas or move overseas on completion of training. In addition, a large number opt to work part time once qualified.

Retention of the workforce both newly qualified and established GPs is a local system priority. Plans therefore focus an intention to:

- develop recruitment & retention strategies to include, for example, portfolio working, incentives, rotational opportunities, collaborative campaigns, sharing specialist staff
- review the impact of wellbeing initiatives targeting general practice and roll out in a sustainable model (supported appraisals, coaching and mentorship)

**Expand other workforce capacity in general practice**

The Nottinghamshire HR Collaborative is progressing a number of initiatives to support delivery of a collaborative approach to the employment and deployment of the future workforce. Some of these projects will support general practice, including: Advanced Clinical Practice, Holistic/Generic Workers, Rotational Nurse Project, Agency Utilisation, and Carter Review Recommendations.

**Expand clinical pharmacist workforce**

A Pharmacy Workforce Task & Finish Group has been established to develop a workforce strategy to achieve the ambitions of the STP and the GP Forward View. Six action areas have been identified:

- Develop a vision for the pharmacy workforce in Nottinghamshire
- Develop and implement a workforce plan to address priority workforce needs in Nottinghamshire
- Improve recruitment and retention of the pharmacy workforce in Nottinghamshire
- Enable transition within the sector to support a more flexible workforce
- Provide pharmacists with the skills to extend their role in improving health & wellbeing across the health and social care system
- Explore new models of care involving integrated pharmacy workforce

Nottinghamshire has a number of practices participating in the national Clinical Pharmacist in GP Practice scheme. In addition, a locally funded pilot involving 3 practices in Nottinghamshire utilises community pharmacy independent prescribers (CPIP) working in general practice taking on additional clinical work to help ease GP workload. These are evaluating very well throughout the county and an independent evaluation of the local scheme is being carried out by the University of Nottingham.

4.2. Organisational development

A workforce and organisational development enabling workstream of the STP has been established led by the Chief Executive of Nottingham CityCare. East Midlands Leadership Academy (EMLA) is supporting this workstream. During 2017/18 and 2018/19 the CCGs in Greater Nottingham have plans to:

- support practices to maintain their existing training placements and encourage new practices to become training practices with a view to increasing the number of placements by 2019. This will not only increase the overall number of GP trainees working locally but support GP recruitment within the Greater Nottingham area. In addition, the CCGs will enhance education opportunities by offering trainees the opportunity to obtain greater knowledge of CCG commissioning functions.
- support practices to offer GP fellowship placements in partnership with Health Education England
- support practices to offer nurse training placements
- work closely with the Local Education and Training Council (LETC), the Local Education and Training Board (LETB) and the LMC to contribute, where appropriate, to the development of a comprehensive staff development plan that recognises and supports the changing environment in which people are working, the changing ways of working, and changing responsibilities
- promote the services of the Hurley Clinic Partnership who will provide improved access to mental health support for general practitioners and trainee GPs who may be suffering from mental health issues including stress, depression, addiction and burnout
- promote the Retained Doctors scheme within the CCG and other national initiatives that support recruitment, retention and development of the workforce, including the Senior GP Fellowship scheme
- encourage practices to review skill mix within their workforce. Two practices within Greater Nottingham are already participating in a GP pharmacy transformation pilot to examine the benefits of utilising a community pharmacy independent prescriber. The outcomes of this work will be shared to encourage other practices to adopt this approach
- continue to work with Health Education England (HEE) to ensure that the primary care workforce across the East Midlands is sustainable and has the right skills, values, and behaviours, at the right time and in the right place. In working directly with HEE the CCGs are well placed to highlight the particular needs of the general practice workforce in Greater Nottingham while future planning workforce needs, retention and development.
5. Workload

See CCG specific chapters
6. Infrastructure

6.1. Premises

Having the right infrastructure in place in primary and community settings is crucial for the successful delivery of the ambitions contained within the Nottinghamshire Sustainability and Transformation Plan (STP) and the GP Forward View (GPFV). Maximising estates utilisation is a key enabling theme within the STP and an STP Estates Strategy has therefore been produced. The ability to transform care and keep services sustainable will only be possible if efficient, fit-for-purpose, high quality facilities underpin the delivery of services. In order to improve the quality of care provided in general practice going forward, and to meet the demographic challenges of an aging population, it is essential to have GP practice premises that are fit for purpose.

NHS Nottingham North and East, NHS Nottingham West, and NHS Rushcliffe CCGs formed a Local Estates Forum (LEF) and NHS Nottingham City established a separate Local Estates Forum. However the two Estates Forums within Greater Nottingham had close links. The two LEFs have therefore implemented plans to merge to form a key delivery group with other health and local authority partners for projects outlined in the STP and aligned across the footprint. The new LEF will ensure that:

- **the estate is utilised as efficiently as possible** - working across the system and breaking down organisational barriers to improve how the estate is used to release money tied up in buildings and maintenance.
- **the estate is fit for purpose** - and in the right locations to support the delivery of high impact changes; improving access and streamlining and standardising diagnostics in the primary care setting; facilities which attract and support a sustainable workforce.
- **there is sufficient capacity in primary and community care to enable services to be transferred out of the hospital setting and into community-based settings** - deliver new models of planned care in the community that provide services closer to home which have clear pathways should referral to secondary care become necessary; ascertain key estate hotspots for primary care and the development of proactive clinical hubs with new care teams co-located into core estate.
- **opportunities to rationalise estates across the City and the County as part of One Public Estate initiative are explored and implemented through increased utilisation of current assets, and consolidation within and across providers’ assets** - upgrade and make more efficient use of primary care and other NHS and local authority owned estate – including considering where co-locating services would make it easier to deliver swifter access to diagnostics and more integrated care.

Key tasks for the LEF are:

- updating and refining the Strategic Estates Plan identifying clear gaps and priorities for investment/disinvestment
- undertaking space utilisation and rationalisation of all current estate, reducing property running costs where possible
- identifying any surplus estate for disposal
- developing a robust approach to property management and best use of resources
- exploring opportunities to secure development funding and oversee the processing of bids
- maximising the potential of section 106 and CIL contributions with clear protocols which relate to local planning policy in line with the Spatial Planning for the Health and Wellbeing of Nottinghamshire and Nottingham Framework
- facilitating a strategic and collaborative approach to estates management and development across the local health community
- ensuring that the environmental impact of any changes is assessed and taken into account with the overall aim of reducing the carbon footprint
- Ensuring that there is a robust communication and engagement strategy and plan which underpins the case for any changes to the estate and that engagement is factored into the projects at the earliest opportunity.
Both LEFs have made good progress in identifying the strengths and opportunities of the existing infrastructure and have developed an overarching Strategic Estates Plan. Within this individual CCGs have developed their own individual estates strategies.

To enable the transformation of general practice and to support delivery against the ambitions as set out in the STP the CCG Strategic Estates Plans focus on primary and community premises and identify priorities for the next five years based upon a number of factors, including: emerging service models (care closer to home), anticipated increases in the size of the population related to significant housing developments, and whether premises are fit for purpose. The longer term aim is to also include secondary and tertiary care estate and other public sector estate. The emphasis within the Estates Strategies is on maximising estates utilisation and supporting practices to make premises improvements in order to meet existing and future demands on capacity and to ensure high quality premises are available to support the delivery of care. The STP has modelled the revenue implications of changes in estate, with some areas of the system; namely primary and community premises needing to expand while others reduce, thus necessitating a redistribution of associated revenue costs which will need to be agreed at scale and locally.

The CCGs will support practices to determine premises solutions where the existing premises are no longer fit for purpose for whatever reason and will work with practices and other stakeholders to consider options to:

- co-locate services to improve service delivery and reduce costs
- increase the scale and consolidation of the primary care estate in order to reduce costs and increase opportunities to change working practices and service delivery.

In addition the Care Quality Commission (CQC) has a mandate for ensuring that essential standards of quality and safety are met in respect of GP premises. During 2017-2019 the CCG will therefore continue to work closely with practices to support the development of premises to ensure that they meet the required standards in terms of quality and safety.

A number of schemes across Greater Nottingham have already received approval in principle for funding from the Estates and Technology Transformation Fund (ETTF). The fund which was announced in June 2016 provided opportunities to progress priorities identified in the local estates strategies:

**Nottingham City CCG:**

- **Meadows:** to meet the needs of a growing population, a proposal has been supported by the national ETTF for £273K in 2016/17 for internal reorientation and reconfiguration of the Meadows practice to create better use of the existing space and increase clinical capacity
- **Carlton:** to meet the needs of a growing population, a proposal has been supported by the national ETTF for £400K in 2016/17 to expand the existing premise of the Carlton practice to deliver additional clinical capacity
- **Strelley:** the CCG commissioned an options appraisal through the national ETTF for £25K in 2016/17, the preferred option is a new build for the Strelley practice, due to the value being in excess of ETTF available funds alternative funding streams are being considered
- **Sneinton:** the CCG commissioned an options appraisal through the national ETTF for £25K in 2016/17, the preferred option is to extend the Sneinton practice and this is being submitted for cohort 3. The funding available to support this is £635K
- **Wollaton:** the CCG commissioned an options appraisal through the national ETTF for £25K in 2016/17, the options are being reviewed following one Wollaton practice in the Centre closing. The proposal will be for cohort 2 and the funding available to support this is £600K
- **Rise Park:** to meet the needs of a growing population, a proposal has been supported by the national ETTF for £170K in 2017/18 to expand the existing premise of the Rise Park practice to deliver additional clinical capacity
- **Radford:** the CCG will commission an options appraisal through the national ETTF for £25K in 2017/18.
- **Sherwood:** the CCG will commission two options appraisal through the national ETTF for £50K in 2017/18.
• **Wollaton:** to meet the needs of a growing population, a proposal has been supported by the national ETTF for £69K in 2017/18 for internal reorientation and reconfiguration of the Wollaton practice to create better use of the existing space and increase clinical capacity.

• **Clifton:** to meet the needs of a growing population, a proposal has been supported by the national ETTF for £59K in 2017/18 for internal reorientation and reconfiguration of the Clifton practice to create better use of the existing space and increase clinical capacity.

**Nottingham North and East CCG:**

• **Calverton:** to meet the immediate needs of a growing population, a proposal has been supported by the national ETTF for £221K in 2016/17 and £358K in 2017/18 for expansion of the Calverton practice, which represents 66% funding for the cost of the project.

• **Hucknall:** the CCG commissioned an options appraisal in 2016 and submitted a proposal to the ETTF for a clinical hub development in Hucknall to include two GP practices, a pharmacy and community services. This proposal has approval in principle for Cohort 2 as published nationally by NHS England in October 2016. The funding currently available to support this new build is £400K.

**Nottingham West CCG:**

• **Beeston:** To meet the immediate needs of a rapidly growing practice population, a proposal has been supported by the national ETTF for Cohort 1 in 2016/17 for expansion of a central Beeston practice (The Oaks) and £382K, 66% funded. This scheme is now likely to complete in 2017/18.

• **Eastwood:** The CCG commissioned an options appraisal in 2016 and has submitted a proposal to the ETTF for a clinical hub development in Eastwood to include one or more GP practices. This proposal has approval in principle for Cohort 2 as published nationally by NHS England in October 2016.

• **Beeston:** The CCG commissioned an options appraisal in 2016 and has submitted a proposal to the ETTF for a clinical hub development in Beeston town centre to include one or more GP practices.

• **Stapleford:** Hickings Lane practice secured national funding to increase their clinical capacity in 2016, and the addition of five consultation suites and a treatment room was completed in October 2016. The Stapleford Care Centre building opened in 2006 and is one of the largest health centres in Nottinghamshire so there is sufficient clinical space at present in this locality.

**Rushcliffe CCG:**

• **Cotgrave new build:** area of most deprivation within the CCG and the town population is set to grow due to the housing development on the colliery site. It forms part of a multi-agency multi-million pound town regeneration project led by the borough council. Supported by the ETTF £275K in Cohort 1 and £625K in Cohort 2 as published nationally by NHS England in October 2016.

• **East Leake:** the CCG commissioned a feasibility survey through the ETTF to assess the impact of a major housing development along the A453 corridor on nearby practices and branch surgeries within the geographic boundaries of both Rushcliffe and Nottingham City CCGs. This is particularly relevant for East Leake which is also under pressure from further extensive housing developments within the village.

**6.2. Technology**

Delivering technology enabled care is one of the high impact areas within the STP. The Connected Nottinghamshire programme aim is to deliver the technical infrastructure to support patients and their clinicians in accessing more timely, accurate and relevant information at the point of need. The Nottinghamshire Local Digital Roadmap (LDR) sets out the next level of ambition for Nottinghamshire to enable delivery of national targets (patient access to health records, interoperability, etc.) as well as further exploitation of the benefits of using new and existing technology.
Significant progress has already been made against key clinical priority areas across primary care in Nottinghamshire by utilising existing information sharing capabilities, supporting early changes in care models and the sharing of datasets:

- All practices have migrated away from the LSP contracts to NHS Digital commissioned contracts; this is monitored by the clinical commissioning groups IGM&T and Connected Nottinghamshire boards.
- Clinical commissioning groups have a contract with Nottinghamshire Health Informatics Service (NHIS) for the provision of IT services and support, thereby providing common technical solutions across all GP practices to support integration.
- A Records and Information Group (RIG) led by a GP, and with membership from primary, community, secondary and social care has been set up to share best practice within the health and social economy. Key successes include the development and adoption of system wide guidance setting out the principles of sharing for direct care purposes.
- Tactical information sharing solutions have been implemented using TPP SystmOne and the Medical Interoperability Gateway (MIG) with Rushcliffe Clinical Commissioning Group holding the contract with HGL on behalf of other clinical commissioning groups under the GPSoC Lot 3 framework terms and conditions.
- NHIS has contracts in place for IT infrastructure that cover primary care with excellent progress made on; a Community of Interest Network (COIN), Wi-Fi federation, electronic prescribing service, patient on line access to records and mobile enablement.
- GPs make good use of the eReferrals service with >80% of referrals to secondary care being made electronically.
- The use of eDSM in sharing of GP data has made significant progress in the past three years. eDSM sharing of data within practices has grown from ~15% in 2013 to ~90% in 2016.
- The GP out of hours provider (NEMS) uses Adastra as its primary system for a number of direct facing areas.
- The Nottinghamshire NHS 111 service provider (Derbyshire Health United) use Adastra as its primary system.
- The out of hours, urgent care centre and NHS 111 providers access GP records via the MIG Detailed Care Record dataset and will shortly have access to EPaCCS records via this route also.

A number of projects have been completed or are in progress to provide citizen/patient access to records and care plans:

- 100% of Nottinghamshire GPs provide access to repeat prescribing, appointment booking and the Detailed Care Record.
- A number of GP practices across Nottinghamshire have rolled out full access to the GP record in order to assess benefits and resolve any early change management issues. This completed in 2015 and now forms the basis of further roll out plans set out in the clinical commissioning groups’ IGM&T Strategy.

**ETTF technology bids – Cohort 1 2016/17**

In 2016, funds were successfully obtained from the ETTF Cohort 1 to support mobile working, wi-fi and unified communications.

During 2016/17 significant work has been undertaken to support mobile working across general practice. A pilot to assess provision of GP mobile access was delivered during 2016 with full project rollout commencing in July 2016. Mobile access will be provided to all GP practices by April 2017. There is now live Wi-Fi coverage across 157 health and local authority sites across Nottinghamshire. However further work is underway to improve the coverage and speed of this vital infrastructure.

Although ETTF funding to support the delivery of unified communications was confirmed for 2016/17, the tight timescales for delivery resulted in this project not being progressed in 2016/17. It was therefore agreed that this project would not form part of the ETTF Cohort 1 and a bid would be submitted for ETTF Cohort 2 funding for 2017/18.
ETTF technology bids – Cohort 2 2017/18

In order to further progress already made, ETTF Cohort 2 2017/18 bids were submitted to NHSE in January 2017. Whilst the outcome is not yet known, Nottinghamshire has bid for funds to support estates and technology enablement in the following areas:

**Unified Communications** - Several key transformation programmes identified in Nottinghamshire’s Local Digital Roadmap (LDR) and the Nottinghamshire Sustainability and Transformation Plan (STP) identify the need for improved transitions of care across health and care. This is alongside the requirement to extend GP access and hours. Delivery of both will require new ways of working that extend virtual teams outside of normal organisational and estate boundaries. This project will test the projected benefits across health and social care of using instant messaging and video functionality to support these new ways of working. Deployment of instant messaging and video functionality will allow improved communication when working across typical organisational and estate boundaries within selected health and care organisations, the benefits of this approach have been identified as:

- Improved communication with other clinicians (who may be providing specialist or extended services in primary care and social care)
- Improved efficiency through reduced delays in treatment
- Improved access to effective care
- Increased capacity of health and care organisations
- Reduced administration through reduction of letters
- Improved efficiency and a reduction in telephone call costs
- Improved transfers of care between health and care organisations
- Flexibility in the use of estates

**Self-care apps** - A key element of the delivery of the LDR and STP across Nottinghamshire is to purchase and utilise technology to support patient’s health and wellbeing choices and promote self-care.

Nottinghamshire Social Care has developed tools to promote citizen access to key information such as “Wiki” which are delivering benefits to specific groups. Wider deployment and adoption of these types of tools within health will drive efficiencies and enable a cost reduction in the delivery of services, Nottinghamshire has the opportunity to work with another CCG in procuring, developing and implementing the capabilities required to meet this need.

The proposed approach is for selected GP practices across Nottinghamshire to implement a variety of models to determine which self-care apps best support patients to monitor and manage their health. The benefits of this approach have been identified as:

- Improved efficiency through reduced delays in treatment
- Increased capacity for primary care services out of hospital
- Improved access to effective care
- Increased capacity of health and care organisations
- Improved efficiency through patients managing their own health and wellbeing
- Improve patients choice
- Access to information 24/7

**Medical Interoperability Gateway (MIG) Phase Three** - After the success of MIG phases 1 & 2 the proposal is to further utilise the programme to include deployment of the asset to a further cohort of organisations. This will enable more effective information sharing between health and social care organisations across Nottinghamshire.

As detailed within the Nottinghamshire LDR MIG 3 is required to support the delivery of the core capabilities for 2017/18 which will include an enhanced data set and an increase in endpoints across Nottinghamshire. In order to improve information sharing further this phase of MIG deployment will look at the potential to purchase a module of the MIG to utilise as a tool for messaging, tasks and appointments across all MIG consumers which will improve transitions of care across organisational boundaries.
In order to increase capacity in primary care MIG 3 will look to purchase SRV licences and provide system access to a number of community pharmacies. This will provide community pharmacies with the information needed to enable the effective management of minor ailments within the community pharmacy setting and divert activity from GP practices, where appropriate. By providing key information to community pharmacies this will also enable an increase in accessibility of services for patients. The benefits of this approach have been identified as:

- Improved communication with other clinicians (who may be providing specialist or extended services in primary care and social care)
- Improved efficiency through reduced delays in treatment
- Increased capacity for primary care services out of hospital
- Improved access to effective care
- Reduced administration through reduction of letters
- Improved efficiency and a reduction in telephone call costs
- Improve transfers of care between health and care organisations
- Flexibility in the use of estates

In previous phases of this project a patient representative has been actively engaged as part of the project board and a number of key communication and engagement activities have taken place with Nottinghamshire citizens. This approach will continue in phase 3 of the project.

Information governance specialists form part of the project board membership and Information governance arrangements have been a key consideration through-out the life of the project. Privacy impact assessments have been undertaken and regularly reviewed. Formal agreements have been put in place such as information sharing agreements and data processing agreements. In order to support the sharing of data across organisations for the purpose of direct care a county wide multi-agency consent model has been agreed across all health and care partners in Nottinghamshire.

**GP Repository for Clinical Care (GPRCC) Phase Three** — following previous successful phases of this project, it is now proposed to purchase additional eHealthScope functionality. Over the next 12 months the project will continue to support significant improvements in care and the management of patient outcomes. It will be expanded to include data flows from health in Bassetlaw as well as using data flows from Nottingham County and City Councils social care to aid direct and indirect care of patients.

It has been agreed that GPRCC will develop further to support areas including:

- clinical audits
- outcomes measurement
- care integration with social care teams (provide a more holistic view of a patients care pathway across both health and social care settings)
- support system effectiveness measurement
- future strategy development.

GPRCC will become a fundamental tool in risk stratification for the population of Nottinghamshire for direct and indirect care.

The project currently has more than 100 GP practices using the information provided, helping them manage gaps in care and drive out unwarranted variation within clinical practice.

As detailed within Nottinghamshire LDR, GPRCC 3 is required to support the delivery of the core capabilities for 2017/18 which will include an enhanced data set and increase access to timely and relevant data across Nottinghamshire.

The benefits of this approach have been identified as:

- Improved understanding of population needs through risk stratification and segmentation
- Improved access to effective care
- Increased capacity for primary care services out of hospital
- Support areas such as clinical audit and outcome measures
- Improve transfers of care between health and social care organisations
- Reduce unplanned admissions
- Improve proactive health and care by early identification
- Enable joined up working between health and social care

Data sharing of this kind is an enabler to identifying the needs for and gaps in care for the population of Nottinghamshire which in turn will drive efficiencies and performance.

**GP Template Review and Alignment** - Data quality is a critical success factor for the delivery of the LDR and to enable the delivery of the Nottinghamshire STP. To support improvements in the consistency and quality of data and to enable the full utilisation of information sharing programmes the proposal is to purchase a suite of standardised template documents for deployment across Nottinghamshire. In doing so, this will improve data accuracy and quality, and reduce unwarranted clinical variation across GP practices.

The benefits of this approach have been identified as:

- Improved data quality across Nottinghamshire by using consistent templates
- Consistency in coding
- Reduced unwarranted clinical variation and additional associated costs
- Improved access to effective care
- Enabling full utilisation of technological information sharing solutions
- Improved quality of care by ensuring the right information is available
- Improved clinical safety and patient safety

**Digital Access**

There are a number of pilots exploring and testing ways in which digital access can be improved through solutions such as the TPP app. After this initial pilot phase and once the national specification for online consultation software is published there will be further scoping and development in order plan for full roll out across Nottinghamshire.
7. Leadership, governance and programme management arrangements

The CCGs in Greater Nottingham took on full delegated responsibility for commissioning the majority of GP services under co-commissioning arrangements from 2015/16 onwards following approval by NHS England. The Nottinghamshire and Derbyshire shared Primary Care Hub supports CCGs in commissioning primary medical services. Functions relating to quality and safety within primary medical care have been delegated directly to CCGs.

Each CCG has a Primary Care Co-Commissioning Committee, which functions as a corporate decision-making body for the management of delegated functions and the exercise of delegated powers. The Primary Care Co-Commissioning Committees will be responsible for delivery of this GPFV plan at an individual CCG level with overarching delivery against the STP being reported via the Greater Nottingham Out of Hospital Programme Board which in turn reports into the STP Programme Board as set out in the STP governance arrangements.

The Primary Care Strategic Advisory Group (PCSAG) includes representatives of all CCGs in Nottinghamshire and Derbyshire and is also attended by both the Nottinghamshire and Derbyshire LMCs, plus the chair of the Local Prescribing Network, thereby ensuring engagement with key stakeholders on issues relating to general practice. The PCSAG has an advisory role to the CCGs in terms of supporting the commissioning of high quality primary medical services, sharing good practice, ensuring consistency across the patch and working at scale to deliver efficiencies. A GPFV Task and Finish Group has been established within Nottinghamshire which will report to the PCSAG. The group is facilitated by the Nottinghamshire Local Medical Council, a key stakeholder in the delivery of the GPFV locally, and thus ensuring the voice of general practice features in primary care commissioning decisions relating to implementation of the GPFV.

A high level risk register is being developed. Key risks identified to date include:

1. **Models of care**: strategic and local priorities are not delivered due to continuation of unwarranted clinical variation and lack of cohesion across practices/CCGs and with other services
2. **Workforce**: the number of full time equivalent GPs does not increase in line with population growth and is not sufficiently mitigated by increases in other roles. An increase in the predicted number of early retirements, resignations and stress-related sickness contributes to insufficient GP capacity
3. **Workload**: GP practices are unable to deliver the required capacity to meet the increasing workload caused by increasing patient demand, an ageing population, and increased prevalence of long-term conditions
4. **Workload**: inability of individual GPs and practices to meet the competing time demands placed on them as a result of their dual role as both commissioners and providers and increasing levels of management and administration capacity required for governance and inspection purposes e.g. Care Quality Commission visits
5. **Infrastructure - Estates**: new models of care are not delivered due to lack of premises capacity in general practices and community based facilities and/or premises are not fit for purpose
6. **Infrastructure – Technology**: integrated care and interoperability are not delivered due to sporadic uptake and effective use of new technology
7. **Investment**: frontline services including general practice will not be sustainable due to non-delivery of financial efficiencies across the system and lack of sufficient investment
8. Primary care quality

8.1. Priority areas

To support the CCGs in Greater Nottingham drive up the quality of care in order to improve health outcomes and reduce unwarranted clinical variation, a Primary Care Quality Assurance Framework was developed and implemented in April 2016. The framework comprises a quality dashboard, risk matrix, escalation process and Primary Care Quality Group which reports to the Primary Care Commissioning Committee. The dashboard brings together a range of indicators across the domains of patient safety, patient experience and clinical effectiveness. CQC ratings are also included. Feedback regarding the dashboard has been collated and it has undergone further development since its introduction to incorporate the comments received.

The CCG’s Primary Care Quality Group reviews the dashboard identifying potential or actual risks to quality within primary care and any actions to be taken in response to each practice’s rating to ensure that individual practices are supported where necessary to make any required improvements. The dashboard has been (and continues to be) presented at various forums to ensure practice staff and patient groups are aware of it.

During 2017/18 and 2018/19 the CCG’s quality team will continue to work with GP member practices, NHSE Primary Care Hub and the CQC to continually review and refine the quality assurance framework in light of learning from both local and national findings from CQC inspections. The dashboard is currently being revised in light of learning from the closure of The Willows practice and as a result of themes identified from practices rated as inadequate or requires improvement. Additional indicators relating to QOF exception reporting and workforce will be included in future iterations and a programme of notes audits will be introduced to strengthen quality assurance and continual improvement.

Quality improvement priorities for GP practices in Greater Nottingham over the next two years include:

Year 1 2017/18

- Quarter 1:
  - Revision and re-launch of the quality assurance framework
  - Dissemination of learning from CQC inspections
- Quarters 2-4:
  - Strengthening safer recruitment practices
  - Ensuring consistent and comprehensive processes for responding to alerts (e.g. MHRA/ CAS)
  - Improving rates of cervical screening uptake
  - Improving rates of pre-school immunisations/vaccinations
  - Strengthening the monitoring of patients on high risk medicines (particularly where shared care arrangements are in place)
  - Improving prescribing practice in relation to quinolones

Year 2 2018/19

- Quarter 1:
  - Annual review of the quality assurance framework
  - Identification of quality improvement priorities based on 2017/18 dashboard results
- Quarters 2-4:
  - Campaign to increase the rates of incident reporting within primary care
  - Implementation of strategies to address the quality improvement priorities identified in quarter 1

8.2. Care Quality Commission (CQC) inspections

Practices across Greater Nottingham have worked together to prepare for CQC inspections and other regulatory requirements. Practices are supported to develop improvement action plans and
monitor progress against these. Provider quality visits enable triangulation of multiple sources of quality information, including views from patients and staff and provide assurance in relation to CQC outcome compliance and improvement action plan completion.

### Nottingham City

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<th>Practice Name</th>
<th>Inspection Date</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
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Table 3. Nottingham City CCG CQC outcomes
NHS Nottingham North and East CCG

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Table 4. NNE CCG CQC outcomes

NHS Nottingham West CCG

Nottingham West notes: Bramcote Surgery was inspected in November 2016 and is awaiting the result. Linden Medical Group underwent a further full inspection in December 2016 and is awaiting the outcome

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<td>Good</td>
<td>Outstanding*</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding*</td>
</tr>
<tr>
<td>West End</td>
<td>06/09/2016</td>
<td>Req Imp</td>
<td>Req Imp</td>
<td>Req Imp</td>
<td>Req Imp</td>
<td>Req Imp</td>
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</tr>
</tbody>
</table>

Table 5. Nottingham West CCG CQC outcomes
### Table 6. Rushcliffe CCG CQC outcomes

<table>
<thead>
<tr>
<th>Practice</th>
<th>Date of CQC Inspection</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belvoir</td>
<td>12/02/2015</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Castle HC</td>
<td>08/09/2015</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>East Bridgford</td>
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<td>Good</td>
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<td>Good</td>
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</tr>
<tr>
<td>East Leake</td>
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<td>Good</td>
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<td>Outstanding🌟</td>
<td>Outstanding🌟</td>
</tr>
<tr>
<td>Gamston</td>
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<td>Good</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td>Keyworth</td>
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<td>Good</td>
<td>Outstanding🌟</td>
<td>Outstanding🌟</td>
<td>Outstanding🌟</td>
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</tr>
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<td>Good</td>
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</tr>
<tr>
<td>Radcliffe</td>
<td>11/04/2016</td>
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<tr>
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<td>09/02/2015</td>
<td>Good</td>
<td>Good</td>
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<tr>
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<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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</tr>
</tbody>
</table>
8.3. Quality in prescribing

Joint guidelines for prescribing have been developed and implemented across primary and secondary care. Practices where excessive prescribing has occurred are supported by the medicines management team and clinical pharmacists to review their prescribing where appropriate. The Pincer audit tool identifies at-risk patients who are being prescribed drugs that are commonly and consistently associated with medication errors so that corrective action can be taken to reduce the risk of occurrence of these errors. Use of the audit also improves accuracy of records and patient safety.

8.4. Patient safety

The Greater Nottingham CCGs continue to work with providers to ensure that quality schedules and CQUIN schemes promote the development of comprehensive patient safety indicators. The CCGs also work with the Patient Safety Collaborative to develop and deliver root cause analysis training for clinicians to further improve the learning from incidents and ability to identify and implement harm reduction strategies. The CCGs will continue to develop robust methods of feedback and encourage increased reporting by demonstrating the positive impact that this can have on improvement. Mechanisms for staff and patients/carers to raise concerns about the quality or safety of services are in place and appropriate action is taken in response to concerns and that this intelligence is triangulated with other sources of information to provide a comprehensive picture of the quality of services being delivered.

8.5. Safeguarding

The CCGs will meet the accountability and assurance framework requirements for protecting vulnerable people. This will be achieved by:

- training staff to recognise and report safeguarding issues
- clear lines of accountability for safeguarding with the CCGs
- participating in the operation of local safeguarding boards
- ensuring effective arrangements for information sharing
- ensuring there are designated doctors and nurses for safeguarding children and for looked after children and a designated paediatrician for unexpected deaths in childhood in post
- ensuring there is a safeguarding adults lead and a lead for the Mental Capacity Act in post, supported by the relevant policies and training
- undertaking visits to organisations to assess their safeguarding procedures.
9. CCG specific chapters

The previous sections have described plans for delivery of the GPFV across Greater Nottingham. However, as previously mentioned, it is acknowledged that the priorities, approach to delivery and the progress made to date by individual CCGs within Greater Nottingham differs in some areas, although the overarching vision and aims are consistent.

The following sections are therefore CCG specific and provide detail around individual CCG level plans to deliver a number of the key elements of the GPFV not already covered in earlier sections.

9.1. NHS Nottingham City CCG

9.1.1. Introduction

Nottingham City CCG has 56 GP member practices within the City with a combined population of approximately 372,151 (raw list). The practices consist of 12 single handed practices; three practices are run by external provider organisations with the remaining practices delivered through partnership arrangements. Six practices have branch surgeries and practice raw list sizes range from 1,455 to 12,976; the two university practices have the largest list sizes of 17,292 and 39,540.

Primary care services are provided to patients across 20 Nottingham City Council wards, split into 8 Care Delivery Groups for health and social care.

9.1.1.1. Primary care vision

The CCG’s primary care vision is to increase access and improve quality in primary care; this is aligned to other local plans. The vision was built on five essential objectives identified within the plan on a page, below.

![Figure 1. Nottingham City CCG: plan on a page](image)
The five essential objectives are:

- Integrate primary, community and social care
- Standardise and improve access
- Utilise and adapt innovative technology and best practice
- Develop a shared workforce
- Promote shared responsibility of health

The CCG has a strong platform to continue delivery of the Vision's five essential objectives through:

- the primary care patient offer
- co-commissioning process in place
- innovative technology strategy
- integration of health and social care services aligned to care delivery groups
- dedicated care delivery group co-ordinators aligned to practices in their care delivery group
- multi-disciplinary teams (MDT) meeting with primary, social and community care teams
- workforce planning group
- Estates Strategy
- practice diagnostics to increase efficiency
- education and training group

Integrate primary, community and social care

Nottingham City GPs are aligned to a care delivery group based on geographic area recognising practices will have similar patient needs. Community and social care provision are integrated and aligned to each care delivery group. Monthly MDT meetings take place at the practice which includes community and social care to ensure the best outcome for the patient from input from multiple professionals. Quarterly CDG network events take place to enable all professionals within a care delivery group to meet and share best practice, learn about new services and set agenda's for future meetings. Work is now being undertaken to standardise MDT meetings and integrate and align community mental health services to care delivery groups.

Develop shared workforce/working

Within care delivery groups there are GP practices that are now working more collaboratively and have a shared workforce, enabling patients to have greater and improved access to primary care services. Practices are also sharing back office functions and work is in place to share best practice across CDGs and the City to encourage more collaborative working within primary care. However, this is a developing area to support the sustainability of primary care in the long term.

Standardise and improve access

Diagnostics in practice to identify ways practices could be more efficient has resulted in practices utilising triage to increase access, texting with MJOG (where patients are sent a reminder and can cancel, this then removes the appointment enabling another person to have the appointment), utilising online booking more. There is on-going development of the pathways website to enable health care professionals to have access to current pathways.

Utilise and adapt innovative technology and best practice

Increasing the use of technology in practices (and care homes) through tele-health, tele-care and tele-medicine and increasing the use of technology in patients’ homes to help manage their conditions.

Promote shared responsibility of health

Increasing patient’s access to information on how they are able to direct themselves to and around the complexities within health and social care, with support from the practice receptionist. Increasing the number of practices offering patients social prescribing and mechanisms to self-help and manage their conditions in line with their care plans.
9.1.1.2. Population demographics

Nottingham City population is very diverse; the population is growing and the main reason is migration (recently Eastern Europe) but also natural change with more births over deaths. The population is projected to rise from 308,700 in 2012 to 323,400 in 2022 and to 352,200 in 2037. The wards which have had the greatest population increase may be due to new student properties near to Nottingham Trent University.

The City has a very high proportion (28%) of people aged 18 to 29, this is due largely, but not entirely, to the presence of the two universities; full-time university students account for approximately 1 in 8 of the population. The percentages in other age-groups are lower than the average for England, with those between 65 and 74 being particularly low. Of the 81,000 people aged 50+ living in the City, 44,000 (54%) are under 65, 19,000 (23%) aged from 65 to 74, and 18,000 (22%) aged 75 and over.

The gender balance generally follows national patterns. More boys are born than girls (about 106 boys for every 100 girls), but as men tend to die younger, for age-groups aged over 70 there are more women than men; there are twice as many women aged 85 and over as men. However, the percentage of men aged 25 to 39 is unusually high in Nottingham (e.g. 113 men to every 100 women in the 35 to 39 age-group). This is particularly the case in some city centre and inner city areas, including those with high proportions of students or significant numbers of houses in multiple occupation – which may be favoured by single, and often male, migrant workers.

The large majority of people who live in Nottingham are White British. 34.6% of the City’s population are from Black and Minority Ethnic (BME) groups. There has been a large increase in the Asian ethnic groups but the largest increase was the number of people from mixed ethnic groups.

Despite its young age-structure, Nottingham has a higher than average rate of people with a limiting long-term illness or disability. White ethnic groups have higher rates of long term health problems or disability overall, although this varies with age, with some BME groups having higher rates in the older age-groups.

The causes of years lost to disability are:

1. Back pain and neck pain
2. Heart disease
3. Stroke
4. Respiratory disease
5. Lung cancer
6. Dementia
7. Eyesight and hearing loss
8. Depression and anxiety

Many health and wellbeing outcomes are linked to socio economic factors and the 'wider determinants of health'. There are high levels of deprivation in Nottingham City: the 20th most deprived district in England out of 326. There are also particularly deprived areas within the city: 45 of the 176 city lower super output areas (LSOAs) feature amongst the 10% most deprived in the country; 91 LSOAs feature in the 20% most deprived.

Life expectancy in Nottingham is significantly lower than the England average, with three years less for men and two years less for women (Nottingham: 75.7 men; 80.7 women. England: 78.6 men; 82.6 female). Nottingham’s life expectancy for men is ranked 9th worst in England and 18th for women. And 14 of the City’s 20 wards have significantly lower life expectancy for men than the East Midlands average. The largest contributors to the difference between Nottingham’s life expectancy and England’s life expectancy are cardiovascular disease, cancer and respiratory disease. 50% of the gap in life expectancy is due to smoking.
Figure 2. Nottingham City: life expectancy

Cancer is the second highest cause of premature death in Nottingham, accounting for 27% of all deaths in the city. The incidence is increasing nationally and locally and mortality rates locally are significantly higher than the national average and have remained higher for many years. Evidence indicates that of all cancer-related deaths, almost 25-30% is due to tobacco and as many as 30-35% is linked to diet.

Coronary heart disease (CHD) is a major cause of ill health nationally and locally and a major contributor to the gap in premature mortality between Nottingham and England. Premature mortality from CHD accounts for 45% of under 75 mortality from cardiovascular disease, significantly higher than the national figure.

Respiratory disease is a major cause of ill health in Nottingham City, both in terms of unplanned admissions to hospital and premature mortality. This definition includes COPD (chronic obstructive pulmonary disease), asthma and bronchiectasis. The major risk factor for developing COPD is smoking. High levels of deprivation are linked to high smoking and COPD prevalence. Around 130 people in Nottingham die due to COPD each year.

Stroke is the fourth biggest cause of death in England after cancer, heart disease and respiratory disease causing almost 50,000 deaths. Of those who survive a stroke 60% with have a degree of disability. The estimated prevalence of stroke in the CCG is 1.8%, i.e. proportion of patients who have had a stroke in the past. This compares to 2.0% for England and 1.9% for comparator CCGs. This means 78% are potentially diagnosed here compared to 85% nationally.

Key lifestyle behaviours with high prevalence are:

- Low physical activity
- Unhealthy diet
- Smoking
- Harmful use of alcohol

9.1.1.3. Patient experience

Nottingham City CCG engages with patients through member practices, patient experience team, people’s council, Healthwatch, third sector organisations, CCG annual general meeting,
engagement with specific service development, strategic priorities etc, social media and website/tools. Local and national survey results are analysed to understand the patient’s experience of primary care. An example of a recent review showed:

Overall experience of GP surgery:

- Overall, how would you describe your experience of your GP surgery?
  - England (85%), City (85%)

Access to GP services:

- Generally, how easy is it to get through to someone at your GP surgery on the phone?
  - England (70%), City (68%)

Helpfulness of receptionists at GP surgery:

- How helpful do you find the receptionists at your GP surgery?
  - England (87%), City (88%)

Awareness of online services:

- As far as you know, which of the following online services does your GP surgery offer?
  - Booking Appointments Online – England (31%), City (25%)
  - Online Repeat Prescriptions Online - England (31%), City (20%)

Percentage of patients saying ‘good’

Figure 3. Nottingham City practices: map showing overall patient experience
Table 7. Nottingham City: patient survey results

Nottingham City average is generally within 2% of the national average. Clearly shown throughout all the questions is the significantly greater range between lowest and highest grade and that of our closest CCGs.

However, the analysis identified some outliers in two care delivery groups, a deep dive was undertaken and the results shared with the practices and the CCG will monitor the results.

9.1.2. Model of care

9.1.2.1. Multi-speciality Community Provider

The CCG has made significant progress towards integrated care in Nottingham City and has developed proposals for future commissioning of a ‘virtual multi-specialty community provider (MCP)’ incorporating the re-procurement of community health services. This development in Nottingham City supports the STP vision and objectives and the Greater Nottingham plan to deliver an Accountable Care System (ACS) by 2020.

Since 2012 the CCG and Nottingham City Council, along with partners, have taken a whole systems approach to develop and implement a more joined up and sustainable health and care system through the Integrated Care Programme. The programme was established as an integrated care pioneer site in 2015 which provides access to national support and shared learning.

Our approach to integrated care for adults with long-term conditions and the frail elderly will be extended to cover the entire adult population. Importantly, we need patients to continue to receive more care in their home or community, reducing unnecessary hospital admissions and shortening hospital stays. We need to develop an enhanced community offer to achieve this, building on existing good practice.

Our commissioning needs focus on the value achieved or outcomes gained rather than on activity. Wherever services are provided, they must be high quality, accessible, sustainable and based on population need.

Our objectives are:
1. Create a more cost efficient and clinically effective approach to care
2. Ensure care is delivered in the right place – by the right people – with the appropriate skill mix
3. Ensure care is delivered at home or in the community wherever possible
4. Ensure provision of high quality, clinically safe and accessible services
5. Focus on prevention and the ways in which individuals and resilient communities can best support themselves
6. Move away from a ‘paternalistic’ top-down approach to one in which individuals are better informed, empowered and managing their own conditions
7. Ensure that decisions are made in the best interests of patients – not organisations
8. Build medium and long term sustainability in response to rising demand and constrained resource
9. Continue to work towards reducing and ending health inequalities in our communities

The virtual model would create an alliance agreement between providers that would overlay rather than replace traditional commissioning contracts.

9.1.2.2. Care delivery groups

The formation of eight Care Delivery Groups across the city have brought together groups of GP practices, multi-disciplinary teams and social care link workers and includes the integration of former specialist services, such as falls and bone health, into community teams. Care Co-ordinator roles supporting the Care Delivery Groups and the multi-disciplinary team meetings have been in place, these non-clinical roles have helped staff navigate health and social care community services, co-ordinating appropriate support for patients and reducing the administrative burden for clinicians.

Across Care Delivery Groups an evaluation of the primary care vision by The Office for Public Management reported that GPs and practice staff perceive that patients have received improved and more coordinated care as a result of the multi-disciplinary team meetings, helping to integrate health and social care and reduce duplication of services by supporting good care planning and information sharing. Over 90% of respondents in the evaluation agreed that these meetings have improved working relationships between primary, community and social care.

9.1.2.3. Vanguard

Since March 2015 Nottingham City has been a vanguard site for ‘enhanced health in care homes’ – offering older people better, joined-up health, care and rehabilitation services. The vision is to enable residents living in a care home to be healthier, have a better quality of life and to be treated with dignity and respect, focusing on residents’ capabilities rather than their dependencies. There are a number of inter-linked projects to achieve the vision to:

- Ensure the right urgent care response in a crisis, helping avoid hospital/care admissions, seven days a week
- Integrate specialist care homes services including dementia outreach, care homes nursing team and care homes pharmacy
- Create a single reablement service for care home residents so they have the opportunity to remain as independent as possible
- Use video consultations and expanding telemedicine in care homes
- Improve support in the community to allow older people to be discharged earlier from hospital wards
- Encourage older people in care homes to take part in activities that maintain or improve their health and well-being.

We anticipate realising a number of benefits for care home residents, for the care home sector and for the health and care system. Residents will experience better quality care, improved support for long-term conditions, reduced risk of falls and injuries, fewer trips to hospital and improved end-of-life care. The care home sector will become a safer environment, working in partnership with clinicians providing better co-ordinated care around the clock. There will be benefits by operating a more efficient system, using resources more effectively and developing a greater skill mix among a more flexible workforce.

9.1.2.4. Nottingham City GP Alliance

To support the development of new care models, with general practice at the heart of these, the Nottingham City General Practice Alliance was formally established in April 2016. They were
formed to support and strengthen list-based general practice in Nottingham City and their development was supported by NHS England, the CCG and the primary care development centre during 2015. The Nottingham City General Practice Alliance is led by a core group of future local GP leaders (who are not involved in the CCG as commissioners) and has a membership of 48 practices and 327,197 registered patients, this represents 84% of practices and 90% of the population covered by the CCG. The organisation is working on a range of projects to benefit its member practices including:

- Shared back office functions and HR services
- Establishing a register of non-GP bank staff (receptionists, nurses, HCAs) and mobilise spare capacity in the primary care workforce
- Mutual peer support for members with performance / disciplinary issues, CQC requirements
- Supporting practices to meet contract reporting requirements and claiming processes
- Supporting practices to be more resilient, particularly those who may be vulnerable now or in the immediate future

The CCG is currently working with the Alliance to facilitate a number of schemes as part of the GPFV. Work is also taking place with the Alliance around new models of primary care with an aim to improve patient care by improving access and greater integration of primary, community and social care services. In addition the redesign of general practice will need to support the sustainability of general practice going forward with practices being able to maximise the benefits of operating at scale. This will include working more collaboratively, sharing best practice, enhanced clinical mentorship and support as well as the obvious administrative benefits such as shared back office support and clinical cover.

9.1.2.5. Primary care patient offer

In 2016 the CCG launched the primary care patient offer to improve quality and access in primary care. This is a voluntary enhanced service for Nottingham City practices, 42 practices have committed to delivering the offer. The Primary Care Patient Offer aims to deliver:

- Increased access to primary care services
- Equity of service provision to all city patients
- Opportunities to innovate and improve care
- Additional investment in general practice to deliver fairness of funding

Practices could start delivering this offer from 1st October, but all participating practices must commence 1st April 2017.

9.1.2.6. Information technology

The CCG will continue to work with Connected Notts to utilise technology to improve clinical outcomes. Work is progressing with Connected Notts for standardised referral templates, sharing of electronic records between all providers as appropriate, ensuring that all professionals involved in a patient's care have the current up-to-date patient information.

The CCG is also developing a programme of work to increase Assistive Technology in primary care and the potential to roll out ‘Florence Simple Telehealth (Flo)’ across the City. Flo is a text messaging service which supports patients to manage their health condition i.e. blood pressure readings, weight management and medication reminders. We are scope eConsultation to offer online consultation with further signposting, self-help and symptom checkers. Video consultation in care homes is currently being piloted through the Vanguard enhanced health in care homes’.

The CCG is also supporting a programme of work to understand and reduce clinical variation in patient populations by supporting practices to use tools to analyse their baselines, generate plans, and monitor processes and outcome measures. Through peer support and utilising data practices can learn from and manage variation over time. Reducing clinical variation can improve quality resulting in improved and more consistent health outcomes for patients. This programme of work also reviews where services can be provided in the community, and utilisation of clinical assessment services for triage and patient choice. Pathways for trauma and orthopaedic services
and pain management are now provided in the community, other pathways are being developed with other CCGs for gastroenterology and gynaecology.

9.1.3. Access

9.1.3.1. GP Access

The CCG participated in the Prime Minister’s Challenge Fund (wave one) to deliver increased access by providing GP and nurse appointments on a Saturday and Sunday. This has continued to be commissioned whilst awaiting the core standards of the GP Access Fund. The service piloted pre-bookable weekend appointments on a care delivery group hub basis on both Saturdays and Sundays (excluding bank holidays) across 5 care delivery groups by 7 practices. Analysis through the evaluation by the Office for Public Management demonstrated that over an 18 month period 11,000 patients had accessed the service and the service provided an average of 187 weekly appointments, 114 of which are GP appointments.

The CCG has re-designed its model of extended access to general practice to meet the GP Access standards. During 2017/18 the CCG will support the implementation of a new model of care to provide extended access (8am – 8pm) and weekend access in each of the CCG’s eight Care Delivery Groups.

More work needs to be carried out to ensure the technology allows access to patient records from different sites but learning from a neighbouring CCG is being incorporated into the delivery model.

9.1.3.2. Primary Care Patient Offer

Delivery of the Primary Care Patient Offer will be at full capacity from 1st April 2017, which includes standards for delivery of additional primary care services, quality standards for clinical effectiveness, patient safety and patient experience and standards for access. Patient feedback of the Offer will be monitored and a mystery shopper will also be commissioned.

Nottingham City has a number of practices that whilst open as part of their core contract do not provide appointments on a Thursday afternoon. Part of the Primary Care Patient Offer is to be open on Thursday’s providing reception cover and access to appointments during core hours.

This is a new service that the CCG has invested in to improve access and to sustain primary care. It has been commissioned recurrently for four years and will continue to evolve and develop to respond to the needs in primary care.

9.1.3.3. Collaborative working

Traditionally, primary care have worked in isolation of other practices but there is more recognition for working more collaboratively and how that can improve service delivery and be more efficient. The CCG is committed to supporting collaborative working and the benefits this can bring to primary care. Care Delivery Group network events have been organised which enables practices to meet within their Care Delivery Group to share best practice, this also includes neighbourhood teams. The network events also provide an opportunity to learn more about new services and service developments.

The Office for Public Management in their primary care vision evaluation report reported that on the whole practices have found the network events useful with two thirds of respondents agreeing or strongly agreeing that these events have enabled them to find out more about local health services. They have helped to improve working between neighbouring practices and provide a forum to feedback and raise areas for improvement with the CCG, enabling a two-way dialogue during the events.

9.1.4. Workforce

The CCG recognises the workforce pressures facing primary care and is well placed to highlight what the needs are in Nottingham City. All places on the Nottinghamshire Vocational Training Scheme have been filled in round 1 of recruitment. This equates to 135 over three years (45 trainees per year), a further 30 more trainees are currently going through the recruitment process.
Health Education East Midlands have designed a fellowship programme, launched in 2014. The programme is designed to enable doctors in training a range of development opportunities that integrate with their clinical training. Fellows can also obtain a postgraduate qualification and additional competencies. A key aim is to retain the fellows within Nottingham City and the CCG has supported the programme from the outset. A number of Nottingham City practices have signed up to be a placement for fellows and in year one of the programme (2015/16) 4 fellows were placed, all 4 fellows have extended their placement for another year (2016/17). Nottingham City has secured a further 7 placements for their first year (2016/17). One of the second year fellows has been working at the CCG to support service redesign and commissioning, this fellow has continued to work with the CCG in their second year. The fellow has also become a partner in a Nottingham City practice.

Nottingham City has a number of training practices with an aim to increase the numbers of training practices across the City. We are also engaged with the LMC who are exploring a scheme to recruit clinicians from abroad.

Nottingham City has a lead GP and nurse lead for workforce. We have an education programme for nurses that want to work in primary care but don’t have all the necessary skills; this has been successful and resulted in 2 full time nurses being employed by two Nottingham City practices.

The CCG supports PLT sessions, sessions are split so they are more focused to the audience (GPs, nurses, practice manager, and administration staff sessions); these are well attended. In addition to this we have a learning & development programme for practice managers and Administration staff. We also support practices by contributing 50% of the annual cost to use BlueStream Academy for their mandatory training needs.

As part of the Prime Ministers Challenge Fund (wave one) we piloted training for reception staff. The purpose of the training was to empower front line staff to help navigate patients to services available to reduce the number of clinical ‘signposting’ appointments. The training also provided front line staff with tools to handle difficult conversations with patients, to be able to engage with the patient to ensure that they see the right health professional in the practice. The evaluation of the training was very positive, there were 16 sessions and 240 front line staff attended. The feedback was that the training exceeded their expectations and they felt better prepared and more positive.

The CCG supports pharmacists in primary care and is currently participating in wave one of the Clinical Pharmacist in GP Practice scheme. We are also working with practices that would like to participate in wave two of the scheme.

The Nottingham City GP Alliance is developing a resource pool that practices can access if they are struggling to recruit or have an unplanned shortage of resource in the practice. This includes a register of non-GP bank staff (receptionists, nurses, HCAs) to help mobilise spare capacity in the primary care workforce. We are also keen to support practices with their skill mix in primary care in particular the role of pharmacists in primary care, following initial evaluation of the wave one Clinical Pharmacist in GP Practice scheme.

We are also engaging with a neighbouring CCG that is participating in a scheme to provide primary care experience to pre-registration pharmacists, this is due to commence in July 2017.

Further work is taking place to collaborate with neighbouring CCGs on education based schemes, the Primary Care Development Centre and Health Education East Midlands. These include supported appraisals, coaching and mentorship, also the challenges and the changing NHS landscape and the role of collaborative working. We are working with partners to improve recruitment and retention in primary care; this includes developing a ‘recruitment pack’. The CCG also works with the East Midlands Leadership Academy and the Institute of Healthcare Management to provide local development sessions.

9.1.5. Workload

The Primary Care Patient Offer builds on the national plan to equalise funding but crucially offers the chance to positively accelerate this process, bringing under-funded practices up more quickly and cushioning higher funded practices from national reductions in the minimum income practice
guarantee (MPIG) and personal medical services (PMS) changes. A key part of the Offer is where practices can work more collaboratively to deliver the standards.

We have also been working with the GP Alliance around reducing duplication in primary care through having a central resource for certain requirements, for example NICE guidelines, each practice having a lead but guidance reviewed and summarised centrally, clinical system templates being standardised centrally and shared.

The CCG is also using the guidance for ‘Services for Practices Serving atypical Populations’, in particular relating to extended appointments to accommodate language needs. We are currently developing a programme to support practices that have high numbers of double appointments for patients that require interpretation services. The service is aimed to support practices but to also enable additional appointments.

In Nottingham City each practice has a ‘buddy’ practice that they discuss operational as well as clinical matters with, sharing best practice. Practices can utilise best practice to adapt their own business model to be more sustainable and resilient, which is a key requirement for a more innovative primary care.

We are working with the Nottingham City GP Alliance to facilitate practices access to the Vulnerable Practice and GP Resilience schemes. This will include an initial diagnostic but the practice, with the Alliance, can consider what support would best meet their needs to become more resilient. Specialist support for practices, that meet the criteria, has been identified and practices are currently accessing support through this programme. The practice will need to report the impact of the support over a period of time to the CCG.

We are also piloting ‘Workflow Optimisation’, a programme to support practices and free up GP time. This is a system by which practice administration staff are trained and supported to read code and action incoming clinical correspondence safely and accurately. The outcome is that up to 80% of the patient correspondence is completed without the GP. Patients next steps are facilitated in a timely way and the clinical notes are more accurate when they are needed. This was a programme supported through wave one of the Prime Ministers Challenge Fund.

The CCG is raising awareness of the ‘Releasing Time to Care’ programme which will support the implementation of the ‘Ten High Impact Changes’. Further engagement will be taking place with the Nottingham City GP Alliance to see how participation can be increased.

We are engaged with practices and partners to deliver the ‘Ten High Impact Changes’ and mechanisms to improve access, quality and sustainability in primary care.

We will continue to support practices with workload pressures through our GP Alliance, support skill mix in primary care and education and tools to develop primary care teams to be more resilient and sustainable.

9.1.6. Investment

Below provides information about the schemes that the CCG has invested in for 2017/18, these are all annual figures:

- Primary Care Patient Offer: This offer has received £2.43m of investment recurrently over 4 years (commenced 1st October 2016)
- Services for practices serving atypical populations: Service to support practices with high interpretation needs, budget to be confirmed.
- Care Delivery Group Co-ordinators: The CCG invests £1.16m recurrently to provide assistance to practices in the co-ordination of patients care.
- GP Access Fund: To deliver extended access to meet the GP Access core standards through an investment of £6 per patient (2017/18) and £6 per weighted patient in 2018/19. This equates to £2.2m in 2017/18 and £2.18m in 2018/19.
- Primary Care Transformation: An investment of £1.50 per patient in 2017/18 and 2018/19 to support primary care transformation. The funding will be used to support implementation of the 10 ‘high impact actions’ identified in the planning guidance to improve access and sustainability. The CCG is finalising plans and this will include the potential to extend the scope of the Primary Care Patient Offer.
• Estates Technology and Transformation Fund: The CCG has secured funding of £670K in 2016/17 to increase clinical capacity in two GP practices. £75K was also secured in 2016/17 to undertake three options appraisals for three health centres. £75K has been approved in principle for 2017/18 to undertake three options appraisals for three GP practices. £898K has been approved in principle for 2017/18 for internal reorientation and reconfiguration and expansion of 4 GP practices. £635K has been requested for 2018/19 for an extension at one GP practice.
• GP Practice Resilience Programme: Investment of £101K in 2017/18 to support practices, scheme and roll out has been agreed with practices. £51K investment in the following three years to deliver the programme.
• Vulnerable Practice Scheme: Investment of £91K in 2017/18 to support vulnerable practices, scheme and implementation has been agreed with practices.
• Training for reception and clerical staff: Investment of £32K in 2017/18, a product has been sourced and the roll out is being finalised with practices.

9.2. NHS Nottingham North and East CCG

9.2.1. Introduction

NHS Nottingham North and East Clinical Commissioning Group comprises 20 GP practices covering a population of approximately 150,000, organised collectively to commission health services for the patient population living in and around Arnold, Burton Joyce, Calverton, Carlton, Colwick, Daybrook, Gedling, Giltbrook, Hucknall, Lowdham, Mapperley, Netherfield, and Newthorpe.

NNE CCG’s vision is:

“Putting Good Health into Practice”

This vision will be delivered through:

1. Improving the health of the community and reducing health inequalities
2. Securing the provision of safe, high quality services
3. Achieving financial balance and value for money

NNE CCG’s aims reflect its population profile and groups with the greatest need, whilst also ensuring that focus on the wider population is maintained.

For 2017/18-2018/19 NNE CCG’s key aims will continue to be to:

• reduce health inequalities in the local population by targeting those people with the greatest health needs
• drive up the quality of care in order to improve health outcomes and reduce unwarranted clinical variation
• direct available resources to where they will deliver the greatest benefit to the local population
• commission appropriate models of care for older and vulnerable people with complex needs, ensuring all patients are treated with dignity and respect
• ensure that patients are able to make choices about the care they receive and are seen in the right place at the right time by the right person.

9.2.1.1. The local population

The population of NNE CCG is spread across a mixture of urban areas and rural villages. The Index of Multiple Deprivation (IMD) 2015 shows a wide variance in overall deprivation across the NNE area. While the CCG average (18.2) is below the England average of 21.5, there are areas of significant deprivation in the area, particularly around Hucknall.
The population profile for the CCG shows that the population is slightly older than the national average, whereas the proportion of people under 40 is lower than the national average. Across the CCG area, it is estimated that the population will grow by 11.66% between 2010 and 2025.

9.2.1.2. Disease prevalence and patient outcomes

Figure 4 below shows the prevalence (number and percentage) of diseases covered by the Quality and Outcomes Framework (QOF) for NNE CCG in 2015/16.

<table>
<thead>
<tr>
<th>CCG indicator key</th>
<th>General key</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significantly worse than England average</td>
<td>Significantly better than England average</td>
</tr>
<tr>
<td>Not significantly different from England average</td>
<td>No significance can be calculated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Population</th>
<th>Rate</th>
<th>Eng Avg</th>
<th>Eng Low</th>
<th>England Range</th>
<th>Eng High</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 AF - Atrial Fibrillation</td>
<td>150741</td>
<td>1.8%</td>
<td>1.8%</td>
<td>42.3%</td>
<td></td>
<td>3.0%</td>
</tr>
<tr>
<td>2 CHD - Coronary Heart Disease</td>
<td>150741</td>
<td>3.6%</td>
<td>3.4%</td>
<td>1.3%</td>
<td></td>
<td>5.1%</td>
</tr>
<tr>
<td>3 CVD-P - Coronary Heart Disease - Primary Prevention</td>
<td>86633</td>
<td>80.3%</td>
<td>1.1%</td>
<td>47.7%</td>
<td></td>
<td>1.9%</td>
</tr>
<tr>
<td>4 HF - Heart Failure</td>
<td>150741</td>
<td>63.2%</td>
<td>78.1%</td>
<td>31.8%</td>
<td></td>
<td>1.5%</td>
</tr>
<tr>
<td>5 HYP - Hypertension</td>
<td>150741</td>
<td>14.7%</td>
<td>14.0%</td>
<td>7.7%</td>
<td></td>
<td>18.4%</td>
</tr>
<tr>
<td>6 PAD - Peripheral Arterial Disease</td>
<td>150741</td>
<td>56.7%</td>
<td>61.1%</td>
<td>23.3%</td>
<td></td>
<td>1.2%</td>
</tr>
<tr>
<td>7 STIA - Stroke and Transient Ischaemic Attack</td>
<td>150741</td>
<td>2.0%</td>
<td>1.8%</td>
<td>71.6%</td>
<td></td>
<td>2.7%</td>
</tr>
<tr>
<td>8 AST - Asthma</td>
<td>150741</td>
<td>6.8%</td>
<td>6.1%</td>
<td>3.6%</td>
<td></td>
<td>7.8%</td>
</tr>
<tr>
<td>9 COPD - Chronic Obstructive Pulmonary Disease</td>
<td>150741</td>
<td>1.9%</td>
<td>1.9%</td>
<td>76.4%</td>
<td></td>
<td>3.7%</td>
</tr>
<tr>
<td>10 OB - Obesity (16+)</td>
<td>120791</td>
<td>10.9%</td>
<td>9.7%</td>
<td>3.9%</td>
<td></td>
<td>14.8%</td>
</tr>
<tr>
<td>11 CAN - Cancer</td>
<td>150741</td>
<td>2.8%</td>
<td>2.5%</td>
<td>81.6%</td>
<td></td>
<td>3.7%</td>
</tr>
<tr>
<td>12 CKD - Chronic Kidney Disease (18+)</td>
<td>120791</td>
<td>6.4%</td>
<td>4.1%</td>
<td>1.5%</td>
<td></td>
<td>8.2%</td>
</tr>
<tr>
<td>13 DM - Diabetes Mellitus (17+)</td>
<td>122412</td>
<td>6.6%</td>
<td>6.7%</td>
<td>3.6%</td>
<td></td>
<td>10.3%</td>
</tr>
<tr>
<td>14 PC - Palliative Care</td>
<td>150741</td>
<td>37.9%</td>
<td>30.9%</td>
<td>9.8%</td>
<td></td>
<td>92.6%</td>
</tr>
<tr>
<td>15 DEM - Dementia</td>
<td>150741</td>
<td>84.7%</td>
<td>78.5%</td>
<td>28.6%</td>
<td></td>
<td>1.3%</td>
</tr>
<tr>
<td>16 DEP - Depression (18+)</td>
<td>120791</td>
<td>7.0%</td>
<td>8.4%</td>
<td>4.5%</td>
<td></td>
<td>14.1%</td>
</tr>
<tr>
<td>17 EP - Epilepsy (18+)</td>
<td>120791</td>
<td>84.8%</td>
<td>82.7%</td>
<td>44.3%</td>
<td></td>
<td>1.9%</td>
</tr>
<tr>
<td>18 LD - Learning Disabilities (18+)</td>
<td>150741</td>
<td>46.0%</td>
<td>45.2%</td>
<td>19.1%</td>
<td></td>
<td>80.7%</td>
</tr>
<tr>
<td>19 MH - Mental Health</td>
<td>150741</td>
<td>68.3%</td>
<td>84.8%</td>
<td>52.5%</td>
<td></td>
<td>1.5%</td>
</tr>
<tr>
<td>20 OST - Osteoporosis (50+)</td>
<td>60245</td>
<td>25.6%</td>
<td>28.7%</td>
<td>10.3%</td>
<td></td>
<td>83.0%</td>
</tr>
<tr>
<td>21 RA - Rheumatoid Arthritis (16+)</td>
<td>124000</td>
<td>65.5%</td>
<td>75.6%</td>
<td>40.1%</td>
<td></td>
<td>1.2%</td>
</tr>
</tbody>
</table>

Figure 4. NNE CCG disease prevalence (QOF data 2015/16)

The above table demonstrates the levels of disease prevalence and shows the variation from the national average. In particular, this indicates that there is a higher prevalence of chronic kidney disease, asthma, coronary heart disease, stroke, and dementia, and a lower prevalence for mental health, which could indicate there is either a lower diagnostic rate for mental health or a true lower prevalence.

As nationally evidenced in Improving general practice – a call to action (NHS England, August 2013), the prevalence of many diseases is increasing. This is compounded by the fact that the incidence of people having two or more long-term conditions is also increasing.

Figure 5 below shows the performance of CCGs against each outcome indicator.
The NHS England Right Care Commissioning for Value information (October 2016) for NNE CCG indicates that significant improvements can be made in terms of both spend and quality for cancer, mental health, trauma and injuries, gastro-intestinal, and respiratory outcomes.

### 9.2.1.3. Unwarranted clinical variation

The CCG has identified unwarranted variations and inequalities in the quality and range of primary care services that patients receive locally which will have an impact on health outcomes. This is reflected in first outpatient appointment referral patterns, both between practices and between individual GPs; this is also apparent in respect of emergency admissions.

There also remains statistically significant unwarranted variation between GP practices, not only in secondary care activity, but also, for example, in:

- **Figure 5. NNE CCG performance against outcome indicators (most recent data available for each indicator, to March 2016)**

The table below shows the performance of NNE CCG against various outcome indicators:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Register Rate</th>
<th>England Rate</th>
<th>Low England</th>
<th>High England</th>
<th>Interquartile Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Potential years of life lost amenable to h/c (f)</td>
<td>1446</td>
<td>1774</td>
<td>1843</td>
<td>1055</td>
<td>3204</td>
</tr>
<tr>
<td>1.1 Potential years of life lost amenable to h/c (m)</td>
<td>1947</td>
<td>2470</td>
<td>2159</td>
<td>1325</td>
<td>902</td>
</tr>
<tr>
<td>1.2 Under 75 mortality rates from CVD</td>
<td>84</td>
<td>55</td>
<td>64</td>
<td>37</td>
<td>130</td>
</tr>
<tr>
<td>1.6 Under 75 mortality rates from respiratory disease</td>
<td>41</td>
<td>27</td>
<td>29</td>
<td>14</td>
<td>74</td>
</tr>
<tr>
<td>1.8 Emergency adm. for alcohol related liver disease</td>
<td>30</td>
<td>24</td>
<td>26</td>
<td>60</td>
<td>92</td>
</tr>
<tr>
<td>1.9 Under 75 mortality rates from cancer</td>
<td>201</td>
<td>131</td>
<td>119</td>
<td>90</td>
<td>181</td>
</tr>
<tr>
<td>1.10 One-year survival from all cancers</td>
<td>69</td>
<td>69</td>
<td>64</td>
<td>74</td>
<td>181</td>
</tr>
<tr>
<td>1.7 Under 75 mortality rates from liver disease</td>
<td>31</td>
<td>21</td>
<td>16</td>
<td>7.9</td>
<td>40</td>
</tr>
<tr>
<td>1.4 MI, stroke and stage 5 CKD in people with diabetes</td>
<td>154</td>
<td>106</td>
<td>97</td>
<td>60</td>
<td>203</td>
</tr>
<tr>
<td>1.11 One-year survival: breast, lung &amp; colorectal cancers</td>
<td>68</td>
<td>69</td>
<td>62</td>
<td>76</td>
<td>88</td>
</tr>
<tr>
<td>1.17 Record of stage of cancer at diagnosis</td>
<td>650</td>
<td>74</td>
<td>77</td>
<td>45</td>
<td>88</td>
</tr>
<tr>
<td>2.2 % people feel supported to manage their condition</td>
<td>582</td>
<td>66</td>
<td>65</td>
<td>51</td>
<td>73</td>
</tr>
<tr>
<td>2.6 Unplanned hospitalisation for chronic ACS conditions</td>
<td>1269</td>
<td>789</td>
<td>832</td>
<td>80</td>
<td>1544</td>
</tr>
<tr>
<td>2.7 Unpl. hosp. for asthma, diabetes &amp; epilepsy, &lt; 19s</td>
<td>52</td>
<td>165</td>
<td>302</td>
<td>28</td>
<td>693</td>
</tr>
<tr>
<td>2.15 Health-related quality of life for people with LTCs</td>
<td>850</td>
<td>0.75</td>
<td>0.74</td>
<td>0.66</td>
<td>0.82</td>
</tr>
<tr>
<td>3.1 Em. adm. for acute cons not usually requiring adm.</td>
<td>1767</td>
<td>1137</td>
<td>1322</td>
<td>227</td>
<td>2383</td>
</tr>
<tr>
<td>3.2 Em. readmissions &lt; 30 days of hospital discharge</td>
<td>1584</td>
<td>11</td>
<td>12</td>
<td>8.9</td>
<td>14</td>
</tr>
<tr>
<td>3.3 Elective Hip replacement PROMS - Avg. EQ-5D gain</td>
<td>0.41</td>
<td>0.43</td>
<td>0.35</td>
<td>0.48</td>
<td>0.48</td>
</tr>
<tr>
<td>3.3 Elective knee repl. PROMS - Avg. EQ-5D gain</td>
<td>0.33</td>
<td>0.31</td>
<td>0.18</td>
<td>0.38</td>
<td>0.38</td>
</tr>
<tr>
<td>3.3 Elective groin hernia PROMS - Avg. EQ-5D gain</td>
<td>0.09</td>
<td>-0.01</td>
<td>0.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 Em. adm. children with lower resp. tract infections</td>
<td>116</td>
<td>388</td>
<td>444</td>
<td>61</td>
<td>851</td>
</tr>
<tr>
<td>3.1 Patient experience of GP out-of-hours services</td>
<td>146</td>
<td>64</td>
<td>68</td>
<td>49</td>
<td>85</td>
</tr>
<tr>
<td>3.2 Patient experience of hospital care</td>
<td>76</td>
<td>77</td>
<td>68</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>4.5 Responsiveness to Inpatients personal needs</td>
<td>70</td>
<td>69</td>
<td>60</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>5.4 Incidence of HCAI – C. difficile</td>
<td>136</td>
<td>91</td>
<td>73</td>
<td>27</td>
<td>158</td>
</tr>
<tr>
<td>5.3 Incidence of HCAI – MRSA</td>
<td>5</td>
<td>3.3</td>
<td>4.2</td>
<td>0.46</td>
<td>13</td>
</tr>
</tbody>
</table>
- childhood vaccinations
- screening for cancer
- disease prevalence as recorded in the QOF registers versus expected disease prevalence
- prescribing.

Figure 6 and Figure 7 below (source: Secondary User Services data) highlight some areas of variation across the CCG.

9.2.1.4. GP referrals to outpatients – all specialties

![Figure 6. NNE CCG GP referrals to outpatient first attendances (seen) in 2015/16 (April 2015 to March 2016)](image-url)
9.2.1.5. Emergency admissions from GP

Figure 7. NNE CCG emergency admissions from GPs in 2015/16 (April 2015 to March 2016)

9.2.1.6. Patient experience

The national GP patient survey (July 2016) results for practices in NNE CCG confirm that, for the most part, the patient experience in the CCG reflects the national picture.

Whilst acknowledging that there are shortcomings to the survey, it does highlight that variations continue to be seen across the CCG area regarding patient experience of, and satisfaction with, the services offered by GP practices. Figure 8 to Figure 10 below give examples that highlight these variations.
9.2.1.7. Patients rating overall experience of GP surgery as very good or fairly good

Figure 8. NNE CCG percentage of patients rating overall experience of GP surgery as very good or fairly good (GP patient survey, July 2016)

9.2.1.8. Patients rating overall experience of making appointment as very good or fairly good

Figure 9. NNE CCG percentage of patients rating overall experience of making appointment as very good or fairly good (GP patient survey, July 2016)
9.2.1.9. Patients rating satisfaction with opening hours as very satisfied or fairly satisfied

Figure 10. NNE CCG percentage of patients rating satisfaction with opening hours as very satisfied or fairly satisfied (GP patient survey, July 2016)

9.2.1.10. What patients are telling us

Patient and public involvement and engagement are very important to NNE CCG. As such, the CCG regularly encourages both patients and the public to feed back their views on health services. This information is collected at community events and patient groups, and via opportunistic feedback, and is used to inform on-going service improvement and commissioning plans.

A number of key themes relating to primary care have emerged to date and are outlined below:

- There appears to be variation in how patients perceive the quality of care they receive. Some patients describe having high levels of confidence and trust in their GP. They feel fully involved in decisions about their care, with GPs taking time to discuss, explain, and provide information about their illness/condition. Some GPs have specialisms in certain areas, e.g. dermatology, thereby removing the need to see a specialist at the hospital, which is considered to be good. Others report not being as involved in the planning of their care as they would like, or believing their GP lacks the necessary knowledge and experience to be able to ensure quality of care, e.g. regarding mental health, alcohol, and drugs.

- Some patients report that GPs and practice nurses are good at providing information to enable them to manage their conditions at home, thereby reducing the number of visits they need to make to hospital. This is often supported by practice staff providing information regarding self-help groups not only to support patients to self-care but also to provide opportunities for them to socialise, e.g. Juggle, Breathe Easy, Nottingham Hospice. At the same time, other patients feel that their GP has a lack of awareness of services into which they could be referred, particularly self-help and third sector services. In addition, it has been suggested that GPs need to provide more information about the side-effects of drugs they are prescribing, so that the patient has a greater understanding of what is happening should side effects be experienced.

- It seems that there is significant variation between practices in respect of access. Some patients tell us that their practice operates a very effective telephone triage system, with GPs calling back quickly and same-day appointments being arranged if required. Online booking systems have been praised as convenient and time-saving. The role of advanced nurse practitioners has been praised as it is believed they can free up GP time to see patients with
more serious conditions. However, other patients report the appointment system and opening times in their GP practice to be inflexible, particularly for those who work. It can be difficult to make an appointment at a GP practice by telephone. It is also difficult to get an appointment within what is perceived as a reasonable time period. In winter it is quicker to call for an ambulance. In addition, the approach and attitude of some reception staff has negatively affected some patients' perception of their practice. Automated phone systems are not always considered to be helpful, particularly to those who do not speak English as their first language. The use of locums within practices has been commented on as having a negative impact on continuity of care.

In addition, patients have told us the following:

- GPs and practice staff need to be more visible in their local community promoting health awareness, especially to schools. Practice staff are respected and are therefore listened to when they are out of the context of their practice.
- There should be more use of information technology in healthcare, including patient access to Wi-Fi in practices. However, although assistive technologies are felt to be useful, consideration needs to be given to the confidence patients (particularly older people) have in using these to support their care.
- Self-management of diabetes, with the provision of good information and guidance from clinical staff who understand the condition and its complications, is paramount.
- NNE CCG and GP practices need to address the perceived variations in diabetes care across practices, educate more staff to understand the condition, and promote self-management initiatives, to both engage with, and gain more trust from, their patients.
- More support is required for the older population, who suffer loneliness and are isolated in their own home.
- Communication systems between providers (e.g. the GP and the hospital) need to be improved, as the current system of writing letters is inefficient and a waste of money.
- Systems need to be reviewed to avoid duplication of tests/assessments/treatment between primary and secondary care, which wastes money.
- Local GP surgeries could work together so that if one is at full capacity in terms of appointments, other local surgeries that are not at capacity could arrange to take the ‘overspill of patients’.
- The huge increase in people living longer means early intervention is a key way to address future potential long-term conditions.
- There need to be more GPs.
- Confidentiality and data protection are an issue at GP surgeries. People queuing can hear everything that is said at reception desk.

9.2.2. Model of care

To support delivery of the Greater Nottingham vision for primary care, NNE CCG’s vision is for general practice to be the bedrock of healthcare for the population of NNE, delivering equitable, high quality, efficient, accessible, and sustainable primary care services that are clinically effective and patient-centred.

Through collaboration with neighbouring CCGs, the CCG aims to further integrate care across primary, community, secondary, and social care, with general practice at the heart of this, coordinating care across the health and care system.

With a focus on prevention and proactive care, the CCG’s mission is to ensure care is provided in the most appropriate setting, with people cared for at home whenever possible and admission to hospital viewed as a last resort. In 2017/18, NNE CCG will continue work to improve clinical and patient outcomes through proactive care and care in the community. This includes ensuring general practice has the skills and tools to best care for patients. In terms of patients with or at risk of long term conditions, NNE CCG will build on the long term conditions disease registers to develop new pathways and protocols to improve pre-emptive care and long term condition management.
In addition, during 2017/18 NNE CCG will work collaboratively with the other Greater Nottingham CCGs to increase the number and range of elective care services provided in a community rather than a hospital setting.

In delivering this vision, the CCG is committed to redirecting resources towards primary care to support the shift of services out of the acute sector.

The vision is for improved access and quality in primary care to enable primary care to be more responsive and sensitive to local needs and priorities. The CCG believes that as co-commissioners of general practice it is well placed to work with its member practices as providers to explore, develop, and implement new ways of working, both within and between practices. The goal is to ensure the sustainability of general practice so that it can continue to support patients in the context of increasing demand and limited resources.

As such, the Greater Nottingham vision and the CCG’s vision for primary care as described above align with and support delivery of the Nottinghamshire Sustainability and Transformation Plan.

9.2.2.1. Collaboration, federation and sustainability

Following a meeting of member GP practices in October 2016 a number of GPs within the CCG have come together to establish an NNE CCG Collaboration Task Group. Over the last few months the group has been exploring existing models of federation, analysing which model might be the most appropriate for NNE GPs and gauging the appetite for formal collaboration at a CCG level. This has been informed by other local approaches to primary and community care redesign such as the Rushcliffe MCP Vanguard and the Nottingham City GP Alliance. The task group is working at pace and with a realisation that collaborative working is not just desirable, but essential. The intention is to create a model of federation that best meets the expectations and requirements of the majority of NNE GP practices. Some models have been discounted and others considered in detail. This process has been supported by legal advice.

A CCG wide survey of GP partners is being undertaken to formalise the expectations and willingness of constituent members to engage in a formal collaborative arrangement. A meeting of all NNE GP practices is scheduled for early April 2016 at which the task group will present on the work it has been progressing on behalf of all NNE GP practices. It is anticipated that at this meeting a consensus regarding the preferred optimal model for federated working will be reached and a way forward determined and agreed. The intention is to achieve an agreement from the majority of practices to sign up to the federation concept by early April 2017 and for a working federation of practices to be operational by June 2017.

The aim of the federation will be to foment greater cooperative working between GP practices and to enable more care to be delivered closer to home. This is with the intent of promoting the sustainability of general practice but also improving access and the quality of patient care through greater integration of primary, community, and social care services. In addition the redesign of general practice in NNE will need to support its sustainability going forward with practices being able to maximise the benefits of operating at scale. This might include the sharing of best practice, enhanced clinical mentorship and support as well as the obvious administrative benefits such as shared back office functions support and clinical cover. From this new model of cooperation will come opportunities to share resources, capitalise on existing specialisations within our GP community, and reduce overall costs. Where staff resources are duplicated there may be a long term opportunity to address this and achieve a more efficient approach to service delivery. Where individual GP practices are currently not in a position to be able to directly employ specialist nurses and doctors, therapists, or pharmacists due to limited resources, collaboration between practices will create the opportunity for shared costs, shared utilisation and shared benefit. Examples might be the employment of pharmacists, between practices, to deliver more detailed pharmacological management opportunities, or the introduction of a community based gynaecological service.

The CCG is made up of three distinct geographical areas and the new model of care for general practice in NNE will maximise the value of working at a locality level. These localities are also the basis on which the CCGs community services and Care Delivery Groups operate, therefore providing a solid foundation on which to deliver the STP vision and objectives and the Greater Nottinghamshire plan to deliver an accountable care system.
During 2017/18 the CCG, along with the Local Medical Committee will therefore continue to support its GP practices to determine, develop and implement a new model for primary care in NNE CCG. This will build on the existing Primary Care Home pilot within the CCG, an initiative supported by the National Association of Primary Care, and which aims to facilitate practices working together to commission and provide services.

During 2016/17 the CCG has funded a GP practice development facilitator to progress this work. This funding will continue throughout 2017/18. In addition the CCG is currently working with GP practices to identify their support requirements going forward. Once these have been confirmed the CCG will consider how best support can be provided during 2017/18 and also determine its plans for utilisation of funding to support practice transformation during 2018/19. This has already been discussed by the CCG’s PCCC at its meeting in February. Use of the funding might include:

- dedicated time for GPs and other practice staff to design and implement a new model of care for general practice in NNE CCG
- dedicated time for GPs and other practice staff to engage all the member practices in this work, ensuring all practices commit to participating in any new organisation that is developed
- initial management support and support to meet the overheads involved in establishing and embedding a new organisation.

In addition the CCG will support delivery of the Greater Nottingham and STP vision for primary care through:

- implementation of Map of Medicine to provide a central resource on approved standardised pathways of care, referral forms and patient information
- investment in practices to enable them to enhance the pro-active support they provide to care homes through the One Care Home One Practice local enhanced service. This aims to reduce the demands currently placed on practices that provide medical cover for patients residing in care homes
- roll-out of the Care Delivery Group model across the CCG and implementation of a developing work programme around multi-disciplinary population health management and risk stratification
- development of a clinical hub that is linked to NHS 111 and which, it is hoped, will reduce the number of face to face contacts being requested from general practice following calls to NHS 111

9.2.3. Access

In 2014 NNE CCG participated in Wave One of the Prime Minister’s Challenge Fund (PMCF) and developed an urgent/same day service for a group of practices that was delivered from one central location and provided by advanced nurse practitioners (ANPs). The service was successful in demonstrating that ANPs could successfully manage the majority of patients without recourse to a GP and that GP and practice time could be released. The service also evaluated well with patients. However, there were a number of operational issues around staff recruitment, IT, information governance and premises which meant that the service could not be sustained. The PMCF pilot therefore came to an end in NNE CCG although some of the learning from the pilot has been implemented with a focus on supporting practices to implement telephone triage systems in order to improve access.

The CCG has used the results of the GP patient survey (July 2016) to identify inequalities across practices in terms of access. Targeted support has been provided to GP practices where access has been identified as an issue. This support will continue during 2017-19. In addition, the CCG has commissioned a Care and Quality in General Practice local enhanced service. Delivery of this enhanced service will reduce inequalities and improve access to primary care across a range of indicators, including: telephone access during core hours, physical access to premises during core hours, same day appointments for urgent needs, progress towards routine appointments within 3 working days, use of technology to book and provide appointments. In the second half of 2017/18 the access elements of the Care and Quality in General Practice service specification will be reviewed in conjunction with the results of the GP patient survey that will be undertaken in July 2017. This review will assess the impact of delivering the specification on reducing inequalities in
access to primary care and as a result changes will be made to the specification as required. The review of the specification will also be undertaken to ensure that it continues to align with the requirements of the General Practice Forward View and the ambitions of the Nottinghamshire STP going forward.

The CCG is also supporting the expansion of the primary care service at the NUH Emergency Department to ensure that patients who attend A&E services with primary care needs receive a service that is commensurate to their needs. The service will seek to educate patients about choosing more appropriate services in future and will support patients to register with a GP practice if they do not already have one.

During the early part of 2017/18 the CCG will work with GP practices and engage with the local population to determine the requirement for extended hours within each of the three CCG localities. This will include an assessment of the level of demand at a locality level for appointments in the evenings and at weekends. In the latter part of 2017/18 the CCG will co-design its model of extended access to general practice with practices and patients. During 2018/19 the CCG will use the £3.34 per head funding provided to support the implementation of 8am to 8pm and weekend access in each of the CCG’s three localities where this is achievable; implementation will be via a phased roll out ensuring that additional consultation capacity equates to 30 minutes 1000 population. This will include:

- ensuring that the level of provision takes into account feedback from patients and a review of current utilisation rates
- supporting practices to set up responsive systems and processes to ensure patients with urgent needs are seen in a timely manner by a clinician with the appropriate skills; this could be at an individual practice level and/or across a number of practices.

### 9.2.4. Workforce

The workforce of the CCG’s member practices is pivotal to the delivery of the CCG’s Primary Care Strategy. NNE CCG is not currently identified as an under-doctored area and although practices sometimes struggle to recruit to vacant posts, there are no practices in the CCG that currently rely completely on locum or other interim arrangements. The CCG recognises the workforce pressures that currently exist in general practice and therefore increasing capacity is a key priority. During 2017/18 and 2018/19 the CCG plans to:

- support the delivery of the workforce elements within the Nottinghamshire Sustainability and Transformation Plan, including:
  - developing and implementing recruitment & retention strategies that may include: portfolio working arrangements, recruitment and retention incentives, rotational opportunities, collaborative recruitment campaigns and the sharing of specialist staff between practices
  - review the impact of wellbeing initiatives targeting general practice and roll out effective initiatives in a sustainable way (this may include supported appraisals, coaching and mentorship programmes)
- support and provide workforce development/education to ensure general practice has the capability and capacity to deliver both high quality care and the transformation of primary care that is required. This will be through the organisation and delivery of practice learning time events and other training, an early priority is to provide training for clinicians on early intervention in mental health
- support practices to offer GP fellowship placements in partnership with Health Education England and enhance education opportunities by offering trainees the opportunity to obtain greater knowledge of CCG commissioning functions
- support practices and groups of practices to review and optimise how they deploy their staff. The specific investments in enhanced roles and use of new technology will support this initiative
- work with partners to review the impact of wellbeing initiatives targeting general practice during 2017/18 and roll them out in a sustainable model during 2018/19, for example, supported appraisals, coaching and mentorship
encourage practices to review skill mix within their workforce. One practice within the CCG is already participating in a GP pharmacy transformation pilot to examine the benefits of utilising a community pharmacy independent prescriber. The outcomes of this work have been shared to encourage other practices within the CCG to adopt this approach and a number have already expressed interest in this initiative

- incentivise practices to promote Improved Access to Psychological Therapies and increase referrals. During quarter 1 of 2017/18, the CCG will engage with practices to review how practice based mental health therapists can add capacity and value to both practices and patients
- Work with other local CCGs, the LMC and HEE to utilise the funding available to support training for care navigators and medical assistants (£23K in 2017/18 and £25K in 2018/19)
- ensure training is made available for practice staff around signposting and clinical record management. In 2017/18, the CCG will also ensure that training on the management of mental health is made available to GPs and other practice based clinical staff

9.2.5. Workload

The CCG has secured resources via the GP Resilience Programme and is working with the Local Medical Committee to roll out a programme of support to all practices that will enable them to assess their requirements and then provide them with the practice specific support required. The initial assessments will take place by March 2017 with a plan to provide tailored support developed and delivered shortly after.

Practices will be encouraged to participate in the ‘Releasing Time for Care’ programme to support them to implement the “Ten High-Impact Changes” as referenced in the GPFV. The CCG will identify a champion to lead on the promotion of this programme and to share best practice. The CCG has liaised with NHS England’s Sustainable Improvement Team regarding local implementation of the Time for Care Programme and a formal expression of interest has been submitted via the Time for Care portal. The programme has already been communicated out to the CCG’s GP practices and this will be followed by more formal engagement with practices around which elements of the programme would be of most benefit in the first instance. The Time for Care programme comprises of:

- Time for Care Learning in Action Programme – the Sustainable Improvement Team has recommended that the CCG initially focuses on two or three of the high impact actions over the next 12 months using a collaborative approach to learning and improvement. The practices will decide on which of the actions they will take forward with a view to them working together through the programme. The remaining high impact actions that are not being taken forward within the initial 12 months will be managed within the CCG. For example the active signposting will be linked to the care navigation programme and the productive workflows will be developed through the correspondence management programmes.
- General Practice Improvement Leaders Programme – this programme will be advertised to GPs, practice managers and nurses within the CCG. The programme is over six days and as such will require commitment from the candidates. The CCG has discussed local options and subject to expressions of interest is looking to hold the initial two days training (Fundamentals of change and improvement) locally, thus reducing the impact of being away from home. The remainder of the programme will be residential.
- Quick Start modules taken from the Productive General Practice series – the CCG has invested funds into this programme for a number of practices previously. The CCG will promote the new quick start module to those practices who initially did not take part in the CCG scheme.
- The CCG is awaiting further information on the Practice Manager Development Programme. The CCG has had interest from a small number of practice managers following the publication of the GP Forward View. Once more information is known, the CCG will promote, support and implement this.

During 2017-2019 the CCG will continue to support practices with workload pressures in a number of areas:
implementation of a quality dashboard to enable practices to identify issues early and pro-active support for practices to help them prepare for inspections and respond appropriately to any issues that are raised

- promote closer working relationships and/or integration with other primary care providers to maximise the capacity and impact of primary care, for example community pharmacists

- support the sharing of learning across all practices to ensure that skills, knowledge and experience are maximised across the CCG. This will principally be achieved through GP practice locality meetings and the CCG’s Clinical Cabinet

- where practices are vulnerable, support through the Vulnerable Practice Scheme and GP Resilience Programme will be encouraged and co-ordinated by the CCG

- there will be continued support for peer-review of referrals (both internal and external) where information (for example referral rates to secondary care) indicates this may be beneficial in addressing unwarranted clinical variation.

In addition during 2017-2019 the CCG will support practices to make better use of technology to enhance patient care and patient experience whilst also improving practice efficiency. The CCG will principally pursue this through collaboration with the Connected Nottinghamshire Programme and supporting the implementation of the Digital Roadmap for Nottinghamshire. This will include:

- enabling patients to consult with their GP using online consultation systems without necessarily having to visit the surgery e.g. video consultations/e-mail consultations

- ensuring IT systems are in place that support communication between practices and between practices and other providers. This will improve the sharing of information to support the delivery of care

- supporting practices to maximise the use of IT to enable patients to view their own health care records, make and change appointments, and order repeat medications

- encourage practices to maximise the use of assistive technologies to empower patients (and their carers) to take more control of their care through self-management, for example through increasing the use of FLO within the CCG.

9.2.6. Infrastructure - Technology

9.2.6.1. Patient Online

NNE CCG has supported Connected Notts colleagues and practices with the implementation of Patient Online (POL) services. POL services comprises of appointment booking, repeat prescription requests and viewing of records. The key uptake has been in appointment booking and prescription requesting. Currently 21% of the NNE CCG patient population has access to POL services. 75% of the NNE GP practices have met or exceeded the national 10% target and the remaining practices are working towards achieving the target. Further work is planned with practices to increase uptake to meet the 2017/18 target of 20% by March 2018. Through discussion with NNE practices, an aspirational stretch target of 50% POL by March 2019 has also been set. In addition the CCG has plans to promote on-line services through Patient Participation Groups in order to increase awareness and uptake. This work will also encompass ensuring that there is uptake across POL services and not restricted to prescriptions and appointments. It is acknowledged that not all patients will want to access services on line, however this work is important to engage cohort patient groups who perhaps to do not regularly access the GP and may not find it easy to do so within normal working hours. The provision of POL services such as prescription ordering and appointment booking supports practices to manage their workflows and removes unnecessary burdens on the telephones thus enabling easier access for patients.

9.2.6.2. Map of Medicine

NNE CCG has invested in the Map of Medicine product ensuring that all 20 GP practices utilise the system and have access to up to date local and national pathways and local service information. The system sits alongside the clinical system and is quick and easy to access. GPs and practice staff have a single place to visit to obtain relevant information including pathways, patient information, and access to the integrated service directory. This work is important to ensure
equitable access to services and pathways across the CCG. Much of the content can be further developed to facilitate its use within the F12 project.

9.2.6.3. F12

NNE CCG is actively supporting the F12 project which will be developed and implemented during 2017/18. F12 is a CCG developed in-house tool working cross organisationally to develop standardised referral templates and supporting information integrated into the GP clinical systems (TPP and EMIS). This project will incorporate the work already undertaken within NNE CCG’s Map of Medicine. The standardisation of pathways, referrals, and templates ensures that all practices are not only providing the correct information at the right time but that they are also fulfilling any prerequisite prior to referrals. Additionally it will bring about data quality benefits as practices will use standard templates, thus ensuring the correct coding is adhered to. This is important as more and more information is shared electronically across multiple organisations within the local health and social care providers.

9.2.6.4. Other IT projects

The CCG continues to support the various Connected Notts programmes of work which are addressing the sharing of GP patient records across the wider health and urgent care settings locally. These include:

- EDSM shares which enable patient records to be shared in and out of the various services and GP practices – currently 95% of patient records in NNE CCG are enabled to be shared out from the 20 GP practices
- Medical Interoperability Gateway (MIG) which all NNE CCG GP practices provide information into – **there is currently no requirement to consume such information but this might change in the future.** The MIG enables 111, OOH, EMAS, the Urgent Care Centre, and Nottingham University Hospitals NHS Trust and Sherwood Hospitals Foundation Trust ED departments to view a specific coded subset of data direct from the GP patient record
- GP Repository for Clinical Care (GPRCC) enables data flows from all NHS local providers into the local eHealthScope system enabling clinicians to have a full view of their patient data along with other health care providers. It provides risk stratification and will identify gaps in care enabling clinicians to address them in a timely way. The GPRCC is enabled across all 20 NNE CCG practices. This system provides a wealth of information that supports the needs of the population and supports the reduction of inequality within healthcare.

9.2.6.5. National universal capabilities

Based on the previous sections the CCG is therefore meeting the national universal capabilities in all areas by virtue of the use of POL services, the MIG, the use of electronic referrals to secondary care via the e-referrals system, the use of electronic prescribing (undertaken by the majority of NNE CCG practices), the receipt of electronic discharge information from secondary care providers. In addition there has been considerable work as part of the Connected Notts programme on the sharing of social care data via GPRCC and CPIS. All EOL and EPACCs data is shared across the health community via the MIG and EPACCs system.

9.2.6.6. Online consultations

The CCG is awaiting confirmation of the detailed specification. However, preliminary work is underway with other CCGs in the area to assess what is currently available in the market and how this may address the CCG requirements. Due to the expectation that whatever system is implemented will be across the STP footprint it is envisaged that a full procurement will be required. Without the specification it is not possible to give any further details information at this point but it will be reviewed regularly. There are currently no local pilots of any e-consultation systems.
9.2.7. Investment

In addition to the core GP contract funding the CCG is committed to investing in general practice over and above core funding and plans the following investment in primary care for 2017/18 and 2018/19:

- Full funding of core GP contract services in line with the CCGs allocations and the % increase included in these. This allocation will be protected for investment in primary care
- over £1 million investment to deliver a Care & Quality in General Practice local enhanced service and a One Care Home One Practice local enhanced service. Implementation of these enhanced services will make a significant contribution to improving access and quality of care as well as reducing unwarranted clinical variation, inequalities and unnecessary attendance or admission to hospital. In addition patients will be able to access more of the care they need closer to home. The payment mechanism for the Care and Quality in General Practice service also includes an element of levelling up of the £ per registered patient payments made to practices in recognition that currently there is significant variation across the CCG area. Continuation of these locally enhanced services will be dependent on delivery of outcomes during 2017/18. In any event it is likely that the specification for 2018/19 will be amended to reflect the requirements of the GPFV and the ambitions of the STP
- support for the rollout of investments in primary care as detailed in the General Practice Forward View and Operational Planning Guidance, including providing continued support for primary care transformation. The CCG has allocated funding of £3 per patient in its financial plans for 2018/19 which will be used to support implementation of the 10 ‘high impact actions’ identified in the planning guidance, to stimulate the development of at scale providers to improve access, and to secure the sustainability of general practice. The CCG will determine its approach for the use of this funding during Q4 of 2016/17.
- continued work with practices to support premises and infrastructure improvements through funding from the Estates, Technology and Transformation Fund. For the three year planning period to 2018/19 the CCG was successful in securing finance in principle which will contribute to the development of the Calverton Practice and Hucknall premises. The CCG will also work with the local authorities and GP practices to identify and invest section 106 funds and will explore other funding routes for capital developments. The revenue consequences of progressing ETTF projects has been fully considered by the CCG.
- support for new and enhanced roles in primary care. For example reception and clerical staff will be supported to undertake enhanced roles within practice (including actively signposting and navigating patients to ensure their care needs are met and increasing their capability to manage clinical correspondence). Medical assistant roles will be developed within primary care.
- delivery of the General Practice Resilience Programme locally (in conjunction with practices and the Local Medical Committee), to provide a menu of support that will enable practices to become more sustainable and resilient for the future. The CCG has plans to invest £42K in 2016/17 and then £21K in each of the three following years for delivery of this programme
- delivery of enhancements to online consultations within general practice. Investment of £39K in 2017/18 and £52K in 2018/19 has been identified.
- investment of £3.34 per head in 2018/19, increasing to £6.00 per head in 2019/20 to improve access to general practice to meet the requirements detailed in the GPFV
In addition the CCG is currently committed to reinvesting the PMS premium (value to be confirmed) back into general practice in 2017/18.

9.3. NHS Nottingham West CCG

9.3.1. Introduction

Welcome to NHS Nottingham West Clinical Commissioning Group’s (NHS NWCCG) local plans for delivery of the GP Forward View 2017-2019. In this section we consider how general practices and provider services in Nottingham West will work together for the benefit of our population, responding to their health needs and improving their health & wellbeing, and reducing inequalities.
We will outline our plans to improve access, how we will create and deploy resources to support transformation in primary care, and how we will utilise the national funds for general practice across the CCG. This plan should be read in conjunction with the CCG Operational Plan narrative.

The membership of our CCG is made up of 12 local GP practices who are working together to plan and pay for local health services for 94,000 patients. The GP practices in Nottingham West CCG have been working together since April 2007 and have created a number of innovative clinical pathways which have brought high quality patient care closer to home.

Nottingham West has achieved recognised success through the spread of good clinical practice and by reducing variation between practices. Practice visits are undertaken annually to each practice using a standard agenda supported by detailed information packs, including national high level indicators.

We have commissioned a number of community pathways and work closely with community providers to integrate services. The plan is to build on this success, with all 12 GP practices in Nottingham West transforming their service offer to increase productivity, add capacity and deliver quality improvements for all registered patients, supported by responsive and locally-facing community services, and other partners in the health and social care system.

We have established the foundation for delivery of our vision for primary care. We are already working towards our vision of an integrated model of care with primary care as the cornerstone, and have:

- Co-commissioning arrangements in place
- The Engaged Practice Scheme which has delivered real benefits and shared learning
- An integrated model of care in place organised into community hubs – Care Delivery Groups
- Collective general practice is developing
- A prioritised Estates Strategy
- Workforce planning locally and at scale
- Organisational Development needs identified and supported
- Technology to deliver seamless care for patients

9.3.1.1. Our Vision for Primary Care and key priorities

The CCG’s vision is for general practice to be the cornerstone of healthcare for the local population, delivering equitable, high quality, efficient, accessible, and sustainable primary care services that are clinically effective and patient-centred. The CCG has developed a primary care plan and will also work collaboratively with other CCGs to implement the GPFV. The key elements of the local plan for primary care and specifically general practice are:

**Responsive to local health needs:** Primary care will work with providers, partners and commissioners to promote independence and integration, reduce inequalities and focus on prevention and early intervention

**Structures in place to enable primary care to transform at scale and pace:** Nottingham West practices work cohesively and have developed a comprehensive structure for practices to work together at operational level as well as clinically.

**A locally developed information system:** eHealthScope (eHS) is an interactive and responsive system that supports as primary care providers but also in monitoring how interventions and clinical decisions impact upon performance as commissioners.

**Effective partnerships are in place:** Nottingham West GPs work with local clinicians to agree and deliver service improvements. Nottingham West is a key member of the Health & Wellbeing Board, Broxtowe Partnership and partners in the Sustainability & Transformation Plan. We have a long history of collaborative arrangements with stakeholders.

**Patient and citizen engagement is well developed and will continue to grow:** In addition to the Patient Reference Group and Patient Participation groups for each practice, Nottingham West is committed to deliver and support an extensive engagement events planner each year.
9.3.1.2. Our plans for delivery align with the CCG Values and Strategic Objectives

Our values are at the heart of our decision-making as an organisation. We review our core values annually to ensure they remain relevant and continue to guide us in the priorities we set for service change and in the way we approach new challenges:

- Clinical leadership at the heart of the organisation
- Constantly innovate to improve quality and experience for patients
- Work closely with local providers and partners for the benefit of the whole of our population
- Apply the best evidence available to improve local services and reduce health inequalities
- By good governance, openness and sensible use of resources, produce the maximum health outcomes for the whole of our population.

Our strategic priorities are to:

- reduce health inequalities in the local population by targeting the health and wellbeing of people with the greatest health need
- improve the quality of our local health services, particularly around health outcomes, patient safety, access and patient satisfaction
- organise services around the needs of local service users wherever possible
- maintain and optimise the health of people with long term or chronic illness living in our community
- focus our available resources where they will deliver the greatest benefit to our population
- enable, support and encourage development of the local workforce to deliver health improvements.

9.3.1.3. We understand the health needs of Local People

Local demographics
The majority of patients registered with GP practices in Nottingham West CCG live in Broxtowe Borough. The remainder live in Nottingham City and Erewash Borough in Derbyshire. In most areas Broxtowe is not significantly different to the national average. Deprivation is lower than average, and life expectancy for both men and women is higher than the England average.

However, there remains a gap that is slowly narrowing in life expectancy between the most deprived areas of Broxtowe and the least deprived. There are significant differences between ward areas and a ward level rapid needs assessment evidenced that for all indicators, Eastwood South, Eastwood North & Greasley (Beauvale), Stapleford North and Brinsley were the top four wards of highest need. There has been targeted action and engagement in these areas.

Broxtowe has the highest proportion of non-white, working-age population in the county and it is essential that the voices of all sections of society are heard when planning health services. Services will operate within the cultural and spiritual needs of all local residents.

The CCG is a member of Broxtowe Health Partnership and has continued to work with local partners to the key principles of the Health and Wellbeing strategy around early intervention, supporting independence and promoting integration across partners.

Over the last 4 years a large range of projects and groups across Broxtowe have been supported by the Broxtowe Partnership Lifestyle Fund, including support groups, exercise programmes, mental health support, domestic violence workers, older people, dementia café, and BME communities. The CCG also targets engagement, information and education at specific cohorts of the local population.

In response to our local population and their health needs, the CCG is committed to:

- working with partners to improving the health and the lives of children and vulnerable families
- meeting the challenge of an ageing population, ensuring that effective health and social care is commissioned to support older people to remain at home and prevent unnecessary admissions to hospital
- delivering parity of esteem for mental health service users and increasing investment into talking therapies, targeting long term conditions and people most at risk of hospital admission
• engaging with families and carers when planning and commissioning services, for all age groups
• targeting resources where need is greatest and reducing inequalities
• preventing escalation and deterioration of patients’ conditions through managing patients in primary and community settings
• promoting positive lifestyle choices, especially relating to smoking, alcohol, diet, sexual health, teenage pregnancy, physical exercise and substance misuse.

9.3.1.4. We work collaboratively with stakeholders and engage on our plans

We have a communications and engagement strategy which details the locally agreed approach with our patients, public and local partners and includes an events calendar. We have always focused on outcomes and tangible improvements for patients. Our values, strategic objectives, local plans and priorities evolve from listening to patients, the public, partners and stakeholders. We have an established Patient Reference Group which has representatives from each GP practice’s patient participation group. Patient and/or lay representatives are members on all committees and working groups, including the groups that have developed the Engaged Practice Scheme and the Care Delivery Group model.

In addition to engaging with patients and carers, we work with local stakeholders including Broxtowe Borough Council, Nottinghamshire County Council, healthcare providers and voluntary sector members.

We have a range of arrangements already in place to support effective working with partners from the County and District Councils, including as members of the Health and Wellbeing Board and Broxtowe Partnership Board.

In developing our plans, we reflect the priorities in the Health & Wellbeing Strategy and Better Care Fund Plans, as well as the priorities of the Broxtowe Partnership and its groups. We consult on our draft plans with our committees including the Governing Body, Patient Reference Group, and Clinical Development Committee.

We will continue to engage with patients, the public and stakeholders, including our member practices, local providers, Broxtowe Partnership Board and Broxtowe Health Partnership, and the Health & Wellbeing Board. We will take every opportunity to work collaboratively with local partners and providers to redesign and integrate care pathways and improve outcomes.

9.3.2. Model of care

9.3.2.1. Developing new models of care from locality to system level

We are committed to redirecting resources towards primary care and community services to support the shift of services out of the acute sector and therefore our plan for our population is to develop a Multi-specialty Community Provider (MCP) to support delivery of the Sustainability & Transformation Plan 2016-21 (STP). There is strong support to develop the MCP model of care.

A community hub care delivery group model is already in place in our three localities and this model of practice collaboration will support practices to be sustainable.

The CCG is also working in collaboration with Greater Nottingham CCGs and across providers and commissioners to coordinate and integrate care across primary, community, secondary, and social care. There is commitment to implement a place-based model of care with an increasing focus on prevention and proactive care, in order to increase the healthy life expectancy of local people, to manage long term conditions wholly in the community wherever possible, and to decrease the need for acute hospital episodes and long term residential and home care placements.

The care model will be informed by the local vanguards and other programmes, including the Rushcliffe MCP Vanguard, Primary Care Home programme in Nottingham North & East and the Greater Nottingham Integrated Urgent Care vanguard.
9.3.2.2. An integrated model of care is in place organised into Care Delivery Groups

Integration is a cornerstone of the STP. In Nottingham West, the alliance contract for local integrated community services brings together a number of services into an Integrated Community Hub Care Delivery Group model. The aim is to rapidly expand the range of services within this model and focus on proactive care and admission avoidance as well as post discharge support.

From 2016 the model includes a range of professionals working together to support frail older people, people with long term conditions and people at risk of hospital admission. The integrated team uses a range of risk stratification tools to identify who may benefit from early intervention, treatment and support. The team includes:

- specialist nurses for long term conditions and end of life
- specialist consultant and GP supervision and mentoring
- therapeutic re-ablement at home
- respiratory and cardiac rehabilitation
- clinical care co-ordinators
- care navigators who co-ordinate MDT meetings and liaise with a large range of local services including the voluntary sector
- level 2 and 3 mental health talking therapies
- community matrons and district nursing
- therapy & allied health professionals
- dedicated social workers.

We are an Early Implementer site for the NHSE Adult Mental Health talking therapies programme and from January 2017 have expanded our existing bespoke talking therapies service for people with long term conditions and frail older people, to people with other chronic conditions such as pain, diabetes and skin conditions.

There is commitment to implement a MCP model, to bring together general practice, social care, mental health, community providers, specialist consultants, district council and voluntary sector groups, to deliver patient-centred, joined up care that fits around the citizen’s needs.

It will focus on primary and secondary prevention and health promotion and provide patient advocates to help navigate the local services available. This model aligns with the STP aims and the Population Health Management workstream for Greater Nottingham.

9.3.2.3. Collective general practice is developing

Most GPs in Nottingham West are members of the well-established GP provider company Primary Integrated Community Services (PICS Ltd), which has a successful trading history of innovative pathways that are integrated across primary, community and specialist care.

Most recently PICS have employed a number of clinical pharmacists to directly support local practices as part of the national pilot.

Local providers have developed strong clinical relationships and already work in partnership, including GP practices, PICS, Nottingham University Hospitals, Nottinghamshire Healthcare Trust, County Health Partnerships, British Red Cross and British Oxygen Company, to deliver integrated services for people with long term conditions and end of life care.

We will link practices’ core contract services and formalise and simplify contractual arrangements, and rapidly expand the range of community services delivered. To bid for extra commissioned services in primary care as part of a Multispecialty Community Provider model practices will work together and commit to delivering standards of service.

As well as ongoing discussions at the Practice Managers Forum, practices have come together to form a Collective General Practice Group which meets monthly with a workplan to progress agreed objectives and other emerging priorities. Practices have agreed to work together to access the support afforded though the GP Resilience Programme and the funding for receptionist and administrative staff training. Practices in Nottingham West are also engaged in several Productive
General Practice projects. Plans are currently being developed collectively for the implementation of extended hours at CDG/hub level when the GP Access Fund becomes available.

Practices working together enables:

- sharing of learning and good practice in a supportive environment
- avoidance of competition and discord between practices
- supporting improving quality of care and delivering better outcomes for patients
- workforce planning for all professions to be done at scale i.e. Nurses, ANPs, MH practitioners, clinical pharmacists, HCAs etc. as well as GPs
- operational and business continuity planning and maximising the effectiveness and efficiency of back office functions
- developing and progressing at one pace as a collective, rather than differentially as individual practices.

9.3.3. Access

9.3.3.1. We have invested in our GP practices with tangible results

In 2014 Nottingham West practices were part of a Nottinghamshire & Derbyshire wide Prime Minister’s Challenge Fund (PMCF) £5.2m pilot, where different CCGs tested different projects and improvements in primary care.

In Nottingham West, practices came together to deliver an Engaged Practice Scheme (EPS) to define and deliver a common policy for improved access, peer review all potential non-urgent referrals to secondary care in order to reduce variation in clinical practice, promote a safety culture by sharing learning from serious incidents and increase Clinical leadership and engagement.

Practices have improved their access and all have standardised opening times and supported staff to access training.

The EPS has continued since 2014/15 onwards. Since the £600K PMCF funding ended the CCG budget has supported this key advancement in enhanced primary care. The CCG is committed to continue to invest in primary care.

There is much enthusiasm for working together and sharing services and operational arrangements and the dialogue between practices and patients has delivered a good foundation for further development and engagement. The educational and iterative approach to the scheme has proved popular and engaged practices to participate.

Practices have shared their operational arrangements and details of managing capacity and demands and from 2016 have meet with other local practices (known as buddy meetings) to share good practice, as well as meeting across all practices at a regular monthly meeting and education sessions.

The evolution of the EPS will continue to link expectations of practices to commissioning plans and delivery of national and local priorities. Practices support this by participation in the following:

- Where the patient says that their problem is medically urgent, they should be offered a consultation in that day
- Practices should aspire to offer non-urgent pre-bookable appointments with an appropriate clinician within 3 working days.
- Referrals review and use of triage services where required
- Optimum use of local pathways and community services, especially to avoid unnecessary emergency admissions for frail older people and those with long term conditions
- Following good practice in prescribing
- Engaging in review of CHC and fast-track patients
- Proactive management of cohorts of patients at high risk of admission e.g. end of life, long term conditions, care home residents
- Referring to education, prevention and self-care services e.g. National Diabetes Prevention Programme
- Signposting patients who may benefit to talking therapies
Patient feedback is excellent. Continuity of the standards for access is important to patients as they know what to expect in Nottingham West. The EPS has made a tangible difference and patients would not wish want to go back to a system that is variable by practice.

The national survey benchmarks the practices against local and national peers and the CCG average compares very favourably nationally and locally, in the top 5 CCGs nationally for some aspects.

We also undertake a real-time local patient survey annually, when for two weeks all patients attending our practices are invited to participate. In the 2016 local patient survey a total of 3,257 surveys were completed which equated to 3.9% of the CCG’s population. Feedback was overwhelmingly positive.

For 2017/18 the specification will be further revised and developed to meet aspects of the General Practice Forward View.

The focus will be on what we need to achieve next year and in the future, such as:

- financial stability and sustainability
- growing together as a collective
- thinking about what general practice will look like in 5 years’ time, and planning for it now.

### 9.3.3.2. Delivery of Extended hours

To date the focus in Nottingham West has been on successful delivery of improved access in-hours across all practices as part of delivery of the Engaged Practice Scheme.

As a former Wave 1 PMCF site Nottingham West would like to commence to deliver the extended hours as soon as possible. Practices have successfully mobilised additional capacity at short notice over the winter of 2016/17 and aim to have plans in place be ready to start as soon as funding can be secured, ideally in 2017/18.

The aim is to develop a plan for delivery across practices, potentially as hubs/localities, as it is not feasible to deliver the requirement as individual practices. By taking this approach Nottingham West would be in a stable position to respond at speed and scale if funding did become available.

The CCG is engaging with patients as part of the local patient survey in February 2017 to ascertain preferences for extended access.

### 9.3.4. Workforce

#### 9.3.4.1. Workforce planning has been modelled locally as well as at scale

Nottingham West is not identified as an under-doctored area and practices are usually able to recruit to vacant posts, with no practices in the CCG currently having a single partner or complete reliance on locum or other interim arrangements. As part of the Collective General Practice work in Nottingham West there are plans to develop a locum pool of both GPs and practice nurses, and to promote Nottingham West practices as employers of choice for newly qualified GPs. There are several training practices in the CCG and most practices do manage to recruit additional GPs when required.

In Nottingham West, on behalf of local practices the GP Provider Company Primary Integrated Community Services (PICS Ltd) submitted a bid to NHS England for clinical pharmacists in GP practices, and funding has been provided for the 4 year program for additional clinical pharmacist posts. The pharmacists work with practices to deliver quality and efficiencies in prescribing, care home reviews, post discharge reviews, polypharmacy reviews etc. Their duties will continue to expand with training to potentially include long term conditions reviews, repeat dispensing, anticoagulation etc.

It is recognised within the CCG and across the system that retaining and growing the general practice workforce is pivotal to the delivery of the CCG’s key priorities and the CCG will support the delivery of the workforce elements within the Nottinghamshire Sustainability and Transformation Plan.
9.3.4.2. Development needs are identified and supported

For Nottingham West, in addition to the regular education events for general practice, the CCG funds additional sessions on specific topics or to share good practice and supports personal development for Practice Managers and for GPs, including those who are interested in lead roles in clinical pathways redesign or who have an interest in engaging in the commissioning responsibilities of the CCG.

Practices have agreed collectively how the GP Resilience Programme funds and funds for training of receptionist and administrative staff will be used across the CCG for maximum impact and ensure delivery of a high standard.

The existing GP practice education (PLT) budget has been added to this funding so that it can be co-ordinated as part of a single collective plan led by the practices themselves. Practices have agreed how to deliver across all practices, and will prioritise the PLT programme with the CCG.

Attendance at education sessions will continue to be monitored.

The CCG works closely with the shared OD Team and the East Midlands Leadership Academy (EMLA) for advice and provision of OD support.

The Institute of Healthcare Management (IHM) also provides local development sessions for primary care.

The Primary Care Development Centre supports GP and primary care providers with development and training and to ‘future-proof’ general practice by helping practice providers cope with and adapt to the changing NHS landscape, helping them as organisations to pool resources and share functions, to operate at scale and realise efficiencies.

9.3.5. Workload

9.3.5.1. Supporting practices to support each other

Practices have come together to ensure they can be sustainable and resilient. Each practice now has a “buddy” practice with which they discuss operational as well as clinical matters, rapidly moving away from the historical way of working as individual businesses.

Practices have worked together clinically for many years to spread good practice and reduce unwarranted clinical variation and inequalities, and this same methodology is now being applied to staffing and operational functions and delivery of the CCG priorities and financial imperatives.

The Collective General Practice working group has a number of workstreams each with a local champion, including standardising referral templates and clinical letters, and coordinating mandatory training across 12 practices. There are CCG wide forums in place for practice secretaries, nurses and managers.

As well as the Collective General Practice working group, where practices come together as providers, there is a monthly Practice Commissioning Group meeting where each practice updates on their areas in their individual practice plans and shares their actions and learning in specific areas where there is variation and performance is above/below the CCG average e.g. ED attendances, prescribing, elective referrals etc.

The CCG works closely with individual practices where support is required. Where a practice is identified as vulnerable, support through the Vulnerable Practice Scheme will be offered. The CCG has secured resources via the GP Resilience Programme and the practices have agreed a programme of support for all practices.

Closer working relationships and integration with other primary and community care providers have developed in recent years and will help to sustain general practice into the future.

9.3.5.2. There is commitment to address core funding disparities between practices

Core funding of practices in Nottingham West varies per registered patient. As an issue this is potentially divisive at the very time practices need to work together more than ever before. Core funding disparities between practices will be addressed and there is commitment to gradually
equalise core funding over several years, if the budget to support this can be liberated by practices from their commissioning budget.

In order to raise core funding across practices to the CCG average, a connection between core funding and the commissioning budget has been established, to encourage all practices to take responsibility and consider the most effective and efficient use of their commissioning budgets, the majority of which is spent on secondary care. In 2016/17 practices below the average per weighted registered patient have been funded up to the average at a cost to the CCG of £166K. Practices above the average are on a trajectory to reduce to average by 2021.

Practices need to “own” their commissioning budget and have started to develop differential plans to target areas of variation. They are working more closely with other providers and neighbouring practices to deliver a standard of care and progress us towards an MCP.

9.3.5.3. Sustaining and Strengthening Clinical Leadership

Whilst Nottingham West has achieved success through strong clinical leadership and engagement, we have acknowledged that existing clinical leads have an ever increasing number of demands placed upon their capacity. We will continually seek GPs to come forward as clinical leads for specific areas to expand the number of members involved in pathways development and have an identified group of clinicians who can act in an advisory capacity on specific and general topics.

The aim is that each practice supports at least one clinical area or pathways group. We will scope and plan for the future with regard to sustaining our clinical leadership, and support potential leaders coming through. Succession planning will become part of our business continuity plans and board assurance framework.

9.3.5.4. Releasing Time to Care programme

Practices will be encouraged to participate in the ‘Releasing Time to Care’ programme to support them to implement the ‘Ten High-Impact Changes’ as referenced in the GPFV. The practices submitted a formal expression of interest via the Time for Care portal and identified their initial priorities as ‘Productive workflow’ and ‘Developing the Teams’. Practices are also participating in Productive General Practice programmes.

9.3.6. Infrastructure - technology

9.3.6.1. Patient Online

NW CCG has supported Connected Notts colleagues and practices with the implementation of Patient Online (POL) services. Further work is planned with practices to increase uptake to meet the 2017/18 target of 20% by March 2018. It is acknowledged that not all patients will want to access services on line, however this work is important to engage cohort patient groups who perhaps do not regularly access the GP and may not find it easy to do so within normal working hours. The provision of POL services such as prescription ordering and appointment booking supports practices to manage their workflows and removes unnecessary burdens on the telephones thus enabling easier access for patients.

9.3.6.2. F12

NW CCG is actively supporting the F12 project which will be developed and implemented during 2017/18. F12 is a CCG developed in-house tool working cross organisationally to develop standardised referral templates and supporting information integrated into the GP clinical systems (TPP and EMIS). The standardisation of pathways, referrals, and templates ensures that all practices are not only providing the correct information at the right time but that they are also fulfilling any prerequisite prior to referrals. Additionally it will bring about data quality benefits as practices will use standard templates, thus ensuring the correct coding is adhered to. This is important as more and more information is shared electronically across multiple organisations within the local health and social care providers.
9.3.6.3. Other IT projects

The CCG continues to support the various Connected Notts programmes of work which are addressing the sharing of GP patient records across the wider health and urgent care settings locally. These include:

- EDSM shares which enable patient records to be shared in and out of the various services and GP practices
- Medical Interoperability Gateway (MIG). The MIG enables 111, OOH, EMAS, the Urgent Care Centre, and Nottingham University Hospitals NHS Trust and Sherwood Hospitals Foundation Trust ED departments to view a specific coded subset of data direct from the GP patient record
- GP Repository for Clinical Care (GPRCC) enables data flows from all NHS local providers into the local eHealthScope system enabling clinicians to have a full view of their patient data along with other health care providers. It provides risk stratification and will identify gaps in care enabling clinicians to address them in a timely way. The GPRCC is enabled across all 20 NNE CCG practices. This system provides a wealth of information that supports the needs of the population and supports the reduction of inequality within healthcare.

9.3.6.4. National Universal Capabilities

Based on the previous sections the CCG is therefore meeting the National Universal Capabilities in all areas by virtue of the use of POL services, the MIG, the use of electronic referrals to secondary care via the e-referrals system, the use of electronic prescribing, the receipt of electronic discharge information from secondary care providers. In addition there has been considerable work as part of the Connected Notts programme on the sharing of social care data via GPRCC and CPIS. All EOL and EPACCs data is shared across the health community via the MIG and EPACCs system.

9.3.6.5. Online consultations

The CCG is awaiting confirmation of the detailed specification. However, preliminary work is underway with other CCGs in the area to assess what is currently available in the market and how this may address the CCG requirements. Due to the expectation that whatever system is implemented will be across the STP footprint it is envisaged that a full procurement will be required. Without the specification it is not possible to give any further details information at this point but it will be reviewed regularly. There are currently no local pilots of any e-consultation systems.

9.3.7. Investment

In addition to the designated primary care budget and year on year growth, the CCG is committed to invest in primary care over and above national funding and plans the following investments in 2017/18 and 2018/19:

Engaged Practice Scheme: around £600K per annum into general practice through the Engaged Practice Scheme.

Care Co-ordination: the CCG continues to invest £5 per head (£470K) annually to assist practices to manage the care of frail older people through investment into the community hub care delivery group model of care co-ordination.

Equalising core funding: the CCG is committed to reducing the funding gap between practices and this will continue into 2017/18, cost in 2016/17 was £166k, cost for 2017/18 to be advised.

Primary Care Transformation: the CCG has allocated funding of £3 per patient in its financial plans for 2018/19 which will be used to support implementation of the 10 ‘high impact actions’ identified in the planning guidance, to stimulate the development of at scale providers to improve access, and to secure the sustainability of general practice. The CCG plans to link this funding to delivery of an extended scope Engaged Practice Scheme and can confirm that this funding will be allocated in general practice.
**GP Access Fund:** The plans for delivery of extended access as articulated in our delivery plan will be supported through an investment of £3.34 per head (£307,830) in 2018/19, increasing to £6.00 per head in 2019/20. However, the CCG will be in a position to implement during 2017/18 if funds become available.

**Estate, Technology and Transformation Fund:** For the three year planning period to 2018/19 the CCG has secured £673,404 of funding (of which c£73K is for GPIT) and the development of the Oaks practice in Beeston and the Eastwood hub have been supported in principle in Cohorts 1 and 2. The CCG will also work with the Local Authorities and GP practices to identify and invest Section 106 funds and will explore other funding routes for capital developments.

**General Practice Resilience Programme:** The implementation plan has been agreed between the practices. The CCG has plans to invest £26K in 2016/17 and then £13K in each of the three following years for delivery of this programme.

**Online consultation within general practice:** Investment of £24,742 in 2017/18 and £32,971 in 2018/19 has been confirmed.

**Training for reception and clerical staff:** The CCG has £8K of investment per annum so practices have agreed their priorities collectively and a plan is in place for delivery to optimise usage across all practices.

**Training care navigators & medical assistants:** Investment of £16,495 in 2017/18 and £16,486 in 2018/19 has been confirmed.

In addition the CCG is currently committed to reinvesting the PMS premium (value to be confirmed) back into general practice in 2017/18.

### 9.4. NHS Rushcliffe CCG

#### 9.4.1. Introduction

NHS Rushcliffe Clinical Commissioning Group comprises 12 GP practices covering a population of approximately 124,000, coterminous with the borough of Rushcliffe, with 96% of patients resident in the borough.

The area comprises of a mix of suburban and rural locations in and around Bingham, Cotgrave, Cropwell Bishop, East Leake, East Bridgford Keyworth, Kegworth, Ruddington and West Bridgford with 5 wards in national deprivation groups.

Rushcliffe CCG’s vision for general practice is to be the bedrock of healthcare for the local population, delivering equitable, high quality, efficient, accessible and sustainable primary care services, that are clinically effective and patient-centred.

#### 9.4.2. Model of care

##### 9.4.2.1. The Principia Multi-Speciality Community Provider

In 2015 the CCG sponsored the application for Principia to develop a Multi-Speciality Community Provider (MCP) new model of care. In 2016/17 the MCP received £3.53m to continue to develop its approach. Development and implementation of the MCP has gone well due to strong local leadership and collaborative, forward thinking culture among clinicians. The GP collective PartnersHealth has been and continues to be instrumental in coordinating delivery. As a result the MCP is on track to meet out outcomes targets for 2017/18.

In November 2016 the MCP submitted an application for transformational funding for 2017/18 to the New Care Model Programme. This application outlines how the MCP will support spread and adoption of successful activity across Greater Nottingham as well as continuing to develop the model in Principia.

In 2017/18, Principia will build on work improving clinical and patient outcomes through proactive care and care in the community. This includes focusing on equipping primary care with the best skills and tools to most proactively and comprehensively caring for patients. In terms of patients
with or at risk of long term conditions, Principia will build on the long term conditions register to develop new pathways and care methods to increase pre-emptive care and condition management, in addition to up skilling primary care to detect and manage conditions and co-morbidities in early stages in patients. Principia will look to expand 2016/17’s successes, including for example between 28th October-31th December 2016, 145 patients have been diagnosed with AF and 114 additional patients are now on anticoagulation = 6 strokes saved, into other conditions. Principia will also evaluate and increase primary care up skilling in terms of mental health co-morbidities, ensuring patients with both mental health and physical health conditions receive improved clinical outcomes and parity of esteem.

Principia will also continue to work with Connected Notts in 2017/18 to use technology to improve clinical outcomes through endeavours like sharing electronic records between providers where appropriate to ensure that every member of a patient’s care team has accurate and up-to-date information to provide joined-up care.

In addition, Principia has already moved some elective care services into the community and out of secondary care in 2016/17, including gynaecology, gastroenterology, and T&O, with successes such as a 23% reduction in gastroenterology first outpatient appointments. This shift to care in the community allows patients to receive care quicker and closer to home while saving money, and Principia will build on this in 2017/18 by expanding this to other specialties like ENT.

In a similar vein, Principia will continue work on increasing opportunities for non-elective admissions to go via clinical navigation routes and new pathways to community-based care wherever appropriate, as well as extending and increasing work with East Midlands Ambulance Service based on the 2016/17 community EMAS technician pilot.

The MCP awaits the outcome of the New Care Models application process.

The integrated care workstream within the MCP is being led by the clinical locality director from our community service provider, that provides an opportunity to develop model of closer collaboration between GP Practice Nurses and district nursing with joint educational programmes, delivering place based care and focus on attracting and retaining future primary care nursing workforce.

9.4.2.2. The role of PartnersHealth

PartnersHealth (a Limited Liability Partnership) formed in November 2015 comprised of 12 general practices.

The aims of the Federation are to:

- be the GP provider interface for healthcare services in Rushcliffe
- drive continuous quality improvement
- focus on the design and delivery of sustainable healthcare solutions that provide higher quality patient centred care which improve the health outcomes for the Rushcliffe population and develop new alliances to enable this.

In 2017/18 the CCG will continue to work with PartnersHealth to support the sustainability of local practices through collaborative working regarding delivery of initiatives and services and best use of collective resources seeking to maximise effectiveness of delivery. In 2017/18 this will include progress and development of the General Practice Local Enhanced Delivery Specification.

9.4.2.3. General Practice Local Enhanced Delivery Specification

A voluntary local enhanced service for Rushcliffe GP practice was commissioned from 2014/15 as an annual recurrent scheme, subject to achievement of indicator thresholds and objectives. The scheme has a detailed specification with measures and outcomes which will offer an extended quality and service offer to Rushcliffe patients. It addresses themes of access, long term conditions care, the interface with secondary care, relationships with other professionals and integration of care, appropriate use of resources and governance. During 2017/18 the specification will be further revised and developed to meet aspects of the General Practice Forward View and is likely to include a focus on personalised care planning, improved long term conditions management and continued participation in the Diabetes Prevention Programme.
9.4.3. Access

9.4.3.1. Core hours

Since April 2015, all Rushcliffe practices have delivered standardised core hours opening of 8.30am to 6.30pm, with no lunchtime or afternoon closures Monday to Friday.

9.4.3.2. Outside core hours

Rushcliffe CCG participated in the former Prime Ministers Challenge Fund as a wave one pilot site during 2015, and has continued to commission this service through 2016, whilst awaiting the core requirements for the GP Access Fund.

As a result of the participation in the Prime Ministers Challenge Fund and our Vanguard status, the CCG will be accelerating the delivery requirements set out in the planning guidance and GPFV for improving access and delivering from 1st April 2017. The CCG will be commissioning an additional access of 62 hours per week, 6.30pm to 8.00pm Monday to Friday and on Saturdays and Sundays.

The agreed model will be delivered by our GP Federation delivering at scale access to same day/pre-bookable routine appointments with a rotating Rushcliffe clinical and non-clinical workforce. To address inequalities of access, the hubs will initially be based in each of the three CCG locality areas and patients who opt to be seen during this period will be offered a choice of location to attend. In addition the service will proactively reach out to those long term condition patients who currently experience difficulties in attending for their annual review.

As a result of the technical infrastructure put in place for the previous Prime Ministers Challenge Fund pilot, our IT systems share patient information across all practice sites which means any GP in Rushcliffe can view a patient’s information if given explicit consent to do so by the patient, irrespective of the GP clinical system as we have 10/11 practices on SystmOne with the remainder on EMIS Web. All GP practices in Rushcliffe have signed an information sharing agreement to support the appropriate of information, underpinned by the necessary information governance and confidentiality policies.

There are a number of mechanisms available within Rushcliffe that facilitate this sharing of information:

- Shared admin (between SystmOne practices)
- Medical Interoperability Gateway (MIG) (between EMIS and SystmOne practices, and other local health providers outlined in the ISA)
- EDSM (between EMIS and SystmOne practices)

9.4.4. Workforce

The CCG recognises the workforce pressures that currently exist in general practice and therefore increasing capacity is a key priority.

In place:

- Rushcliffe has 9/12 practices are training practices and the plan is to increase to all practices by 2019.
- Participation in the GP Fellowship, currently two GPs on the scheme
- Designated GP Clinical Lead for workforce
- Nurse workforce transformation lead in post, jointly funded between Health Education England and the CCG with a focus on developing the nurse pipeline into general practice.
- Commissioned PartnersHealth to deliver training for practice staff for the management of clinical correspondence
- Joint training programme developed to deliver care navigator/signposting training to the planned community pharmacist care navigators and practice staff
- 24 NMC nurse mentors so that an increase in capacity for undergraduate nursing placements can be realised.
Participates in the training hub project as part of the Health Education England East Midlands Primary Medical Services Programme, offering placements to undergraduate medical/nurse/pharmacy students and work experience for year 10 pupils in general practice.

Application submitted to participate in the national Clinical Pharmacist in GP Practice scheme wave two

Supporting Nursing Associate training with the East Midlands Collaborative test bed site with two TNA being employed in Rushcliffe practices. This is the start of a programme of work based learning to become an NMC regulated Nursing Associate with a route to undertake further learning and end in Registered Nurse status.

During 2017/18 and 2018/19 the CCG plans to do the following:

- Provide primary care experience to pre-registration pharmacists within Rushcliffe CCG. This will be the first time that Rushcliffe CCG has provided any experience of this type. We are planning to provide two types of experience:
  - One pre-registration pharmacist is due to start in July 2017 from Nottingham University as part of their 5 year pharmacy degree course with integrated pre-registration training. This will be a split provision over 6 months between Rushcliffe CCG and a local community pharmacy. Rushcliffe CCG will have the student for 6 weeks out of the 6 month period. The plan is for the pharmacist to spend time within GP practices and with the Medicines Management team. In January, it is hoped that this provision can be replicated with a split post between Rushcliffe CCG and Nottingham University Hospitals.
  - Also in early discussions with the pre-registration co-ordinator at NUH to provide two short day experiences to traditional NHS funded pre-registration pharmacists who are undertaking their training at Nottingham University Hospitals. Other local CCGs may also be involved with this provision.

Traditionally, primary care experience has not been offered to pre-registration pharmacists. With the increase in the number of pharmacists working in GP practice and the NHS England funded pilot to support this increase it is important that pre-registration students can access experience in the primary care sector. The GP forward view acknowledges that pharmacists could be used more to relieve workplace pressures in primary care and it is hoped that by providing these experiences future pharmacists will be encouraged to consider primary care pharmacy as a career.

- Continue to support training practices to expand their capacity and increase the number of training practices by 3 with a view to increasing the number of placements and training practices by 2019. This will not only increase the overall number of GP trainees working locally but support GP recruitment within the CCG area. In addition, the CCG will continue to support the GP fellowship programme and facilitate the education opportunities by offering trainees the opportunity to obtain greater knowledge of CCG commissioning functions.

- Expand the number of NMC nurse mentors so that an increase in capacity for undergraduate nursing placements can be realised.

- Continued support of the Rushcliffe Training Hub
- Encourage practices to review skill mix within their workforce
- Continue to promote Improved Access to Psychological Therapies and increase referrals
- Use the funding that is available to train care navigators to signpost patients to the best solution for their needs and develop medical assistant roles that support GPs.
- In 2017/18, the CCG will also ensure that training on the management of mental health is made available to GPs and other practice based clinical staff.

In addition during 2017-2019 the CCG will do the following:

- Support the implementation of national recruitment and retention initiatives, including the NHS GP Health Service
- Work with partners in the local community to develop recruitment and retention strategies for example, portfolio working, incentives, rotational opportunities, collaborative campaigns, sharing specialist staff
• Work with partners to review the impact of wellbeing initiatives targeting general practice during 2017/18 and roll them out in a sustainable model during 2018/19, for example, supported appraisals, coaching and mentorship.
• Continue to work with Health Education England (HEE) to ensure that the primary care workforce across the East Midlands is sustainable and has the right skills, values, and behaviours, at the right time and in the right place. In working directly with HEE the CCG is well placed to highlight the particular needs of the primary care workforce in RCCG while future planning workforce needs, retention and development.
• Whilst none were appointed in Rushcliffe, the CCG plans to continue to support the development of General Practice Nurse fellowships funded through HEE to help recruitment of newly qualified nurses to general practice, building on the workforce resilience of GP should there be further funding for 2017/18.
• Scope with PartnersHealth the role of and opportunity for medical assistants in General Practice, once guidance and a specification has been received.

9.4.5. Workload

The GP local enhanced delivery specification is supporting the development of a sustainable base of high quality local practices by facilitating a movement to equitable resources for all the Rushcliffe CCG practices. The delivery of the specification has been supported by PartnersHealth, the GP Federation providing centralised functions to support delivery of the specification, such as standardised clinical system templates, standardised clinical operating procedures for reviewing LTC patients as well as centralised casefinding functions to reduce the workload on individual practices.

The CCG has secured resources via the GP Resilience Programme and commissioned PartnersHealth to deliver the “Working Together” programme across all practices covering 7 workstreams: processes, finance, HR, workforce and training, business continuity, governance and IT. Practice Manager leads and support agreed for each workstream. Scoping work has begun and where specialist external support has been identified as being required (HR/H&S/IG) meetings with relevant providers have been set up to outline the required specification and commence the options appraisal for members. The baseline assessments will take place by January 2017 and recommendations reported by 31st March 2017. Following the recommendations, GPRP recurrent funding will be utilised to release a member of staff to implement the recommendations and maintain the policies across all practices. The objectives for this programme will be to provide a platform from which practices can centralise and streamline business processes, share clinical and non-clinical resources and support business continuity and provision of short notice clinical bank staff - administration and project support to aid practice resilience.

Practices will be encouraged to participate in the ‘Releasing Time to Care’ programme to support them to implement the ‘Ten High-Impact Changes’ as referenced in the GPFV, where they apply and fulfil a gap to what is already been delivered by the GP Federation. Practices have already participated in Productive GP and Doctor First and have been adopting the lessons from these schemes to make further improvements to access and workload.

The CCG will identify a champion to lead on the promotion of this programme and to share best practice.

The remaining high impact actions will be managed within the CCG for example the active signposting will be linked to the care navigation programmes and the productive workflows will be developed through the clinical correspondence management programmes.

• General Practice Improvement Leader programme – this programme will be advertised to those working within general practice within the CCG and include GPs, practice managers and nurses. The programme is over 6 days, as such will require commitment from the candidates.
• The CCG is awaiting further information on the practice manager development programme. Once more information is known, we will promote, support and implement within the CCG.

During 2017-2019 the CCG will continue to support practices with workload pressures in a number of other areas:
- Collaborating with PartnersHealth to improve referral management through the on-going development of standardised pathways of care, referral forms and patient information
- Development of a clinical hub that is linked to NHS 111 and which, it is hoped, will reduce the number of face to face contacts being requested from general practice following calls to NHS 111
- Implementation of ‘care delivery groups’ within the CCG and a developing work programme around multi-disciplinary population health management which will have a positive impact on practice workloads
- Support the development of general practice nurse fellowships funded through HEE to help recruitment of newly qualified nurses to general practice, building on the workforce resilience of GP subject to future funding
- General practice nurse training in areas that will contribute to the 10 high impact areas of equipping MDT to contribute and reduce GP time

In addition, during 2017-2019 the CCG will support the workload pressures on general practice in a number of areas:

1. **Variation:**
   - Through the general practice local enhanced delivery specification to reduce unwarranted clinical and non-clinical variation between general practices in the CCG
   - Continued support for PartnersHealth’s model of peer-review of referrals (both internal and external) where information (for example referral rates to secondary care) indicates this may be beneficial in addressing unwarranted clinical variation.

2. **Access:**
   - During 2017/18 the CCG will be monitoring the level of demand at a locality level for appointments in the evenings and at weekends and ensure that the level of provision takes into account feedback from patients and will be continuously undertake monthly monitoring of utilisation rates.
   - Working with PartnersHealth to develop standardised processes and responsive systems and processes to ensure patients with urgent needs, particularly those who require a home visit are seen in a timely manner; initially this will be at individual practice level, but could be developed to be delivered at scale.
   - Work with PartnersHealth to ensure maintenance of standardised core hours opening 8.00am to 6.30pm, with no lunchtime/afternoon closures.

3. **Sustainability:**
   - During 2017-2019 the CCG will continue to work with PartnersHealth to support the sustainability of all its GP practices, including agreement of business continuity plans where individual practices resilience and sustainability is at risk. Where issues of sustainability arise the CCG will work with PartnersHealth and the individual practice(s) to identify solutions.
   - The GP local enhanced delivery specification is supporting the development of a sustainable base of high quality local practices by a movement to equitable resources for all the Rushcliffe CCG practices. The delivery of the specification has been supported by PartnersHealth providing centralised functions to support delivery of the specification, such as standardised clinical system templates, standardised clinical operating procedures for reviewing LTC patients as well as centralised casefinding functions to reduce the workload on individual practices.

### 9.4.6. Investment

In addition to the core GP contract funding the CCG is committed to investing in general practice over and above core funding and plans to invest in primary care for 2017/18 and 2018/19 as follows.

**The CCG has:**

Invested £1.1m in 2016/17 in the GP Local Enhanced Delivery Specification commissioned from practices to:

- join up care and work in partnership health and social care community
• improve and raise the quality of core primary services
• support the development of a sustainable base of high quality local practices and the CCGs business objectives.
• move to equitable resources for all the Rushcliffe CCG practices
• support an increase in primary care capacity and capability.
• reduce unwarranted variation in health and care
• standardise service delivery and quality across CCG providing equity for patients

…and will be looking to support the commissioning of this scheme in 2017/18 following approval March 2017.

The CCG will:

**Primary care transformation:** Support the rollout of investments in primary care as detailed in the General Practice Forward View and Operational Planning Guidance, including providing continued support for primary care transformation. The CCG has allocated funding of £3 per patient in its financial plans for 2018/19 which will be used to support implementation of the 10 ‘high impact actions’ identified in the planning guidance. The CCG will determine its approach for the use of this funding during Q4 of 2016/17.

**Infrastructure - Estates - Cotgrave new build:** Area of most deprivation within the CCG and the town population is set to grow due to the housing development on the Colliery Site. It forms part of a multi-agency multi-million pound town regeneration project led by the borough council. Supported by the ETTF £156K in Cohort 1 and £642K in Cohort 2 as published nationally by NHS England in October 2016.

**East Leake:** The CCG commissioned a feasibility survey through the ETTF to assess the impact of a major housing development along the A453 corridor on nearby practices and branch surgeries within the geographic boundaries of both Rushcliffe and Nottingham City CCGs. This is particularly relevant for East Leake which is also under pressure from further extensive housing developments within the village.

**Care navigation/signposting:** The CCG will be working with PartnersHealth to support new and enhanced roles in primary care, such as supporting practice reception and clerical staff to undertake enhanced roles within practice (including actively signposting and navigating patients to ensure their care needs are met and increasing their capability to manage clinical correspondence). Medical assistant roles will be developed within primary care (awaiting guidance). Investment of £21.6K in 2017/18 and £21.6K in 2018/19 has been identified.

**General practice resilience programme:** Work with PartnersHealth to deliver the programme locally, delivering a menu of support that will help support collectivisation, delivering primary care at scale, whilst ensuring practices to become more sustainable and resilient for the future. The CCG has plans to invest £17K in 2017/18, and £17K 2018/19 for delivery of this programme.

**Online consultation within general practice:** Investment of £32.4K in 2017/18 and £43.2K in 2018/19 has been identified.

**Access:** Delivery of the core requirements to improve access to general practice; and will be supported through an investment of £6 per head in 2017/18, and £6.00 per weighted population head in 2018/19, providing an investment of £676K in 2017/18 and £681K in 2018/19.

In addition the CCG is currently committed to reinvesting the PMS premium (value to be confirmed) back into general practice in 2017/18.
Appendix 1: Nottinghamshire Sustainability and Transformation Workforce Plan 2016-21
G. Workforce plan

Context and introduction

The Nottinghamshire Workforce and Organisational Development Strategy is a statement of intent for the next five years. It is based on an assessment of the current and predicted workforce challenges across the health and care system and a collaborative, system-wide approach to re-design and development solutions. Delivery of the Strategic Workforce and Organisational Development Plan will be underpinned by the activity and investment plans of the Local Workforce Action Board (LWAB) and its delivery infrastructure.

Figure 1: Workforce Governance September 2016

Aim – To adopt a single approach to workforce across Nottingham and Nottinghamshire to ensure that the workforce is mobilised to deliver future services in a timely manner.

Key challenges identified for our workforce are:
difficulties in attracting and retaining key staff groups including senior medical staff in a range of settings, hospital pharmacists, care home nurses and home care staff

an unsustainable use of agency staff, with competition between providers

the health and wellbeing of our workforce leading to a high turnover of staff and early retirement.

The strategy is based on a whole workforce approach, to include:

- Enhancing the skills of citizens, families, carers and communities for self-care and prevention;
- Volunteers and the third sector
- Staff employed by organisations commissioned to deliver health and care services in the private and public sector
- The wider public sector workforce, e.g. fire & rescue, housing
- Attracting young people and under-represented groups into careers in health and care
Figure 2: Nottinghamshire workforce strategy

MODELLING OUR FUTURE WORKFORCE WITH SYSTEMS DYNAMICS MODELLING TOOLS

The model

A key foundation of developing our five year strategy is to develop a population and place based approach to service redesign using a systems dynamics modelling tools and techniques. The model we have used assesses the level of ‘activity’ required (either a time limited episode of care, or the input required for ongoing care), described in terms of care functions, taking into account demographic change and service transformation initiatives. It translates the future balance between care functions into an estimate of the workforce required to deliver it based on the ‘ideal’ skill mix to deliver each care function. It then compares current and future workforce requirements and provides a route map to
achieve the change. The model uses skills rather than traditional roles and job titles and takes a whole system approach with no organisational boundaries.

We have applied the latest available Nottinghamshire activity assumptions to assess the impact of transformation and efficiency on the Nottinghamshire system on future skill mix required to deliver health care in Nottinghamshire. So far we tested our assumptions in the areas of urgent and proactive care only, so they will need refining. We will re-run the model in the coming months as we continue to build the model and refine our assumptions.

Results

The resulting illustrative future skill mix projection indicates a growth in our primary and community care workforce of 24% over the next five years but with a potential £12 million savings on future pay costs. These savings are accounted for in organisational finance plans and this work will support delivery of the STP transformation workstreams and initiatives.

Staff costs for childrens services and mental health remain broadly similar, with increases in demand being mitigated by service redesign and improved efficiencies. Significant reductions elsewhere are indicated that will contribute to closing the financial gap based on the assumption that primary and community care or self-care will increase in capacity and capability.

The overall skill mix shows an increase in advanced and enhanced levels, and reductions in other skill levels, the largest being the group in the core skills group. Further efficiencies could be achieved by reducing agency costs and non-patient facing staff who have not been included in the model to date.

Work is continuing to further refine our workforce baseline intelligence and to define our future workforce vision. This will enable a scenario based options appraisal for the system as we develop our service models in more detail for each priority transformation workstream.

Methodology and results of worked example

1. The current estimate of the combined health, social care and housing workforce in Nottinghamshire is 40,000 to 45,000 wte in the areas identified in the diagram below. We have so far applied modelling to patient facing health staff only.
The main areas of care for applying the systems modelling were agreed in engagement workshops with staff. The areas of care are primary care, proactive care, urgent care, planned care, women and children, mental health and learning disabilities and diagnostics. The main staff groups currently working in these areas of care are shown below.

Current estimate in the range of 40,000 to 45,000 wte in the areas identified above.
3. We mapped the workforce into four skills levels (foundation, core, enhanced and advanced) against each area of care.

Figure 5: Skill levels
4. We agreed the activity assumptions, baseline and impact of transformation and efficiency.
Running the model showed a change in skill mix across each area of care, with an overall reduction of 2.68%
Figure 8: Changes in skill mix arising from worked example

<table>
<thead>
<tr>
<th></th>
<th>Foundation</th>
<th>Core</th>
<th>Enhanced</th>
<th>Advanced</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline workforce</td>
<td>6,489.5</td>
<td>5,308.2</td>
<td>6,975.5</td>
<td>2,240.7</td>
<td>21,014.0</td>
</tr>
</tbody>
</table>

**Workforce FTE change:**

<table>
<thead>
<tr>
<th></th>
<th>Foundation</th>
<th>Core</th>
<th>Enhanced</th>
<th>Advanced</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women &amp; Children's</td>
<td>-80.6</td>
<td>-55.4</td>
<td>138.8</td>
<td>-7.8</td>
<td>-4.9</td>
</tr>
<tr>
<td>Primary Care</td>
<td>58.6</td>
<td>38.9</td>
<td>59.8</td>
<td>153.0</td>
<td>310.3</td>
</tr>
<tr>
<td>Proactive Care</td>
<td>337.6</td>
<td>-86.2</td>
<td>351.4</td>
<td>40.6</td>
<td>643.5</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>-325.6</td>
<td>-217.1</td>
<td>-153.8</td>
<td>49.3</td>
<td>-647.2</td>
</tr>
<tr>
<td>Planned Care</td>
<td>-226.4</td>
<td>-189.1</td>
<td>-208.8</td>
<td>-66.1</td>
<td>-691.1</td>
</tr>
<tr>
<td>MH/LD</td>
<td>78.2</td>
<td>-116.5</td>
<td>19.9</td>
<td>-2.3</td>
<td>-20.7</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>-59.6</td>
<td>-17.5</td>
<td>-54.2</td>
<td>-20.8</td>
<td>-152.1</td>
</tr>
<tr>
<td>Total</td>
<td>-217.8</td>
<td>-643.6</td>
<td>153.1</td>
<td>146.0</td>
<td>-562.2</td>
</tr>
<tr>
<td>Change on base</td>
<td>-3.36%</td>
<td>-12.12%</td>
<td>2.20%</td>
<td>6.52%</td>
<td>-2.68%</td>
</tr>
</tbody>
</table>

6. The demand and efficiency assumptions are shown in Figure 9.

**Figure 9: Demand and efficiency assumptions**

<table>
<thead>
<tr>
<th>Workstreams:</th>
<th>Current workforce</th>
<th>Syr demand pressure</th>
<th>Do nothing FTE in Syrs</th>
<th>Syr service transformation</th>
<th>Syr efficiency reduction</th>
<th>Change in FTE</th>
<th>Future FTE</th>
<th>Share of wte</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Current</td>
<td>Future</td>
<td></td>
</tr>
<tr>
<td>Women &amp; Children’s</td>
<td>2,479.3</td>
<td>10.40%</td>
<td>2,737.1</td>
<td>0.00%</td>
<td>9.6%</td>
<td>-4.9</td>
<td>2,474.4</td>
<td>11.8%</td>
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<td>Primary Care</td>
<td>1,298.4</td>
<td>24.60%</td>
<td>1,617.8</td>
<td>10.00%</td>
<td>9.6%</td>
<td>310.3</td>
<td>1,608.7</td>
<td>6.2%</td>
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<tr>
<td>Community/proactive Care</td>
<td>3,732.6</td>
<td>17.90%</td>
<td>4,400.8</td>
<td>10.00%</td>
<td>9.6%</td>
<td>643.5</td>
<td>4,376.1</td>
<td>17.8%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>3,088.7</td>
<td>9.30%</td>
<td>3,375.9</td>
<td>-20.00%</td>
<td>9.6%</td>
<td>-647.2</td>
<td>2,441.5</td>
<td>14.7%</td>
</tr>
<tr>
<td>Planned Care</td>
<td>6,240.7</td>
<td>9.30%</td>
<td>6,821.1</td>
<td>-10.00%</td>
<td>9.6%</td>
<td>-691.1</td>
<td>5,549.6</td>
<td>29.7%</td>
</tr>
<tr>
<td>MH/LD/CAMHS</td>
<td>2,800.8</td>
<td>9.80%</td>
<td>3,075.3</td>
<td>0.00%</td>
<td>9.6%</td>
<td>-20.7</td>
<td>2,780.0</td>
<td>13.3%</td>
</tr>
<tr>
<td>Diagnostics</td>
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<td>9.30%</td>
<td>1,501.2</td>
<td>-10.00%</td>
<td>9.6%</td>
<td>-152.1</td>
<td>1,221.4</td>
<td>6.5%</td>
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<tr>
<td></td>
<td>21,014.0</td>
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<td>23,529.2</td>
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<td>-562.2</td>
<td>20,451.8</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.0%</td>
<td></td>
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</tr>
</tbody>
</table>

FTE change: -2.7%
7. The future skill mix was costed based on the average cost for each skill level:

- £22,589 for foundation
- £31,065 for core
- £39,673 for enhanced
- £59,130 for advanced

**Figure 10: Summary of financial information – future**
8. We developed a plan to move our current workforce from the current grades to a future skill mix based on the four skill levels.

**Figure 11: Illustrative route map**

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer - Foundation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfer - Core</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfer - Enhanced</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfer - Advanced</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Upskill to Foundation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Upskill to Core</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Upskill to Enhanced</td>
<td>0</td>
<td>9.71</td>
<td>34.36</td>
<td>25.33</td>
<td>14.26</td>
<td>8.83</td>
<td>6.06</td>
<td>6.66</td>
<td>7.35</td>
</tr>
<tr>
<td>Upskill to Advanced</td>
<td>0</td>
<td>0.42</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Recruit - Foundation</td>
<td>0</td>
<td>17.22</td>
<td>28.58</td>
<td>28.97</td>
<td>29.33</td>
<td>28.27</td>
<td>26.99</td>
<td>27.66</td>
<td>29.86</td>
</tr>
<tr>
<td>Recruit - Core</td>
<td>0</td>
<td>12.47</td>
<td>55.66</td>
<td>75.13</td>
<td>56.7</td>
<td>36.26</td>
<td>26.17</td>
<td>22.74</td>
<td>24.77</td>
</tr>
<tr>
<td>Recruit - Enhanced</td>
<td>0</td>
<td>22.69</td>
<td>33.14</td>
<td>20.62</td>
<td>11.21</td>
<td>8.24</td>
<td>5.46</td>
<td>7.17</td>
<td>7.12</td>
</tr>
<tr>
<td>Recruit - Advanced</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total - Foundation</td>
<td>823.37</td>
<td>827.67</td>
<td>851.77</td>
<td>880.64</td>
<td>910.04</td>
<td>938.25</td>
<td>967.14</td>
<td>993.34</td>
<td>1022.36</td>
</tr>
<tr>
<td>Total - Core</td>
<td>416.76</td>
<td>417.58</td>
<td>424.78</td>
<td>461.33</td>
<td>509.86</td>
<td>545.33</td>
<td>569.1</td>
<td>587.05</td>
<td>603.49</td>
</tr>
<tr>
<td>Total - Enhanced</td>
<td>260.97</td>
<td>268.82</td>
<td>322.93</td>
<td>382.49</td>
<td>418.76</td>
<td>439.44</td>
<td>454.21</td>
<td>466.28</td>
<td>480.74</td>
</tr>
<tr>
<td>Total - Advanced</td>
<td>278.52</td>
<td>280.01</td>
<td>280.06</td>
<td>280.06</td>
<td>280.06</td>
<td>280.06</td>
<td>280.06</td>
<td>280.06</td>
<td>280.06</td>
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</table>
### Appendix 2a: NHS Nottingham City CCG forward view delivery plan 2016/17-2018/19

#### GPFV - Model of Care

<table>
<thead>
<tr>
<th>Work Priority Area</th>
<th>Key deliverables</th>
<th>Baseline position</th>
<th>Investment (inc dates)</th>
<th>Action / milestones</th>
<th>Action owner (organisation)</th>
<th>Milestone delivery date</th>
<th>Success measures</th>
<th>KPIs/ Plan trajectory</th>
<th>RAG</th>
</tr>
</thead>
</table>
| Multi-community Specialist Provider | • Alliance contract with service providers:  
  • Community health  
  • Mental health  
  • 3rd sector  
  • Local Authority  
  • Primary Care | • Health & social care integration model in place and operational | • Virtual MCP (next phase)  
  17/18 | • Present business case to Governing Body  
  • Engagement plan produced  
  • Development of draft Alliance contract  
  • Support third sector to work collaboratively  
  • Engagement of stakeholders  
  • Alliance contract finalised  
  • Stakeholder sign up to Alliance  
  • Alliance contract commences | • DM/JW  
  •  
  •  
  •  
  •  
  •  
  •  
  •  | • Mar 17  
  • Apr 17  
  • Jun 17  
  •  
  • Jun 17  
  • Jun– Sep 17  
  • Sep 17  
  • Oct– Dec 17  
  • Apr 18 | • 3rd sector consortium established  
  • No of providers that sign up to Alliance contract |  
| Practice transformation | • 10 ‘high impact actions’ identified in the planning guidance  
  • Stimulate the development of at scale providers to improve access  
  • Secure the sustainability of primary care | • £1.50 per patient in 17/18 and in 18/19 | • GPFV working group to meet to discuss proposed plans  
  • Develop transformation plans  
  • Present plans to Primary Care Co-commissioning Panel  
  • Programme timeline finalised | | LD/FW  
  •  
  •  
  •  
  •  | Feb 17  
  • Mar 17  
  • Apr 17  
  • Apr 17 | • Proposal supported and implementation  
  • Success measures to be developed |  
| Care Delivery Groups | • Increased integration of community and social care services within Care Delivery Groups  
  • Use of the new risk stratification tool to support vulnerable people and those at risk of hospital admissions | • Community/neighbourhood teams working across Care Delivery Groups and attending MDT meetings in practice | • Community mental health teams integrated into Care Delivery Groups  
  • Integrated MDT meetings including mental health teams  
  • Review of multiple admissions and attendance (mental health) | | CK/KB  
  •  
  •  
  •  | Jan 17  
  • Mar 17  
  • Mar 17 | • Collaborative working across community and social care providers  
  • Improved patient outcomes through multi-disciplinary teams involvement in care plans and attendance at MDT meetings  
  • Proactive care and admission avoidance as well as post discharge support |
### GPFV - Improving access

<table>
<thead>
<tr>
<th>Work Priority Area</th>
<th>Key deliverables</th>
<th>Baseline position</th>
<th>Investment (inc dates)</th>
<th>Action / milestones</th>
<th>Action owner (organisation)</th>
<th>Milestone delivery date</th>
<th>Success measures</th>
<th>KPIs/Plan trajectory</th>
</tr>
</thead>
</table>
| **Primary Care Patient Offer**     | • Primary Care Patient Offer (PCPO) – range of standards & services to improve and standardise the quality and access to primary care. Standards included in the following areas:  
  • **Access** – to be open with telephones on during core hours of 8am – 6:30pm with no lunchtime or Thursday afternoon closures and facilitate access to male and female GPs  
  • **Services** – to provide key services including phlebotomy, ECG, treatment room, ear irrigation, H Pylori and PSA monitoring  
  • 3 domains of **Quality** – clinical effectiveness, patient safety and patient experience  
  • 42 out of 56 practices signed up to deliver the PCPO standards  
  • Phased start for practices – 13 practices started during Q3  
  • 16/17, 15 practices started during Q4  
  • 18/17, 14 practices start 1st April 2017  
  • 14 practices not signed up to the PCPO – CCG to commission the key services for these patients  
  • CCG funded  
  • Remaining practices to mobilise for start date  
  • Procurement for a single provider to deliver services by 1st April 2017 (practices not signed up)  
  • FW / GP practices  | 1st April 2017  
  • Tender evaluated and contract awarded  
  • February 2017  
  • Service mobilisation during February and March 2017  
  • Practices start delivering new requirements, reducing inequality across primary care  
  • Improved patient satisfaction with primary care  
  • New provider delivering services  | 1st April 2017  
  • Tender evaluated and contract awarded  
  • February 2017  
  • Service mobilisation during February and March 2017  
  • Practices start delivering new requirements, reducing inequality across primary care  
  • Improved patient satisfaction with primary care  
  • New provider delivering services  | 1st April 2017  
  • Tender evaluated and contract awarded  
  • February 2017  
  • Service mobilisation during February and March 2017  
  • Practices start delivering new requirements, reducing inequality across primary care  
  • Improved patient satisfaction with primary care  
  • New provider delivering services  | **KPIs included in PCPO contract**  
  **KPIs in service specification**  |
| **Improving Access to General Practice**  | Commission extended access hubs during 2017/18 and 2018/19 to meet new core requirements for the total Nottingham City population - 30 mins per 1,000 population equivalent to 186 hours of extended access outside of core hours (min. of 1.5 hours a day) and on a weekend in Nottingham City  
  • GP Appointment utilisation tool – to be installed at the 7 practices currently delivering the PMCF weekend opening pilot  | Current PMCF wave one weekend opening pilot delivered at 7 practices covering a population of 236,000 across 5 Care Delivery Groups. Pilot commissioned to 31 March 2017  
  • Extended access patient survey conducted 2015 through Primary Care Vision  
  • Evaluation to understand preferences for services outside of core hours  | 2016/17  
  • £420k for pilot  
  • 2017/18  
  • £6 per head of weighted population – circa £2.2m  
  • 2018/19  
  • £6 per head of weighted population – circa £2.18m  
  • No additional investment  
  • Extend current weekend pilot to 30th June 2017 to align to start of new hubs  
  • mobilisation  
  • Design & cost new extended access model – Allocation to be confirmed with finance  
  • Undertake procurement for a single provider to deliver the extended access hubs  
  • APMS contract awarded for extended access hubs  
  • Mobilisation & communication May & June for new extended access hub by 1st July 2017  | Contract variations issued  
  • March 2017  
  • February – March 2017  
  • April 2017  
  • May 2017  
  • 1st July 2017  
  • Increased capacity provided and utilised easing pressure on in hours core services  
  • Improved patient satisfaction with primary care access and opening hours  
  • Feedback from workforce  
  • Tool installed at remaining practices participating in current pilot  
  • Tool installed at new hubs  | **KPIs for new extended access hub by April 2017**  
  **KPIs included in PCPO contract**  
  **KPIs in service specification**  |
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<th>Work Priority Area</th>
<th>Key deliverables</th>
<th>Baseline position</th>
<th>Investment (inc dates)</th>
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<th>Success measures</th>
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|                   | • Development of strategy across Greater Notts:  
|                   |   • - Retention  
|                   |   • - Retirement  
|                   |   • - Recruitment  
|                   |   • Increase training capacity and no. training practices  
|                   |   • Support the GP fellowship programme and facilitate opportunities for fellows to obtain greater knowledge of the CCG and commissioning  
|                   |   • Support nurse education to upskill  
|                   |   • Support nurse education to enable working in primary care  
|                   |   • Engage with Alliance for education opportunities and to increase skill mix in primary care (including pharmacists, medical assistants, nurse prescribers)  
|                   |   • Engage with Alliance developing clinical & non-clinical bank staff |                   |                        |                   |                             |                          |                 |                       |     |
|                   | • Development of local plans  
|                   | • No training practices  
|                   | • Participating in GP Fellowship scheme (11 GP Fellows in place)  
|                   | • CCG training hub for nurses  
|                   | • Lead Nurse for Education  
|                   | • Lead GP for Education |                   |                        |                   |                             |                          |                 |                       |     |
|                   | • Workforce strategy developed  
|                   | • Increase number of training practices  
|                   | • Identify education programmes  
|                   | • Support CCG wide/national programmes to increase no of GPs/retain GPs in primary care | FW/LD/AM | 17/18 & 18/19 Jun 17 2019 |                       | No of fellows that remain in Nottingham City post scheme  
|                   | • Increase no of GPs  
|                   | • Increased number of Nurse Practitioners  
<p>|                   | • Increased number of nurses | | | | |     |     |     |     |</p>
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| Clinical Pharmacists in general practice Wave 1 site | • Additional capacity in practices through allocated NHS England scheme Clinical Pharmacists  
• Reduction in GP workload  
• Reduction in prescribing spend | • CCG part of the NHS England Clinical Pharmacists in GP practices scheme  
• Pharmacists recruited and in post between  
• Eight practices participated across 3 CDGs  
• CCG funding in 16/17 and 18/19 – no funding in year 3 | • National Clinical Pharmacist  
£262,000 with NHS England funding  
60% in year 1, 40% in year 2, 20% in year 3 and 0% in Year 4  
• CCG contribution year 1, year 2 = £98,000 | • Staff recruited and in post  
• Evidence of impact | CG  
August 2016 | • Capacity delivered  
• Reduction in prescribing spend in 2016/2017 by a projected 11%, in comparison to a 4% increase in spend the previous year | |
| Training for reception and clerical staff – national funding | • To support reception and clerical staff to undertake enhanced roles in active signposting and management of clinical correspondence  
• More detailed coding of clinical information in the GP record leading to improved monitoring and management of certain conditions | • Engaged with Alliance to identify education/tools  
PMCF – responsiveness contract included  
reception training to help navigate  
Workflow Optimisation programme | £32,000 year one, subsequent funding in | • Product identified  
• Product currently being piloted prior to staggered roll out  
• Roll out plan to be finalised | SP/LP  
Mar 17 | • Reduction in GP workload (80% for clinical correspondence)  
• Increased responsibility for administration staff  
• Increased job satisfaction | |
| Practice Education Protected Learning Time | • Provide education sessions to practice teams  
- GPs  
- Nurses  
- Practice Manager  
- Administrations  
• Education and training programme for practice managers and administrators | • 4 city-wide PLTs per year (clinical and non-clinical)  
• 4 practice based PLTs per year (practice specific) | • PLT budget  
Out of area provider provides phone cover | • PLT subgroup set agenda for city-wide PLTs  
PLT subgroup meet quarterly | OS/NR  
Annual | • Education around clinical variation  
• New pathways  
• New skills and knowledge for practice teams  
• Evaluation from each city-wide PLT  
• Number of attendees at each PLT, representation by individual practices | |
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| Promote the services of the Hurley Clinic Partnership                             | • Improve access to mental health support for general practitioners and trainee GPs who may be suffering from mental ill-health including stress, depression, addiction and burnout  
• Increase awareness of the service to local Practices and workforce                   | • In place January 17 – and promoted to GPs                                                                                                                            | • Regular updates of the services in 6 monthly intervals                                                                                                             | FW/LP                                 |                        | • Practice bulletins                                                           |                        |      |
| Support wellbeing initiatives targeting general practice                           | • Provide information to clinical on local services that provide Pastoral support, coaching and mentorship                                                                                                         | • Awaiting information on local services                                                                                                                             | • Identify services available  
• September 17 - Promote services to clinicians  
• December 17 - Review                                                                                                           | FW/LP                                 |                        | • Advertising of services  
• Feedback from services                                                                         |                        |      |
| Support the Retained Doctors scheme within the CCG and other national initiatives that support recruitment, retention and development of the workforce, including the Senior GP Fellowship scheme | • Provide alternative workforce options to support the delivery of Primary Care                                                                                     | • No retainers in post  
• GP Fellowship scheme running since 15/16                                                                                                                             | • Scope need with practices  
• February 17 – promote the retainer scheme with practices and offer support  
• September 17 – promote the retainer scheme with practices and provide update of existing clinicians working on the programme | FW/P                                  |                        | • Practice bulletins  
• Increase number of retainers within the CCG                                                   |                        |      |
<p>| Medical Assistants within Primary Care                                             | • Awaiting information from NHS England                                                                                                                            | • None in place                                                                                                                                                | • Awaiting guidance from NHS England                                                                                                                      | NC/PH                                 |                        | • •                                                                        |                        |      |</p>
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| Vulnerable Practice Programme             | • CCG commission Alliance to facilitate the programme  
• Diagnostic on practice to be completed  
• Alliance works with each Practice to prioritise areas requiring improvement support from diagnostic or CQC rating  
• Support from specialist providers to be procured                                                                 | • Alliance facilitating access to support  
• Standardised policies and procedures agreed | £93K  2016/17 | • Objectives agreed  
• Diagnostics completed on all practices  
• Support packages to be rolled out to practices as required by appropriate provider | LP | January 17 | March 17  
• Log to be maintained of identified need and support provided  
• Evidence of impact (developed against diagnostic baseline)  
• Completion of evaluation form.  
• All practices on programme to have completed by March 2017 |
| GP Resilience Programme                   | • CCG commission Nottingham City General Practice Alliance (NCGPA) to facilitate the GPRP  
• Alliance works with each Practice to prioritise areas requiring improvement support  
• Diagnostic on practice to be completed if required.  
• Support from specialist providers to be procured  
• CCG commission Nottingham City General Practice Alliance (NCGPA) to facilitate the GPRP  
• Alliance works with each Practice to prioritise areas requiring improvement support  
• Diagnostic on practice to be completed if required.  
• Support from specialist providers to be procured  | • Alliance facilitating access to support  
• Standardised policies and procedures agreed | £101K  2016/17,  £51K  2017/18,  £51K  2018/19,  £51K  2019/20 | • Objectives agreed  
• Diagnostics completed  
• Support packages to be rolled out to practices as required by appropriate provider | LP | Decemb er 16 | January 17,  February 17  
• Log to be maintained of identified need and support provided  
• Evidence of impact (developed against diagnostic baseline)  
• Completion of evaluation form.  
• First wave of practices to complete programme - March 2017  
• Second Wave – March 2018  
• Third Wave – March 2019  
• Forth Wave – March 2020  
• (Wave 2,3 & 4 will comprise of all remaining practices in Nottingham City CCG) |
| Implementation of a Primary Care Quality Assurance and Improvement Framework, including a quality dashboard. | • Enables assurance to be gained in relation to the quality and safety of services being provided by GP practices  
• Enables CCG / practices to identify any quality and safety issues early  
• Appropriate support able to be offered and provided to practices  
• Enables practices to either prepare for CQC inspection / for those who have already been inspected, to help address actions which the CQC have identified as being required or to demonstrate ongoing quality and safety  
• CCG Primary Care Quality Assurance Dashboard in place 18 months  
• Reviewed at CCG Primary Care Quality Sub-Group which meets 12 times per year  
• Quarterly refresh of the quality dashboard  
• Highlight report to CCG Quality Improvement Committee | • CCG Primary Care Quality Assurance Dashboard in place 18 months  
• Reviewed at CCG Primary Care Quality Sub-Group which meets 12 times per year  
• Quarterly refresh of the quality dashboard  
• Highlight report to CCG Quality Improvement Committee | | • Targeted deep dive per domain/quality marker  
• Further development of dashboard | AM/FW/LD | | • Quality Dashboard  
• Primary Care Quality Sub-Group  
• Quality Improvement Committee  
• (Wave 2,3 & 4 will comprise of all remaining practices in Nottingham City CCG) |
### Implementati
on of F12 pathfinder
- Provide a central resource for approved standardised pathways of care, referral guidelines, forms and patient information
- Reduce variation

#### Baseline position
- Some standardised clinical system/ referral templates already in place

#### Action / milestones
- Engagement with project officer (led by Rushcliffe CCG)
- Participate in roll out programme
- Practices to be engaged and utilising resource

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<tr>
<th>Action owner (organisation)</th>
<th>Milestone delivery date</th>
<th>Success measures</th>
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<tbody>
<tr>
<td>LD</td>
<td>Feb 17</td>
<td>Review usage</td>
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<td></td>
<td></td>
<td>Referral activity</td>
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<td></td>
<td>May 17</td>
<td>Reduction in prescribing costs</td>
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<tr>
<td></td>
<td>Apr 17</td>
<td>Reduction in clinical variation</td>
</tr>
</tbody>
</table>

#### KPIs/ Plan trajectory
- • Review usage
- • Referral activity
- • Reduction in prescribing costs
- • Reduction in clinical variation

### Development of a clinical hub that is linked to NHS 111
- Reduce the number of face to face contacts being requested from general practice following calls to NHS 111
- Being developed across Notts/Leics/Derbys

#### Baseline position
- Clinical Hub in place
- Direct booking to OOH & Urgent Care Centre in place
- Green 1&2 (999) calls re-triaged by hub
- 111 GP required calls sent direct to OOH Provider

#### Action / milestones
- Increase provision of functions

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<tr>
<th>Action owner (organisation)</th>
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<th>Success measures</th>
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<tbody>
<tr>
<td>HJ</td>
<td>April 17</td>
<td>Awaiting update from STP Urgent Care Lead</td>
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</table>

#### KPIs/ Plan trajectory
- • Awaiting update from STP Urgent Care Lead

### Implementation of the Time for Care programme
- Support practices to manage their workload differently
- Implement new innovations
- Delivery of the 10 High Impact Actions

#### Baseline position
- Some workload initiatives have/are already been delivered
- Already participated in Productive GP/Doctor First

#### Action / milestones
- Identify remaining high impact opportunities to implement
- Identify clinician to lead the local implementation of the Time for Care programme
- Promote the programme

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<th>Action owner (organisation)</th>
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<th>Success measures</th>
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<tbody>
<tr>
<td>FW/LP</td>
<td>April 17</td>
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</table>

#### KPIs/ Plan trajectory
- • Identifying high impact opportunities to implement
- • Identifying clinician to lead the local implementation of the Time for Care programme
- • Promoting the programme

### Translated Assisted Appointment s (TAA) Incentive Scheme
- Increase clinical capacity/increased access for patients for atypical practices with higher than average TAA
- Increase admin support for practices for practices with higher than average TAA

#### Baseline position
- Engagement of GP practices with high levels of TAA has taken place
- Process for TAA Incentive Scheme agreed
- Business case scoped and written

#### Action / milestones
- To be agreed

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<th>Action owner (organisation)</th>
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<tr>
<td>LP</td>
<td>March 17</td>
<td>KPIs and outcome measures met</td>
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<td></td>
<td>April 17</td>
<td>Increased clinical capacity/patient access.</td>
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<tr>
<td></td>
<td>June 17</td>
<td>KPIs to be agreed by March 17</td>
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</table>

#### KPIs/ Plan trajectory
- • KPIs and outcome measures met
- • Increased clinical capacity/patient access.
- • KPIs to be agreed by March 17
- • TAA Incentive Scheme to start April 17

### Practice Infrastructure

### ETTF Estates - Investment Wave 1
- Increased capacity in primary care
- Meadows - internal reorientation and reconfiguration

#### Baseline position
- Estates Strategy in place
- Prioritisation of ETTF schemes

#### Action / milestones
- Approval from PCC
- Due diligence with NHS England
- Options appraisal and scoring

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<th>Action owner (organisation)</th>
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<th>Success measures</th>
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<tr>
<td>JM</td>
<td>Jun 16</td>
<td>Additional capacity in primary care</td>
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<td></td>
<td>Oct 16</td>
<td>Monitoring of spend</td>
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<td></td>
<td>March 17</td>
<td>Submission of business case following options</td>
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#### KPIs/ Plan trajectory
- • Additional capacity in primary care
- • Monitoring of spend
- • Submission of business case following options

#### RAG
- • Build works complete

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<td><strong>CCG attended demo of My GP 24/7</strong></td>
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<td><strong>CCG visiting Birmingham with GP colleagues to look at e-Consult system in live use</strong></td>
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<td><strong>TBC once national guidance is released</strong></td>
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<tr>
<td><strong>MIG fully enabled in all practices</strong></td>
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<tr>
<td><strong>First CCG to enable MIG and utilise to support delivery of PMCF wave one pilot</strong></td>
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<tr>
<td><strong>All practices fully enabled for MIG sharing out to other providers including EPaCCS data</strong></td>
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<td><strong>MIG 2 implementation with enriched data</strong></td>
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<td><strong>Connecte d Notts</strong></td>
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<tr>
<td><strong>Report from MIG Project Board</strong></td>
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<tr>
<td><strong>EDSM shares</strong></td>
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<tr>
<td><strong>Shared admin (between SystmOne practices) in place since 2015</strong></td>
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<tr>
<td><strong>Medical Interoperability Gateway (MIG) (between EMIS and SystmOne practices, and other local health</strong></td>
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<td><strong>MIG 2 implementation with enriched data</strong></td>
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<td><strong>Build works complete</strong></td>
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Transforming General Practice in Greater Nottingham V1_0 20170224.docx | 24/02/2017 16:54
<table>
<thead>
<tr>
<th>Work Priority Area</th>
<th>Key deliverables</th>
<th>Baseline position</th>
<th>Investment (inc dates)</th>
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<th>Success measures</th>
<th>KPIs/Plan trajectory</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>providers outlined in the ISA) in place since 2015</td>
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<td></td>
<td>• EDSM (between EMIS and SystmOne practices) in place since 2015</td>
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</tbody>
</table>
|                   |                 | • GPRCC  
• GP Repository of Clinical data implementation | | | | | | | |
|                   |                 | • All practices to be enabled for GPRCC  
• Rich profile information in e-Healthscope | | Go live including 2 pilot practices | Connected Notts | May 17 | Report from GPRCC Project Board | | |
|                   |                 | • Community Portal | | | | | | | |
|                   |                 | • All practices to be aware of community portal and what benefits it will bring  
• Sharing of as many patient records via EDSM as possible | | | | | | | |
|                   |                 | • Mobile Working | | All practices to have completed the business change process for mobile working project by 30.04.2017  
All practices to have received mobile working devices and training by 30.05.2017  
All practices to be using the mobile working devices within day to day working by 30.09.2017 | DW | Apr 17  
May 17  
Sep 17 | Report from Mobile Working Project Board  
Report from Mobile Working Project Board  
Self-return on usage including benefits and problems/issues to locality meetings in October 2017 | | |
|                   |                 | • GP Wi-Fi | | All practices to have completed the survey for GP Wi-Fi by 30.04.2017  
All practices to have completed the installation process by 30.05.2017  
All practices to be using GP Wi-Fi in normal working processes by 30.09.2017 | DW | April 17  
May 17  
September 17 | Report from GP Wi-Fi Project Board  
Report from GP Wi-Fi Project Board  
Self-return on usage including benefits and problems/issues to locality meetings in October 2017 | | |
|                   |                 | Practices to maximise the use of IT to enable | | Increase the number of patients who have access to and using Patient OnLine services | | | | | |
|                   |                 | | | | | | | | |

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<th>KPIs/ Plan trajectory</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>patients to view their own health care records, make and change appointments, and order repeat medications</td>
<td>• Maximise the use of booking on line appointments where appropriate</td>
<td>• Installed GP Appointment utilisation tool as part of GPAF</td>
<td>•</td>
<td>• Assess whether tool can provide utilisation rates of online usage for each function</td>
<td>DW</td>
<td>April 17</td>
<td>•</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Practices to increase the number of on-line bookable appointments</td>
<td></td>
<td>March 18</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Maximise the use of patients requesting their repeat prescriptions on line where appropriate</td>
<td>• Installed GP Appointment utilisation tool as part of GPAF</td>
<td>•</td>
<td>• Assess whether tool can provide utilisation rates of online usage for each function</td>
<td>DW</td>
<td>March 18</td>
<td>•</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Practices to increase the number of patients who have access to make on line appointments</td>
<td></td>
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</tr>
<tr>
<td>Practices to maximise the use of assistive technologies</td>
<td>• FLO – increase use of FLO to empower patients (and their carers) to take more control of their care through self-management</td>
<td>• Minimal number of practices using flow</td>
<td>•</td>
<td>• Scope use of Flo and benchmark against other CCGs</td>
<td>DW/Connected Notts</td>
<td>From April 17</td>
<td>•</td>
<td>•</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Ensure technology supports</td>
<td></td>
<td>May 17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• CCG to explore other assistive technologies available and what other CCGs in Notts are doing</td>
<td>•</td>
<td>• Shared working and joint approached wherever possible to maximise on the impact of AT</td>
<td>DW</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• CCG scoping provision and viewing systems</td>
<td></td>
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</tbody>
</table>
## Appendix 2b: NHS Nottingham North and East CCG forward view delivery plan 2016/17-2018/19

### GPFV – Model of care

<table>
<thead>
<tr>
<th>Work Priority Area</th>
<th>Key deliverables</th>
<th>Baseline position</th>
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<th>Success measures</th>
<th>KPIs/Plan trajectory</th>
<th>RAG (delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Transformaton</td>
<td>Practices federated across NNE</td>
<td>Meeting Oct 16 to determine interest</td>
<td>£3.00 per patient 2018/19</td>
<td>NNE CCG Collaboration Task Group Clinical to identify options for federation</td>
<td>RR</td>
<td>Mar 17</td>
<td>Subject to proposal yet to be developed</td>
<td>Federation in place</td>
<td>Business/develpment plan</td>
</tr>
<tr>
<td></td>
<td>Greater cooperative working between GP practices, more care delivered closer to home; this is with the intent of promoting the sustainability of general practice and improving access and quality of care</td>
<td></td>
<td></td>
<td>Preferred option/model for federation agreed by all practices</td>
<td></td>
<td>Apr 17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support 10 high impact actions</td>
<td></td>
<td></td>
<td>Federation</td>
<td></td>
<td>Jun 17</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Governance structure</td>
<td></td>
<td>July 17</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Development of federation business/development plan in line with STP model of care ambitions</td>
<td></td>
<td>Sep 17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roll out One Care Home, One Practice model</td>
<td>100% of care homes aligned to general practice</td>
<td>No practices are currently aligned</td>
<td>12 month investment of £310,000 from January 17</td>
<td>Service specification approved</td>
<td>CL</td>
<td>Oct 2016</td>
<td>Practice referral activity</td>
<td>Reduce ED attendances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service delivered through a local enhanced service</td>
<td></td>
<td></td>
<td>Residents Representative service to commence</td>
<td></td>
<td>Nov 16</td>
<td>Commissioning spend</td>
<td>Reduce non-elective hospital admissions</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Practices sign up to enhanced service specification</td>
<td></td>
<td>Dec 16</td>
<td>ED attendance and admissions data</td>
<td>Reduce emergency demand on GP practices</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Service launch to care homes</td>
<td></td>
<td>Jan 17</td>
<td>EPACC data</td>
<td>Reduce out of hours contacts</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Service start</td>
<td></td>
<td>Feb 17</td>
<td>Prescribing spend</td>
<td>Reduce the costs and risks of prescribing</td>
<td></td>
</tr>
<tr>
<td>Integrated model of care organised in Care Delivery Groups (CDGs)</td>
<td>20 practices aligned to care delivery groups</td>
<td>Pilot Arnold practices aligned</td>
<td>£274k for 2017/18 Funding via BCF</td>
<td>Service outline agreed</td>
<td>CL</td>
<td>Jun 15</td>
<td>Emergency Department attendances</td>
<td>Reduce Emergency Department attendances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Working within an agreed specification</td>
<td>All practices geographically aligned to 3 localities</td>
<td></td>
<td>Initial pilot commenced</td>
<td></td>
<td>Dec 15</td>
<td>Emergency hospital admissions</td>
<td>Reduce emergency hospital admissions</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Review Pilot and next steps</td>
<td></td>
<td>Jan 16</td>
<td>Admission to long term care</td>
<td>Reduce emergency demand on GP practices</td>
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<td></td>
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<td></td>
<td></td>
<td>Recruitment social care workers and Living Well Coordinators</td>
<td></td>
<td>Feb 17</td>
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<td></td>
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<td></td>
<td></td>
<td>Commencement with practice</td>
<td></td>
<td>Jan 17</td>
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<td></td>
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<td></td>
<td></td>
<td>Review outcomes</td>
<td></td>
<td>Sep 17</td>
<td></td>
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<tr>
<td></td>
<td>Care &amp; Quality Specification</td>
<td>Equalisation of funding to ensure all practices funding to at least the existing CCG average £ per patient</td>
<td>£700k September 2016-17 Funding via BCF &amp; re-</td>
<td>Service specification agreed</td>
<td>SN</td>
<td>Oct 2016</td>
<td>Practice referral activity and commissioning spend</td>
<td>Improved prevalence</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Service specification defined</td>
<td></td>
<td>All Practice signed up to specification</td>
<td></td>
<td>Dec 16</td>
<td>QOF Prevalence, Management exemption reporting</td>
<td>Improved management of LTC</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Individual practice reviews</td>
<td></td>
<td>May 17</td>
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<td></td>
<td>Improved exception reporting</td>
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</table>
### Work Priority Area

**Developing a place based model of care (Detailed in GPFV Plan narrative)**

- **Key deliverables**: Delivery of Accountable Care System model for Greater Nottingham
- **Baseline position**: Detailed design work from July to mid November 16
- **Investment (inc dates)**: £80.52
- **Action / milestones**: Value proposition developed. Sign up to progress to the next stage across organisations
- **Action owner (organisation)**: Director of Transformation
- **Milestone delivery date**: Nov 16, Mar 17
- **Success measures**: Delivery via MCP model of care, including prevention, proactive care, admissions avoidance, risk stratification of population, care coordination
- **KPIs/ Plan trajectory RAG**: Delivery of new model of care
- **RAG (delivery)**: Green

### GPFV – Improving access

**Work Priority Area**

**Key deliverables**

- 100% of NNE population having access to:
  - pre-bookable and same day appointments to general practice 8am - 8pm
  - pre-bookable and same day appointments on weekend from Hub location
  - Provision against services specification
  - Reduced inequalities to primary care services
  - 11/20 currently delivering Extended Access DES
  - Population coverage DES 60.2% with 90,685 patients being able to access services outside of core hours.
  - £501k (€3.34 per patient) 2018/19
  - £900k (€6.00 per patient) 2019/20
  - Project plan developed
  - Review current access provision and patient feedback
  - Review local pilot and best practice
  - Review technology requirements
  - Development of model
  - Hub locations and estate requirements to be identified to support access
  - Outcomes of capacity / demand & utilisation rate audit
  - Agree specification
  - Procurement commenced
  - Procurement awarded
  - Service commencement
  - Review service provision against demand
  - Outcomes of capacity / demand & utilisation rate audit
  - Agree specification

**Baseline position**

- £80.52
- Deployment of ‘PMS Premium’ funding

**Investment (inc dates)**

- Oct 17

**Action / milestones**

- Project plan developed
- Review current access provision and patient feedback
- Review local pilot and best practice
- Review technology requirements
- Development of model
- Hub locations and estate requirements to be identified to support access
- Outcomes of capacity / demand & utilisation rate audit
- Agree specification
- Procurement commenced
- Procurement awarded
- Service commencement
- Review service provision against demand
- Outcomes of capacity / demand & utilisation rate audit
- Agree specification

**Action owner (organisation)**

- RR

**Milestone delivery date**

- Feb 17
- Mar 17
- Apr 17

**Success measures**

- Patient Survey
- Procurement process
- Award contract
- Additional access

**KPIs/ Plan trajectory RAG**

- Access data
- Patient feedback
- % patient coverage
- Reduced inequalities across the CCG

**RAG (delivery)**

- Green
### Workforce

<table>
<thead>
<tr>
<th>Work Priority Area</th>
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<th>Success measures</th>
<th>KPIs/ Plan trajectory</th>
<th>RAG (delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specification – Access Standards</td>
<td>Specification – Access Standards</td>
<td>• Reduced inequalities for patients</td>
<td>Baseline position: times and practices arrangements in relation to access</td>
<td>Care &amp; Quality Specification above</td>
<td>specification - • Involve PPG in service review and evaluation and findings • Feedback access, capacity and utilisation information to CCG • CCG to review against specification</td>
<td>Sep 17</td>
<td>• Access data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Workforce and Organisational Development Plan</td>
<td>Strategic Workforce and Organisational Development Plan</td>
<td>• Greater Nottingham Strategic Workforce and Organisational Development Plan</td>
<td>Baseline position: Systems dynamics modelling tools used to determine baseline for STP footprint</td>
<td>Action / milestones: • Ascertain CCG support required • Support awareness to strategy and its development within Primary care • Await refined plans Local Workforce Action Board • Implement key actions from plan where appropriate • Attendance at PCSET</td>
<td>Action owner (organisation): RR</td>
<td>Milestone delivery date: Mar 17</td>
<td>Success measures: • NNE Baseline • Workforce monitoring</td>
<td>KPIs/ Plan trajectory: TBC</td>
<td></td>
</tr>
<tr>
<td>Support the national implementation of the Workforce and Retention 10 Point Action Plan</td>
<td>Support the national implementation of the Workforce and Retention 10 Point Action Plan</td>
<td>• Access to GP Training Placements</td>
<td>Baseline position: • 9/20 GP Training Practices</td>
<td>Investment (inc dates): £0.00</td>
<td>Action / milestones: • Confirmed training practices 17-18 • Determine new interest / increase capacity • Liaise with Workforce &amp; organisational development work stream • Promote experiences of training practices • CCG to offer awareness of CCG functions</td>
<td>Action owner (organisation): RR</td>
<td>Milestone delivery date: Jan 17</td>
<td>Success measures: • Number of training practices &amp; placements • Practice bulletin</td>
<td>KPIs/ Plan trajectory: Number of training practices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Access to Nurse Training Placements</td>
<td>Baseline position: • 1 practice a nurse training facility</td>
<td>Investment (inc dates): £0.00</td>
<td>Action / milestones: • Understand gaps of training provision &amp; support process • Promote the opportunities to</td>
<td>Action owner (organisation): RR</td>
<td>Milestone delivery date: Mar 17</td>
<td>Practice accepted as a training practice</td>
<td>Number of training practices</td>
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</tbody>
</table>

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### Work Priority Area

**Key deliverables**

<table>
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<tr>
<th>Baseline position</th>
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<th>Action / milestones</th>
<th>Action owner (organisati)on</th>
<th>Milestone delivery date</th>
<th>Success measures</th>
<th>KPIs/ Plan trajectory</th>
<th>RAG (delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment of GP Retainers</td>
<td>No retainers within CCG</td>
<td>£0.00</td>
<td>Obtain baseline</td>
<td>RR</td>
<td>Jan 17</td>
<td>Advertisement of scheme</td>
<td>No of GP Retainers within the CCG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Promote the scheme with practices and offer support</td>
<td>Feb 17</td>
<td>Increase number of retainers within NNE</td>
<td></td>
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</tr>
<tr>
<td>Appointment of GP Fellow</td>
<td>Fellowship placement at CCG 15/16</td>
<td>£0.00</td>
<td>Promote opportunities and timelines expressions of Interest to HEE</td>
<td>RR</td>
<td>Jan 17</td>
<td>Appointment of a GP Fellow</td>
<td>Number of GP Fellows within the CCG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Appointment of GP Fellows for 12 months</td>
<td>Aug 17</td>
<td>Feedback on the work and impact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment of GP Induction and Refresher Scheme</td>
<td>No Placement within CCG known</td>
<td>£0.00</td>
<td>Promote the opportunities of the GP Induction &amp; Refresher Scheme</td>
<td>RR</td>
<td>Mar 17</td>
<td>Advertisement of scheme</td>
<td>Number of GP Induction &amp; Refresher scheme placements</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Understand the process for practices opportunities to register to hold the work placements</td>
<td>Apr 17</td>
<td>Number of placements</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Health & Wellbeing

**Support wellbeing initiatives targeting general practice**

| Directory of local service provision | LMC offer Pastoral, Coaching mentoring support | £0.00 | Identify services available (Pastoral, Coaching mentoring etc) | RR | Mar 17 | Advertising of services | Directory of Services |
| | | | Incorporate within local DOS | May 17 | DOS |
| | | | Promote services to clinicians | Jun 17 | |
| | | | | | |
| Promote the services of the Hurley Clinic Partnership | Advertisement of service | £0.00 | Promote the clinic once launched | RR | Jan 17 | Advertising of services | Directory of Services |
| | | | Include links on the DOS | May 17 | DOS |
| | | | Regular updates of the services in 6 monthly intervals | Ongoing | |

### Wider Workforce & Development

**Broader range of staff providing care**

<p>| Pharmacists in General Practice | Existing provision Gilbrook – 2 days p/w Peacock 3 days p/w | Subject to approved applications | Promote alternative ways | RR | Jan 17 | Awareness of submitted applications | Pharmacists employed within general practice |
| | | | Application cut off | Feb 17 | Successful applications |
| | | | Successful applications | Mar 17 | Review next application rounds and promote |
| | | | Review next application rounds and promote | Mar 17 | |
| Medical Physicians / Assistants employed within | None currently employed | TBC | Awaiting further information NHS England | RR | TBC | TBC | TBC |</p>
<table>
<thead>
<tr>
<th>Work Priority Area</th>
<th>Key deliverables</th>
<th>Baseline position</th>
<th>Investment (inc dates)</th>
<th>Action / milestones</th>
<th>Action owner (organisation)</th>
<th>Milestone delivery date</th>
<th>Success measures</th>
<th>KPIs/ Plan trajectory</th>
<th>RAG (delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>the CCG within the CCG</td>
<td>Mental Health Therapists working within Primary Care</td>
<td>None currently employed within the CCG</td>
<td>TBC</td>
<td>Awaiting further information from NHS England</td>
<td>RR</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Enhanced provision through Care Navigation</td>
<td>20 practices will be providing care navigation support</td>
<td>Standard Red flag protocols to be used across CCG</td>
<td>£6.5k 16-17</td>
<td>Liaise with Practice Managers and LMC to determine training needs</td>
<td>RR</td>
<td>Dec 16</td>
<td>Monitoring of attendance</td>
<td>Number of staff completing the training</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Identification of training provision</td>
<td></td>
<td>Jan 17</td>
<td>Feedback from the events</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>Review training providers and confirm</td>
<td></td>
<td>Feb 17</td>
<td>Patient feedback</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td>Proactive signup from practices</td>
<td></td>
<td>Mar 17</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>First programme arranged</td>
<td></td>
<td>Apr 17</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ongoing plans to meet workforce during 17/18</td>
<td></td>
<td>Apr 17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhanced correspondence management</td>
<td>20 practices will deliver correspondence management within practice</td>
<td>Protocols used across CCG</td>
<td>£6.5k 16-17</td>
<td>Liaise with Practice Managers and LMC to determine training needs</td>
<td>RR</td>
<td>Dec 16</td>
<td>Monitoring of attendance</td>
<td>Number of staff completing the training</td>
<td></td>
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<tr>
<td></td>
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<td>Identification of training provision</td>
<td></td>
<td>Jan 17</td>
<td>Feedback from the events</td>
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<td>Review training providers and confirm</td>
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<td>Mar 17</td>
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<td>Apr 17</td>
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<td></td>
<td>Ongoing plans to meet full workforce during 17/18</td>
<td></td>
<td>Apr 17</td>
<td></td>
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</tr>
<tr>
<td>Practice Management Development Programme</td>
<td>Practice Managers taking part in the programme</td>
<td>TBC</td>
<td>TBC</td>
<td>Awaiting further information from NHS England</td>
<td>RR</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>Protected Learning Time Clinical</td>
<td>Dedicated Protected Learning Time (PLT)</td>
<td>6 sessions a year provided 4 in-house supported events</td>
<td>£20,000</td>
<td>PLT Dates confirmed</td>
<td>RR</td>
<td>Jan 17</td>
<td>Monitoring of attendance</td>
<td>6 PLT sessions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Training plan</td>
<td></td>
<td>Jan 17</td>
<td>Feedback from the events</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Monthly publicity of training sessions</td>
<td></td>
<td>Monthly</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>6/12 Reviewed at Primary Care Development Group</td>
<td></td>
<td>Aug 17</td>
<td></td>
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</tr>
</tbody>
</table>
### Workload

#### Protected Learning Time, Admin and Clerical

- **Key deliverables**: Dedicated Protected Learning Time (PLT)
  - 2 sessions a year provided
  - 4 in-house supported events
- **Baseline position**: 
- **Investment (inc dates)**: £5,000
- **Action / milestones**:
  - PLT Dates confirmed
  - Training Plan
  - Monthly publicity of training sessions
  - 6/12 Reviewed at Primary Care Development Group
- **Action owner (organisation)**: RR
- **Milestone delivery date**: Jan 17
- **Success measures**:
  - Monitoring of attendance
  - Feedback from the events
- **KPIs/ Plan trajectory**: 2 PLT sessions

#### GP Resilience Programme

- **Key deliverables**: 20 practice sustainability reports
- **Baseline position**: 
- **Investment (inc dates)**: £42,000 16-17
  - Ongoing investment allocation each year of £21,000 for 2017-2018, 2018-2019
- **Action / milestones**:
  - Expressions of interest sought
  - Development of approach
  - Review local provision
  - Practice sign up to the MOU
  - Deep Dive commences
  - Sustainability reports developed
  - Development plan for ear 17-18 and 18-19 to incorporate:
    - Investment
    - Specific practice needs identified from the deep dive report
    - Share learning across localities
    - Group practices together with similar need.
    - Monitoring of support
- **Action owner (organisation)**: JB
- **Milestone delivery date**: Sep 16
  - Oct 16
  - Oct 16
  - Jan 17
  - Feb 17
  - Mar 17
  - Apr 17
- **Success measures**:
  - Deep Dive completed
  - Practice Business plans created
  - Continued practice specific support identified from the Deep Dive
  - Shared learning discussed at Locality Meetings
- **KPIs/ Plan trajectory**: 20 individual practice sustainability reports
  - 17-18 Development plan
  - 17-18 KPI to be confirmed once deep dive complete and key needs identified

#### Vulnerable Practice Scheme

- **Key deliverables**: Improvement and sustainability plan
  - Recruitment
- **Baseline position**: 2 practices approved under the scheme
- **Investment (inc dates)**: £15,000 16-17
- **Action / milestones**:
  - Submit bid to NHS England for uncommitted funds
  - Bid outcome
- **Action owner (organisation)**: RR
- **Milestone delivery date**: Dec 16
  - Jan 17
- **Success measures**:
  - Individual practice action plan
  - Findings from the work undertaken and shared
- **KPIs/ Plan trajectory**: Individual Practice Plans
<table>
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<th>Success measures</th>
<th>KPIs / Plan trajectory</th>
<th>RAG (delivery)</th>
</tr>
</thead>
</table>
| Standardised Pathways & Referral forms – Map of Medicine and F12 | - Provide a central resource on approved standardised pathways of care, referral forms and patient information  
- Reduced variation | - DOS available but not integrated with Clinical System  
- Map of Medicine in place 2015 | £24,978 MOM  
£10k F12 | - Review pathways MOM  
- Referral forms enhanced MOM  
- Forward plan new pathways MOM  
- Integrate within CCG Service Directory | RR | Jan 17  
Feb 17  
Mar 17  
Feb 17 | - Referral activity MOM  
- Usage Mom  
- Usage review of F12  
- Referral activity F12  
- Prescribing monitoring  
- Variation monitoring | | |
| Care & Quality Specification Clinical variation | - Referral activity to reflect outcomes from Audits  
- High variance of referral activity | - Included within total Care & Quality Specification above | | - Practice visits to confirm audits  
- Variation audit cycle complete  
- Learning Clinical Cabinet  
- Review against secondary care activity (e.g. CCG averages)  
- Continue to review | MT | Feb 16  
Mar 17  
Apr 17  
May 17 | - Peer review learning  
- Audit feedback  
- Reduced variation | | |
### Time for Care programme

- Implement the 10 High Impact Actions

**Baseline position**
- CCG completed Productive General Practice in 2014/15

**Investment (inc dates)**
- National funds available

**Action / milestones**
- CCG expression of Interest on portal

**Action owner (organisation)**
- RR

**Milestone delivery date**
- Feb 17

**Success measures**
- Promote and share learning through weekly bulletin and locally meetings
- Event feedback

**KPIs/ Plan trajectory**
- Delivery against the 10 High Impact Actions
- Attendance and completion of programmes
- Programme feedback

**Work Priority Area**
- Key deliverables

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review &amp; submit outcomes to CCG</td>
<td>Sep 17</td>
<td></td>
</tr>
<tr>
<td>Development of programme to meet needs</td>
<td>Feb 17</td>
<td></td>
</tr>
<tr>
<td>Targeted event &amp; confirm 3 high impact areas</td>
<td>Apr 17</td>
<td></td>
</tr>
<tr>
<td>Programme sign up</td>
<td>Apr 17</td>
<td></td>
</tr>
<tr>
<td>Implement programme</td>
<td>May 17</td>
<td></td>
</tr>
<tr>
<td>Review programme and outcomes 6/12</td>
<td>Sep 17</td>
<td></td>
</tr>
<tr>
<td>Review programme and outcomes 12/12</td>
<td>Mar 18</td>
<td></td>
</tr>
</tbody>
</table>

### Practice Infrastructure

#### ETTF Funds Cohort 1

- Calverton - Refurbish and reconfigure existing premises and secure building for further development.

**Baseline position**
- Priority in CCG Premises and Estates Strategy

**Investment (inc dates)**
- Investment £221k
- Y/E 31/03/2017

**Action / milestones**
- Approval from PCCC
- Due Diligence with NHS England to take place
- Work commence
- Spend of funds by 31st March 2017

**Action owner (organisation)**
- JB

**Milestone delivery date**
- Dec 16
- Jan 17
- Feb 17
- Mar 17

**Success measures**
- Delivery in line with NHS England requirements and monitoring
- Monitoring of spend

**KPIs/ Plan trajectory**
- Build schedule complete

#### ETTF Funds Cohort 2

- Hucknall - Develop premises in Hucknall that will be fit for purpose and meet the demands of the growing population

**Baseline position**
- Priority in CCG Premises and Estates Strategy

**Investment (inc dates)**
- Investment £400k
- Y/E 31/03/2019

**Action / milestones**
- Plan space requirements
- Estimate outline costs
- Source additional finance for business case development and building

**Action owner (organisation)**
- JB

**Milestone delivery date**
- Feb 17
- Feb 17
- Mar 17

**Success measures**
- Delivery in line with NHS England requirements and monitoring
- Monitoring of spend

**KPIs/ Plan trajectory**
- Plans developed
- New facility
<table>
<thead>
<tr>
<th>Work Priority Area</th>
<th>Key deliverables</th>
<th>Baseline position</th>
<th>Investment (inc dates)</th>
<th>Action / milestones</th>
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<th>Success measures</th>
<th>KPIs/ Plan trajectory</th>
</tr>
</thead>
</table>
| Calverton - Extend the building to provide additional clinical and training/meeting room space for the practice to enable them to meet the increased demands of the rapidly growing population | Priority in CCG Premises and Estates Strategy | Investment £358k 2 YIE 31/03/2019 | • Identify land  
• Develop business case and gain approval  
• Specify and tender for the premises development  
• Complete the development of the premises | JB | TBC | TBC | TBC | TBC | Delivery in line with NHS England requirements and monitoring  
Monitoring of spend |
| Practices to maximise the use of assistive technologies | Use of FLO across all practices | 3 Practices actively managing patients | • Practices to be provided with case study and baseline of their usage  
• Development of practice plans for implementation  
• Training & support | BH | Feb 17  
Mar 17  
Apr 17  
Feb 17  
Mar 17  
May 17 | Practices to feedback to locality meetings by 30.06.2017  
Increased usage of FLO  
Improved patient outcomes | Number of patients self-managing through FLO technology |
| Implementation of the Gedling Borough Council AT project for providing technology into residents homes to enable them to stay at home longer and be safe e.g. smoke detectors, falls alarms, lifeline assistance | No provision locally | Funding from LA – Gedling Borough Council | • Approval of project at SIG  
• Awareness of the project to practices  
• Go Live to patients & referral into service | MT | Feb 17  
Mar 17  
Apr 17  
Feb 17  
Mar 17  
May 17 | Feedback on the uptake of patients using the system | Number of patients using system |
| CCG to explore other assistive technologies available and what other CCGs in Notts are doing | Reviewing | STP work stream | • Workshop to map out available technology  
• Development of plan to be defined | Dec 16  
TBC | AT Meeting feedback | TBC |
| Online consultation systems | Awaiting definition from NHS England & detailed specification | No local pilot undertaken | • Review existing systems to understand existing market  
• Work in collaboration with CCGs locally  
• Awaiting further information | Connecing Notts  
MT | Mar 17  
Mar 17  
TBC | Options appraisal of existing providers  
TBC subject to specification | TBC – subject to specification |
<table>
<thead>
<tr>
<th>Work Priority Area</th>
<th>Key deliverables</th>
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<th>RAG (delivery)</th>
</tr>
</thead>
</table>
| IT systems in place to support communication between practices other providers | • MIG 1 fully enabled in all practices  
• MIG 2 enabled in all practices  
• MIG 3 enhanced sharing and data sets | All practice sharing | Connected Notts funds | • All practices fully enabled for MIG1 sharing out to other providers  
• All practices fully enabled for MIG 2 including EPaCCS data.  
• MIG 3 development implemented  
• MIG 3 complete | Connecing Notts MT | Complete  
Apr 17  
Apr 17  
Mar 18 | Report from MIG Project Board  
MIG 1 complete  
MIG 2 complete  
MIG 3 to be confirmed | | |
| • 95% EDSM shares to facilitate patient record sharing | 95% achieved | Connected Notts funds | • All practices to ensure EDSM share out for MIG is enabled for 95% of their practice population (not over-riding any dissents)  
• Regular monitoring | Connecing Notts MT | Aug 16  
Quarterly 17 | Report from MIG Project Board  
CCG to run quarterly report from TPP reporting unit | MIG Reporting | |
| • GP Repository for Clinical Care (GPRCC) enhanced information within eHealthscope to support clinical decision and patient management | 20 practices to be enabled | Connected Notts funds | • All practices to be enabled for GPRCC  
• Monitor new data sets and enable  
• GPRCC3 development being scoped  
• GPRCC3 complete | Connecing Notts MT | Dec 16  
Quarterly 17  
Apr 17  
Mar 18 | Report from GPRCC Project Board  
Board reporting | | |
| • Enhance provision of devices to enable GP mobile working | 2 practices pilot programme | Connected Notts funds | • All practices to have completed the business change process for mobile working project  
- All practices to have received mobile working devices and training  
- All practices to be using the mobile working devices within day to day working | Connecing Notts MT | Apr 17  
May 17  
Sep 17 | Report from Mobile Working Project Board  
Self-return on usage including benefits and problems/issues to locality meetings  
20 practices access to devices  
20 practice actively using the mobile working | | |
| • Provision of GP Wi-Fi service into practices for GP practice staff and healthcare workers  
• Support Mobile working | 95% of practice surveyed  
95% of practices | Connected Notts funds | • All practices to have completed the survey for GP Wi-Fi  
• All practices to have completed the installation process | Connecing Notts MT | Apr 17  
May 17 | Report from GP Wi-Fi Project Board  
Report from GP Wi-Fi Project Board  
100% practices enabled | | |
<table>
<thead>
<tr>
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<th>RAG (delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient OnLine</td>
<td>• 50% aspirational stretched target for CCG of patients who have access to Patient OnLine services</td>
<td>installation complete</td>
<td>• All practices to be using GP Wi-Fi in normal working processes</td>
<td>• Self-return on usage including benefits and problems/issues to locality meetings in October 2017</td>
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<tr>
<td></td>
<td>• 12 Practices 10%-19% • 3 practices 20% + • 5 practices below 10% • 21% of CCG population is registered for POL (as of 31/1/17)</td>
<td>• Connected Notts funds</td>
<td>• 10% of practice population to be registered for POL services</td>
<td>• CCG to run reports via the TPP reporting unit for TPP practices quarterly</td>
<td>MT</td>
<td>Mar 17</td>
<td>• Number of patients registered on POL</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• All practices to have generic information about POL on their websites</td>
<td>• EMIS practices to self-declare quarterly</td>
<td></td>
<td>Mar 17</td>
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<td></td>
<td>• 20% national target of practice population to be registered for POL</td>
<td>• Practices to self-declare baseline</td>
<td></td>
<td>Mar 18</td>
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<td></td>
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<td></td>
<td>• Review POL service breakdown (prescriptions, appointments &amp; record viewing)</td>
<td>• Practices to self-declare information held on practice website re POL</td>
<td></td>
<td>Jun 18</td>
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<td></td>
<td>• 50% CCG aspirational target of practice population to be registered for POL - subject to National change</td>
<td>• Practices to self-declare information held on practice website re POL</td>
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<td>Mar 19</td>
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GPFV Delivery Plan
V2 23rd February 17
## Appendix 2c: Nottingham West forward view delivery plan 2016/17-2018/19

### Model of care

<table>
<thead>
<tr>
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<th>RAG</th>
</tr>
</thead>
</table>
| **Practice Transformati on and Collective General Practice** | • 10 ‘high impact actions’ identified in the planning guidance  
• Stimulate the development of at scale providers to improve access  
• Secure the sustainability of general practice. | • Commitment to direct funding to general practice for transformation  
• Discussions commenced on use | • £3 per patient in total 2017/18 to 2018/19 | • Agreement to the approach and outline plans to link to Engaged Practice Scheme  
• Development of a full proposal and agreement with the Financial team on the funding availability | TL | March 17 | | TBC | Amber |
| **Integrated model of care organised in Care Delivery Groups** | • Closer working across key professional groups  
• Use of the new risk stratification tool to support vulnerable people and those at risk of hospital admissions | • The alliance contract for local integrated community services has brought together a number of services into an Integrated Community Hub Care Delivery Group model. | • £5 per head for over 75s since 2014 (over and above baseline value of alliance contract) | • Commencement of the integrated care team contract  
• Update the data reporting | KW | April 16 | April 17 | | Green |
| **Long Term Condition – IAPT Early Implementer Pilot** | • Reduced secondary care admissions linked to the conditions.  
• Increased IAPT referrals – contributing to the 2020-21 target of 25% of identified IAPT cases.  
• Integrated community care. The LTC-IAPT services will be co-located with existing community services – seeking to engender a biopsychosocial model of care in the community. | • Bespoke local service for some LTC conditions and frail older people in place from 2014  
• Successful bid to NHSE EI funds to be used to expand service to Chronic pain, diabetes and dermatology.  
• Mobilisation from October  
• New service model from January 2017. | • 2016-17 funding is £122,521 from NHS England.  
• 2017-18 funding is £298,744. | • Bid for Early Implementer  
• Awarded pilot  
• Agree split of roles between the two providers  
• Appoint IAPT posts  
• Establish monitoring of the scheme.  
• Mobilisation and promotion of new service model  
| **Developing a place based model of care Detailed in** | • Delivery of Accountable Care System model for Greater Nottingham | • Detailed design work from July to mid-November 2016 | • TBC | • Value proposition developed  
• Director of Transformation | Director of Transformation | Nov 2016 | | Delivery via MCP model of care, including prevention, proactive | Delivery of new models of care | Delivery of financial | Amber |
<table>
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</thead>
<tbody>
<tr>
<td>shared narrative</td>
<td></td>
<td></td>
<td></td>
<td>Sign up across organisations</td>
<td></td>
<td>Jan 2017</td>
<td>care, admissions avoidance, risk stratification of population, care co-ordination</td>
<td>targets in STP</td>
<td></td>
</tr>
</tbody>
</table>

### Improving access

<table>
<thead>
<tr>
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<th>Success measures</th>
<th>KPIs/ Plan trajectory</th>
<th>RAG</th>
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</thead>
</table>
| Engaged Practice Scheme | • Access standard  
   • Reduced unwarranted variation and inequalities  
   • Quality in prescribing  
   • Improved patient satisfaction  
   • Increased practice participation | Scheme in place since 2014  
   • Initial focus on improvements in in-hours access  
   • Excellent patient feedback in local and nation survey  
   • Peer review all potential non-urgent referrals to secondary care | Up to £600K per annum | Quarterly reporting | TL | • Improvements in in-hours access  
   • Quality in prescribing  
   • Reduced variation between practices  
   • Reduced inequalities | | | | Amber |
| Improving Access to General Practice GP Access Fund (formerly PMCF) | • Delivery of extended access from a number of locations across the CCG area.  
   • Link to CDG areas and teams weekdays  
   • Weekend service delivered from a hub location.  
   • Offer face to face appointments and/or telephone consultation with GPs, practice nurses or Health Care Assistant (HCA) between 6.30pm-8.00pm every weekday, and on Saturdays, Sundays  
   • For weekend appointments Patients will be able to book routine pre-bookable appointments through the reception desk of their | EPS resulted in improvements in in-hours access  
   • Individual practices provide extended hours as part of the Extended Hours DES.  
   • 10 of 12 practices delivered additional over winter 2016/17 using GPAF  
   • Some practices already providing pre-bookable appointments on a Saturday morning to their registered population  
   • Discussions ongoing re locality working & skill Mix across localities | £3.34 per head (£307,830) in 2018/19, increasing to £6.00 per head in 2019/20 | Discussion with practices re: Use of System one and EMIS and scoping interoperability between clinical systems | Dr MON & AR | March 2017 | Delivery of extended access to meet the needs of patient population | TBC | Amber |
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</table>
| Clinical Pharmacists in general practice Wave 1 site | - Additional capacity in practices through allocated NHS England scheme Clinical Pharmacists  
- Fit with NHS England requirements around deprivation, recruitment of GPs,  
- Implementation of the NHS England pharmacists to contribute to a reduction in prescribing spend | - NW CCG primary care prescribing team won a bid in conjunction with PICS to be part of the NHS England Clinical Pharmacists in GP practices scheme.  
- Pharmacists were recruited and started in post between June and August 2016.  
- Two Practices within NW CCG have agreed to fund a pharmacist to work within their practice  
- Additional staff previously funded in 2015 by CCG | - National Clinical Pharmacist £363,800 with NHS England funding  
- 60% in year 1, 40% in year 2, 20% in Year 3 and 0% in Year 4.  
- NW CCG has already committed £75,600 to extra permanent posts | - All staff recruited and in post  
- Evidence of impact | BC | August 2016 | - Capacity delivered  
- Reduction in prescribing spend in 2016/2017 by a projected 11%, in comparison to a 4% increase in spend the previous year | |
| GP recruitment and retention | - Retain GP trainees as they qualify  
- Recruit to all vacancies as they arise  
- Mitigate number of retiring GPs  
- Create locum bank to reduce external expenditure | - Work across CCGs as part of STP modelling  
- Local plans in development | TBC | TBC | TBC | TBC | TBC | |
| Training for reception and clerical staff | - To support reception and clerical staff to undertake enhanced roles in active | - Practices collaborating to identify training needs.  
- £8K per annum for 5 years from Training provider identified January 2017  
- Bespoke solution for AS (The Oaks) | April 2017 | All participating practice will have completed their training  
- 80-90% of letters can be processed without the involvement of a | | | |
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<tbody>
<tr>
<td>– national funding</td>
<td>signposting and management of clinical correspondence • More detailed coding of clinical information in the GP record leading to improved monitoring and management of certain conditions.</td>
<td>• Receptionist training delivered in previous years as part of Engaged Practice Scheme.</td>
<td>2016/17</td>
<td>participating practices identified &amp; agreed.</td>
<td></td>
<td>by 01/04/17</td>
<td>GP, freeing up approx. 40 minutes per day per GP. • Clerical Team improved job satisfaction</td>
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<tr>
<td>Practice Education – Protected Learning Time – local funding</td>
<td>• Topics are driven by new pathways developments, QIPP or GP requests for enhanced of skills and knowledge • Attendance from all 12 Practices</td>
<td>• Clinical – GP and Practice nurse and non-clinical PLT supported • Budget devolved to practices to link to training budget above and delivery of GPRP</td>
<td>£22K per annum to fund PLT sessions • CCG funds phone cover (out of hours provider)</td>
<td>• 5 sessions per annum plus practice based sessions</td>
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<tr>
<td>Productive General Practice</td>
<td>• 2 projects from choice of 8 being undertaken in each practice • Capacity project ‘chasing the tail’ across CCG</td>
<td>• Commenced February 2017 • Weekly update between practice and facilitators</td>
<td></td>
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<td>March 2017</td>
<td>Engagement of practices • Impact of projects within and across practices operationally</td>
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### Workload

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</thead>
<tbody>
<tr>
<td>Equalising core funding</td>
<td>• Core funding disparities between practices to be addressed</td>
<td>• Six practices funded up to average in 2016/17 • Linked to delivery of EPS requirements</td>
<td>£166K in 2016/17 • 2017/18 to be confirmed</td>
<td>• Review and action annually until complete</td>
<td>JL</td>
<td>December 2016</td>
<td>All practices at CCG average</td>
<td>Annual review until 2021 or earlier</td>
<td></td>
</tr>
<tr>
<td>GP Resilience Programme</td>
<td>• Develop and implement standardised governance, HR and operational frameworks across all member practices • Project Lead to work with each Practice Manager to identify and prioritise areas requiring improvement support for example: health &amp; safety issues due to changes</td>
<td>• Practice Managers meet monthly to provide peer support, share ideas &amp; work collaboratively • Project lead and detailed project plan agreed • Accountancy package commissioned with the</td>
<td>£26K 2016/17 • £19K 2017/18 • £13K 2018/19 • £13K 2019/20</td>
<td>• Objectives agreed • Purchasing audit undertaken and top thirty treatment room items tendered on behalf of practices • Roll out of agreed accountability package across member practices • Joint training programme developed for 2017/18 and</td>
<td>AT (The Manor)</td>
<td>January 17 • February 17 • March 17 • Training matrix developed</td>
<td>Individual training needs and provision identified. • Training completed by and feedback from attendees recorded. • Efficiencies due to scale of changes and training</td>
<td>Log to be maintained of identified need and support provided. • Feedback against priority areas from Practice Managers to be collated • Evidence of impact of training</td>
<td></td>
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<tr>
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<td>Baseline position</td>
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</table>
| Time for Care programme | • Support practices to manage their workload differently  
  • Implement new innovations  
  • Development of the 10 High Impact Actions | • Expression of interest submitted on behalf of all practices  
  • ‘Productive workflow and Developing the Teams’ identified as initial priorities | | • Linking to collective general practice working group workplan  
  • Meet with NHSE to establish parameters and next steps | AR | | October 2016 | TBC |
| Infrastructure | | | | | | | | | |
| Work Priority Area | Key deliverables                                                                 | Baseline position                                                                 | Investment (inc dates) | Action / milestones                                                                 | Action owner (organisation) | Milestone delivery date | Success measures | KPIs/ Plan trajectory | RAG |
| ETTF Estates Investment (Detailed in shared narrative) | • Estates Strategy priorities delivered  
  • Additional capacity in primary care and community premises in order to move care closer to home and deliver priorities of STP | • Estates Strategy in place.  
  • Hickings Lane practice Stapleford extension completed October 2016 (from previous funding) | • £600K in total over 3 years | • The Oaks approved in Cohort 1 and announced Eastwood hub approved in principle and announced nationally in Cohort 2  
  • Full business case and due diligence for The Oaks | RH | October 16 | | Additional capacity in primary care  
  • Ensure premises meet quality standards | |
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</table>
| ETTF Technology (Detailed in shared narrative) NW funding £73K | - Mobile Working  
- GP Wi-Fi  
- Medical Interoperability Gateway  
- EDSM  
- Unified Communications  
- Self Care Apps  
- GP Repository for Clinical Care  
- GP Template review and alignment  
- Increase % the number of patients Patient OnLine services  
- Maximise the use of booking on line appointments  
- Maximise the requesting their repeat prescriptions on line  
- Maximise the use of assistive technologies  
- Development of online consultations | - Local ETTF schemes prioritised and submitted by CCGs on central portal.  
- Oaks practice extension to complete 2017  
- Eastwood hub to commence | | | Dr MON & RH | Detailed in shared narrative | Detailed in shared narrative | Detailed in shared narrative |
## Appendix 2d: NHS Rushcliffe CCG forward view delivery plan 2016/17-2018/19

### GPFV – Model of care

<table>
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</thead>
<tbody>
<tr>
<td>Expansion of existing gynae community clinic</td>
<td>Community Gynae pathway in place since 16/17</td>
<td>MCP investment 17/18-tbc</td>
<td>Present business case to MCP CDG</td>
<td>SS/MJ</td>
<td>Mar 17</td>
<td>tbc</td>
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<tr>
<td>Gastro pre-assessment pathway</td>
<td>MCP Vanguard status since 2015</td>
<td>Expansion commences</td>
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<tr>
<td>Respiratory pre-assessment pathway</td>
<td>10 delivery workstreams</td>
<td>Extend across Greater Notts</td>
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<tr>
<td>Extension of existing fracture liaison service</td>
<td>GP Federation (PartnersHealth) – legal entity since November 2015</td>
<td>Commences</td>
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<tr>
<td>Community ENT service</td>
<td>Fracture liaison service in place since 15/16</td>
<td>Extend across Greater Notts</td>
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<tr>
<td>Commission GP Local Enhanced Delivery Specification 17/18</td>
<td>None in place, meeting taken place</td>
<td>Business case to MCP CDG</td>
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<td>GP Local Enhanced specification commissioned since 14/15</td>
<td>Implementation</td>
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<td>Extend duration of pilot</td>
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<td>Development/agree indicators/thresholds/weightings at GPDG</td>
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<td>Agreement by PCCC</td>
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### GPFV – Improving access

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<th>KPIs/ Plan trajectory</th>
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<tbody>
<tr>
<td>Improving Access</td>
<td>Delivery of NHSE core requirements from 01.04.17</td>
<td>APMS contract agreed July16-March17 to continue through 16/17</td>
<td>2016-17 £170k £53k</td>
<td>Contract negotiations concluded for continuation of GPAF with current provider throughout 16/17</td>
<td>JM</td>
<td>June 2016</td>
<td>Patient satisfaction</td>
<td>KPIs tbc by Mar 17</td>
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<tr>
<td>Work Priority Area</td>
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<td>JM/SM</td>
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<td>JM/PH</td>
<td>1st April 2017</td>
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**Key deliverables:**
- 30 mins/1000 population
- 1.5 hours per weekday outside core hours and weekends
- Provide extended access in GPAF sites
- Prioritise implementation of GPFV & prepare
- Specify and procure full coverage extended access for 17/18
- GP Appointment utilisation tool
- Communication
- Contracting and commissioning of service

**Baseline position:**
- Whole population survey conducted June 14 by CCG for accessing local health services
- 100% of practices open throughout core hours 8am-6.30pm, no lunchtime or afternoon closures since April 15
- Existing PMCF deliver to 100% population coverage and delivered at scale
- PMCF wave one site (hub model with rotating workforce providing 100% CCG population coverage)
- Continued PMCF under APMS contract(GPAF) service 2016-17 Sat & Sundays 8.30-12.30
- Tool installed by NHSE deadline

**Action / milestones:**
- Transition GPAF to mainstream extended access from April 17
- Implementation plan with key deliverables including extended access (Dec) through 17/18 submitted
- Guidance issued to provider on extended access requirements
- Agree implementation plan & delivery model with PCCC (& local NHSE team)
- Commence procurement of 17/18 extended access contracts (January 2017 or earlier)
- Agree/Communicate with PH and practice requirements to practices
- Agree installation plan with Head of Primary Care IT
- Installation on all individual practice units & federated unit
- Switch on tool
- Joint communication plan agreed (commissioner/provider)
- Proposed delivery model agreed by PCCC
- Commissioning of service (APMS contract signed)
- Service commences

**Success measures:**
- System wide impact
- Increased screening/vaccination/NHS Healthcheck uptake
- Improved patient participation/engagement for LTC annual reviews
- Utilisation rates
### Workforce

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<thead>
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| Developing and implementing recruitment & retention strategies | - Development of strategy across Greater Notts  
- Increase training capacity and no. training practices  
- Support the GP fellowship programme and facilitate the education opportunities by offering trainees the opportunity to obtain greater knowledge of CCG commissioning functions.  
- Continued support of the Rushcliffe Training Hub  
- Workforce greater use of skill mix in primary care  
- Pharmacists  
- Provide PC placement experience to pre-registration pharmacists  
- Provide 2 short day experience days in primary care for pre-registration pharmacists  
- Care navigators – Programme to train practice staff with community pharmacy care navigators  
- Management of clinical correspondence | - Established basic quarterly CCG GP workforce data collection process (wte, DOB, gender, partner/salaried)  
- 66 wte GPs @01.01.17 (headcount: 82)  
- Average list per wte GP (1.1.17 population) 1895  
- WTE total wte/Gender 0.25  
- 0.25 Male  
- 0.5  
- 6.5 Female  
- 0.5  
- 3 Male  
- 0.75  
- 12.75 Female  
- 0.75  
- 4.5 Male  
- 1  
- 10 Female  
- 1  
- 29 Male  
- 9/12 training practices  
- Participating in GP Fellowship scheme (2 GP Fellows in place)  
- CCG training hub for nurses  
- Joint post between HEE/CCG – Nurse workforce transformation lead  
- Established RCCG baseline of GP workforce (updated quarterly)  
- GP workforce lead  
- Supporting Nursing  
- Associate training – none appointed in Rushcliffe  
- 24 Nurse Mentors in place  
- Didn’t participate in wave one clinical pharmacist in GP | £11k-16/17  
£21.6k-17/18  
£21.6k-18/19 | - Expand existing training capacity  
- Increase to 12/12 practices  
- Awaiting £ confirmation for 17/18  
- Training in progress (1)  
- Awaiting funding for second to be trained  
- Wave two application submitted  
- Pre-registration placement commences  
- Early discussions taken place  
- First tranche of training to be completed  
- Develop protocols  
- Trial in two practices  
- Evaluate impact  
- Refine  
- Full roll-out | NC/GB | By 2019  
By 2019  
Tbc (dependant on £)  
Awaiting application  
July 17 (6wks)  
Completed  
Tbc  
Feb – Mar 17 | - Increase in no.s GPs  
- Workforce monitoring  
- Recruitment & retention  
- Encourage more into Rushcliffe | | |
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<tbody>
<tr>
<td>Support wellbeing initiatives targeting general practice</td>
<td>• Provide information to clinical on local services that provide Pastoral support, coaching and mentorship</td>
<td>• Awaiting information on local services</td>
<td>• Identify services available</td>
<td>NC</td>
<td>• Advertising of services</td>
<td>• Feedback from services.</td>
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<tr>
<td>Promote the services of the Hurley Clinic Partnership</td>
<td>• Improve access to mental health support for general practitioners and trainee GPs who may be suffering from mental ill-health including stress, depression, addiction and burnout</td>
<td>• In place January 17 – and promoted to GPs</td>
<td>• Regular updates of the services in 6 monthly intervals</td>
<td>NP</td>
<td>• Practice bulletins</td>
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<tr>
<td>Support the Retained Doctors scheme within the CCG and other national initiatives that support recruitment, retention and development of the workforce, including the Senior GP Fellowship scheme</td>
<td>• Provide alternative workforce options to support the delivery of Primary Care</td>
<td>• No retainers in post GP Fellowship scheme running since 15/16</td>
<td>• Scope need with practices</td>
<td>NC/PH</td>
<td>• Practice bulletins</td>
<td>• Increase number of retainers within RCCG</td>
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<tr>
<td>Medical Assistants within Primary Care</td>
<td>• Awaiting information from NHS England</td>
<td>• None in place</td>
<td>• Awaiting guidance from NHS England</td>
<td>NC/PH</td>
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| Enhanced provision through Care Navigation | • Enhanced role for Reception and Administrative role signposting patients  
• Free up GP time  
• 12 practices involved | • MCP developing self-care hub  
• Embedded Notts’ Helpyourself website widgets onto all practice & GP Federation websites  
• Weblink included on LTC personalised care plans clinical template  
• Facility set up to text URL link to specific patient cohorts  
• Working on TV screens in all practices to be consistent self-care/navigation messages | • £6.5k 16-17  
• £21.6k-17/18  
• 21.6k 18/19 (split between care navigation & medical assistants) | • Staff groups identified as reception staff in GP practices and health champions in community pharmacy - (aligning with MCP development re community pharmacy and match funding to train both staff groups at same time and in same way)  
• Self Help UK directory of services - is this available in every practice / pharmacy  
• Identify training provider - scoping no. of people requiring training to inform no. of sessions  
• Train both staff groups together in localities  
• Agree expected learning outputs  
• Reception staff and community health champions understand each other's roles and when appropriate to contact each other or signpost patients  
• Knowledge of local directory of services  
• Confidence to have conversation with patients when appropriate | SL (PH) | February 17 | • Monitoring of attendance  
• Feedback from the events  
• Patient feedback  
• Reporting to NHS England |                       |
| Enhanced correspondence management | • Enhanced role for Administrative staff in handling paperwork  
• Free up GP time  
• 12 practices involved | | • £6.5k 16-17 | • Scoping work/meetings  
• Develop protocols  
• Trial system  
• Evaluate impact  
• Refine  
• Roll-out across Rushcliffe  
• Develop protocols | SL/PH | Jan-Mar 17  
April 17 | • Evaluate impact on workload of GPs and non-clinical staff |                       |
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| GP Resilience Programme rolled out across the CCG | CCG commissioned GP Provider (PartnersHealth) to deliver “Working together” programme across all practices.  
- Covers 7 workstreams: processes, finance, HR, workforce and training, business continuity, governance and IT.  
- The objectives for this programme will be to provide a platform from which practices can centralise and streamline business processes, share clinical and non-clinical resources and support business continuity and provision of short notice clinical bank staff - administration and project support to aid practice resilience. |  | £35k 16/17 |  
  - Trial system  
  - Evaluate impact  
  - Refine  
  - Roll-out across Rushcliffe | SL/PH | Jan-Mar 17 |  |  |
|  | Practice Manager leads and support agreed for each workstream.  
  - Project plans developed and agreed by Operational meeting.  
  - Scoping work has begun and where specialist external support has been identified as being required (HR / H & S / IG) meetings with relevant providers have been set up to outline PH specification and commence the options appraisal for members. |  |  |  |  |  |  |  |
|  | Specialist HR input to advise on policy framework consolidation across all practices and ongoing maintenance of this.  
  - New contract for all new members of staff.  
  - Determine pay scales for posts across primary care and standard terms and conditions for new employees.  
  - Specialist training for line managers in recruitment, retention, managing sickness absence, grievance, disciplinary and appraisal.  
  - Specialist health and safety input to review existing practice and provide recommendations to ensure best practice and legal compliance, plus overarching policy framework  
  - Information Governance specialist input  
  - Project support for processes workstream  
  - Business continuity and provision of short notice clinical bank staff - administration and project support |  |  |  |  |  |  |  |
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| Implementation of F12 pathfinder | • Provide a streamlined central resource on approved standardised pathways of care, referral guidelines/forms and patient information  
• Reduce variation | • Some standardised clinical system/referral templates in place | • MCP funding | • Recruitment of project officer  
• Identify clinical champion, librarian function; service improvement lead in each CCG  
• Demo of system to GP Federation  
• Continue dev’t of prototype  
• Development of further standardised referral templates  
• Commence testing of F12 pathfinder within interested practices across participating CCGs  
• Disseminate configuration information to Rushcliffe practices to enable testing and provide feedback  
• Launch completed specialties in 1 CCG and instigate feedback loop on tool to incorporate into ongoing development  
• Develop roll-out strategy | SM | Jan-Mar 17  
February 17  
February 17  
February 17  
Feb-March 17  
Mar 17  
Mar 17  
April 17 | • Usage review  
• Referral activity  
• Reduction in prescribing costs  
• Reduction in clinical variation | |
| Implementation of Care Delivery Groups (CDGs) within the CCG | • Positive impact on practice workloads  
• Reduce Emergency Department attendances, emergency hospital admissions, emergency demand on GP practices and out of hours contacts.  
• Reduce admission to long | • 3 CDGs in place  
• 2 Community Care Officers recruited  
• 3 Age UK Living Well Co-ordinators recruited  
• Social worker appointed | | | | | | |
| | | | | | | | | | |
## Work Priority Area

### Key deliverables
- Improve the coordination of care for individuals and their carer(s)
- Reduce duplication
- Improve patient quality and experience of care
- Improved shared knowledge and understanding of roles and responsibilities

### Baseline position

### Action / milestones

### Action owner (organisation)

### Milestone delivery date

### Success measures

### KPIs/ Plan trajectory

### RAG

### Implementation of the Time for Care programme

- Support practices to manage their workload differently
- Implement new innovations
- Delivery of the 10 High Impact Actions

### Key deliverables

### Baseline position

### Action / milestones

### Action owner (organisation)

### Milestone delivery date

### Success measures

### KPIs/ Plan trajectory

### RAG

### Practice Infrastructure

## Work Priority Area

### Key deliverables
- MIG fully enabled in all practices

### Baseline position

### Action / milestones

### Action owner (organisation)

### Milestone delivery date

### Success measures

### KPIs/ Plan trajectory

### RAG
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|                   | Practices to maximise the use of IT to enable patients to view their own health care records, make and change appointments, and order repeat medications | (between EMIS and SystmOne practices, and other local health providers outlined in the ISA) in place since 2015  
EDSM (between EMIS and SystmOne practices) in place since 2015  
- Increase the number of patients who have access to Patient OnLine services  
- As CCG is a Vanguard, target is 25%  
- Currently CCG average % for percentage of patients registered is 27%, the highest 56% | @ End January 2017  
- Thresholds of 25% and 45% were set due with GP specification due to a number of practices who already had over 25% of their registered population using online services.  
- Current CCG average % for percentage of patients registered is 27%, the highest 56% | • In development to % target being increased for Vanguards | JM/PH | March 18 | • Partners Health to run reports via the TPP reporting unit and report to CCG quarterly | • |
|                   | Practices to provide guidance to patients on their website/ONLINE regarding who and see what conditions/ailments | Process for promoting to patients already in place  
- Personalised care plans  
- Text messaging  
- PPGs | • | • | JM/PH | April 17 | | |
<p>|                   | Maximise the use of booking on line appointments where appropriate | Installed GP Appointment utilisation tool as part of GPAF | • | • | JM/PH | April 17 | | |
|                   | | | | | | | | | |</p>
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<td><strong>Practices to maximise the use of assistive technologies</strong></td>
<td>• FLO – increase use of FLO to empower patients (and their carers) to take more control of their care through self-management</td>
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<td></td>
<td>• Flo not being used due to problems with interface with clinical system</td>
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<td></td>
<td>• Exploring patient self-care App/portal</td>
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<td>• Connectec Notts</td>
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<td>• From April 17</td>
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<td>• Shared working and joint approached wherever possible to maximise on the impact of AT</td>
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<td></td>
<td>• CCG scoping provision and viewing systems</td>
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