Strategy for Primary Care Transformation

Derbyshire and Nottinghamshire Area Team

Draft v10 April 2014

Information for the reader:

Document Purpose:	*The purpose of this document is to inform and communicate the detail for Derbyshire and Nottinghamshire Primary Care Strategy for our statutory and key partners. It is a professional facing document for Area Teams, CCGs, Patient Groups and Local Professional networks.*
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Please Note:

This document should be read in conjunction with Clinical Commissioning Group primary care plans, better care funds and Health and wellbeing strategies

This document has been co-produced and signed off by the following:

Dr Doug Black
Medical Director - AT

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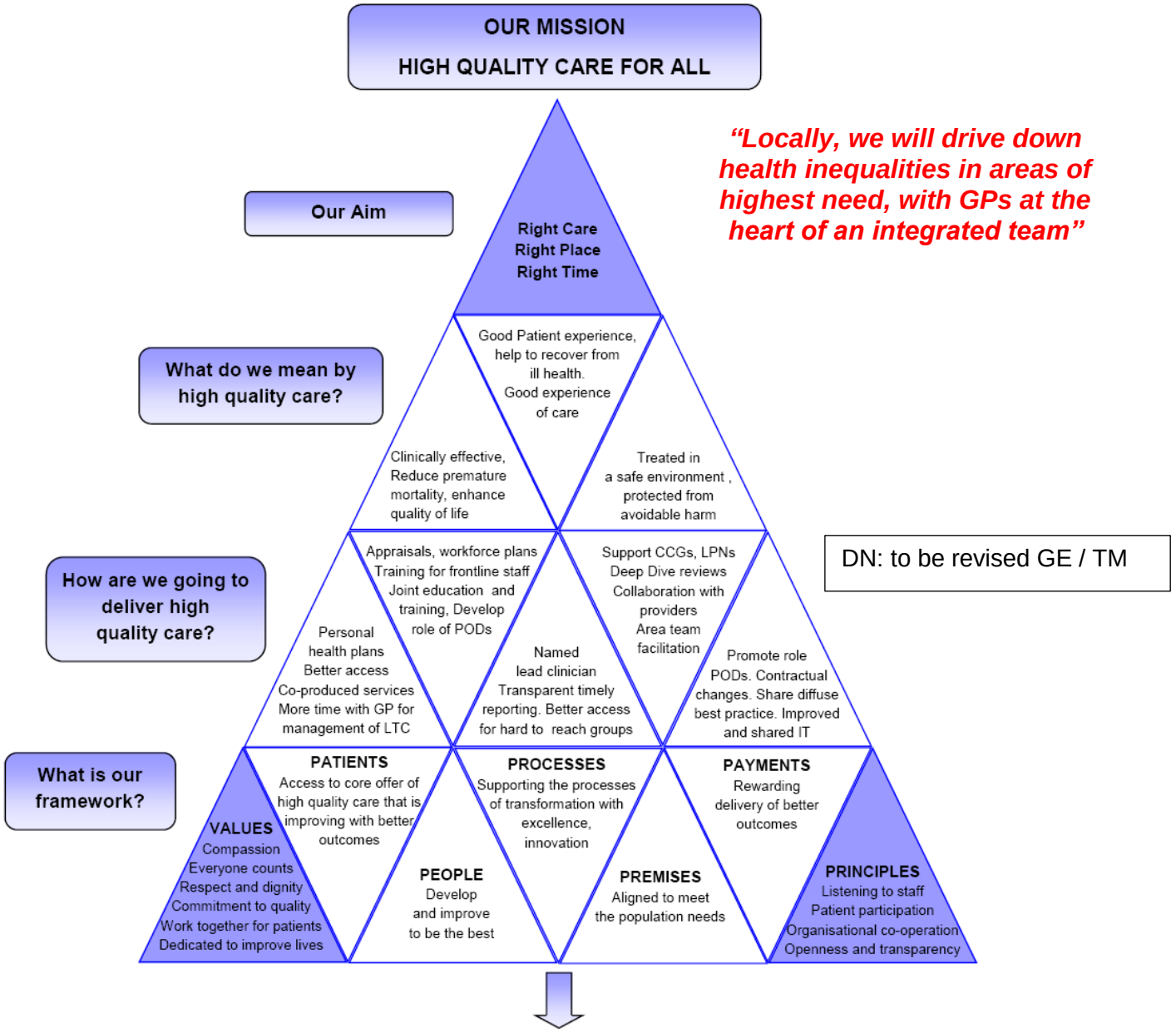
OUR MISSION



"Locally, we will drive down health inequalities in areas of highest need, with GPs at the heart of an integrated team"

DN: to be revised GE / TM

What we will measure:

- Patient survey on access, quality of consultation and care, complaints and incidents
- Number of vaccinations for those at risk
- % of Patient referrals for 2 weeks cancer appointments
- Number of patients with depression
- Number of eye test and dental check ups
- Number of patients with personal health plans
- Number of practices with workforce plans
- Number of patients using technology
- Number of practices with compliance to CQC
- A wide range of additional measures (43) as stated in our 5 ambition areas of Patients, People, Processes, Premises and Payments (Appendix X)

What does my healthcare feel like today…?

"I want to go, home I don't like hospitals can you come and see me at home?"

"We could help this patient without them going to see their GP"

"I'm really worried about my tests results but never seem to get to be able to see my Dr"

"I wish I could have spent more time with that patient"

"Why do I have to give my details every time I see another service?"

"If only I could have got this test done on Saturday"

"I wish I could spend time helping patients look after themselves more"

"I don't want to go to the Dr - it would be great if he could Face Time me"

What will my healthcare feel like in 2018/19…?

I have more time with those complex patients

I can Face Time my GP

I can get to see my Dr for an extended period and he helps me manage my long term condition better. I like my health plan

We help this patient without them going to see their GP

The Patient

I had my test done on Saturday, so it did not affect my work

I really like helping patients manage their health with their personal plans

I can leave hospital and get followed up at home

My care team have access to my records

DN: To be revised to include positives and show transition from now to 2019 more clearly

FOREWORD
AREA TEAM DIRECTOR

FOREWORD – AREA TEAM DIRECTOR

I am proud to introduce you to the primary care strategy for Derbyshire and Nottinghamshire for the period 2014 - 2019.

I hope that after reading about our plans to fundamentally transform the delivery of primary care services, that you will share our excitement for the real opportunities this provides us to deliver a better service for our patients and service users.

We all have a vested interest in how our primary care services (general practices, pharmacists, optometrists and dentists) are delivered. For example, we visit our general practitioner on average 5 times a year, and 95% of all NHS consultations are in primary care.

Through recent engagement with clinicians, our clinical commissioning groups (CCGs) and other partners, we have heard that primary care services are facing increasingly unsustainable pressures and that primary care wants and needs to transform the way it provides services to reflect these growing challenges. There is also a growing body of evidence, national and local, as well as supporting publications from policy makers highlighting the existence of these pressures[1,2,3]. There is unprecedented demand for primary care services, technology is changing rapidly, patients have increasing expectations, and there are economic challenges[x].

This strategy has been developed as a result of working hand in hand with our patients, staff, 10 local CCGs and member general practices, pharmacies, optometrist and dentists. It sets out the context and approach for transforming primary care for the benefit of our population in Derbyshire and Nottinghamshire. It follows our agreed strategic framework[4] which considers our plan based upon the five building blocks (5 Ps) of our healthcare system. These five building blocks are Patients, People, Premises, Processes and Payments. Our strategy will focus on the impact and development of these areas. We know that we cannot deliver the changes needed without aligning our plans with the wider health and social care community. We have worked together to ensure this strategy complements all other strategies and plans. The scope of this strategy is for primary care and CCGs and excludes the wider primary care elements, social care, secondary care and voluntary sector. Full integration plans are included in our partners strategies.

This strategy will describe the area and the ambitions we are setting for primary care over the next 5 years. The CCG are co-commissioners with a statutory duty to support the area team in improving quality of primary care. We know GP is the priority for transformation so we will firstly describe the GP context followed by the community pharmacy, optometry and dental (POD) plans. The CCGs are developing detailed plans for primary care and their overviews are included as appendices.

I do hope that you will take the time to read the remainder of the primary care strategy and join us in our combined efforts to improve the care that is provide to us all locally, in which each and every one of us has a vested interest.

Derek Bray
Area Team Director

DN: Insert graphic ?

VISION

PURPOSE AND VISION

The following section outlines the national picture and our local vision for primary care in Derbyshire and Nottinghamshire, and the improvements in outcomes.

The NHS England mission and vision is that "Everyone has greater control of their health and their wellbeing, supported to live longer, healthier lives by having access to high quality health and care services that are compassionate, inclusive and constantly improving".[2]

Our purpose is to create the culture and conditions for health and care services and staff to deliver the highest standard of care and ensure that valuable public resources are used effectively to get the best outcomes for individuals, communities and society for now and for future generations.

The local primary care vision of healthcare in Derbyshire and Nottinghamshire is being jointly developed by patients and stakeholders including CCGs and providers, Area Team and staff. We have set our sights high and started with the following as our early local vision:

"Everyone has greater control of their health and their wellbeing, supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and constantly improving".[2]

Aim

- The right care in the right place at the right time

Values

- Treated with respect and dignity
- Working together for patients
- Commitment to quality of care
- Dedicated to improving lives
- Shows compassion
- Ensure that everyone counts

Outcomes

- Target our biggest areas of health need - cardiovascular disease, mental health, diabetes, cancer, respiratory, life expectancy, inequalities and deprivation and improve these, year on year
- Deliver value for money to the taxpayer, and work more efficiently (QIPP)
- Improve access with wider primary care - at scale, under different models
- Shift care from secondary care to primary care
- Better partnerships
- Improved ways of working and job satisfaction

These aims, purpose and values are also central to the NHS England approach to care (Compassion in Practice) [3], NHS Mandate and outcomes framework (Appendix 1)

`I want to be able to go to my GP surgery, pharmacy, dentist or optician and have my needs met quickly and efficiently by a professional who knows what they are doing'

Patient - NHS Choices

PLAN ON A PAGE

SYSTEM VISION - PLAN ON A PAGE FOR PRIMARY CARE

Everyone has greater control over their health and their wellbeing, supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and constantly improving.

OUR AIM IS TO PROVIDE THE RIGHT CARE AT THE RIGHT PLACE AT THE RIGHT TIME

WHAT WE WILL DO

Ambition One

Improving primary care

Ensuring **Patients** have access to a core offer of high quality primary care that is continuously improving and delivering better health outcomes

Ambition Two

Developing and improving our **People** to be the best healthcare workforce

Ambition Three

Transforming primary care

Supporting the **Processes** of transformation by innovation, excellence in monitoring and evaluation, and development at pace and scale across primary care

Ambition Four

Our **Premises** will be aligned to meet the needs of the population

Ambition Five

Rewarding delivery of better outcomes

To develop the **Payments** and incentives system to reward improved outcomes and secure value for money

HOW WE WILL DO IT

- Co-production and engagement of patients and public in strategy, core and add-on services and implementation
- Evidence based health plans for all patients over 65 by 2016 for targeted groups to ensure parity of esteem
- Evidence based health plans for the population by 2019
- Longer, more comprehensive appointments for complex care
- Improved use of Technology
- Named lead clinician, GP, Pharmacist, Optometrist, Dentist
- Transparent, timely reporting of activity and outcomes
- Better access hard to reach groups, ensure parity of esteem

- Appraisals for all staff
- Workforce /organisation development plans at contractor level
- LETB/HEEM commissioned plans to increase trainees and develop new pre and post registrar programs/CPD
- Joint education and training across all professional groups
- Customer care training for all first contact staff
- Stakeholder co-production and engagement
- Increased training placements and training practices
- Develop role of pharmacy and dentistry in OOH, urgent care

AREA TEAM

- Systematic quality assurance framework for GPs, Pharmacists, Opticians, Dentists (PODs), including fitness to practice and revalidation
- Support CCGs to integrate other primary care contractors into local plans
- Support LPN's to deliver POD strategies
- AT programme management to facilitate fast track delivery
- Contractual changes to support new ways of working and transformation
- Evaluation of programmes delivered through CLAHRC
- Share, diffuse best practice through the Local Learning Collaborative, AHSN, Senate and Networks, LPNs
- Eye and Oral health needs assessment
- Promote role of community Pharmacist for health advice
- Improved, shared and responsive IT mechanisms
- Improve GP IT systems

DERBYSHIRE

- Patient Engagement
- Access 8-8 7 days, IT
- Integrated care
- Rightcare
- Care home support
- GP Federations
- Online booking
- Online registration
- Health Apps

NOTTINGHAMSHIRE

- Joint health and social care
- Engaged practice scheme
- Access 8-8 7 days IT
- Extended GP teams
- GP federations
- Extended hours
- GP at A & E and MIU
- Online booking
- Online registration
- Integrated care hubs

- Clear policy and guidance on future developments aligned to strategies at local level
- Identifying and monitoring position on all premises, taking account of developments, demographic changes, CQC compliance and strategic fit.

- Ensuring all baseline contract metrics are available at locality level
- Develop metrics to support change programmes
- QIPP programme management
- Reduce variation in payments across the area
- Annual review of MPIG, PMS review and discretionary payments
- Lobby and apply for nationally agreed payments
- Target transformation funds to primary care transformation
- Payments aligned to delivery of core contract elements

HOW WE WILL MONITOR AND EVALUATE

Overseen by governance arrangements:

- Area Team Corporate Management Group
- Area Team (AT) Strategy Steering Group
- Direct Commissioning Performance Group with Primary Care Assurance and Performance List Decision Panel Sub Groups
- AT Primary Care Implementation Group
- Primary Care Panel with professional representatives
- CCG and AT assurance meetings
- CCG Governing Bodies
- Health and Wellbeing boards

Measured using the following success criteria

GP

- Patient satisfaction of access care, consultations
- GPOS and HLIS
- New cancer cases 2 weeks
- Flu vaccinations for at risk
- Identification of depression
- CQC

Community Pharmacy

- Medicines optimisation
- Out of hours / urgent care
- Self care
- First contact
- Lead clinician

For all contractor groups

- Patient Engagement
- Min. of 10 deep dive reviews pa per contractor group
- Improvement in health outcomes top 5 health indicators
- Improved satisfaction consultation, care, access
- Plans to target inequalities, promote equity / parity of esteem
- % increase in use of Technology to improve access, and self -management
- Reduced number of practitioners under performance measures
- Reduced serious incidents and complaints
- Increase in workforce, decrease in leavers, workforce plan
- Learning shared and diffused at pace and scale
- QIPP Targets met for inappropriate use of care
- Increase in funding from redistribution to primary care
- Non-medical prescribers one per 5,000 population
- Improved record sharing for all provider groups

Dental

- Dental access % 24 month
- No of course treatments p 100,000
- GPPS % Positive experience
- Review and redirect pathways
- Increase access hard to reach
- RTT in secondary care

Optometry

- Eye test p 100,000
- % tints, % prisms per voucher
- % repairs per voucher and replacement
- Annual public health
- Review and redirect pathways

System values and principles

- Respect and dignity
- Working together for patients
- Committed to the quality of care
- Dedicated to improving lives
- Shows compassion
- Everyone counts

CONTEXT HEALTHCARE VIEWS

CONTEXT – HEALTHCARE VIEWs….

"It infuriates me when making an appointment with my local GP that we are limited to one or two ailments per appointment. The majority of us have to arrange appointments around work and other commitments.

Source: Patient - NHS Choices

I was so short of time at the end of surgery today, with the added pressure to do my home visits, my last patient, who had a shoulder problem, ended up being referred for an X-ray.

Source: Local GP

"GPs generally have two weeks training on eyes, optometrists have four years. Who do you think will give the best advice regarding eye health?"

Source: Eye health LPN

" There remains a significant unexploited potential for pharmaceutical care provided in community settings to alleviate GP workloads and improve health outcomes and service user satisfaction "

Source: RGCP

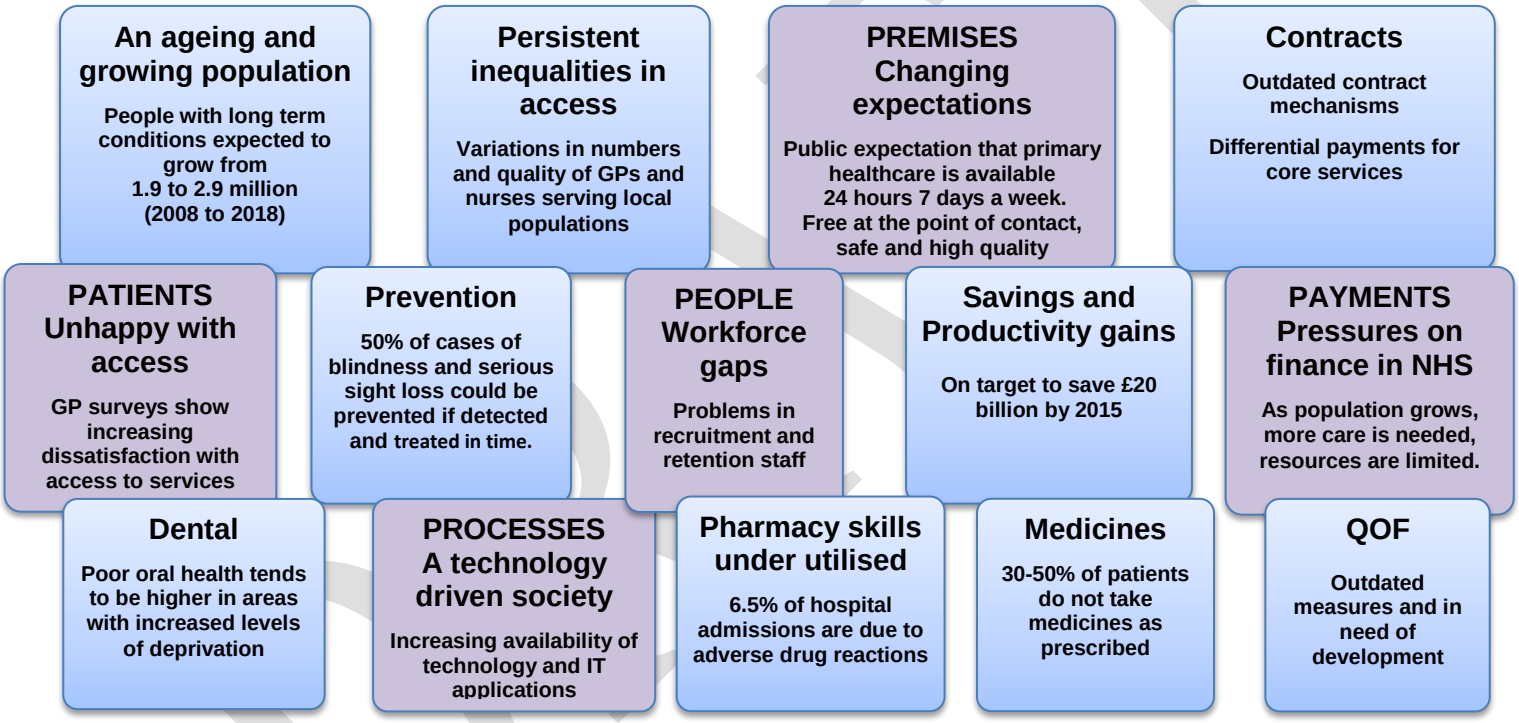
DN: Further quotations to be added and to be moved into main body of document into the appropriate section

CONTEXT – WHY WE NEED TO CHANGE

In this section, the current context and local population and the case for change will be articulated, including the challenges faced, and the views of patients, public, workforce and key partners .Our aims are to improve the quality of Primary care year on year. Whilst there is a significant emphasis on general practices, these improvements extend to pharmacy, eye care and dental.

There is compelling evidence for change in primary care. This evidence includes the findings and recommendations from a range of sources and national think tanks. These include the Winterbourne View hospital interim report: improving care of vulnerable people with learning disabilities (Department of Health, 2012), A promise to learn – a commitment to act: Improving the Safety of Patients in England National Advisory Group on the Safety of Patients in England (Berwick, NHS England, 2013 and the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013), Nuffield Trust and Kings Fund (Making General Practice fit for the future 2014).

We know from local engagement that the national case for change is reflected in our local communities, as described in our response to A Call to Action. Some of these issues include:



We are actively working with Patient Leaders, Patients Association, Healthwatch and all our providers and partners to address these themes in our transformational plans. These themes are reflected at all levels including CCGs, GPs, Pharmacists, Dentists and Optometrists, and their respective representative bodies. In addition our Call to Action engagement with the public, patients and partners has enabled us to capture a number of key themes[10] that support the clinical views emerging from within primary care that we can use as a platform for change.

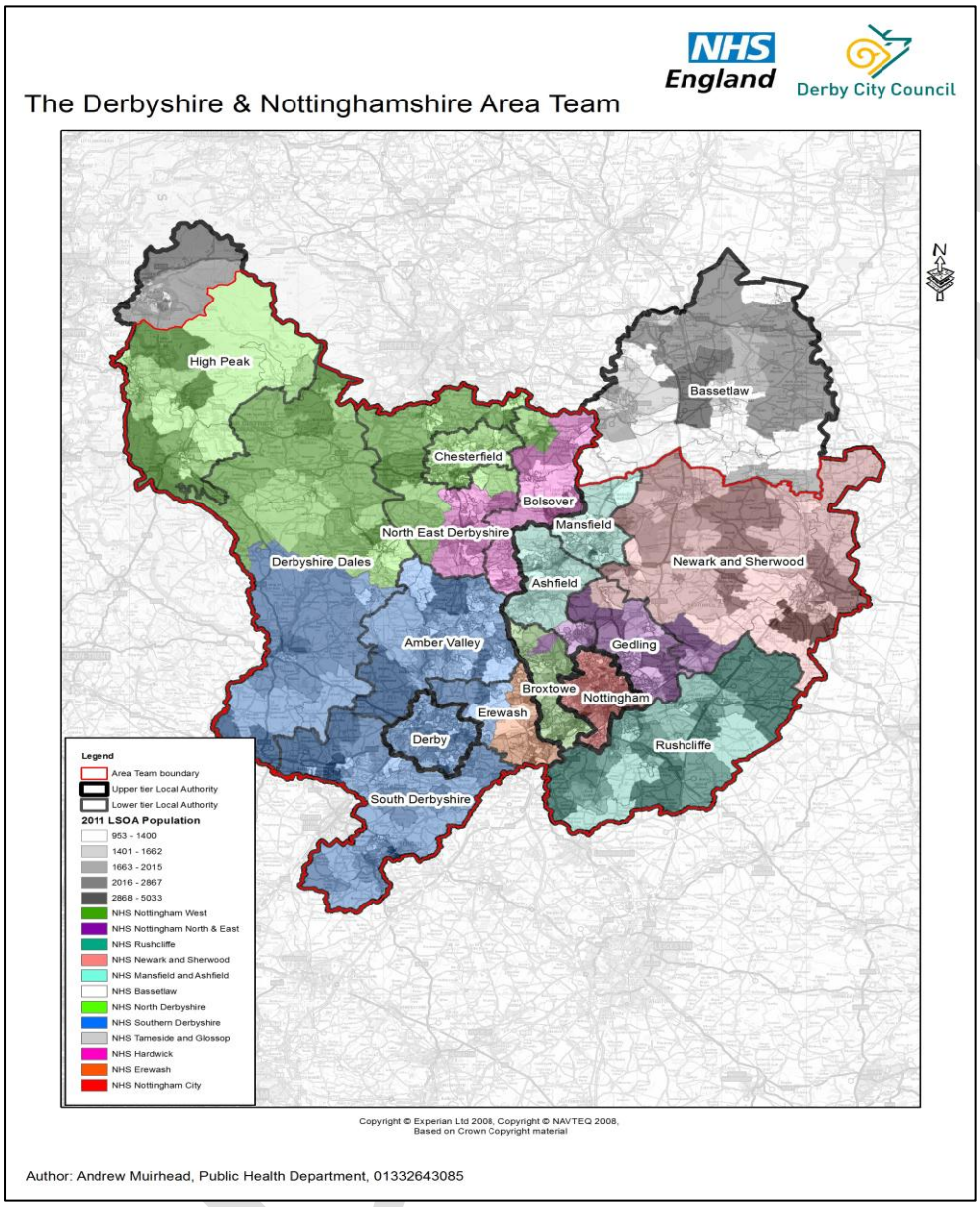
NHS England is governed by the NHS Constitution, which protects the principles of a comprehensive service providing high quality healthcare, free at the point of use for everyone. The constitution also says that the NHS belongs to the people and so does its future. In keeping with this principle, NHS England will be working together with staff, patients and the public to develop a series of new local approaches for the NHS to address the case for change.

The following pages describe key health indicators in the area.

CONTEXT
HEALTH NEEDS

HEALTH NEEDS DERBYSHIRE AND NOTTINGHAMSHIRE

The following pages describe the geography, population, physical health needs of the local area, highlight health issues and comment on associated contextual factors including deprivation, workforce, and where possible a comparison to the national picture.



List Size Population

- Total
- Men : Women Ratio
- Under 5
- Aged 65-75
- Aged 75+

Further detail please refer to Appendix X

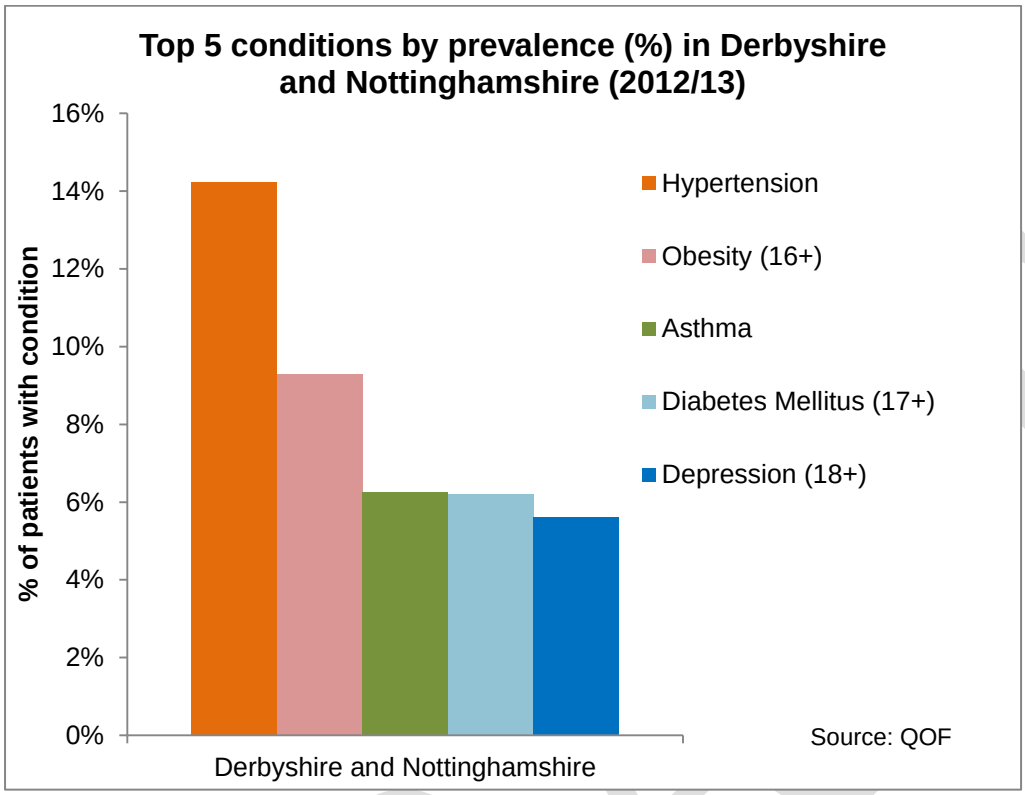
Our strategy starts with understanding where wev are now, which we will describe in the following pages. Then we will describe the processes that we are implementing to transfoirm primary care so that we can demonstrate how we will improve year on year. We will annually rrefresh the plans until 2018.

The following infoirmation describes where we are with our health today.

HEALTH NEEDS

HEALTH NEEDS DERBYSHIRE AND NOTTINGHAMSHIRE

The five most common conditions in Derbyshire and Nottinghamshire are Hypertension, Obesity, Asthma, Diabetes Mellitus and Depression.



DN: National comparisons

DN Clinical context to be provided to these trends

We have looked at how we are performing compared to the other 24 area teams that cover England. We aim to improve year on year so that our population can look forward to living longer, healthier lives and that we value mental health needs equally compared to physical health needs.

The following information describes our health in terms of disease prevalence in more detail, today, and shows how we compare to the National picture.

HEALTH NEEDS DERBYSHIRE AND NOTTINGHAMSHIRE continued

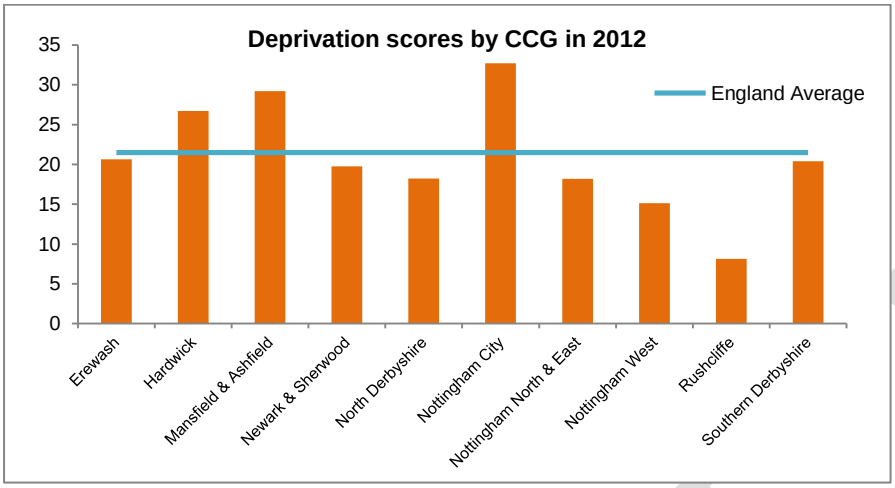
DN: PHE establishing an appropriate comparator area team to replace national ranking below

Derbyshire and Nottinghamshire	National	AT Relative Ranking
Cardiovascular Disease Hypertension • Prevalence 14.2% Strokes • Prevalence 1.8% Smoking • 18.6% Derbyshire 19.7% Nottinghamshire (E. Midlands 2011/12) Source: www.apho.org.uk	**Cardiovascular Disease** Hypertension • Prevalence 13.7% Strokes • Prevalence 1.7% Smoking • National = 13.3% Source: www.apho.org.uk	**Cardiovascular Disease** Hypertension - AT 11 / 25 Strokes - AT 14 / 25 Smoking - not available
Cancers • Prevalence 1.9% • 39,521 patients with cancer	**Cancers** • National = 1.9% • X patients with cancer	**Cancers** (AT 10/25) • AT 8 / 25
Respiratory Disease COPD • Prevalence 1.9% Asthma • Prevalence 6.3%	**Respiratory Disease** COPD • National = 1.7% Asthma • National = 6.0%	**Respiratory Disease** COPD - AT 15/25 Asthma - AT 12/25
Diabetes • Prevalence 6.2% • Lifestyle • Self-care	**Diabetes** • Prevalence 6.0%	**Diabetes** AT 16 / 25
Mental Health Depression • Prevalence 5.6% (ages 18+)	**Mental Health** Depression • Prevalence 6.0% (ages 18+)	**Mental Health** AT 6 / 25
Other Key Health Issues Kidney Disease • Prevalence 5.6% Obesity • Prevalence 11.3%	**Other Key Health Issues** Kidney Disease • Prevalence 4.3% Obesity • Prevalence 10.7%	**Other Key Health Issues** Kidney Disease AT 25 / 25 Obesity AT 14 / 25

DN Clinical comment required on overall statistics and rankings, Impact of smoking rates
Target improvements on outcomes – quantify if possible, put into 5 year position section

HEALTH NEEDS DERBYSHIRE AND NOTTINGHAMSHIRE

We have extracted and used data from JSNAs to inform us about the current state of our health locally. The following chart compares deprivation levels by CCG and to the national average:



Deprivation and Health

Relatively high levels of deprivation found in parts of Nottingham City, Mansfield and Ashfield and Hardwick, across all age groups.

Low levels of deprivation in Rushcliffe.

Higher deprivation is generally linked to poorer health.

Life expectancy:

Life expectancy at birth (Source ONS 2010/12)			
Men: England Average 79.20		**Women: England Average 83.04**	
Derby City	**78.6**	Derby City	**82.8**
Chesterfield	**77.7**	Chesterfield	**82.3**
Erewash	**79.8**	Erewash	**83.6**
N Derbyshire	**79.7**	N Derbyshire	**83.0**
S Derbyshire	**79.4**	S Derbyshire	**83.3**
Nottingham City	**76.9**	Nottingham City	**81.5**
Broxtowe	**80.0**	Broxtowe	**83.6**
Gedling	**80.5**	Gedling	**83.1**
Mansfield	**78.3**	Mansfield	**82.1**
Newark/Sherwood	**79.3**	Newark/Sherwood	**82.7**
Rushcliffe	**80.9**	Rushcliffe	**84.4**

Life Expectancy

- Women higher than men by average of 4 years
- Life expectancy lowest in City areas and areas of high deprivation
- Life expectancy highest in areas of lowest deprivation
- Life expectancy of women is worse than national average in 6 CCG areas

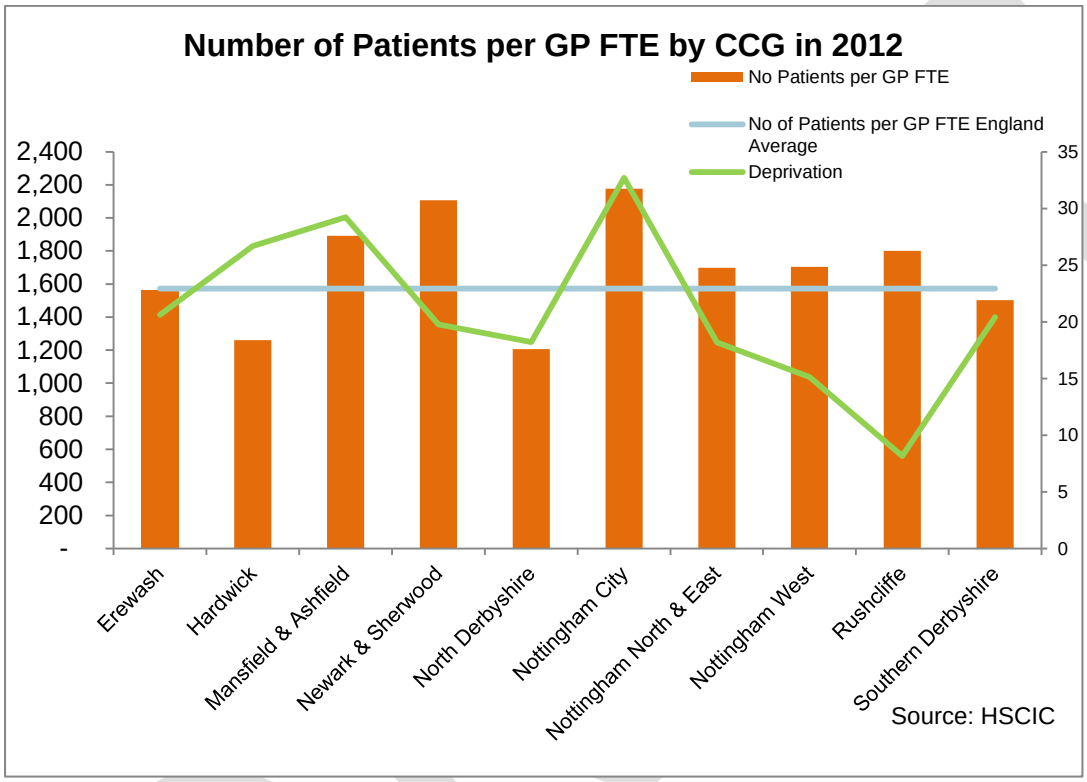
DN: Insert web links to HWB Boards and JSNAS
The following section highlights workforce issues in the area.

HEALTH NEEDS

CONTEXT – WORKFORCE General Practitioners (PEOPLE)

We are working to produce workforce data for all contractor groups, the following summarises the position for general practitioners in the local area.

The following graph of number of patients per GP FTE demonstrates the large discrepancies between CCGs in terms of workforce per patient. Nottingham City CCG has the highest number of patients per GP FTE (2,177). Furthermore, the deprivation score in the CCG is the highest one in Derbyshire and Nottinghamshire. Overall, Nottingham City, Newark & Sherwood, Mansfield & Ashfield, Nottingham NNE, Nottingham West and Rushcliffe all have higher numbers of patients per GP FTE than England average.



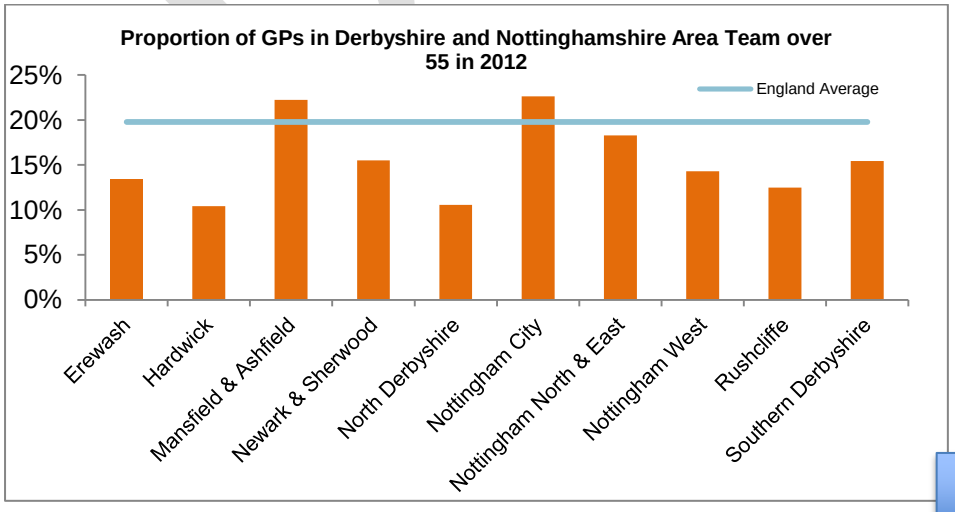
Demand for GP consultations

- Expected to grow by 4% pa
  DN Source tbc

Population growth of aged 85 and over

- Growth of 10% per annum in the last 3 years, expected increase of X consultations pa
  DN Source tbc

One important area of consideration is the age of practitioners in Derbyshire and Nottinghamshire. The graph below outlines the proportion of GPs over 55 years. In Derbyshire and Nottinghamshire 16% of practitioners are 55 years or older. The proportion is particularly high in Nottingham City (23%) and Mansfield & Ashfield (22%).



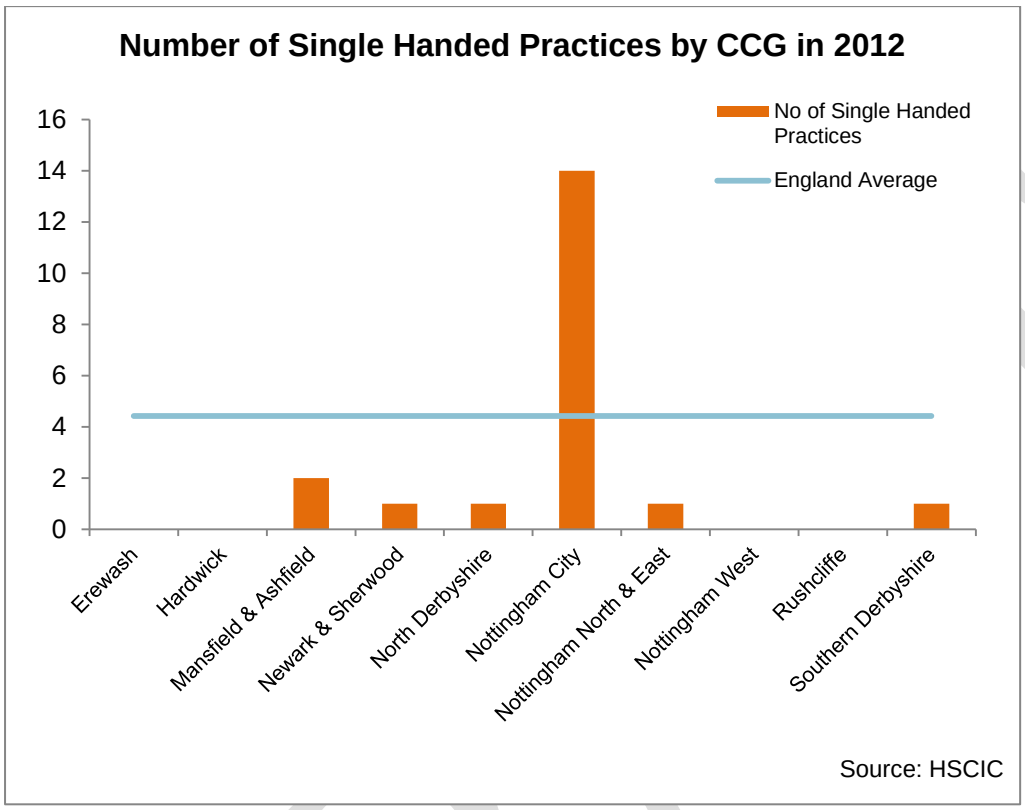
GPs aged 55 and over

- Nottingham City CCG and Mansfield and Ashfield CCG have higher than national average

HEALTH NEEDS

CONTEXT – WORKFORCE General Practitioners

Another important indicator is the number of single handed practices by CCG. Nottingham City has the highest number of single handed practices in Derbyshire and Nottinghamshire (14 out of overall 20). The age profile of GPs in single handed practices in Nottingham City CCG will be further explored in the section dedicated to Nottingham City CCG.



Single Handed GP Practices

- Nottingham City CCG has considerably higher than national average of single handed GP practices

This is important because as we aim to provide care closer to home, we need a primary care workforce that can deliver care more flexibly.

This is in the context of rising numbers of secondary care doctors compared to the numbers of primary care doctors (insert ref C2A GPs).

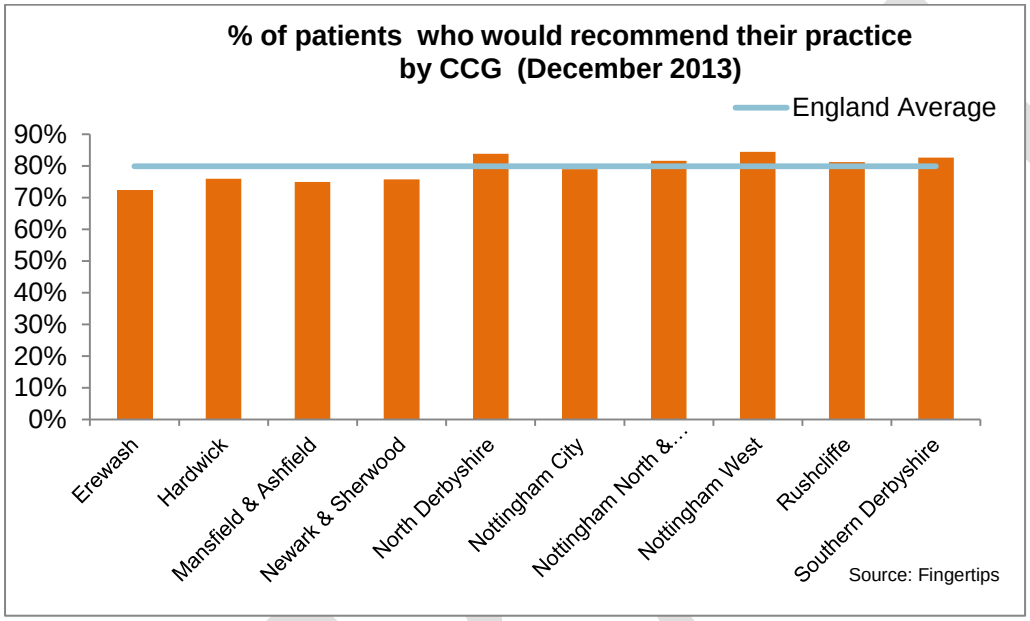
HEALTH NEEDS

CONTEXT – SATISFACTION WITH ACCESS TO GENERAL PRACTICE

Many people measure their experience of general practice through access. Overall, people of Derbyshire and Nottinghamshire enjoy good access, but we need to try to continuously improve this.

Access to primary care is currently measured through access to GPs using the patient survey. The following graphs provide insight into the performance of practices in Derbyshire and Nottinghamshire.

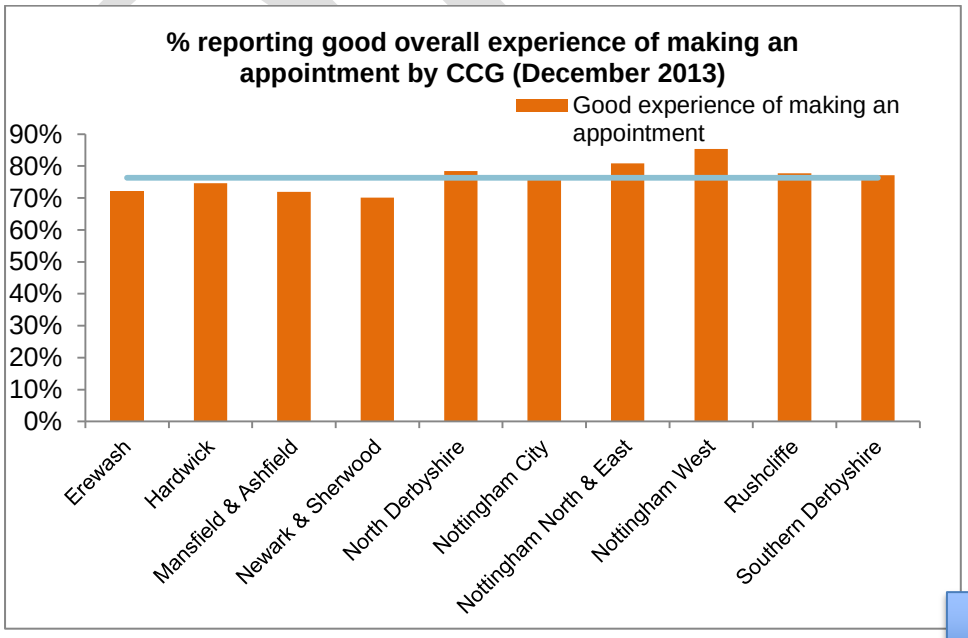
In the chart below, the percentage of patients who would recommend their practice is generally below the England average. A few exceptions are North Derbyshire CCG and Nottingham West CCG (84% of patients would recommend their practice).



Overall satisfaction for access

- In general the area is below the national average for patients who would recommend their practice

Overall, most CCGs are performing better than average on percentage of patients who report a good experience of making an appointment. Nottingham West, Nottingham NNE and North Derbyshire have particularly high patient satisfaction on this question.



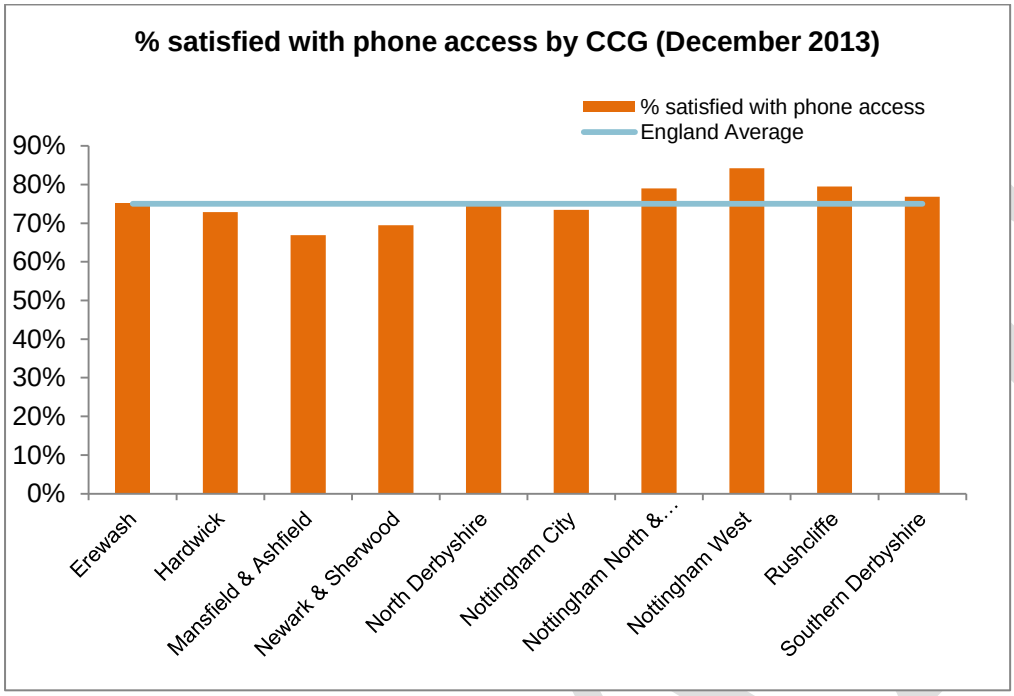
Overall satisfaction for experience of making appointments

- Above national average for reporting a good experience of making appointments

HEALTH NEEDS

CONTEXT – SATISFACTION WITH ACCESS TO GENERAL PRACTICE

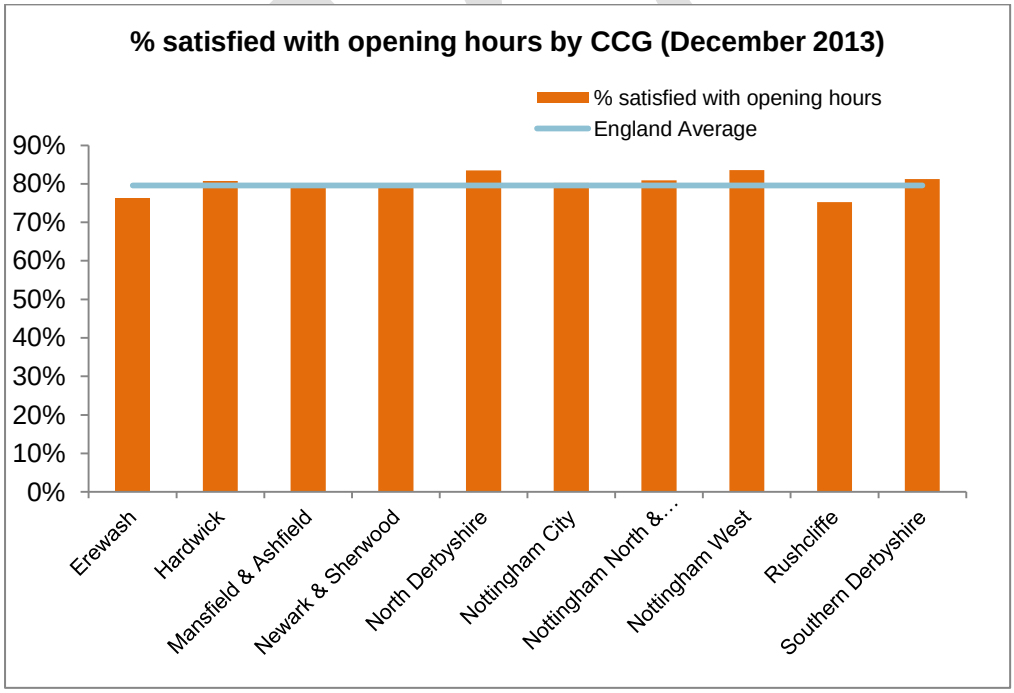
As shown on the graph below, several CCGs have below average satisfaction with phone access. In particular, Mansfield & Ashfield and Newark & Sherwood are 5% or more below the England average satisfaction.



Overall satisfaction for phone access

- On average similar to national picture with some local variation

Satisfaction with opening hours is close to the England average in all CCGs, apart from Rushcliffe and Erewash where satisfaction levels are slightly below average.



Overall satisfaction for opening hours

- On average very similar to national picture

PROVIDER CONTEXT

CONTEXT – DERBYSHIRE AND NOTTINGHAMSHIRE PRIMARY CARE PROVIDERS

The Derbyshire and Nottinghamshire Area Team are committed to patient led transformation and will commission services with the patient voice at the heart of decision making. There are four primary care contractor groups that provide primary care services. These are:

a. Medical (General Practice)
b. Pharmacy
c. Optometry
d. Dental

The following summarises Derbyshire and Nottinghamshire CCGs and practices:

Table 2 Source HSCIC as at Dec 1013

County	CCG Name	No. of GP Practices	Population	Pharmacy	Dental	Optometry
Derbyshire	NHS Erewash CCG	12	97,053	23	8	10
	NHS Hardwick CCG	16	102,207	24	7	5
	NHS North Derbyshire CCG	38	289,575	58	45	36
	NHS Southern Derbyshire CCG	57	537,030	113	60	49
Nottinghamshire	NHS Mansfield and Ashfield CCG	31	186,111	41	19	19
	NHS Newark and Sherwood CCG	16	129,334	26	12	13
	NHS Nottingham City CCG	65	357,889	65	46	32
	NHS Nottingham North, East CCG	21	147,190	28	18	11
	NHS Nottingham West CCG	12	94,043	27	16	12
	NHS Rushcliffe CCG	16	122,791	23	22	18
	Out of area or unknown			1	8	22
		284	**2,063,223**	**429**	**261**	**227**

(Provider listings are available on request)

GENERAL PRACTICE CONTRACTS
279 Contracts
£240 million

PHARMACY CONTRACTS
450 Contracts
£65 million

OPTOMETRY CONTRACTS
214 Contracts
£20 million

DENTAL CONTRACTS
248 Contracts
£82 million

PHARMACY, EYE CARE, DENTAL

COMMUNITY PHARMACY

There are over 11,400 community pharmacies in England; 1.6 million people visit a pharmacy each day, an average of 14 visits per person per year. Over 75 per cent of adults use the same pharmacy all the time. Pharmacies in England dispensed more than one billion prescription items in 2012, more than 2.7 million items per day. 99% of the population can get to a pharmacy within 20 minutes by car and 96% by walking or public transport.

Pharmacists are the third largest group of healthcare professionals in the NHS after nurses and doctors. NHS England Derbyshire and Nottinghamshire Area team directly commission community pharmacy services from 440 pharmacies across the geography. Community pharmacies offer the public open access to trusted health care professionals, across wide opening hours and operate in the heart of their local communities.

Pharmacists are experts in medicines use and their lead role in medicines optimisation has been recognised by the Government.

The current community pharmacy contractual framework consists of three tiers;

- **Essential services (dispensing prescriptions, repeat dispensing, disposal of waste medicines, self-care, signposting, promoting healthy lifestyles) and clinical governance** which are commissioned by NHS England and must be delivered by all contractors.
- **Advanced services** commissioned by NHS England, which can be delivered by all community pharmacies once accreditation requirements have been met. There are currently 4 advanced services medicines use review (MUR), the new medicines service, appliance use review and stoma customisation**.**

Delivery of community pharmacy essential and advanced services is monitored by the Area Team using the nationally agreed community pharmacy assurance framework.

- **Locally commissioned services** – which can be commissioned by NHS England, Clinical Commissioning Groups and Local Authorities in response to the needs of the local population. The Local Professional Network for pharmacy, hosted by the Area Team, will play a key role in ensuring that NHS England, CCGs and local authorities recognise the value and include community pharmacy in their commissioning plans and will provide the clinical expertise and input required to commission services from community pharmacy.

Eye Health

There are 214 optometry contracts across Derbyshire and Nottinghamshire with a value of £20 million and around 500 performers. There were around 400,000 General Ophthalmic Services (GOS) and 200,000 private eye examinations in 2013, (the GOS refers to an eye examination as a sight test). The budget for eye examinations and optical vouchers is centrally held and not limited. Contract compliance is monitored by the area team through the optometric advisor.

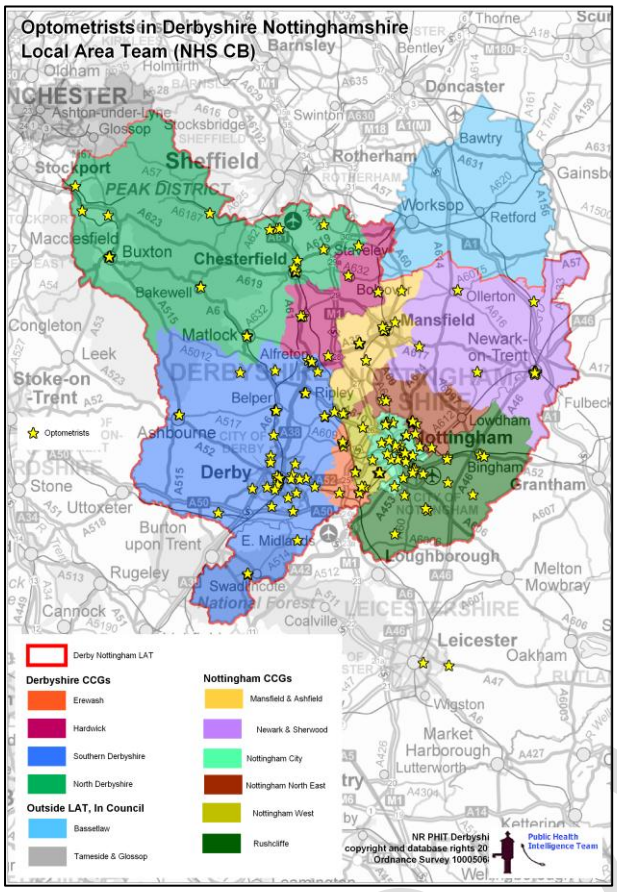
Dental Health

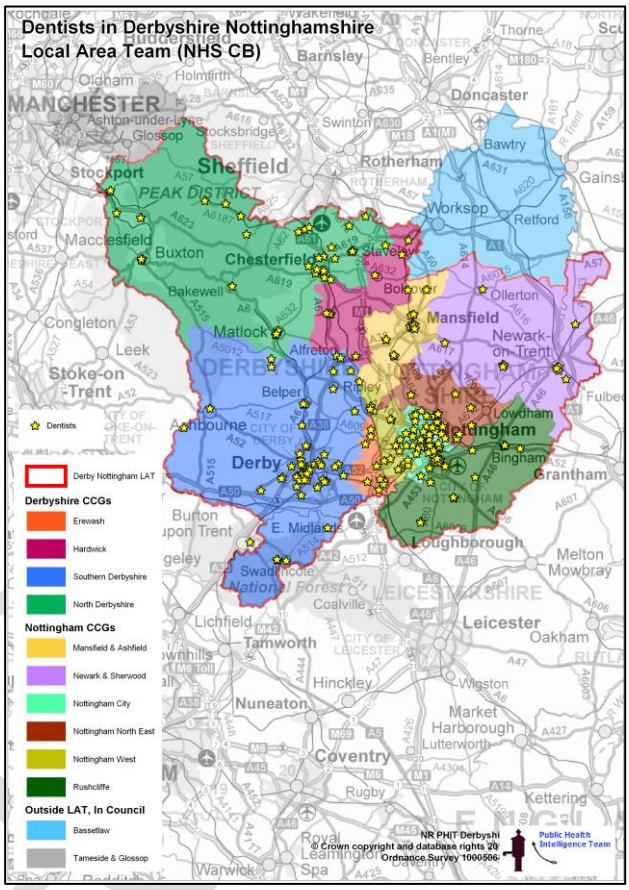
There are 248 dental contracts across Derbyshire and Nottinghamshire with a value of £82 million and around XX performers.

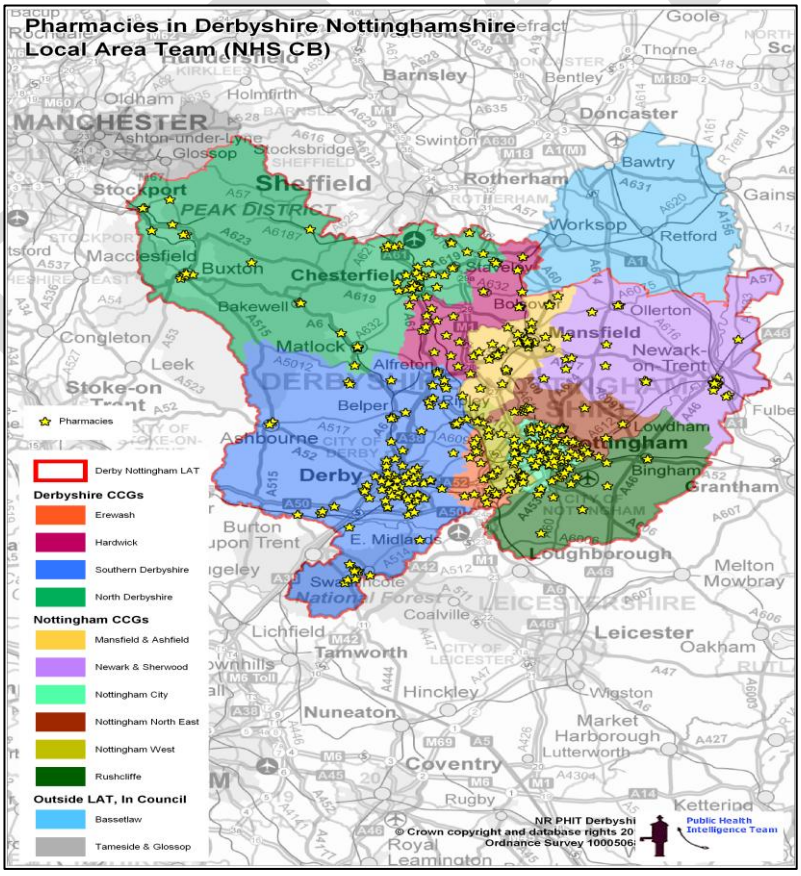
More detailed information on the LPN strategy for Community Pharmacy, Eye Health is available on request

CONTEXT
PROVIDER MAPS

Pharmacies, Dental, Optometry – Providers







CONTEXT
PREMISES

CONTEXT – PREMISES

DN: Proposal to include graphs on the following once baseline data has been validated, and to insert introductory text:

The following table summarises the numbers of premises that there are for general practices by CCG, and their status in terms of ownership and condition

CCG	No of Premises	No of Practices	Ownership	Condition	Comments
Hardwick	25		16 Owner Occupied 3 NHS Property Co 5 Lift Co 1 Unknown	0 A 18 B 1 B/C 6 Unknown	
Southern Derbyshire	76				

DN: Information gathering in progress

Number of premises and patients per premise by CCG

DN: Insert chart

CONTEXT PAYMENTS

DN: Proposal to include graphs on the following once baseline data has been validated:

Number of GMS, PMS and APMS contracts by CCG

Average payment per patient by contract type and CCG

Total payment to practices by contract type and CCG

Average payment to practices per contract type by CCG

AMBITION AND BUILDING BLOCKS OF STRATEGY (5Ps)

The next section will describe how we plan to deliver an improved primary care system.

We have worked with CCGs to agree an approach and how we will co-commission to align our plans with the wider system plans.

Our strategy is focused on addressing the key issues relating to 5 building blocks of our local primary healthcare system:

Patients – covering the whole population with a focus on quality and inequalities for those who don't access services

People – the workforce and how this is planned with patient and stakeholder involvement

Processes – how primary care will transform to deliver the improved outcomes within the context of Quality, Innovation, Prevention and Productivity. Additionally supporting emerging collaboration and different ways of working

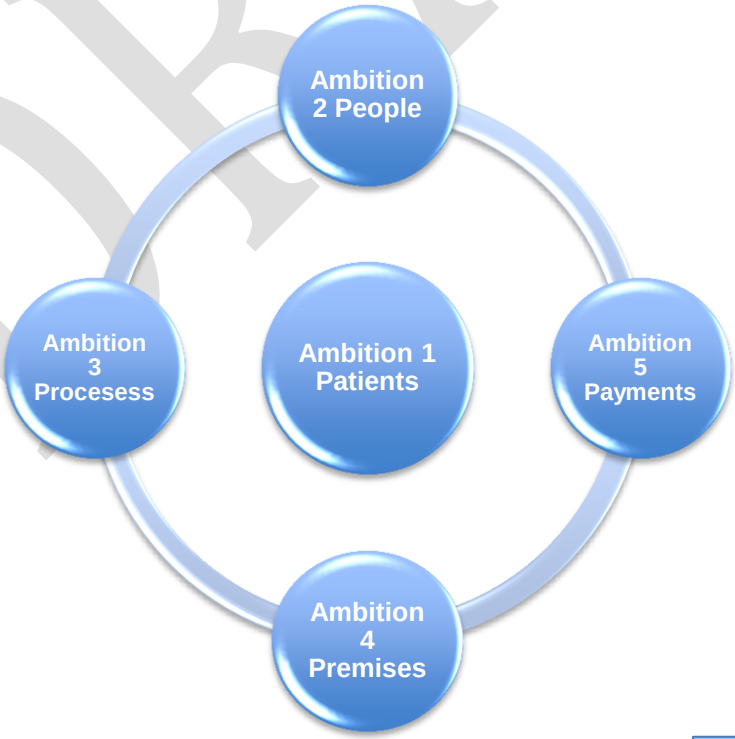
DELIVERY

We have granular two year implementation plans (See Appendix) which show in depth how we aim to deliver our ambitions. We will work hard in partnership with CCGs to deliver the strategy and develop a shared risk profile

Premises – fit for purpose, supporting the shift from secondary care with a golden thread to quality

Payments – to move resources from secondary to primary care settings

Working with our stakeholders we will set out our strategic intentions to asses focus and improve each of the building blocks ensuring that patients are a central focus in all that we do.



AMBITION 1 PATIENTS

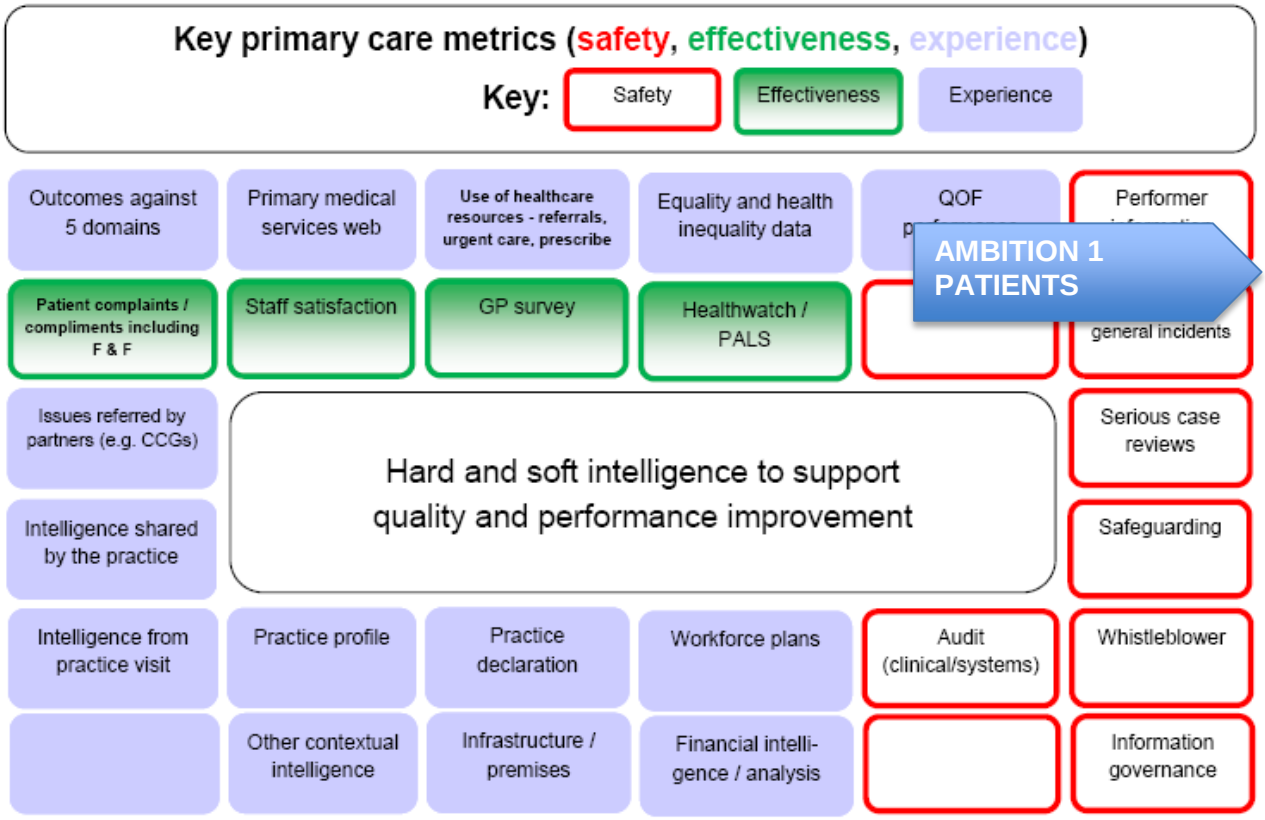
AMBITION 1 - PATIENTS

Ensuring patients have access to a core offer of high quality primary care that is continuously improving and delivering better health outcomes

The Area Team and CCGs are committed to improving quality and health outcomes for the population. Our approach to is to bring together a range of data sources to measure improvement.

These are shown in the diagram below:

The Primary Care Dashboard:



We will add metrics from our strategy into the dashboard to foster a culture of continuous improvements.

The area team has triangulated these sources and developed a RAG rating for General Practices. This will be followed by a similar rating for PODs. This allows the area team to identify those practices and contractors who require additional support to drive up overall quality. This will be transacted in deep dive reviews. Deep dive reviews will be undertaken with CCGs. We describe this process further in ambition 3 (processes).

We will be working with Public Health England to improve locality health outcomes as described in Everyone Counts. We will work to reduce health inequalities, improve integration and parity of esteem. A range of actions are supported by a detailed implementation plan (Appendix x).

AMBITION 1 PATIENTS

AMBITION 1 continued

Action	Links
Improved access to high quality primary care, including satisfaction with consultation and care	CCG plans and Units of Planning
Personal Health Plans (PHP) targeted at high risk groups and on areas requiring improvement in outcomes – cancer, CVD, diabetes, mental health, inequalities, deprivation PHP to agree the interventions required to maintain and improve health across : • Establish review dates and how and where to access care appropriately • Provide technology solutions • Agree self-management plans • Agree other agencies required to support health and wellbeing • Empowering patients to take more control of their long term health where they are in a position to do so. They will be directed to the most appropriate professional under the primary care team. • Empowering carers to assist and support patients to take control of their health • Ensure PHP links with End of Life care • Provide a public health activity plan • Confirm arrangements for any hospital care to ensure this is appropriate and does not result in delayed discharge, including why specialist centres are the best choice for certain conditions. See Appendix for more detail	Better Care Fund plans, CCG plans and Units of Planning
Increased access to dental and eye care for low income groups targeted via needs assessment, improving oral health in deprived communities	Sustainable, Resilient, Healthy People & Places A Sustainable Development Strategy for the NHS, Public Health and Social Care January 2014.
Develop community pharmacy services to support patients with long term conditions	Better Care Fund plans, CCG plans and Units of Planning
Develop pilot projects for prescribing community pharmacists to link up with GP practices, to undertake clinical medication review of specific patient groups.	
Increased medication optimisation and safety: • to ensure learning from significant untoward events involving medicines is shared • Report errors and incidents to the NRLS • take part in the anticipated national incident reporting scheme for community pharmacy • consistent key messages around safe handling of medicines with primary and secondary care colleagues • develop strategies to ensure safer use of high risk medicines safer for patients e.g Insulin / Opiates	Berwick Report (2013)
Parity of esteem - we will ensure that all patients from whatever groups receive parity of service provision. Patients with mental health needs will be provided with the same levels of care as those with physical health needs.	

AMBITION 1 PATIENTS

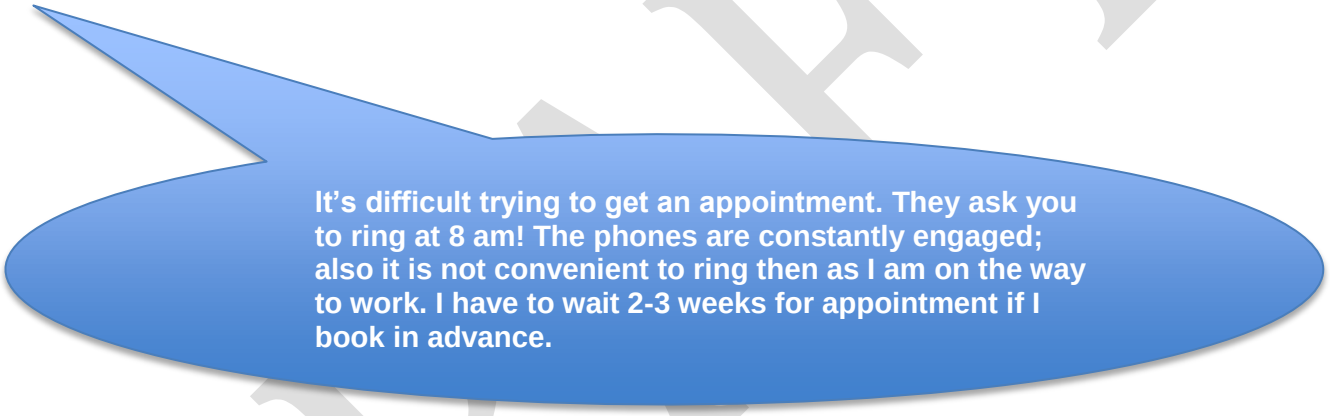
AMBITION 1 – Patients continued

We will continually engage with patients to foster trust in our services and to improve service performance.

Our recent Call to Action (ref) engagement activities identified the following key themes that we will seek to address and improve (see appendix):

- Information for patients
- Education for patients
- Integrated health and social care
- Improved access
- Improvements in communications
- Better access to urgent care
- Other areas such as improved and increased use of technology

Patient – Healthwatch Derby



DN: Insert more comments

AMBITION 2
PEOPLE

AMBITION 2 - PEOPLE (WORKFORCE)

Developing and improving our People to be the best healthcare workforce.

The clinical workforce is responsible for delivering high quality care, and the NHS workforce constitutes some 80% of the healthcare budget. The Area Team is working with the Local Education and Training Committees, the royal colleges representatives, CCG clinical leads, chairs of the Local Professional Networks (LPNs) and representative committees to agree a workforce plan that is responsive and aligned to current and future plans.

By working with the workforce lead in each CCG, the primary care workforce plan is aligned to commissioning plans, providing detailed scenario planning on best and worst case shifts of activity. We have a comprehensive patient and stakeholder engagement plan, and will agree the plan for support with Local Education and Training Committees (LETC).

The National Health Service (Performers Lists) (England) Regulations 2013 entrusts the responsibility for managing the England performers lists (medical, dental and ophthalmic) to NHS England as the commissioner of primary care services. The Area Team maintains the performers lists which includes all the primary care contractor groups but excludes support staff such as nurses. Each of the performers groups is also separately governed by their respective professional regulator and the Care Quality Commission (CQC).

The Area Team has a robust revalidation and fitness for practice system to quality assure primary care contractors. For GPs this demonstrates that doctors on the GP or Specialist Register are continuing to meet the standards that apply to their medical specialty or area of practice and continue to deliver high standards of care to patients. Through annual appraisal it promotes Continuing Professional Development amongst GPs by encouraging improvement in the quality of care, patient safety, team-working, communications and appropriate behaviour.

For nursing and allied health professionals a code of conduct applies as part of their registration with their professional body. This upholds quality standards that must be adhered to.

Expected Outcomes

- Granular workforce plans owned by each CCG and commissioned
- Early support for practitioners who have been identified as underperforming
- Reduction in avoidable harm
- 100% of workforce have Personal Development Reviews (PDRs) appraisals aligned to the NHS Constitution and Compassion in Practice (Francis, 2013)
- 100% of practice staff undertaking training for mandatory training, first contact and customer care (Francis, 2012)
- Increase in list of medical and non-medical trainees in primary care from baseline between contractors / providers
- Increase in research activity by 30% from baseline
- Joint training programmes between contractors/providers
- One non-medical prescriber per 5,000 registered population per practice with increased opportunities for developing community pharmacists as independent prescribers
- All pharmacies have a trained member of staff accredited as a Healthy Living Champion
- Engage with community pharmacy, LPCs, contractors, community pharmacists, technicians, dispensing assistants, medicines counter assistants and a range of stakeholders to capture their views to contribute to the national debate
- Workforce profile aligned to need and demand
- Stakeholder co-design and sign up to work force plan

AMBITION 2 – PEOPLE continued

Action	Links
Promoting the role of the community pharmacist as the first port of call	CCG plans and Units of Planning Winter and Urgent Care Plans
Pharmacists working with CCGs and out-of-hours services	
Rolling out of the emergency supply of medicines service	
Increased pharmacy involvement and/or leadership of clinical case-loads	
Improve communication between secondary care and community pharmacists	

We need to foster improvements in clinical leadership and promote a positive culture in primary care. We need to engage and communicate better with our workforce.

Our recent engagement through Call to Action highlighted a number of key themes relating to our people that we will seek to address and improve (see Appendix):

- Information for patients
- Education for patients
- Integrated health and social care
- Improved access
- Improvements in communications
- Better access to urgent care
- Other areas such as improved and increased use of technology

AMBITION 2 - PEOPLE

Dr. James Betteridge - GP Registrar

GPs have always had to train in a variety of hospital specialities but why not the other way around?

This need not include exposure to all of primary care but why not take a Geriatric Registrar out of hospital for 6 months and second them to primary care where they have a remit only to consult with patients over 70?

Or a Paediatric Registrar that does a GP clinic of only age under 18s once per week…

Source: Local Professional Network

'If the professions are to work together to deliver new models of primary care, training and CPD should be delivered to multidisciplinary groups of independent contractors as many of the skills we require are common to us all'

Source: Eye Health Local Professional Network

"Elderly patients often travel long distances to attend routine out-patient appointments for many eye conditions, often passing on their way number of optometric practices, where the professional has the skills and equipment to do exactly the same job.

Why don't we make it easier for patients?"

DN: Insert more comments

AMBITION 3 PROCESSES

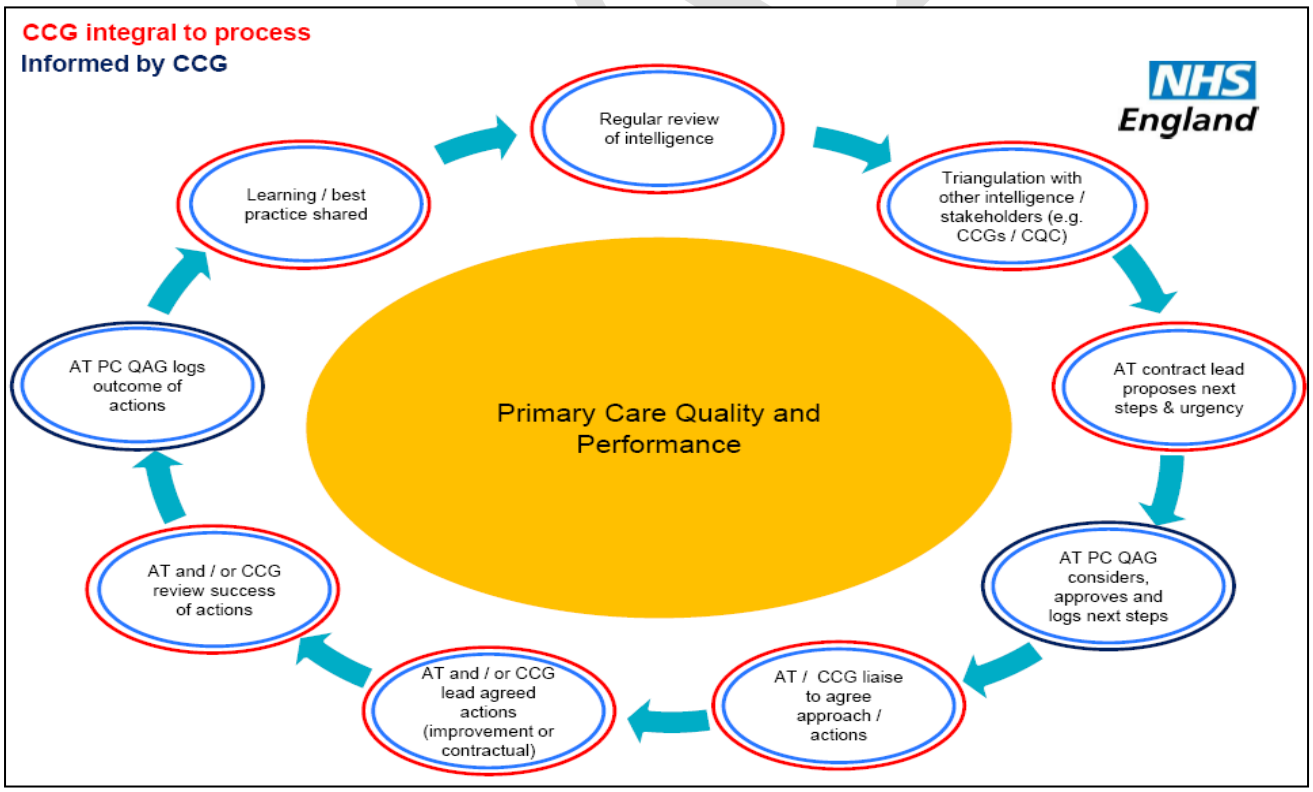
AMBITION 3 – PROCESSES

Supporting the processes of transformation by innovation, excellence in monitoring and evaluation, and development at pace and scale across primary care

The Area Team has established a co-commissioner arrangement with the CCGs to align the processes that will deliver improved outcomes for the population. This approach includes the improving quality across the contractor groups with agreed principles:

- Shared commitment to improving quality and ensuring that our collective resources secure a sustainable NHS.
- Maintaining a clear distinction between quality monitoring (performance assurance) and quality improvement (transformation).
- Jointly building momentum for change and liberate primary care practices/contractors as long as they are delivering contract.
- Ensuring clinical leadership of and patient/public participation in quality improvement.
- Respecting each other as independent statutory organisations.
- Partnership working and sharing between AT and CCGs on common themes (e.g. urgent care)
- Openness, transparency and effective communication ensuring 'no surprises'.
- Accounting to each other for areas of lead responsibility.
- Sharing and triangulating a broad range of quantitative and qualitative intelligence from the dashboard to accurately inform quality improvement in primary care, delivered through deep dive reviews

This approach to deep dive reviews is captured in the diagram below:



AMBITION 3 – Processes continued

Expected outcomes

- Co-production and implementation of a personal health plan for all over 65s (and/or targeted population), funded through local incentive scheme
- Secure improved, responsive and shared Information Technology (IT) system
- Supporting practices and CCGs to be innovative and deliver transformational change, at pace and scale
- Agreement to 'opt out' of any pilot contractual arrangements
- Evaluation across the area working with key academic partners
- Aligning the system to ensure delivery of success and provide assurance
- Diffusion at pace and scale, sharing through the Local Learning Collaborative, AHSN, Senate and Networks

Action	Links
Rolling out of the emergency supply of medicines service	CCG plans and Units of Planning Winter and Urgent Care Plans
Securing community pharmacy access to summary care records	
Maintain and develop the Pharmacy First Minor Ailment Scheme	
Improve medicines adherence / concordance	
Scope and establish innovative methods to reduce the amount of medicines waste	
Increase the use of repeat dispensing within the electronic prescription	
Minimise the volume of unused medicines ordered and disposed of from care homes	
Build on the medicines use review (MUR) and NMS to support long term conditions management	
Develop and implement the Healthy Living Pharmacy concept	
Provision of domiciliary medicines use review	

AMBITION 4
PREMISES

AMBITION 4 - PREMISES

Our premises will be aligned to meet the needs of the population

Introduction

NHS England expects GPs, dentists, pharmacists and optometrists to deliver services from high quality, fit for purpose and sustainable premises.

The Derbyshire and Nottinghamshire Area Team and CCGs' strategies should result in a shift of appropriate hospital services into primary and community settings. They also signal greater use of innovative technology to deliver care and support self - care, for example using technology similar to Skype for patient appointments.

The development of premises therefore needs to address both the quality of premise, but also align with and support the Area Team and CCGs' strategies.

Dental, optometry and pharmacies are responsible for ensuring that the premises they deliver services from are compliant and well maintained.

Whilst GPs are responsible for their premises, one of the functions of the Area Team is to reimburse GPs for rent, rates and clinical waste services and invest in new GP premises and premise improvements.

In order to make sure that the Area Team is investing in the right GP premise developments the current estate must be assessed and solutions developed in line with the overall system objectives. When considering the option of a new development the Area Team will look to solutions that are innovative, make best use of existing public sector estate, demonstrate value for money and ideally deliver savings within the health economy.

Expected outcomes

- All current premises and developments fit with strategic direction and demographics
- Practices/premises numbers in line with movement of secondary care services and growth in self-management
- Co-developed plans with CCGs that target:
  - Equality
  - Inequality
  - Access
- Patient and local clinical engagement in co-production at early planning stages
- All premises statutorily (including CQC) compliant.
- Sustainable for the future
- Identifies economies of scale

GP Premise Development Process

Work is ongoing nationally to address the premises issues inherited by NHS England and a process for evaluating business cases is being developed to enable Area Teams to make informed decisions, making best use of public money. Within this process it is anticipated that business cases will be considered and weighted against set criteria to enable proposals to be benchmarked and approved to deliver solutions in the areas of greatest need.

PREMISES – continued

Before the Area Team considers a new build we would expect the following options to be looked at internally by the practices:

- Room utilisation audit and evidence of the outcomes being implemented
- Workforce implications
- Population implications
- Compliance implications
- Consider options for flexibility – extension of hours, different configuration of services, staggered surgeries etc.

Once the above options have been explored and it is agreed that a new build is the only solution a business case will be submitted for consideration.

NHS Property Services (NHS PS) were set up primarily to manage the premises that were previously owned or leased by PCTs and they have taken on a landlord role for the tenants located in the buildings. They will also act as technical advisors to the Area Teams in their consideration of business cases and attended design meetings as required to provide professional advice. A service level agreement is being drafted between NHS England and NHS PS detailing the responsibilities for each organisation.

Practices that are located within NHS PS buildings will be charged rent for the space occupied and the Area Team will reimburse the practices for space used to undertake core contract services. If there is any void space within these buildings then the commissioner will be responsible for the rent of the buildings until a new tenant is found. As we could be paying for vacate space it is essential that we understand what space is available within the local NHS estate before approving new developments.

To ensure that primary care is delivered from safe, compliant premises we have compiled a capital plan that will be refreshed and updated in line with national directives and our strategy.

Strengthen this with best use of estate, align with premises national framework and ben dyson paper

£Investment from 2 care to 1 care to afford changes

AMBITION 5 - PAYMENTS

To develop the payments and incentives system to reward improved outcomes and secure value for money

The Area Team is responsible for administrating the payments for the national and local negotiated contracts for primary care, including General Medical Services, Personal Medical Services, General Dental Services, General Optometry Services and General Pharmacy Services.

As we move to improve health outcomes we aim to ensure that the payment system is aligned. The shift of services from secondary to primary care is a shared objective of all CCGs. The system needs to allow resources to follow the patient.

This ambition is linked to ambitions 1 – 4:

Expected outcomes

- Reduction in variation of payment
- A local incentive scheme in return for delivery of the measures outlined in objectives/interventions outlined above with better quality and value for money
- Funding flows to practices and other contractors and primary care at locality level
- Transformational resources aligned to progress

DN: More information from Finance and check position with enhanced service contracts in optometry – different pay mechanism

DN: Map all QIPP to strategy actions

AREA TEAM PLANS
Common themes for Area Team Support

All CCGs have primary care plans and underpinning business cases for transforming General Practice and wider primary care aligned to the CCG plan and Better Care Fund (BCF).

These plans set out transformational aspirations for the next 5 years, full details can be found in the links section at the end of this strategy document.

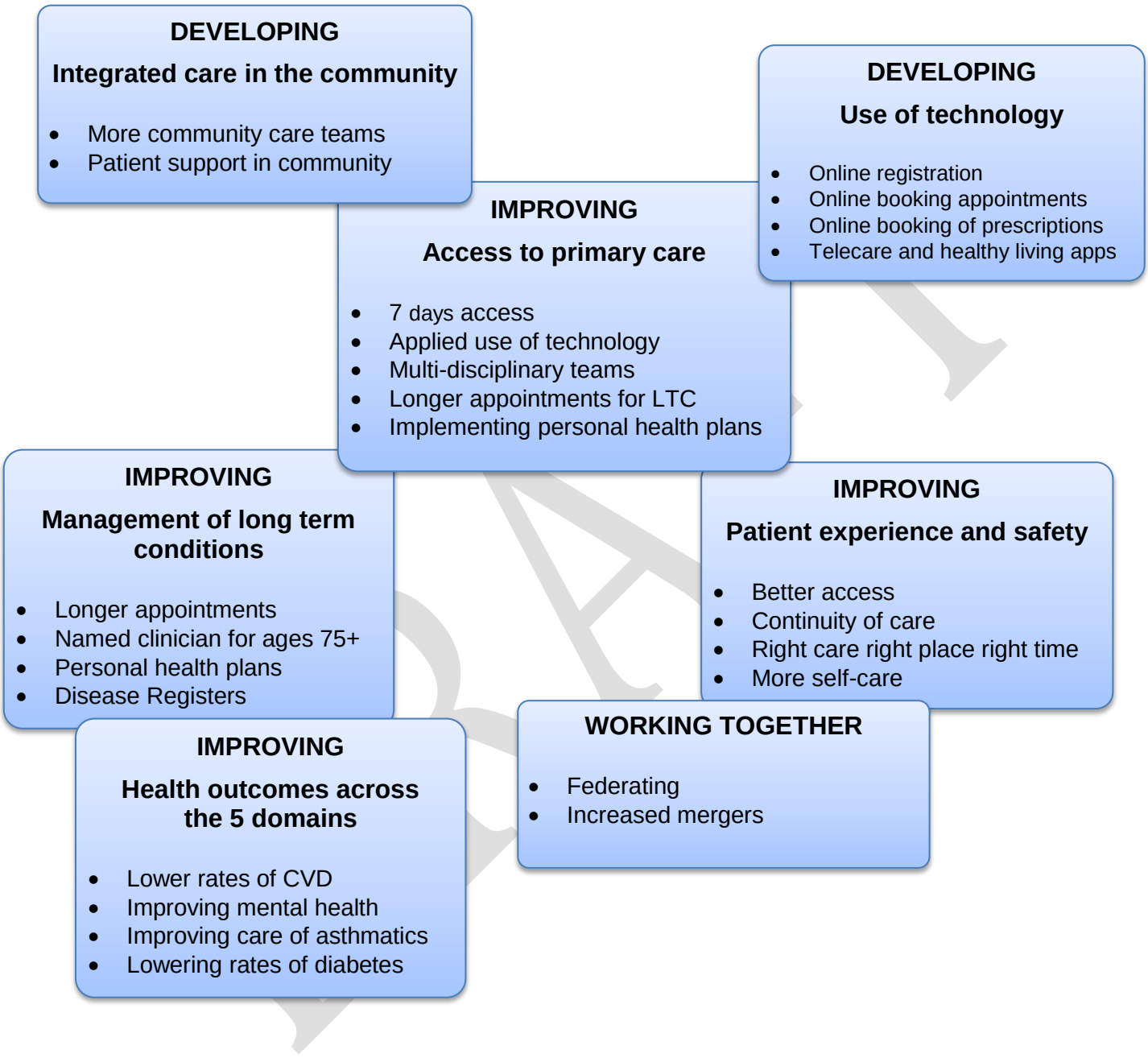
From these plans, a number of common themes are emerging as priorities for the Area Team, for implementation across all ten CCGs.

AREA TEAM PROCESSES

- Co-production and implementation of a health plan for all over 65s (or targeted population)
- Supporting practices and CCGs to be innovative and deliver transformational change
- Agreement for practices to 'opt out' of any pilot contractual arrangements
- Project support and oversight
- Evaluation across the area via CLAHRC
- Aligning the system with LETBs
- Diffusion at pace and scale, sharing through the Local Learning Collaborative, AHSN, Senate and Networks
- Assurance to the public and key stakeholders

LOCAL INITIATIVES

Our strategy is aligned to the CCG plans that have common themes and objectives around access, developing multi-disciplinary teams, technology and improving patient experience



Each CCG has developed its own plan in the form of a local primary care strategy and the following section highlights the key elements of these. Detailed CCG primary care plans are being developed in line with health and social care strategic and better care fund plans.

CCG PLANS
LOCAL INITIATIVES

LOCAL INITIATIVES - CCG PLANS

Patients have told us what they want to see, we therefore have a number of agreed actions to significantly transform the GP services.

These actions create **a compelling picture of how general practice can be improved** across a large population, at speed, and delivering value for money. Our patients will be able to choose to

- Access their general practice from 8am–8pm including access to routine and urgent appointments on Saturday/Sunday
- Have a variety of ways to communicate with their practices, including access to email, Skype and phone consultations according to their choice
- Request electronic prescriptions and use online booking for appointments
- Use on-line registration for their general practice, and have a greater choice of practice
- Have access to joined-up urgent care and out-of-hours care
- Have greater flexibility in how they access general practice
- Use telecare to help manage their conditions in their own homes, including using healthy living apps

Our premise is straightforward. **The member practices will implement an action plan, and quickly deliver local improvements in patient care**. This will be supported by a rigorous framework of evaluation and a primary care learning collaborative to roll out, at pace and scale, the improvements which we've made in one area to the rest of Derbyshire & Nottinghamshire, so not only will patients see the benefits in the areas they'd requested, they will also see improvements based on the projects carried out in other areas.

Dr Ian Matthews, Deputy Medical Director, Area Team and local GP articulates this vision

"…if successful this submission would produce high quality, innovative and accessible general practice services for the people of Derbyshire and Nottinghamshire, with a commitment to roll out our successes to see this vision achieved quickly for our entire population"

Having involved so many general practices and patients across the two counties, this brings the opportunity to test new models for general practice identified, namely;

- More integrated approach to providing general practice and wider out-of-hospital services **with the GP at the heart of the team, with opportunities for staff to rotate between hospital and community services.**
- A more integrated approach to providing urgent care services across a local health economy **including GPs integrated at our A&E departments**
- Extending choice by enabling practices to grow their lists, taking on patients from outside traditional boundary areas, **with GPs sharing information, where patients choose this.**
- More innovative ways for people to access and relate to general practice, **with GPs providing services which would have been previously delivered in a hospital.**

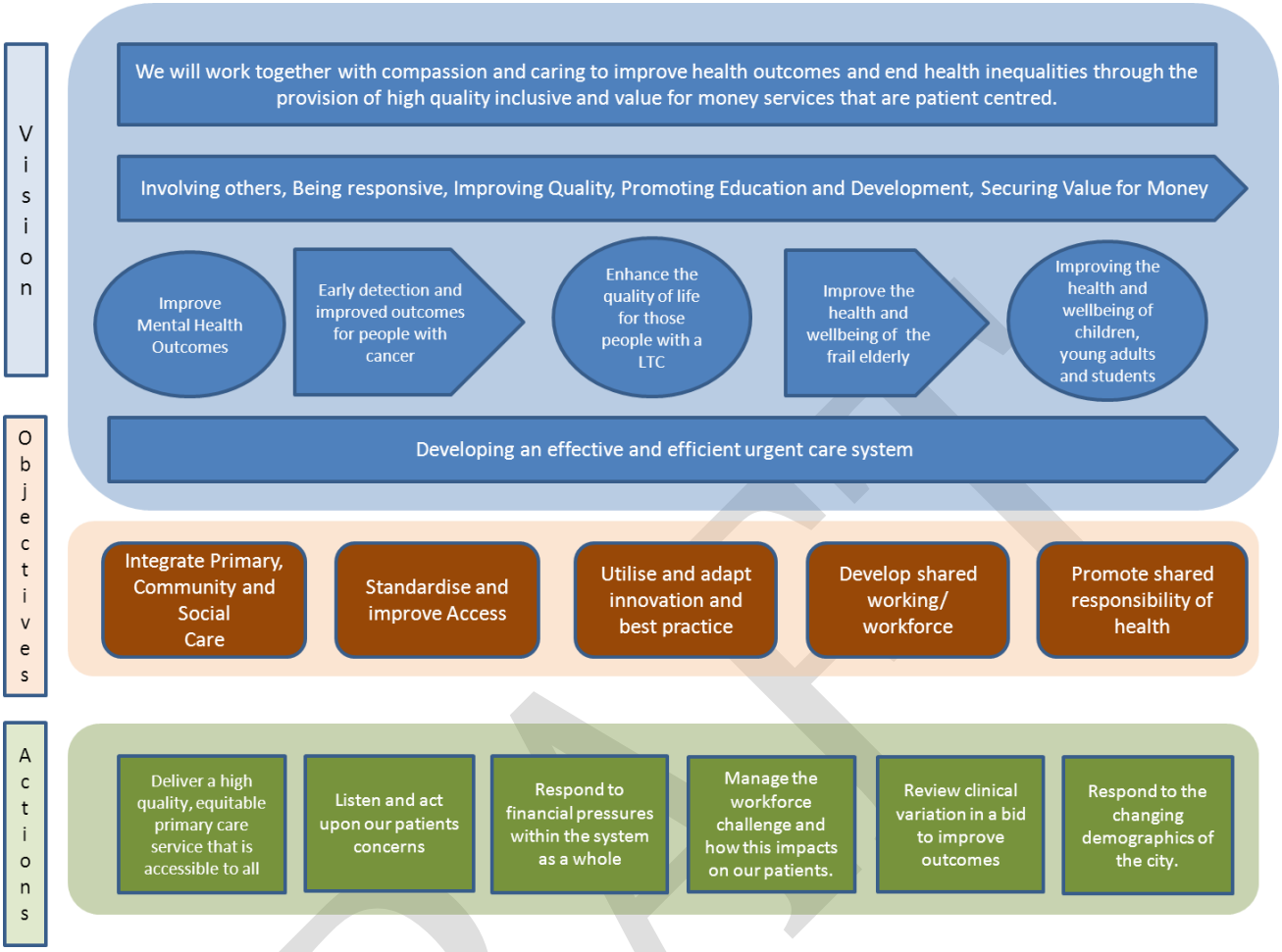
CCG and Better Care funds detail a number of actions to transform services. The following table illustrates the range of activities being undertaken by each CCG within the area over the next 12 months:

CCG	Project Overview
NHS Erewash CCG	**Primary Care Innovation – Integration & Access** • Multi-disciplinary support team for care homes • Access 8-8 7 days per week • Home visiting model
NHS Hardwick CCG	**Project 1 - General Practice & Workload Pilot** • Using Theory of Constraints to remodel capacity and demand in primary care **Project 2 – Building Social Capital to Improve Care** Link patients up to existing voluntary services and community organisations in a quicker and better way, to • Support patients to manage their own care with the help of local community and voluntary services • Reduce demand on the NHS and social care, particularly at night • Build and support existing social capital
NHS Mansfield & Ashfield CCG with NHS Newark & Sherwood CCG	**Mid Nottinghamshire Primary Care Challenge: commissioning more responsive urgent primary care** • Integration of in- and out-of-hours urgent care • Changing patient flows to get the right clinical decision first time • Single front door and extended hours • IT & Estates changes
NHS North Derbyshire CCG	**Project 1 - Patient Care Summary Record Information Sharing** **Project 2 – North Derbyshire GP Federation**
NHS Nottingham City CCG	**Enabling / supporting primary care quality and development in Nottingham City** • Creation of 8 joint Health & Social Care Delivery Groups • Introduction of Neighbourhood Teams • Standardisation of access to primary care
NHS Nottingham North and East CCG	**General Practice Same Day/Urgent Care Service – roll out of pilot in one locality in Nottingham North & East CCG** • Extend roll out of GP extended team • Releasing GP time to manage LTC
NHS Nottingham West CCG	**Engaged Practice Scheme** • Define and deliver a common policy for improved access • Systematic review of all potential referrals and detailed recording of all actual referrals for ongoing learning • Education programmes for clinical and non-clinical staff • Active promotion of a Safety Culture • Clinical Leadership supporting Patient Pathways
NHS Rushcliffe CCG	**Transforming General Practice in Rushcliffe CCG** • Common set of access standards • Extended hours of service and 7 day services • Extended range of access services • “MyRecord” personal web space
NHS Southern Derbyshire CCG	**Improving patient on-line access to records, on-line access for patient to book appointments, register with a GP and electronic prescriptions, with a target of 100% utilisation across all practices.**

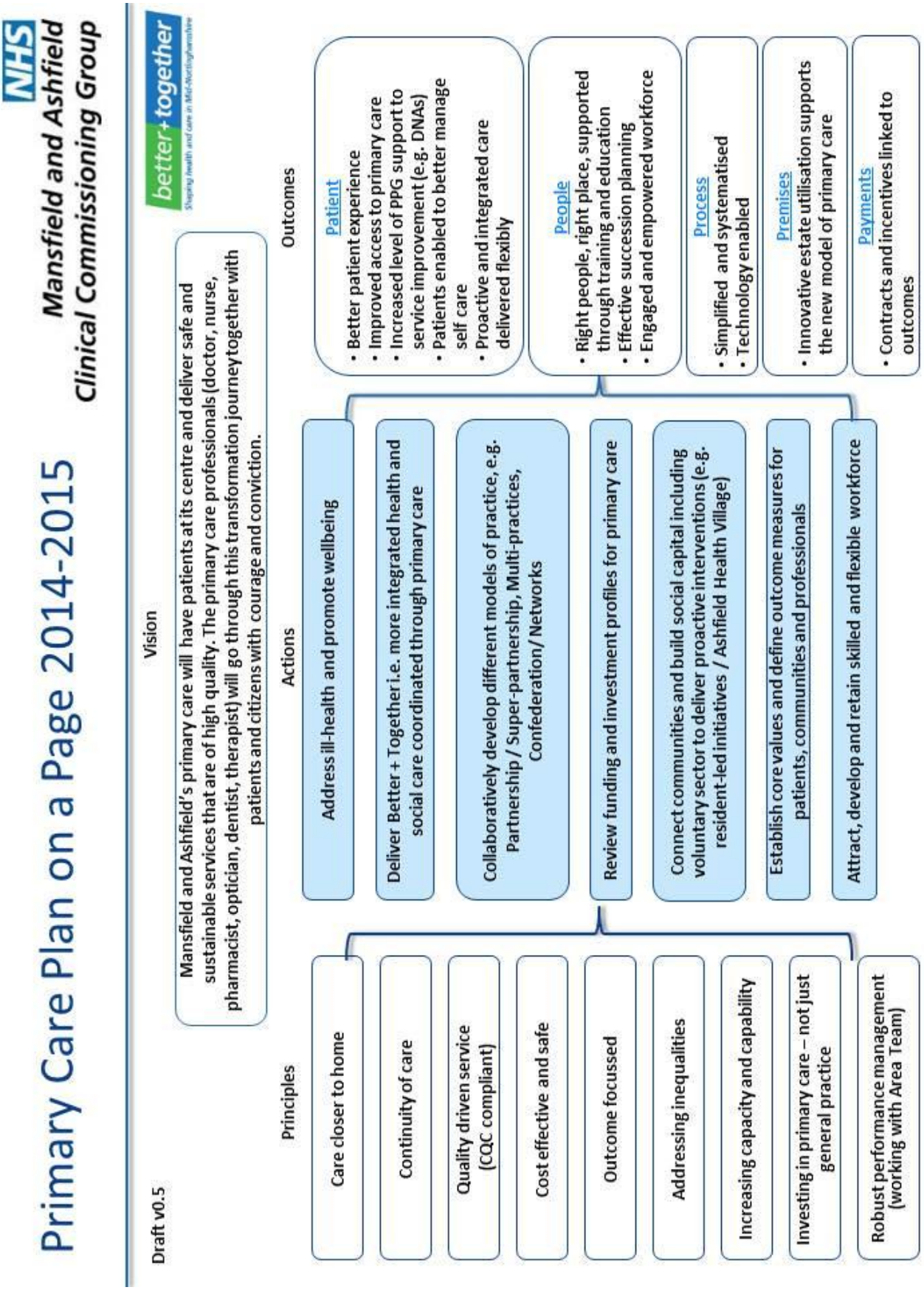
The following pagers describe the longer term 5 year plan and vision developed by each CCG:

CCG PLANS ON PAGE

PLAN ON A PAGE NOTTINGHAM CITY CCG



PLAN ON PAGE Mansfield & Ashfield



PLAN ON PAGE - NOTTINGHAM NORTH AND EAST CCG

Putting good health *into practice*

NHS
Nottingham North and East
Clinical Commissioning Group

Draft Proposed Primary Care Quality Plan on a Page

Our values

Honesty, openness and integrity are central to everything we do
Empowering and communicating with our patient community
Appropriate use of our resources to deliver best value
Leadership that is strong and visible
Together with our partners, strive to improve the health of our community
High quality is our standard

2014 - 2019

Primary Care Vision for Quality

- Member practices deliver an equitable, high quality, efficient and accessible service that is clinically effective for the whole patient population.
- Member practices will be fully supportive of each other and will be at the heart of a more integrated system of services, including other primary, community and secondary care providers, to deliver joined up services that provide person-centred accessible care and which enable people to take control of their health and independence.
- Innovation will be embraced, as will new technologies and ways of working to enable the delivery of the above. Member practices will have an ethos of continuous improvement through education and peer support.
- Member practices will have a stronger role in improving outcomes by empowering patients to self care and will be at the heart of proactive multidisciplinary case management of patients with long term conditions.

Objectives

- Reduce unwarranted clinical variation
- Reduce variation in patient outcomes
- Reduce variation in patient experience
- Address health inequality
- Promote prevention and self-management
- Support and deliver care closer to home
- Support reduction in the number of unnecessary hospital admissions
- Support patients to not remain in hospital for longer than necessary
- Ensure that services and care are fully accessible
- Ensure sustainability of Primary Care
- Be responsive to local need with maximum patient and stake-holder engagement

Delivered by

- Innovations in Primary Care delivery
- Developing and piloting alternative models of primary care in response to patient needs, changing demand and service requirement
- Development of care plans and information sharing with out of hours care provider, 111, EMAS and secondary care providers. The integrated health and social care program of work
- Exploring opportunities to work with community pharmacy to ensure it is an integral part of medicines optimisation
- Supporting development of collaborative models of primary care delivery e.g. federation
- Clinical audit and triage of referral
- Targeted education
- Supporting practices to maximise efficiency
- Support for practice development
- Working with practices to ensure the best possible access for their patients
- Supporting practices to enable sharing of good practice
- Use of technology for care monitoring
- Development of useable clinical guidelines
- Peer review of clinical activity

Measured by

- Evaluation of work such as the CLAHRC evaluation of GP Urgent Care Pilot
- Reduction in unwarranted variation in urgent care activity and resources
- Reduction in unwarranted variation in planned care activity and resources
- Reduction in length of stay in secondary care
- Survey Results
- Increase in number of care management plans shared across providers
- Increase in numbers of people accessing remote care monitoring
- Increase in the number of services delivered closer to patient home
- Increase in the scope of work delivered by the integrated health and social care team
- Improvement in clinical outcomes for patients with long term conditions and co-morbidities
- Increase in the number of people dying in their place of choice
- Increase in the number of practices that have clear business plans that demonstrate future sustainability

Enablers

Workforce | Clinical Leadership | Stakeholder engagement | Contractual levers

Information Management and Technology | CCG Pharmacy Team | Finance

PLAN ON A PAGE – EREWASH CCG

NHS Erewash Primary and Community Care Strategy

"Primary & Community Care Providers working in sustainable relationships delivering innovative services that meet the needs of patients brings care close to home"

Vision Objective One – Better Care

Delivered through the following interventions:

1. Effective primary and community care providers working in innovative configurations with shared aims and resources
2. A Single point of Access of which providers are an integral part including dedicated GP Time
3. 7 Day GP working linked directly with the Erewash Integrated Care Model
4. Further Services delivered within the Erewash integrated care model
5. Utilising the "named co-ordinating GP" to sustain continuity in patients with complex needs
6. Common standards for accessing primary and community care services
7. Enhanced Services targeted at vulnerable groups – e.g. Care Homes, Housebound elderly, high risk patients.

Measured by

1. Robust governance arrangements – eg concordat/federation/joint venture arrangements
2. Each Primary Care provider having agreed robust capacity and workload plans
3. Increase of available GP appointments (against baseline)
4. Improved patient satisfaction surveys
5. Expansion of the number of services delivered by the Erewash Integrated Care model
6. Increase in the number of patients with care management plans
7. Establishment of Care Home support Service
8. Establishment of dedicated Home visiting
9. SPOA percentage successfully diverted

Vision Objective Two – Better Health

Delivered through the following interventions:

1. Proactive population based care – care/case management planning
2. Assistive technologies that support health, well-being and independence
3. A fully integrated approach to ensuring that people are able to remain independent for as long as possible, meeting their physical, social and mental health needs.
4. Improved access to support to enable people to remain in their own homes
5. Promotion of self care and self management
6. Increased involvement and engagement of patients and public in service development

Measured by

1. Reduction in use of urgent care resources , admissions, A&E, MIU and OOHs
2. Improved outcomes and reduction complications for those with long term conditions/complex needs
3. Improved self management of conditions within agreed care plans
4. Increased numbers using technology to support management of conditions

.

Vision Objective Three – Better Value

Delivered through the following interventions:

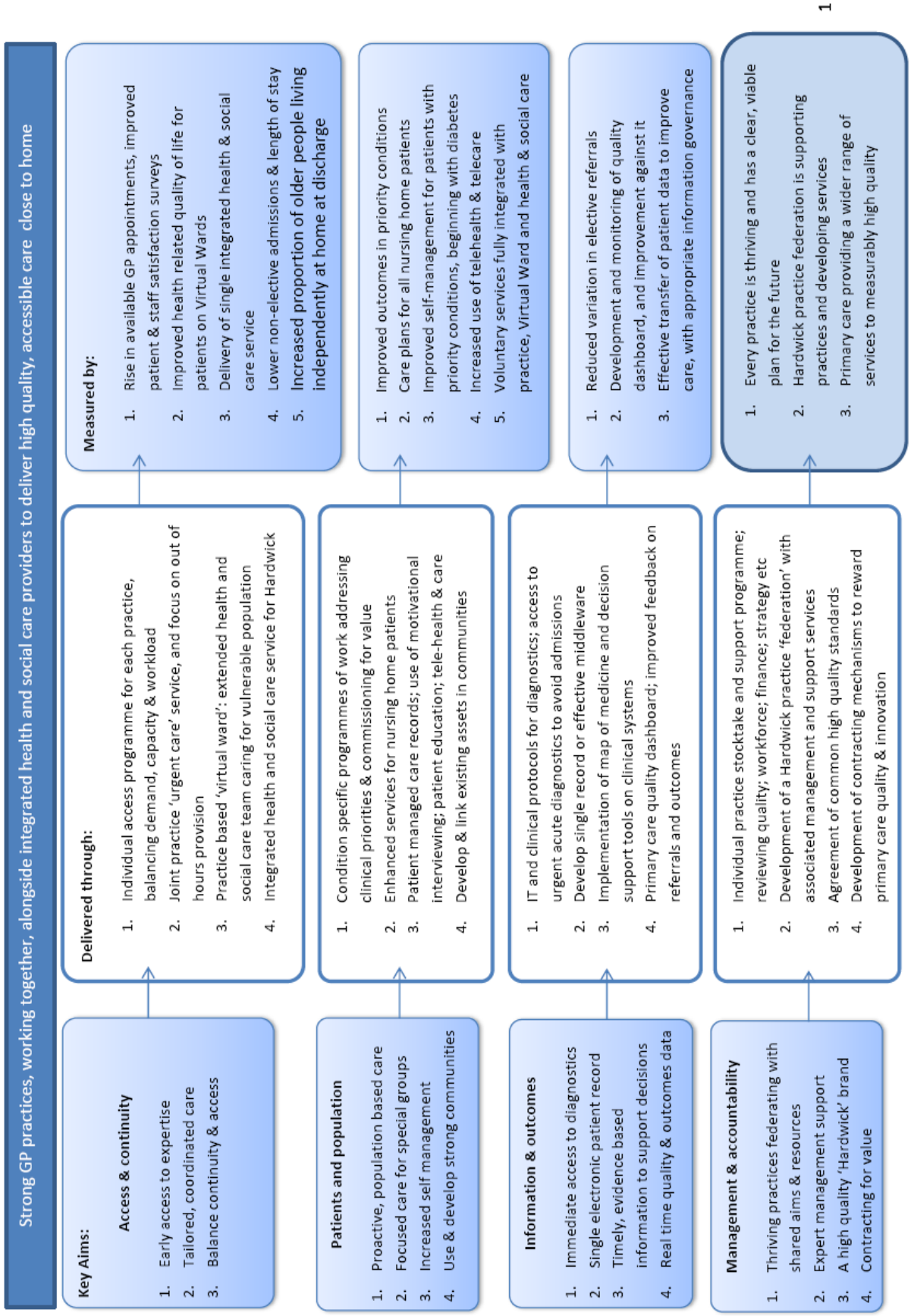
1. Innovative contracting models to support transformation/ Innovation/ Quality
2. Utilising real time quality and outcomes data to improve feedback on and development of services
3. Using a single patient record
4. Supportive work with Individual providers review/assessment of quality , workforce, finance, strategy
5. Active use of all assets across communities
6. Further integration within the Erewash Integrated Care model across voluntary, social and health sectors

Measured by:

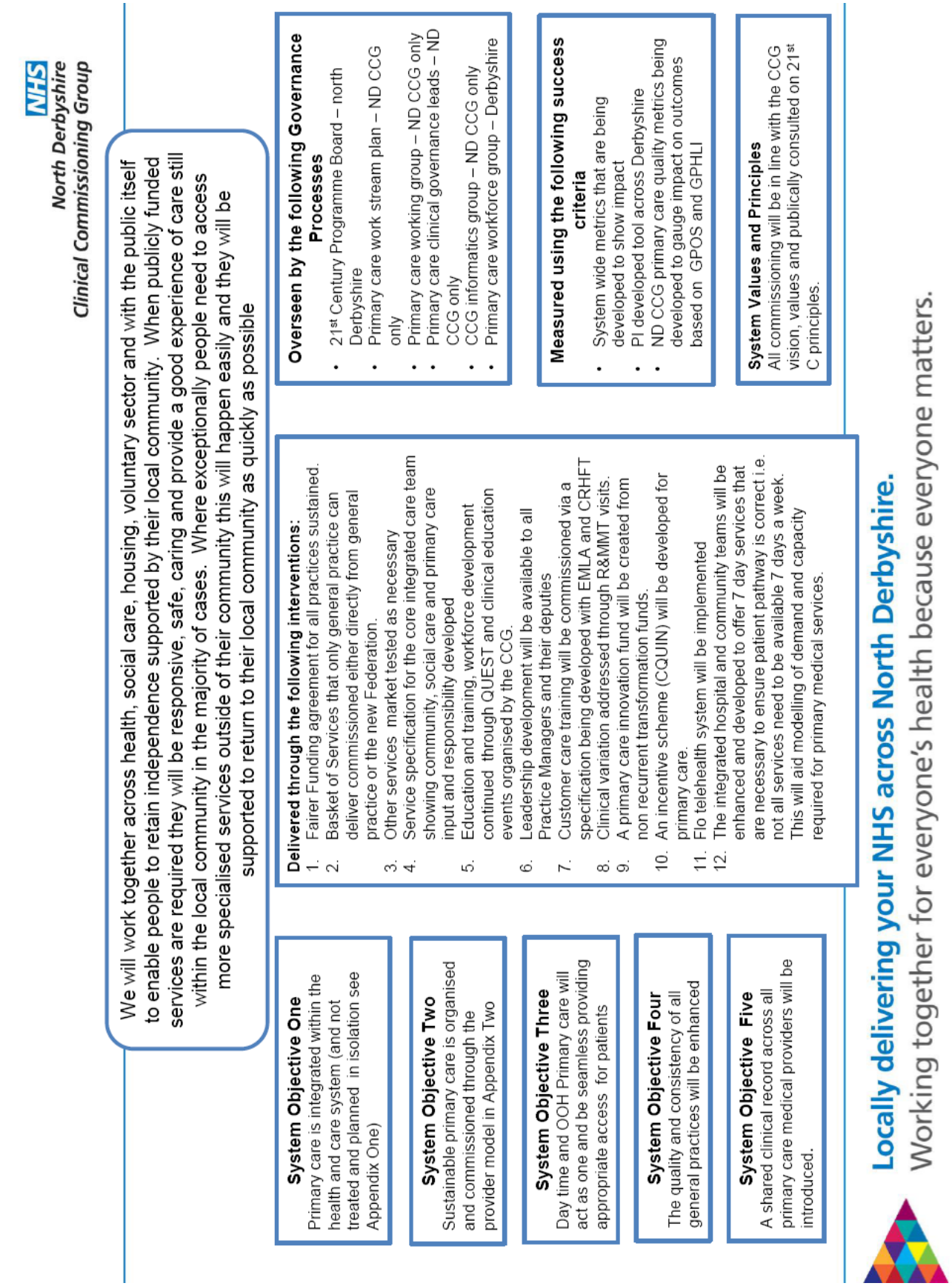
1. Reduction in use of secondary care resources both elective and non-elective
2. Increased proportion of older people living independently at home following discharge
3. reduction in the
4. Transfer of/access to patient data to improve care (within allowed governance arrangements)
5. Primary Care Provider Plans built on quality review
6. Increase in the number of services supported by multiple sectors

Erewash Clinical Commissioning Group NHS

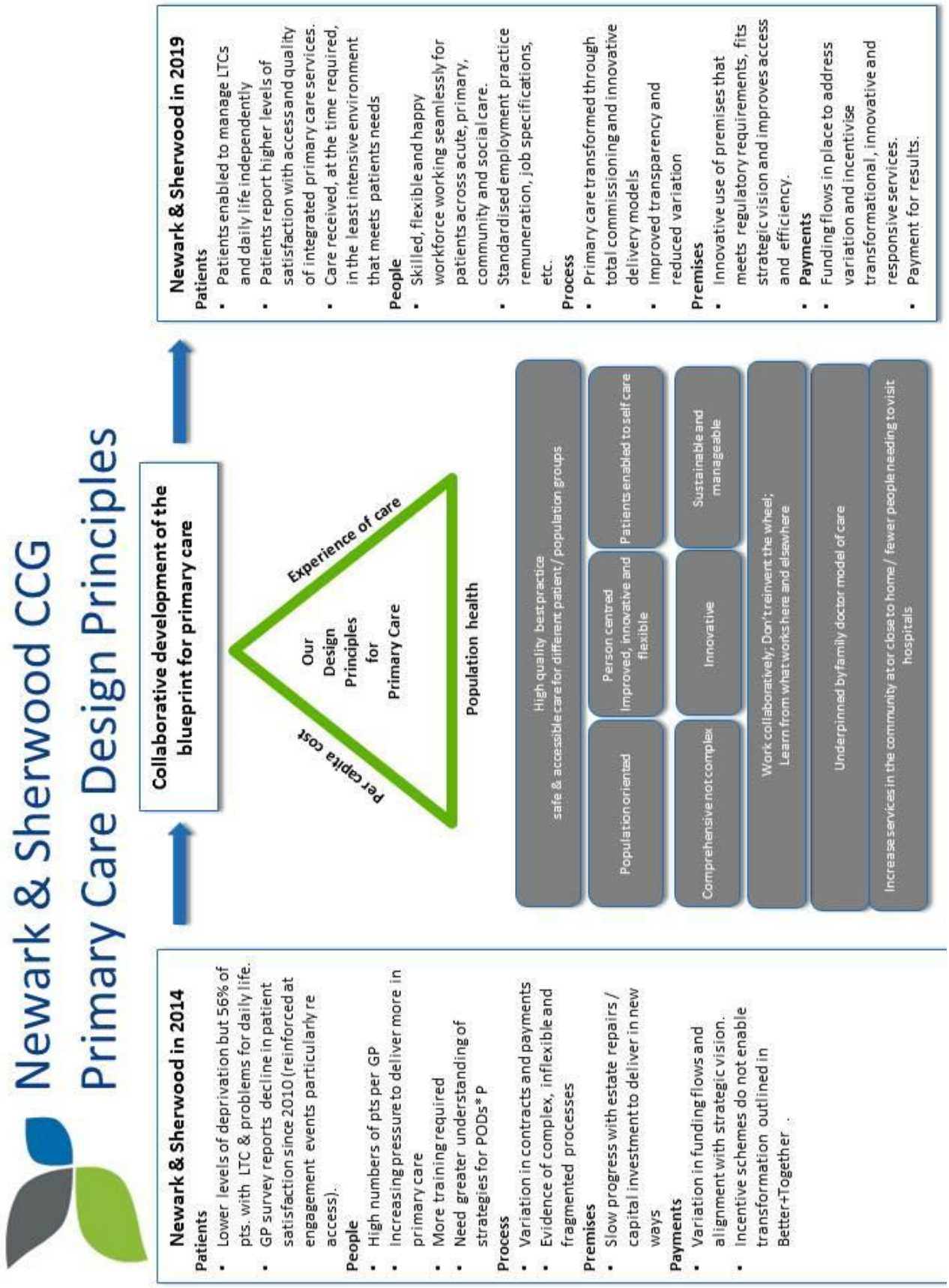
PLAN ON A PAGE - HARDWICK CCG



PLAN ON A PAGE - NORTH DERBYSHIRE CCG



PLAN ON A PAGE - NEWARK AND SHERWOOD CCG



PLAN ON A PAGE - NOTTINGHAM WEST CCG

(NHS partners/stakeholder use only)

NHS
Rushcliffe
Clinical Commissioning Group

Rushcliffe CCG: Primary Care Plan on a Page 2014-19

Rushcliffe GP Practices working together to deliver equitable, consistent, high quality patient centred care		
Key Aims: **Access & standardisation** 1. Equity of approach and delivery 2. Extended range and alternative modes of access 3. Patient centred delivery 4. Developing and implementing integrated coordinated programme of care that starts/ends in primary care	Delivered through: ❖ Common access minimum delivery standards ❖ 7 day service model ❖ Web-based/e-consultations ❖ Whole population survey ❖ Accountable Lead Provider for MSK services, Integrated Community Services	Measured by: ❖ Improved patient satisfaction & recommendation of practices to friends/family measure ❖ Increase in number of GP appointments provided per week across the CCG ❖ Reduction in unplanned attendances/admissions ❖ Access model of delivery based on patient feedback ❖ Reduced fragmentation/duplication of care and improved patient outcomes
Patients and population: 1. Proactive population based anticipatory care planning for LTC patients 2. Focused support for carers 3. Increased Self-care/telecare/personalised care planning 4. Focused & anticipatory care planning for EOL & care home residents	❖ "One stop model" of primary/secondary prevention ❖ Carers Support Service & practice champions ❖ Personalised care planning ❖ "My Record" personal web space ❖ One care home, one practice Enhanced Service specification	❖ Increase then decrease in LTC prevalence ❖ Increase in number of carers identified/referred ❖ PPOD status in place for all EOL patients ❖ Telecare in place across all practices ❖ Increase in number of patients on palliative care/EOL registers ❖ Personalised care plans in place for all LTC patients
Information & outcomes: 1. Improved clinical advice to referrals 2. Whole population risk profiling 3. Real time referral decision making aids	❖ Procurement of referral consultation service ❖ Development of gateway database ❖ Adoption of risk profiling tools ❖ Implementation of referral decision support tools – e.g. map of medicine ❖ Development and monitoring of risk profiling data platform	❖ Reduced variance and inappropriate elective referrals ❖ Reduced variance in LTC risk profiles
Management & accountability: 1. Thriving practices federating with shared aims, values and resources 2. Expert management support 3. Removing barriers to transform general practice to develop community services	❖ Development of Rushcliffe federation of practices ❖ Shared management and supporting resources ❖ Common high quality standards ❖ Levelling of investment in general practice to develop capacity	❖ Each practice has a clear, viable plan for its future workforce ❖ Rushcliffe practice federation is supporting practices and developing services ❖ Consistency of primary care delivery & quality ❖ Improved recruitment opportunities in practice workforce ❖ Whole CCG adoption

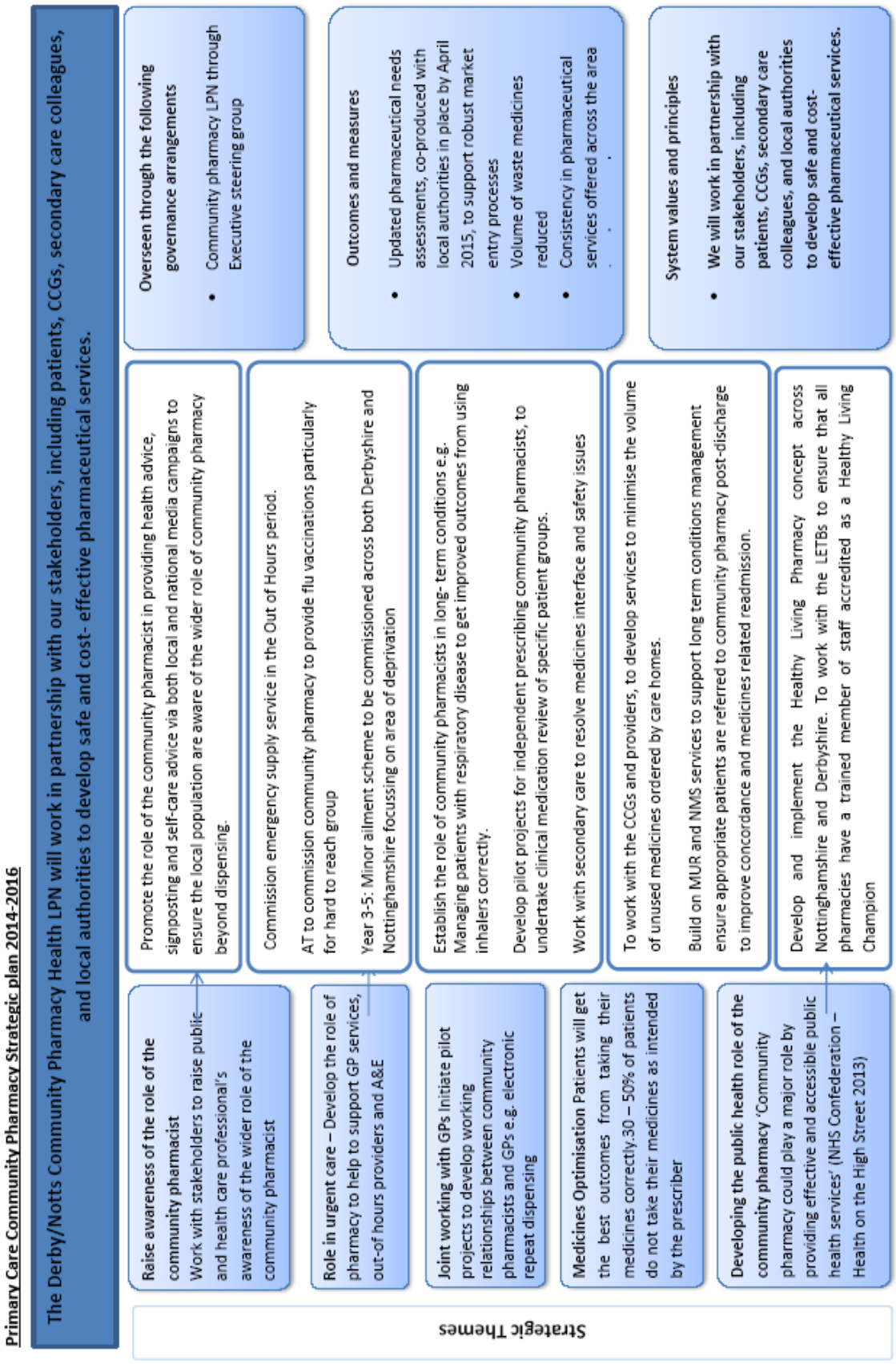
PC Plan on a page 2014-2019v3 06.02.14

PLAN ON A PAGE - SOUTHERN DERBYSHIRE CCG

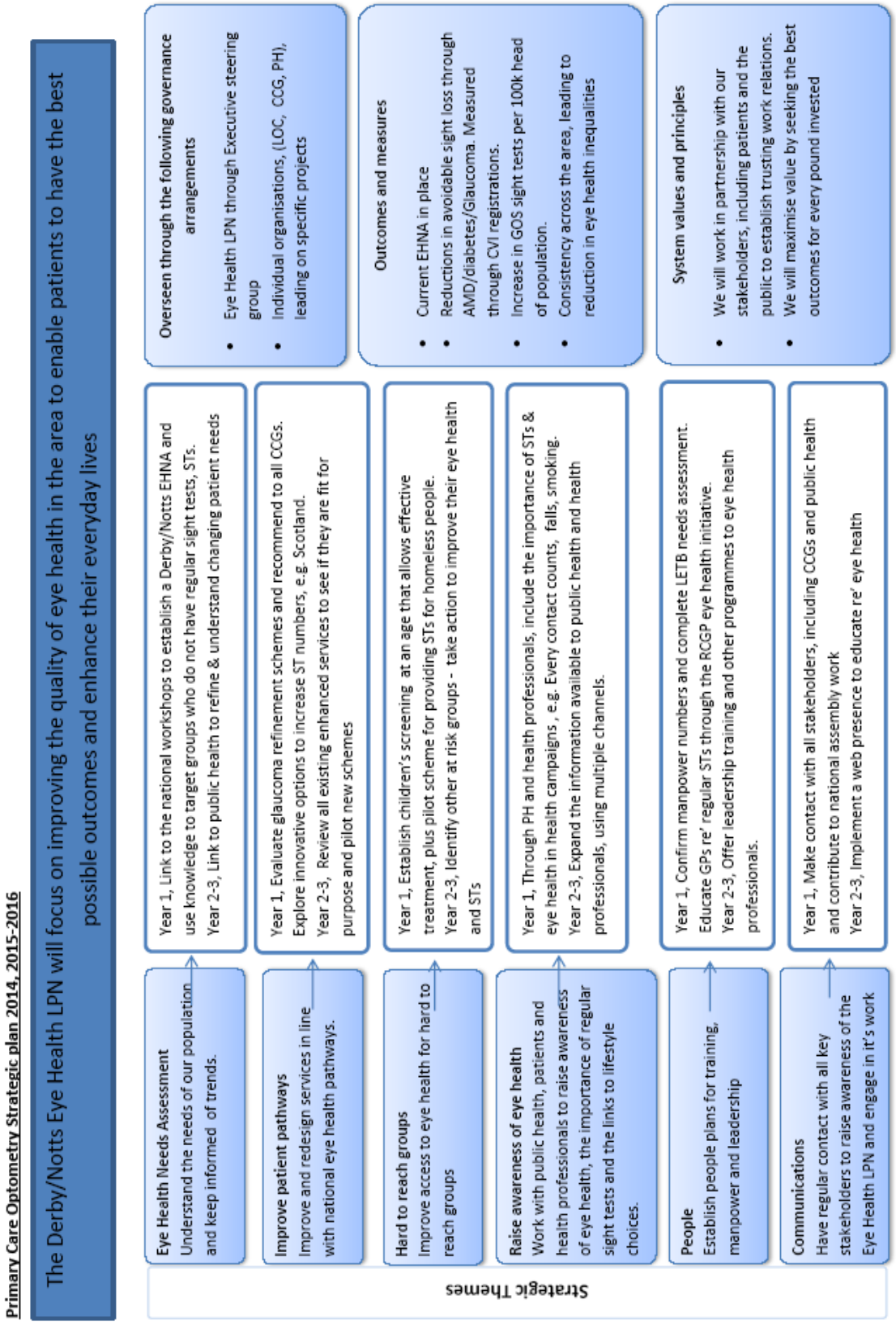
Priority Area	• 1 year operational aim	2 year operational aim	5 yr strategic Aims
Primary Care	• Active promotion of practices working together and targeted support to practices most willing to innovate or most in need. • Support for practices in advance of requirements re >75year olds. CST model implemented. • Identify workforce risks and develop plan with Area Team. Strengthen education programmes; include leadership and commissioning • Identify areas where quality or performance could be enhanced. • Use consistent framework for practice visits, feedback and action planning and use governance structures to support and develop practices • Practices supported (through the Challenge Fund if successful) to implement range of technology solutions to increase on-line services for patients. • Implement new enhanced commissioning framework with consistent specifications and opportunities to work across practice boundaries. • Ensure primary care included in innovation initiatives. Use flexibility of new enhanced commissioning framework to incentivise and reward practices.	Implement number of new arrangements Implement actions from workforce plan. Targeted improvement using suitable benchmark information and patient experience data. Consider and implement technology such as health apps, skype (if evaluate positively nationally). Increase the range of services available Increase opportunities for practices to share and learn from each other.	Federated or networked practices working collaboratively to offer wide range of services at scale. Multi-disciplinary teams based in primary care with GPs at heart of co-ordinated, proactive and personalised care for those in greatest need. Motivated primary medical care staff with high recruitment and retention in the CCG area. Patients confident of access to high quality primary care service across Southern Derbyshire. Patients able to choose to use technology to interface with their practice and to seek advice and support where appropriate. Patient able to access wider range of services from their practice or nearby rather than attending hospital. Practices motivated to innovate and develop

NHS Southern Derbyshire Clinical Commissioning Group

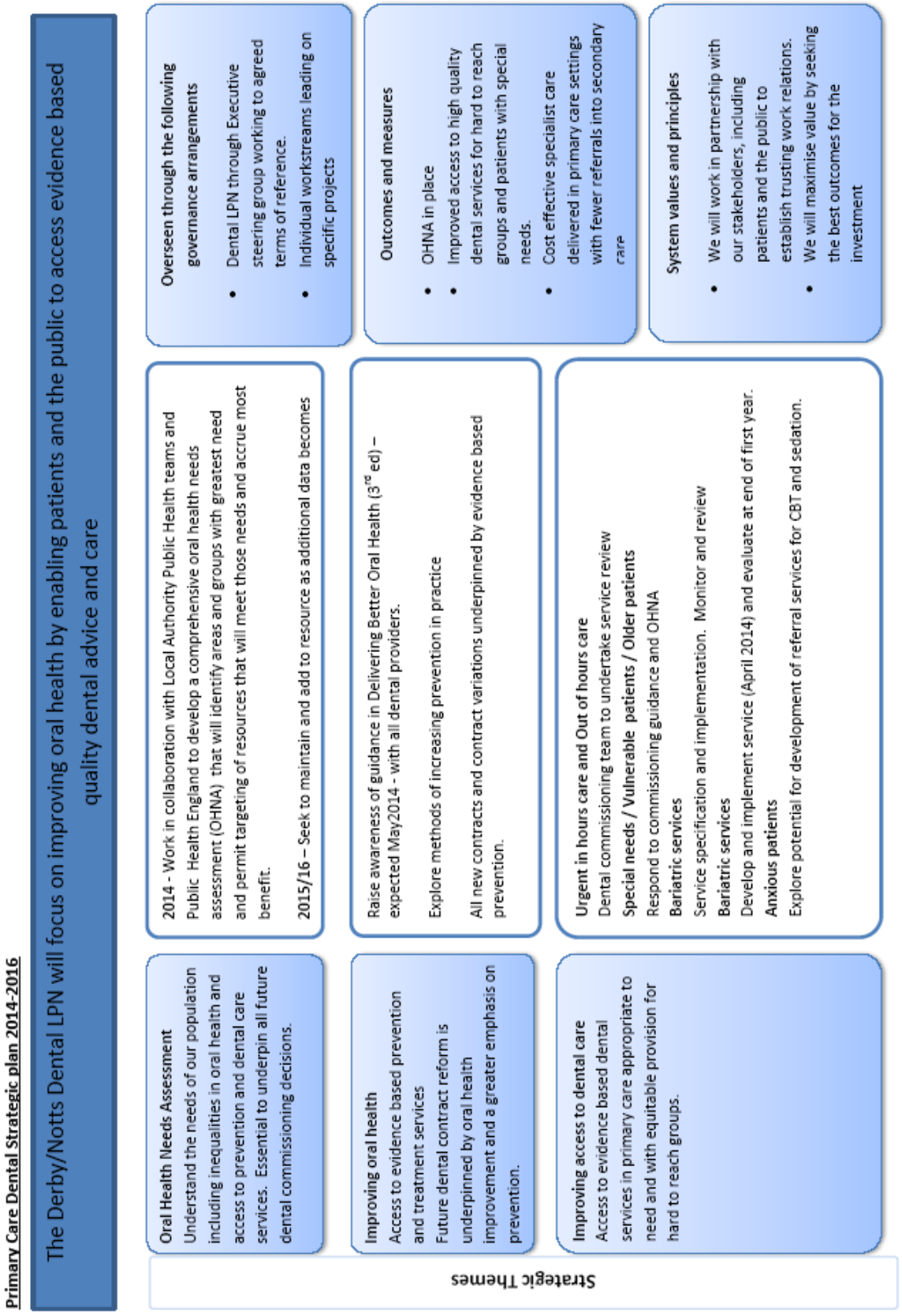
LOCAL PROFESSIONAL NETWORKS - Plan on a Page - Pharmacy



LOCAL PROFESSIONAL NETWORKS - Plan on a Page - Eye Care



LOCAL PROFESSIONAL NETWORKS – Dental



LOCAL PROFESSIONAL NETWORKS – Dental continued

Secondary care services
Undertake a scoping exercise of the various options to establish the best fit for commissioning and managing secondary care and of the potential to move elements of secondary care provision into specialist led primary care settings.
Build on the pathways that have already been developed in the Area Team for minor oral surgery and implement national pathways as they become available for this and other specialties.

Managed Clinical Networks
Continue to support orthodontic MCN.

Confirm dental team numbers and complete LETB needs assessment.
LPN engages with HEE about training needs highlighted by work streams.

Redesign of services using a pathway approach.
In the future the entire dental pathway will be commissioned as an integrated model of service delivery first outlined in *Securing Excellence in commissioning NHS dental services.*

A care pathway approach is proposed to align with the NHS England single operating model. This will ensure consistency in delivery of dental services both in the sequencing, effectiveness and quality of care with a focus on patient outcomes.

National development includes contract reform pilots and development of specialty pathways.
Managed Clinical Networks

Dental Teams
Development of skill mix.

LOCAL PROFESSIONAL NETWORKS

Local professional networks form a vital an integral part of primary care services.

Key themes have emerged for transforming these networks and services and can be summarised as:

Pharmacy

- Medicines optimisation
- First point of contact
- Registered lists of patients

Optometry

- Eye needs assessments
- Target hard to reach
- Review eye casualty pathways

Dental

- Review secondary care pathways
- Improve access
- Address anxiety

Refer to: Appendices: Detailed business plans for each professional networks can be accessed from the following links:

DN: Insert links to plans

FUTURE - WHAT DOES THIS STRATEGY MEAN TO THE LOCAL AREA ?

Patients:

- Self-management plans in place for all patients
- Patient involvement and assurance in improvement monitoring
- Proactive management through public health interventions

People:

- High quality primary care workforce, effective and safe, with future leadership identified and growing
- Primary care providers with self-sustainable workforce and organisational plan

Processes:

- Health plans in place for all the population, with a named GP
- Access to 7/7 high quality primary care for routine and planned care needs

Premises:

- Health and social care plan for premises aligned to community needs and in partnership with commercial and economic planning

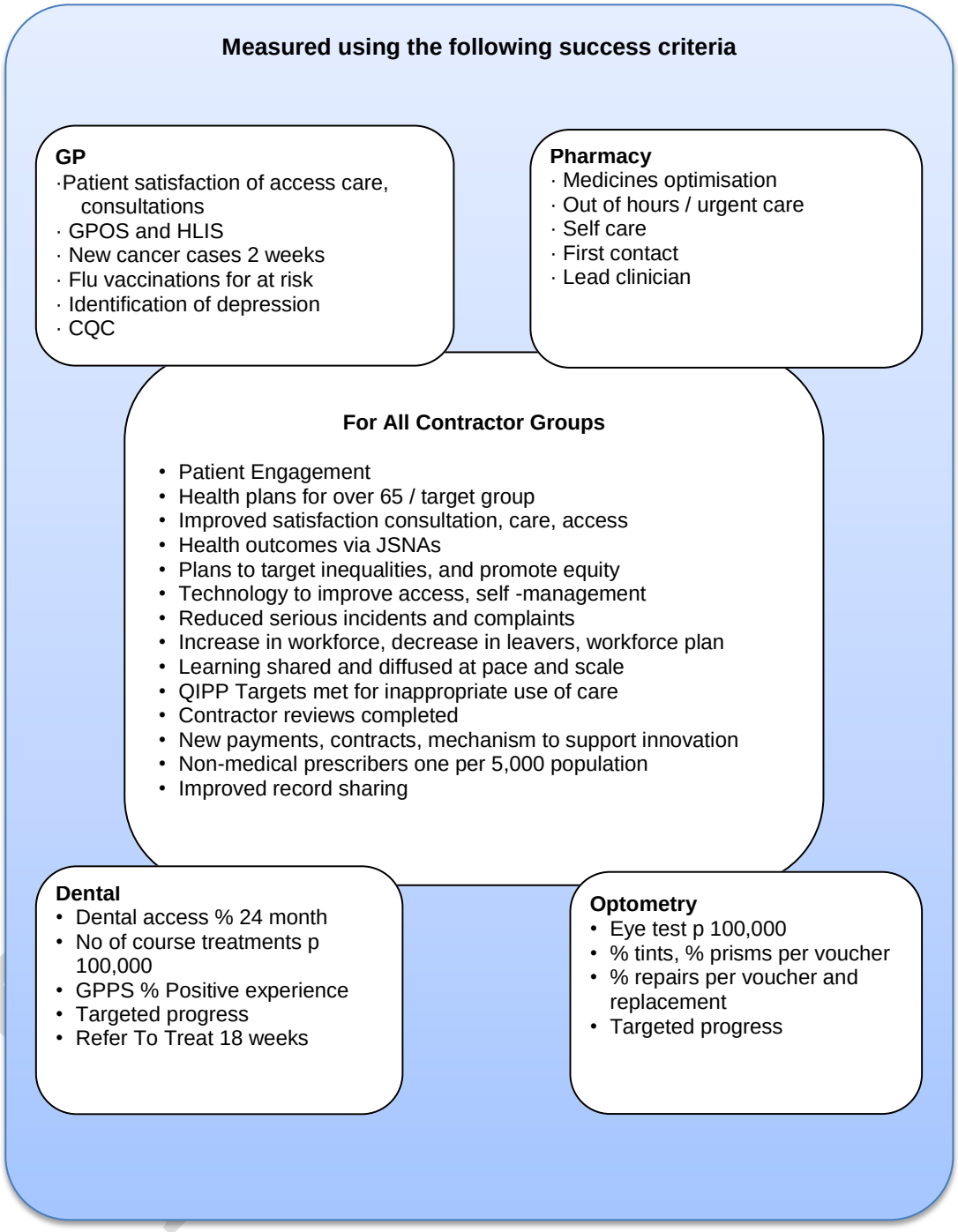
Payments:

- Resources following the patient to reflect the impact primary care can have on reducing inappropriate utilisation

DN Make into a graphic

TRAJECTORIES AND OUTCOMES

TRAJECTORIES AND OUTCOMES



GLOSSARY / ABBREVIATIONS

GLOSSARY - ABBREVIATIONS AND DEFINITIONS

TERM	DESCRIPTION
AHSN	Allied health science network
AT	Area Team
CCG	Clinical commissioning group
CLAHRC	Collaborations for leadership in Leading applied health research and care
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
EQIA	Equality Impact assessment
GP	General Practitioner
GPOS	General practice outcome survey
GPPS	General practice patient survey
HLIS	Health link information system
HWB	Health and wellbeing board
IT	Information technology
JSNA	Joint strategic needs assessment
KPI	Key performance indicator
LETB	Local education and training board
LETC	Local education and training council
LDC	Local dental committee
LMC	Local medical council
LOC	Local optometric committee
LPC	Local pharmaceutical committee
LPN	Local professional network
LTC	Long term condition
MPIG	Minimum practice income guarantee
OOH	Out of hours
PALS	Patient advice and listening service
PDR	Personal development review
PHP	Personal health plan
PMS	Personal medical services
QIPP	Quality innovation productivity performance
QOF	Quality outcomes framework
POD	Pharmacy, Optometry, Dentistry
RCGP	Royal college of general practitioners

LINKS AND DATA SOURCES

Reference Number	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

1 Everyone Counts Planning for Patients 2014/5 to 2018/19
2 NHS Constitution
3 Compassion in practice
4 NHS Mandate
5 NHS Outcomes Framework

APPENDICES

Appendix Number	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

APPENDIX 1 - THE NHS MANDATE, OUTCOMES FRAMEWORK AND AMBITIONS

THE NHS MANDATE[4]

The mandate renews the focus on improving patient outcomes, and reducing health inequalities.

THE NHS OUTCOMES FRAMEWORK [5]

The indicators in the NHS Outcomes Framework are grouped around five domains:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating people in a safe environment; and protecting them from avoidable harm.

Alongside these domains there are 5 offers as set out in the NHS England's planning framework "Everyone Counts: Planning for patients 2013/4"[1]

Offer 1	NHS Services 7 days per week
Offer 2	More transparency more choice
Offer 3	Listening to patients and increasing their participation
Offer 4	Better data, Informed commissioning, Driving Improved outcomes
Offer 5	Higher standards and safer care

Our ambitions will be focused on delivering outcomes in these domains and developing the offers.

THE NHS AMBITIONS

It is vital that we translate these outcomes into specific measurable ambitions that are critical indicators of success and against which we can track progress. Working with clinicians and staff in NHS England, in CCGs and with key stakeholders, 7 ambitions have been developed as outlined in 'Everyone Counts: Planning for Patients 2014/15'. [1]

- Securing additional years of life for the people of England with treatable mental and physical health conditions.
- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions.
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

In addition there are 3 more key measures to focus on and improve:

- Improving health should have as much focus as treating illness
- Reducing health inequalities where the most vulnerable people get better care and services
- Move towards parity of esteem in terms of improving mental as well as physical health

APENDIX – QOF Definitions for health indicators

1. **Definitions of key indicators as obtained from QOF 2012/13** (as provided on: http://www.dhsspsni.gov.uk/statistics_and_research-qof-prevalence)

- **Asthma**: Number of patients with asthma, excluding those who have had no prescription for asthma-related drugs in the last 12 months.
- **Cancer**: Number of patients with a diagnosis of cancer, excluding non-melanotic skin cancers, from 1st April 2003.
    - Because of the date cut-off in the definition of this register, prevalence trends are obscured by the increase in the size of the register due to the cumulative accrual of new cancer cases onto practice registers with each passing year.
- **Chronic Kidney Disease:** Number of patients aged 18 years and over with chronic kidney disease (US National Kidney Foundation: Stage 3 to 5 CKD).
- **Chronic Obstructive Pulmonary Disease (COPD):** Number of patients with chronic obstructive pulmonary disease.
- **Depression 6:** Number of patients aged 18 years and over diagnosed with depression since April 2006.
    - Although the Depression 6 indicator definition does not refer to patient age, the QOF business rules define this register to include only patients who are aged 18 years and over.
- **Diabetes Mellitus:** Number of patients aged 17 years and over with diabetes mellitus (specified as type 1 or type 2 diabetes).
    - Although the practice must record whether the patient has Type 1 or Type 2 diabetes, this level of detail is not collected centrally, therefore the register size cannot be disaggregated by type of diabetes.
- **Hypertension:** Number of patients with established hypertension.
- **Obesity:** Number of patients aged 16 years and over with a Body Mass Index (BMI) greater than or equal to 30 recorded in the previous 15 months.
- **Stroke and Transient Ischaemic Attack (TIA):** Number of patients with stroke or transient ischaemic attack (TIA).

2. **Definition of key indicators from Public Health Observatories 2013** (taken originally from ONS)

- **Prevalence of adult smoking:** Prevalence of smoking, percentage of resident population, adults, April 2011 to March 2012, persons

APPENDIX – PERSONALISED CARE

Proposal for Developing the Personalised Care
Derbyshire and Nottinghamshire Area Team - February 2014

1. The Primary Care Strategy for Derbyshire and Nottinghamshire outlines the case for change in primary care and in particular General Practice.
2. Nationally and locally GPs are voicing their concerns about the viability of the Quality and Outcomes Framework (QOF) and the need to take a fresh look at measuring quality.
3. The strategy has signalled a response to GP concerns and has signalled an intention to develop personalised care and continuity of care by building on the Right Care Plan, Personal Health Plans and introducing a bespoke range of personalised plans for all the population by 2018, in return for a local quality incentive payment.
4. The local quality incentive payment could replace some of the Quality and Outcomes Framework (QOF).
5. There are a number of key actions that will be required to develop and implement the PHP. The Area Team have arranged a scoping meeting to take forward the following actions:

Action	By when	By whom	Progress
1. Share the proposal with CCGs and key stakeholders	March 2014	Dr Doug Black	Verbal presentation to Primary Care Panel in January and February with concern about applicability for all population groups
2. Approval to pilot	March 2014	Dr Doug Black	Area team director approval required
3. Establish a task and finish group to progress the work	March 2014	Dr Doug Black	Commenced with lead GPs from each area
4. Agree the task and finish group Terms of Reference, including membership and communication plan	April 2014	Task and Finish Group	First meeting with GP leads 3 April.
5. Review of the QOF and agree what could be stopped.	May 2014	Task and Finish Group	8 May
6. Develop the template for the PHP - see example below	May 2014	Task and Finish Group	Patients Association and Patient Leaders agreed to support development Meeting planned in April
7. Agree the patient cohort e.g. over 65, over 75, those with most risk factors, Long Term Conditions, complex	May 2014	Task and Finish Group	Not started

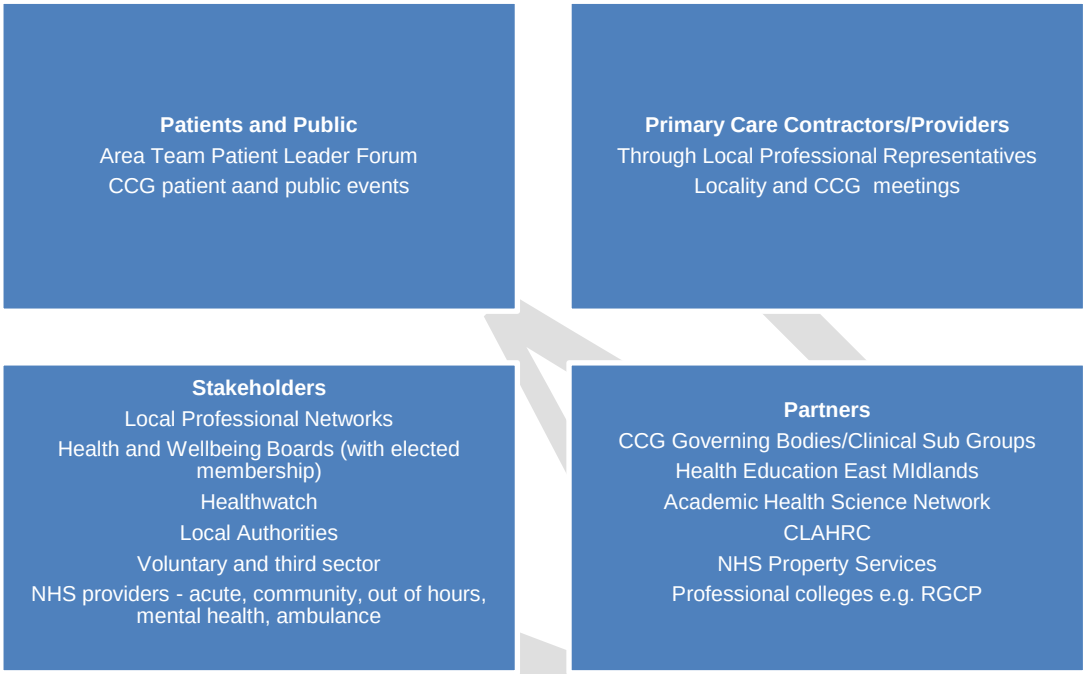
cases etc.			
8. Agree the pilot practices	May 2014	Task and Finish Group	Not started
9. Agree the evaluation	May 2014	Task and Finish Group	CLAHRC support to develop methodology agreed
10. The evaluation report considered by key stakeholders	September 2014	Task and Finish Group	Not started
11. Recommendation from the report shared and actions agreed	October 2014	Area Team Directors	Not started

APPENDIX - COMMUNICATIONS AND ENGAGEMENT

A robust programme of communication and engagement commenced in April 2014. The diagram below captures the broad range of people we have engaged with a full report at Appendix x on the emerging themes. The main theme consistently raised is access to primary care which is system objective 1 of our strategy.

The principles of engagement are based on co-production/design with patients and our partners, building on the Call to Action discussions held across the area. These discussions will be ongoing so the strategy is continually reviewed and revised according to need.

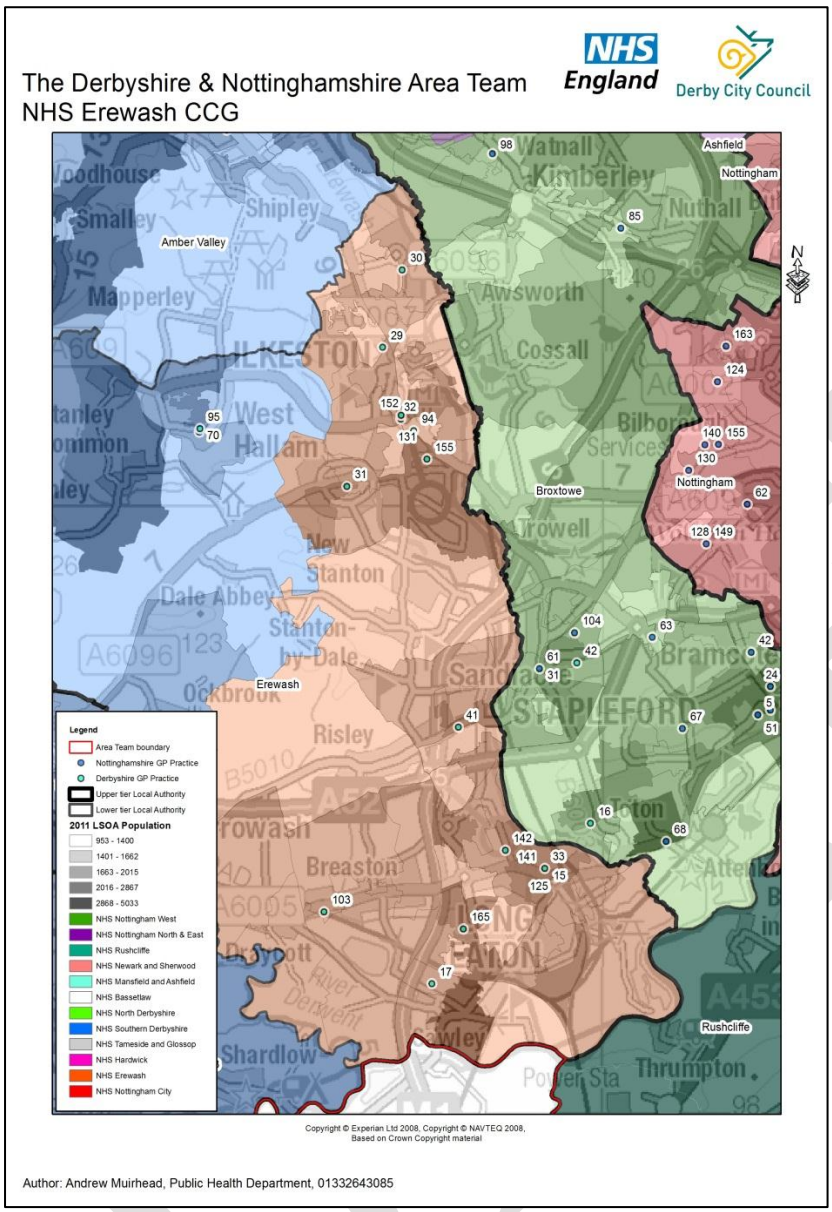
The diagram below shows the four cornerstones of our engagement:



APPENDIX - FINANCE AND AFFORDABILITY

DN: To follow in April

LOCAL CONTEXT – EREWASH CCG



LOCAL HEALTH PRIORITIES

Cardiovascular Disease

Hypertension
- Prevalence 15.8%

Strokes
- Prevalence 2.0%

Smoking
- Prevalence 18.2%

Cancers

- Prevalence 2.0%
- 1,952 patients with cancer

Respiratory Disease

COPD
- Prevalence 2.1%

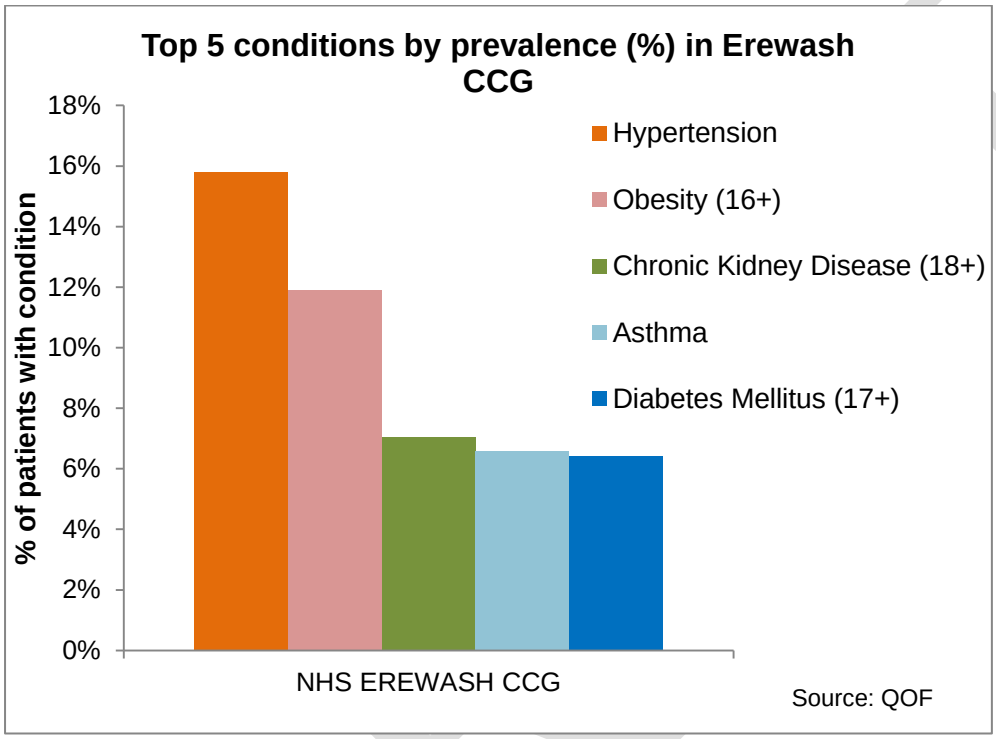
Asthma
- Prevalence 6.6%

LOCAL CONTEXT - POPULATION AND HEALTH NEEDS IN EREWASH CCG

In Erewash the prevalence rates of all conditions and health issues are higher than the Derbyshire and Nottinghamshire average. Some health conditions with particularly high rates are Chronic Kidney Disease (7.1% in Erewash as compared to 4.4% in Derbyshire and Nottinghamshire) and Obesity (11.9% in Erewash as compared to an average of 9.3%).

LOCAL CONTEXT - POPULATION AND HEALTH NEEDS IN EREWASH CCG

The following graph outlines the top five most prevalent conditions in Erewash CCG. As already noted, the prevalence rates for Erewash are higher than the Derbyshire and Nottinghamshire averages.



Other Key Health Issues

Kidney Disease
- Prevalence 7.1%

Obesity
- Prevalence 11.9%

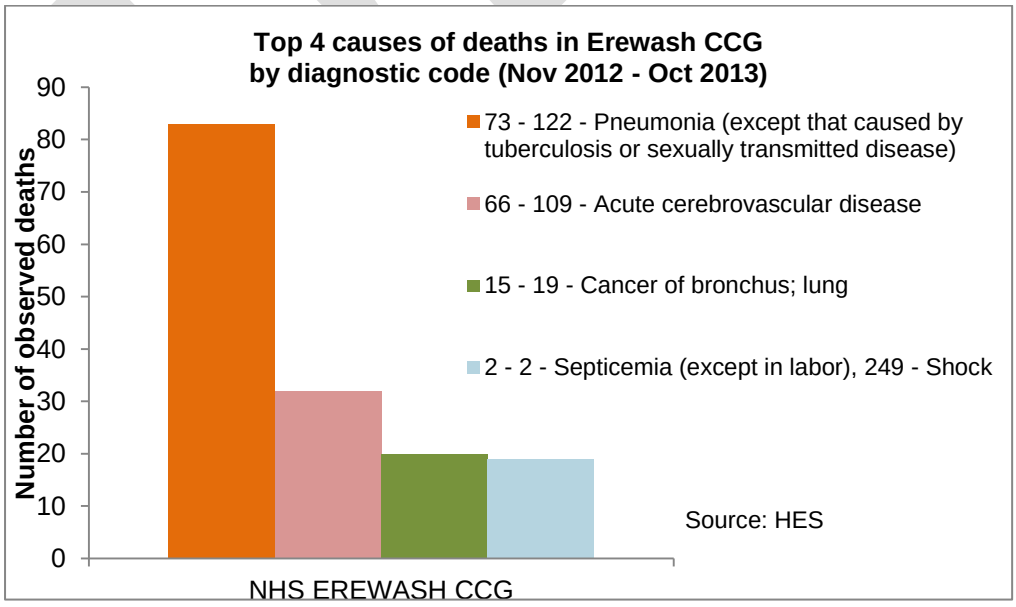
Mental Health

Depression
- Prevalence 6.1% (ages 18+)

Diabetes

- Prevalence 6.4%
- Lifestyle
- Self-care

The highest number of observed deaths is in the diagnostic group of Pneumonia and Acute cerebrovascular disease, similarly to the Derbyshire and Nottinghamshire average.

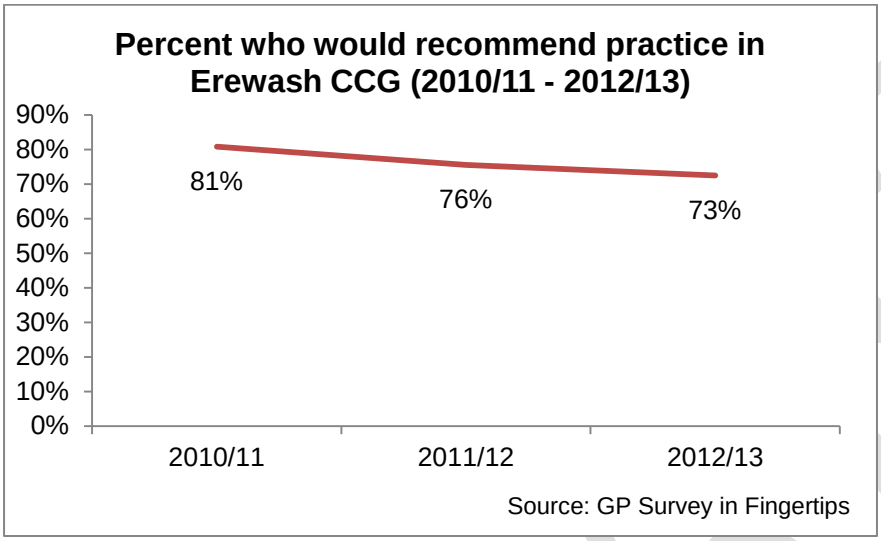


LOCAL CONTEXT – WORKFORCE IN EREWASH CCG

Erewash CCG has a relatively low proportion of GPs over 55 years old (13%) as compared to the Derbyshire and Nottinghamshire average (16%). Out of the total headcount of GPs, 42 are female and 33 are male. The majority of the GPs are GP Partners while the numbers of Salaried GPs and GP Registrar are similar.

SATISFACTION WITH ACCESS TO PRIMARY CARE

The overall percentage of people who would recommend their practice in Erewash CCG has decreased between 2010/11 and 2012/13 by 8%.



SATISFACTION WITH ACCESS

- There has been a significant decline in % of patients that would recommend practice in past 3 years

Provider Overview for Erewash

Provider Overview for Erewash

- 12 General Practices
- 97,053 Registered Patients
- 8,087 Average per GP practice
- 23 Pharmacies
- 8 Dentists
- 10 Optometrists

Erewash CCG Priorities include:

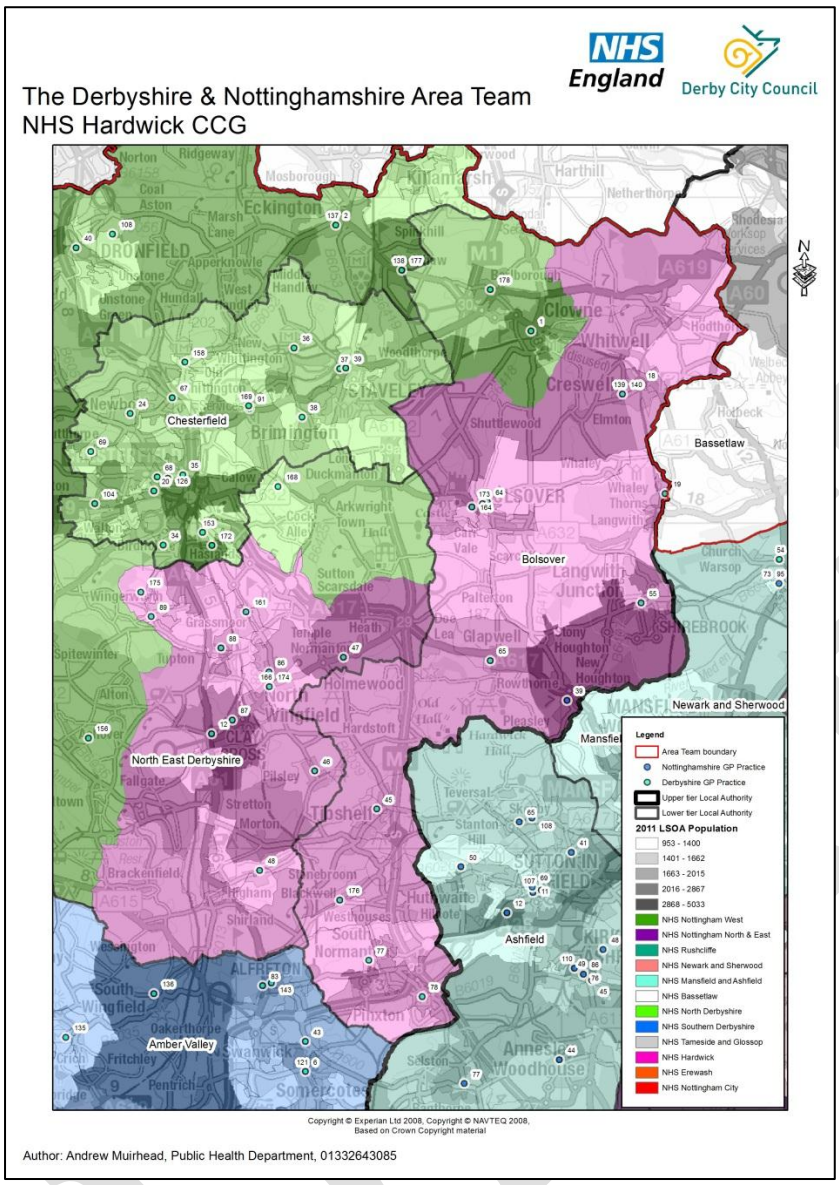
- Better care
- Better health
- Better value
- Develop workforce
- Better access

DN: CCG to amend as appropriate

Key Planned Erewash CCG Developments:

- Care Home support
- Develop same day GP appointment services with 8 to 8, 7 days access to General Practice
- Home visiting model joint primary care and community services model with community teams
- Reinvestment and redistribution of clinical / GP time.
- Wider out of hospital strategy

LOCAL CONTEXT – HARDWICK CCG



LOCAL HEALTH PRIORITIES

Cardiovascular Disease

Hypertension
- Prevalence 17.5%

Strokes
- Prevalence 2.2%

Smoking
- Prevalence 25.2%

Cancers

- Prevalence 2.1%
- 2,141 patients with cancer

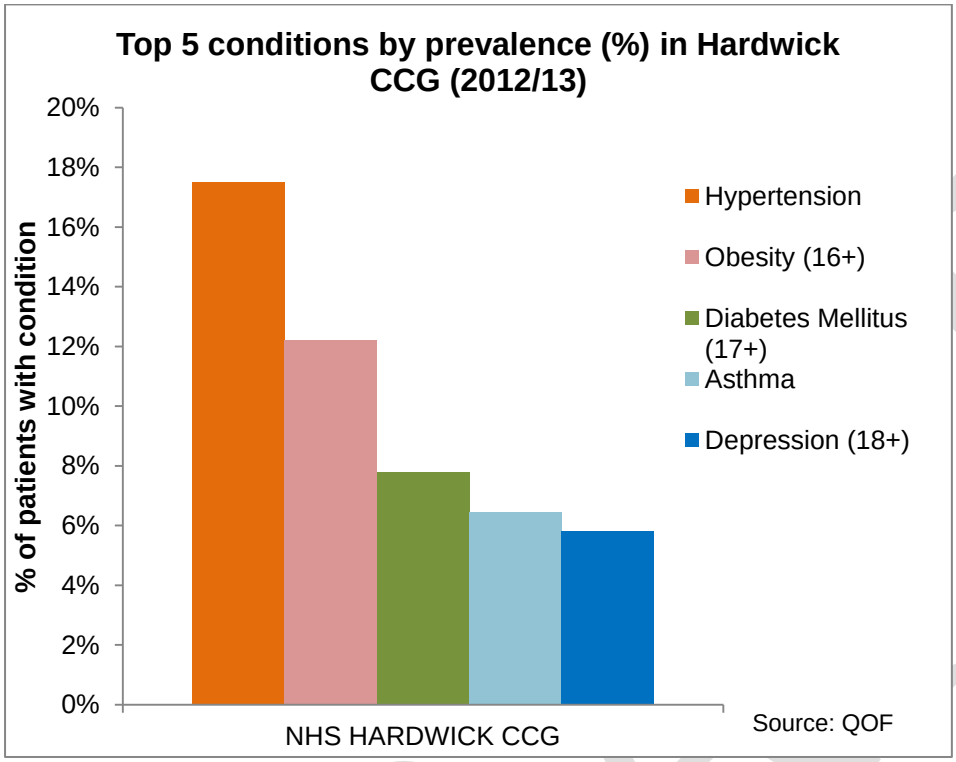
Respiratory Disease

COPD
- Prevalence 2.8%

Asthma
- Prevalence 6.5%

LOCAL CONTEXT - POPULATION AND HEALTH NEEDS IN HARDWICK CCG

The following graph outlines the top five most prevalent conditions in Hardwick CCG. Prevalence rates of hypertension and diabetes are higher than in any other CCG in Derbyshire and Nottinghamshire.



Other Key Health Issues

Kidney Disease
- Prevalence 5.5%

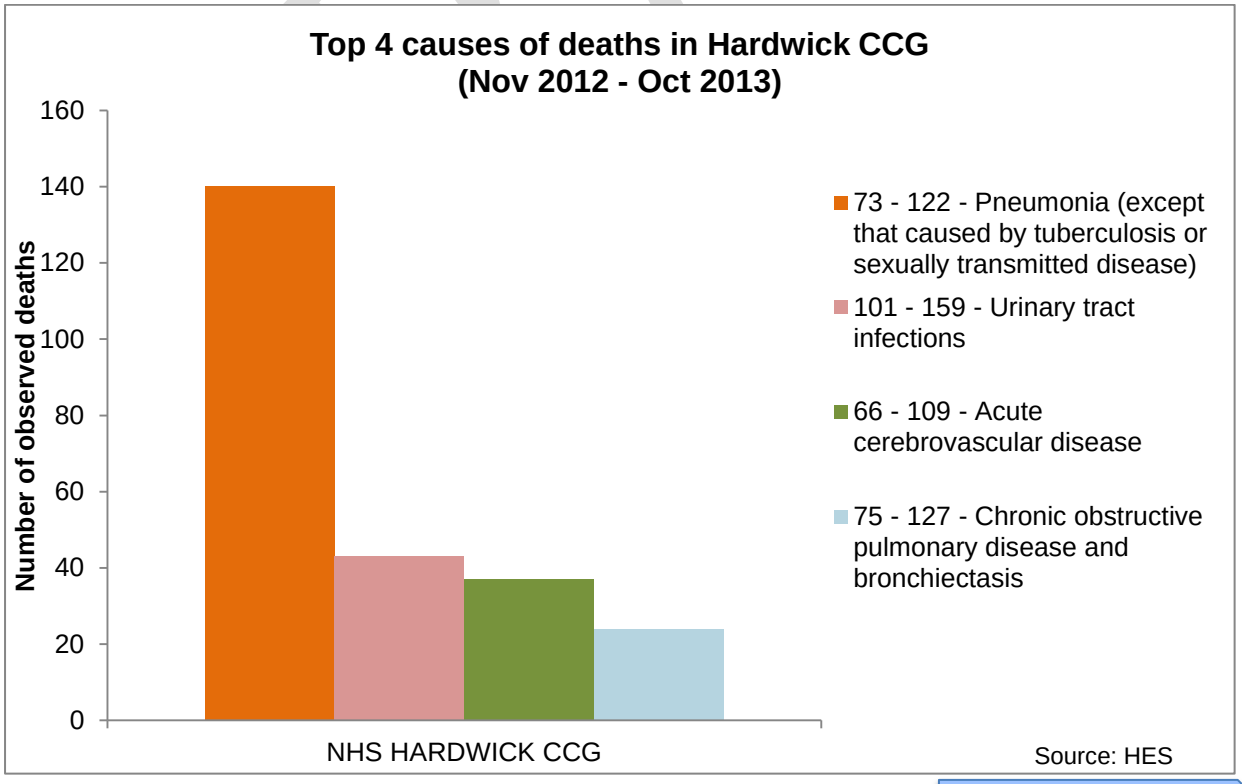
Obesity
- Prevalence 12.2%

Mental Health

Depression
- Prevalence 5.8% (ages 18+)

Diabetes
- Prevalence 7.8%
- Lifestyle
- Self-care

The highest numbers of observed mortalities are due to pneumonia and UTIs.



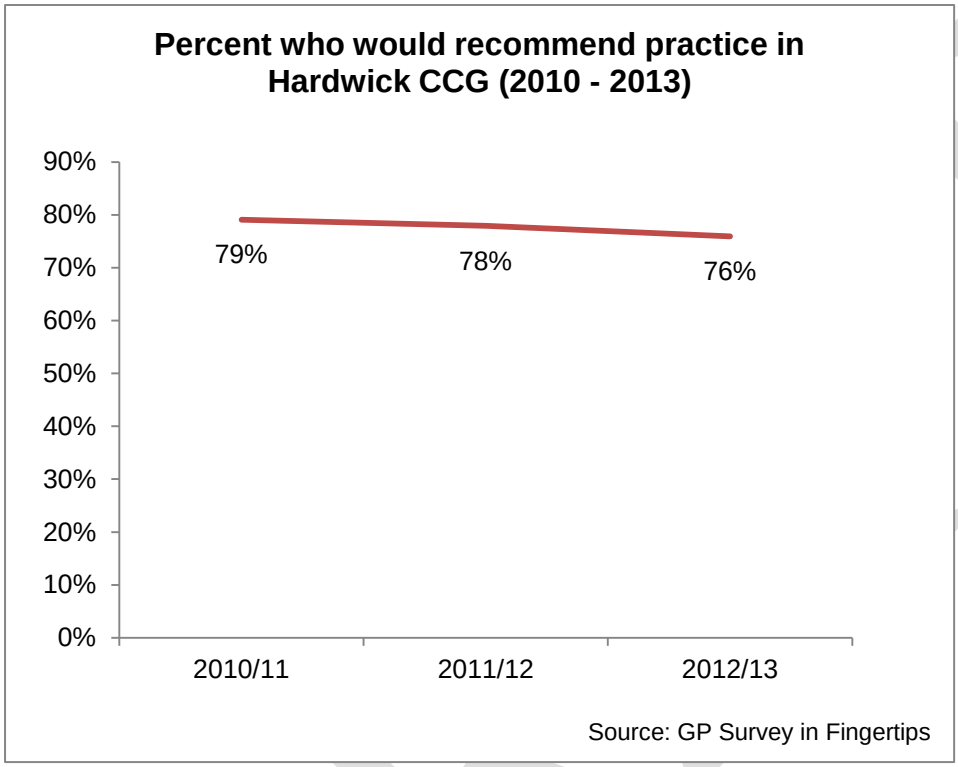
CCGs CONTEXT

LOCAL CONTEXT – HARDWICK CCG - WORKFORCE

Hardwick CCG has a low proportion of GPs over 55 years old (10%) as compared to the England average (19.8%). Out of the total headcount of GPs, 53 are female and 44 are male.

SATISFACTION WITH ACCESS TO PRIMARY CARE

Overall, the percentage of people who would recommend their practice seems to be decreasing since 2010/11 and is currently below the England average of 79.9%.



Provider Overview for Hardwick

Provider Overview for Hardwick

- 16 General Practices
- 102,207 Registered Patients
- 7,462 Average per practice
- 24 Pharmacies
- 7 Dentists
- 5 Optometrists

Hardwick CCG Priorities include:

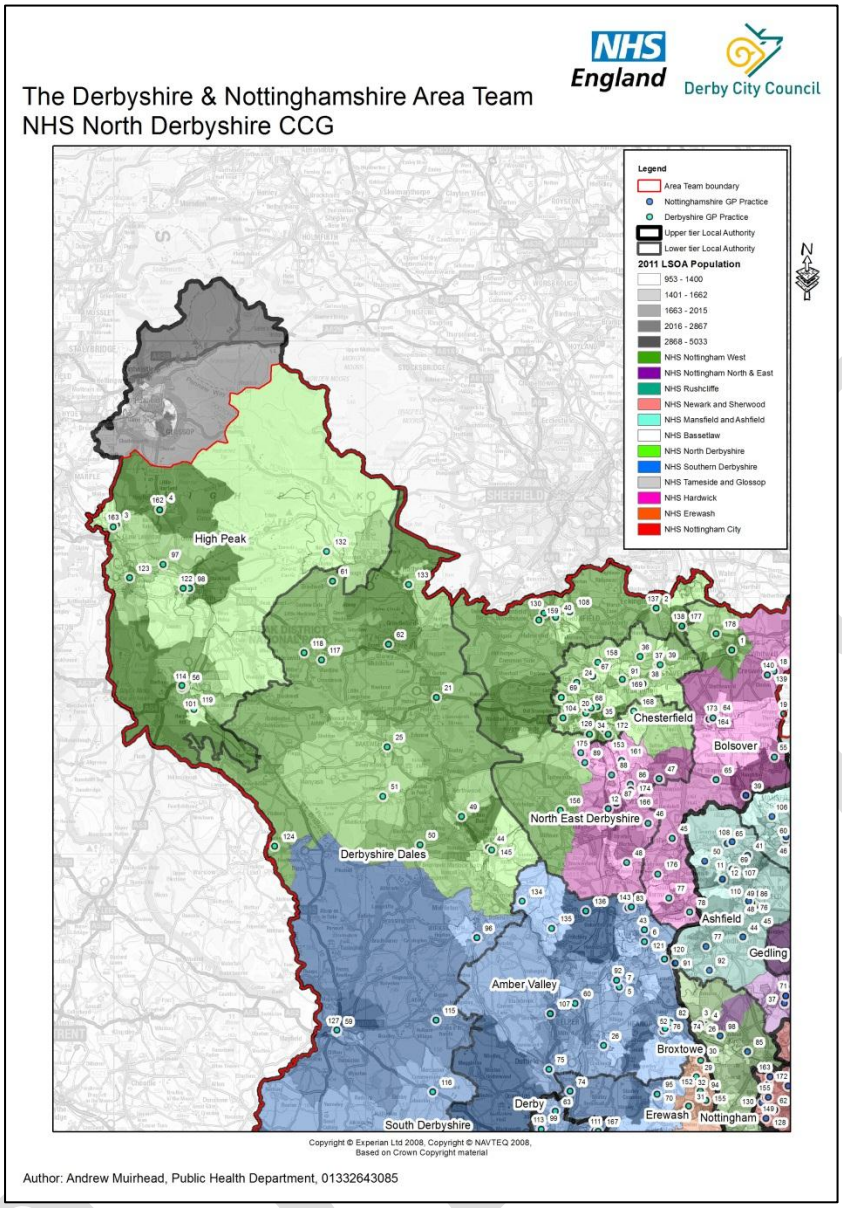
- Remodel capacity and demand in primary care
- Link patients to existing voluntary sector
- Support patients to manager own care
- Reduce demand on NHS and social care
- Build and support existing social capital

DN: CCG to agree and amend or Insert others…

Key Planned Hardwick CCG Developments:

- General practice and workload pilot
- Building social capital to improve care

LOCAL CONTEXT - NORTH DERBYSHIRE CCG



LOCAL HEALTH PRIORITIES

Cardiovascular Disease

Hypertension
- Prevalence 16.0%

Strokes
- Prevalence 2.3%

Smoking
- Prevalence 19.1%

CCGs CONTEXT

- Prevalence 2.3%
- 6,688 patients with cancer

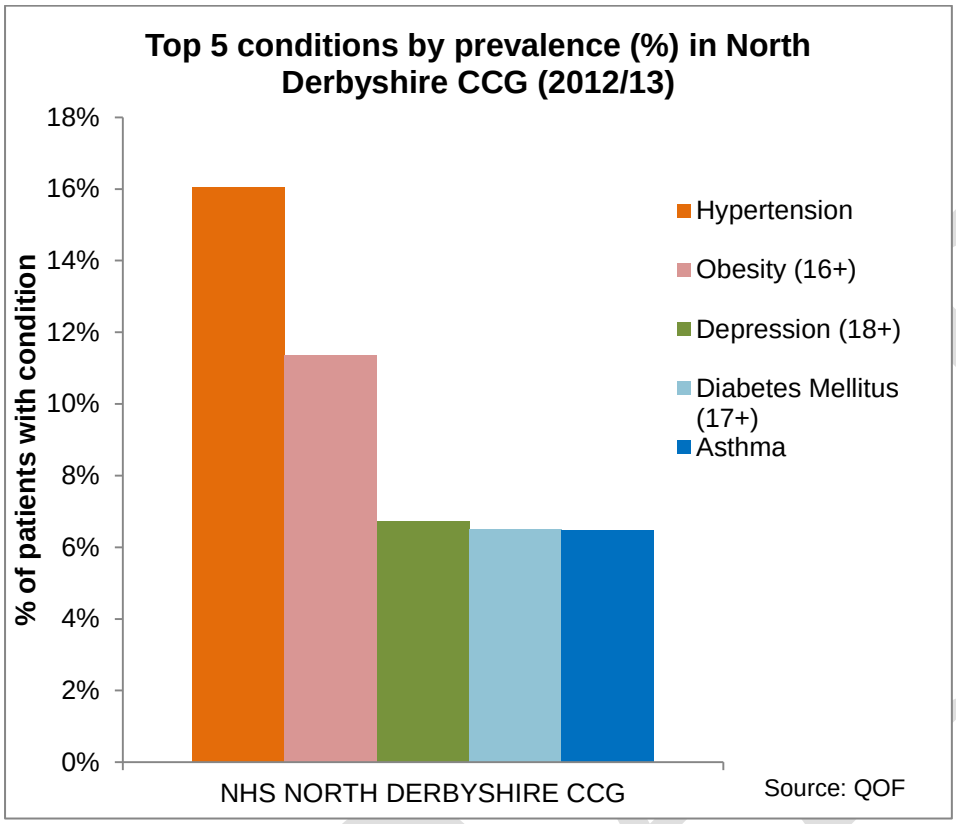
Respiratory Disease

COPD
- Prevalence 2.0%

Asthma
- Prevalence 6.5%

LOCAL CONTEXT – NORTH DERBYSHIRE CCG

The prevalence rate of hypertension in the CCG is higher than the average for Nottingham and Derbyshire. In addition to that, the CCG has the highest prevalence of stroke in the area.



Other Key Health Issues

Kidney Disease
- Prevalence 6.2%

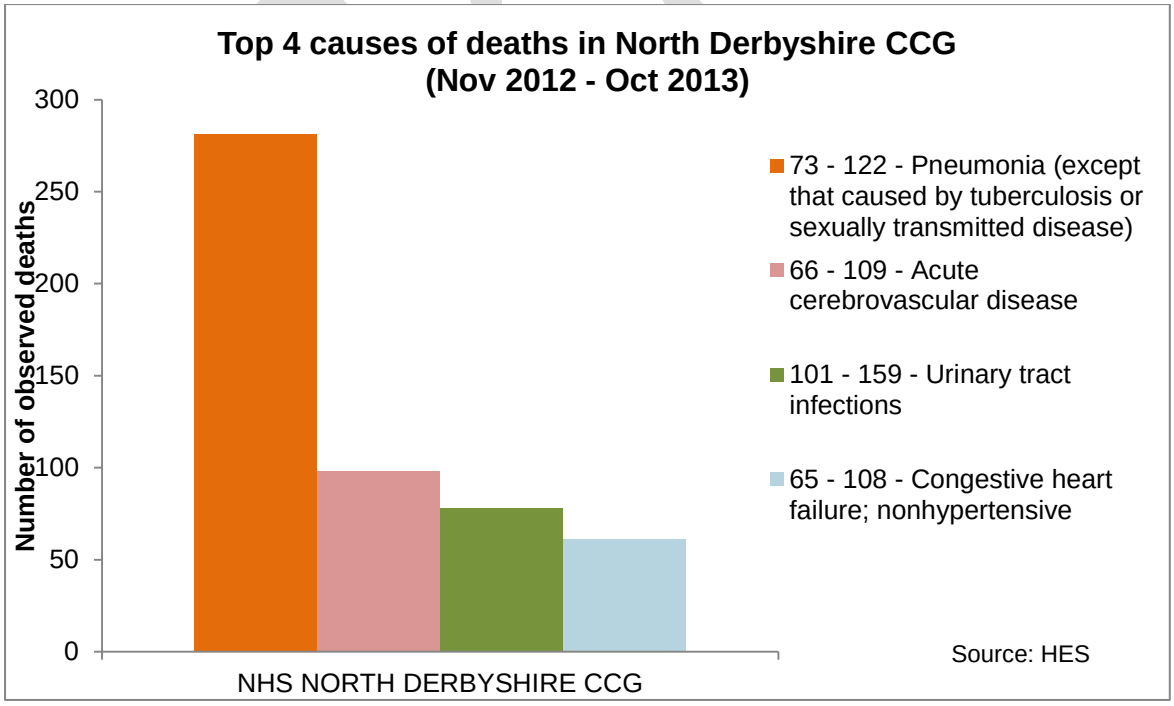
Obesity
- Prevalence 11.4%

Mental Health

Depression
- Prevalence 6.7% (ages 18+)

Diabetes
- Prevalence 6.5%
- Lifestyle
- Self-care

The most common causes of observed deaths are pneumonia and acute CVD.

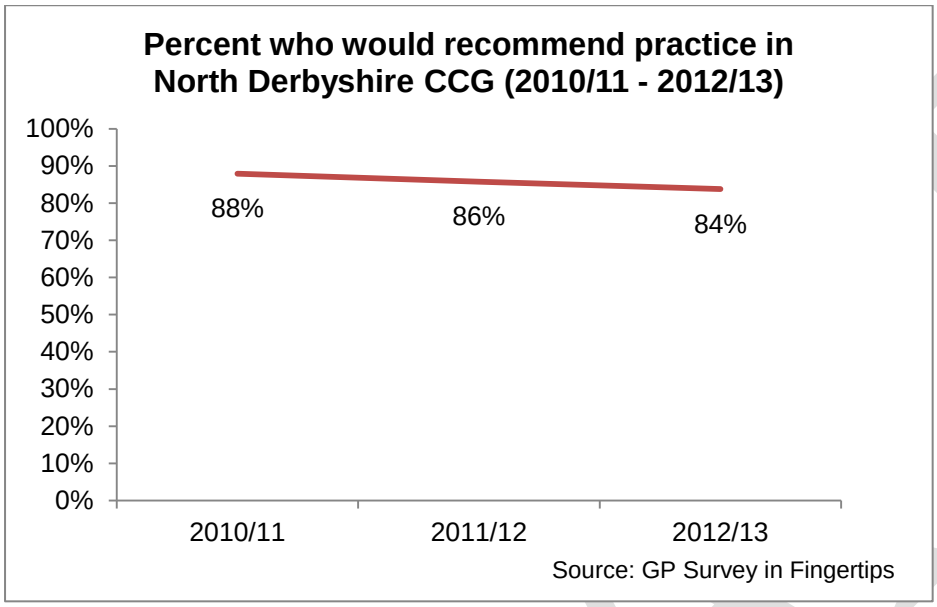


LOCAL CONTEXT – NORTH DERBYSHIRE CCG – WORKFORCE

North Derbyshire has one of the lowest rates of GPs over 55 and patients per GP FTE. There are 129 male and 140 female general practitioners.

SATISFACTION WITH ACCESS TO PRIMARY CARE

Despite the downward trend of people who would recommend their practice in North Derbyshire, the CCG is still above the England average by 4%.



Provider Overview for North Derbyshire CCG

Provider Overview for ND CCG

- 38 General Practices
- 289,575 Registered Patients
- 7,620 Average per GP practice
- 58 Pharmacies
- 45 Dentists
- 36 Optometrists

ND CCG priorities include

- Primary care is integrated within the health and care system
- Sustainable primary care organised and commissioned effectively
- Day time and OOH care seemless
- Quality and consistency within general practices enhanced
- Shared clinical records across primary care providers

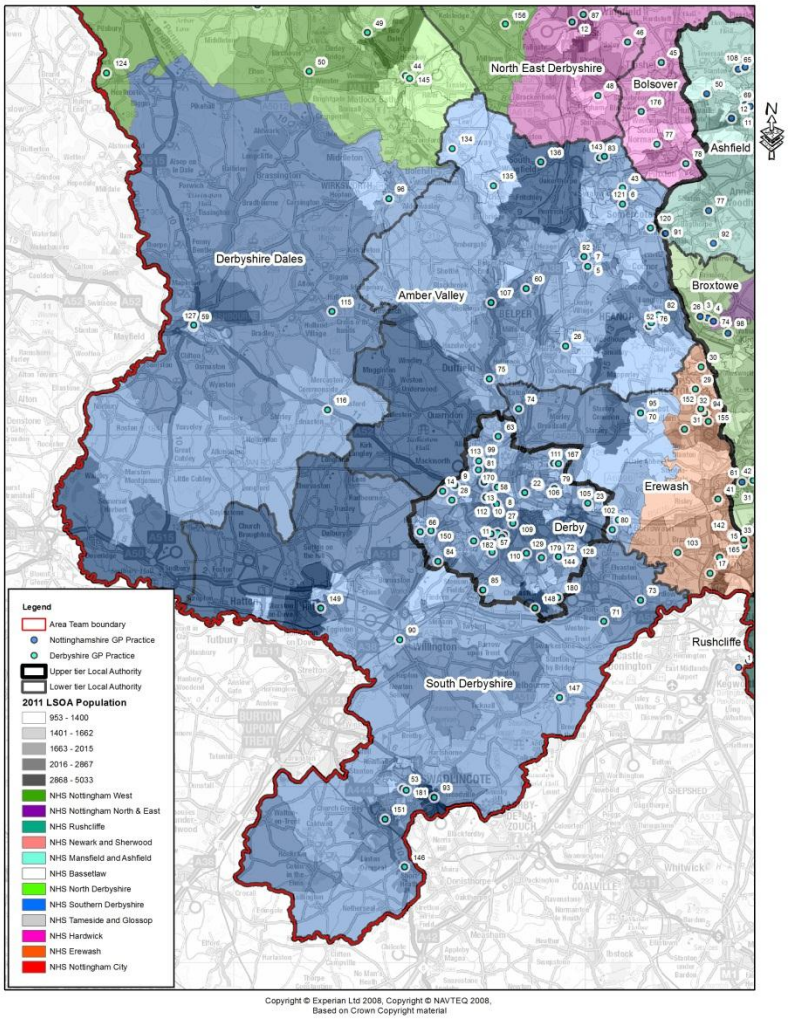
DN CCG to amend as appropriate

Key Developments for ND CCG

- Patient care summary record information sharing
- Federating general practices

LOCAL CONTEXT – SOUTHERN DERBYSHIRE CCG

The Derbyshire & Nottinghamshire Area Team
NHS Southern Derbyshire CCG



Author: Andrew Muirhead, Public Health Department, 01332643085

LOCAL HEALTH PRIORITIES

Cardiovascular Disease

Hypertension
- Prevalence 14.0%

Strokes
- Prevalence 1.8%

Smoking
- Prevalence 14.8% Significantly better than England average

Cancers

- Prevalence 1.8%
- 9,741 patients with cancer

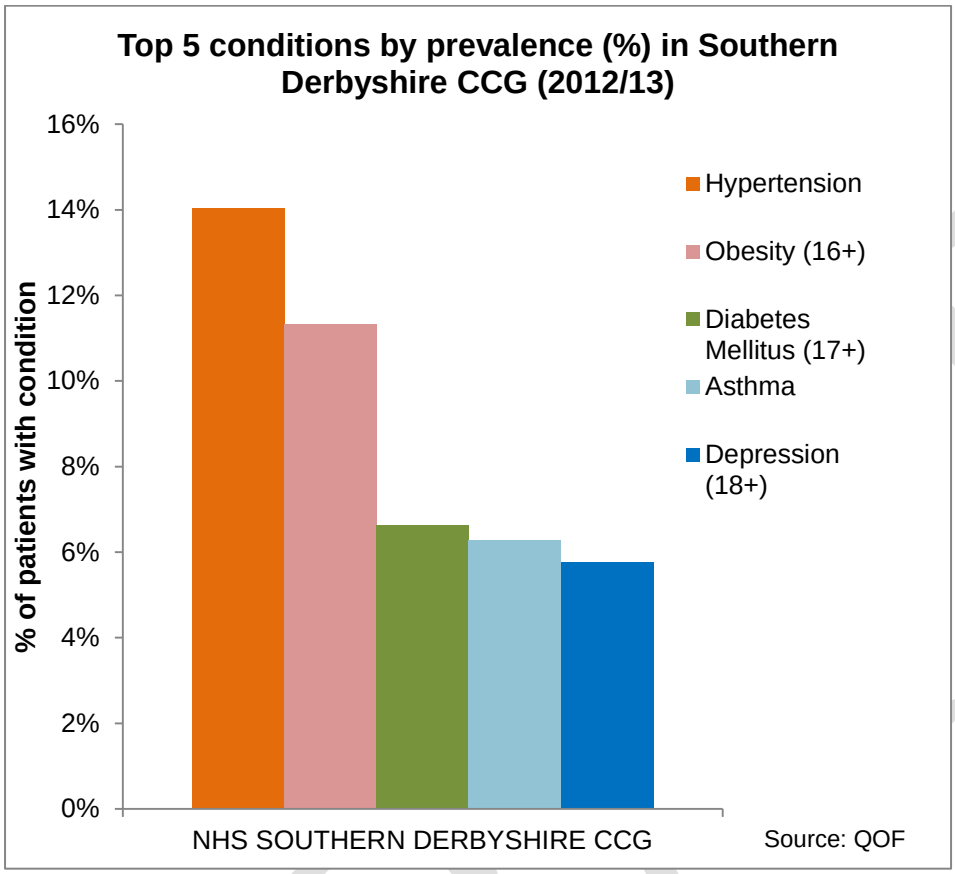
Respiratory Disease

COPD
- Prevalence 1.8%

Asthma
- Prevalence 6.4%

LOCAL CONTEXT – SOUTHERN DERBYSHIRE CCG Key themes

Southern Derbyshire has a significantly better than average percentage of smokers. The prevalence of obesity is above average for Derbyshire and Nottinghamshire.



Other Key Health Issues

Kidney Disease
- Prevalence 4.6%

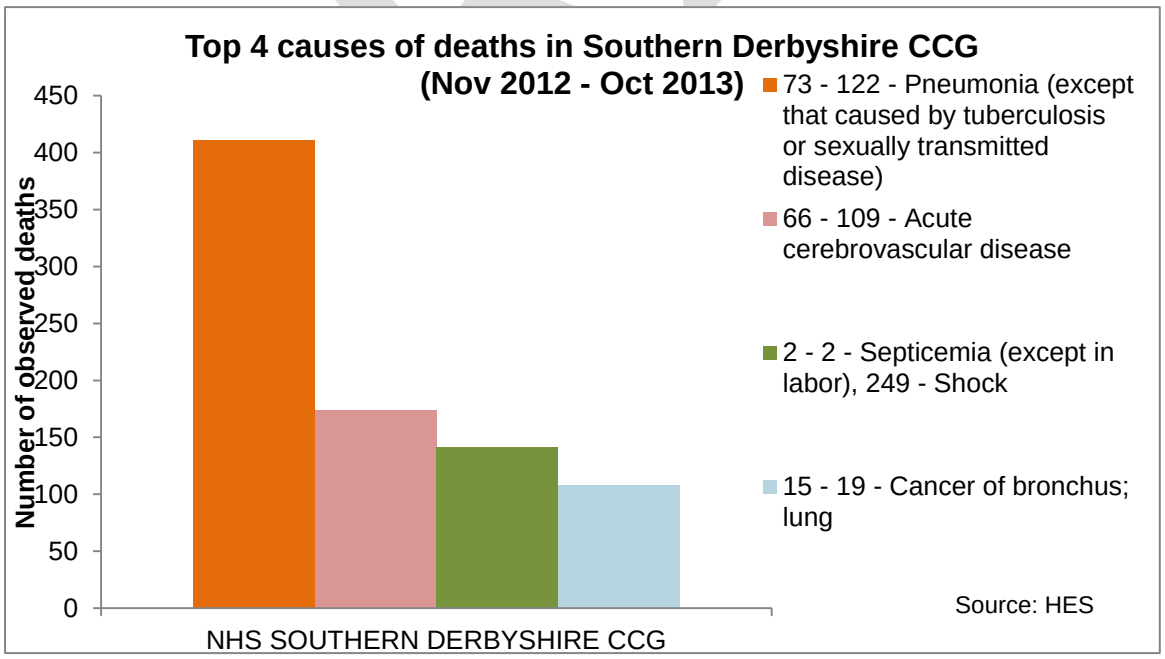
Obesity
- Prevalence 11.3%

Mental Health

Depression
- Prevalence 5.8% (ages 18+)

Diabetes
- Prevalence 6.6%
- Lifestyle
- Self-care

The most common causes of death are pneumonia and acute CVD.

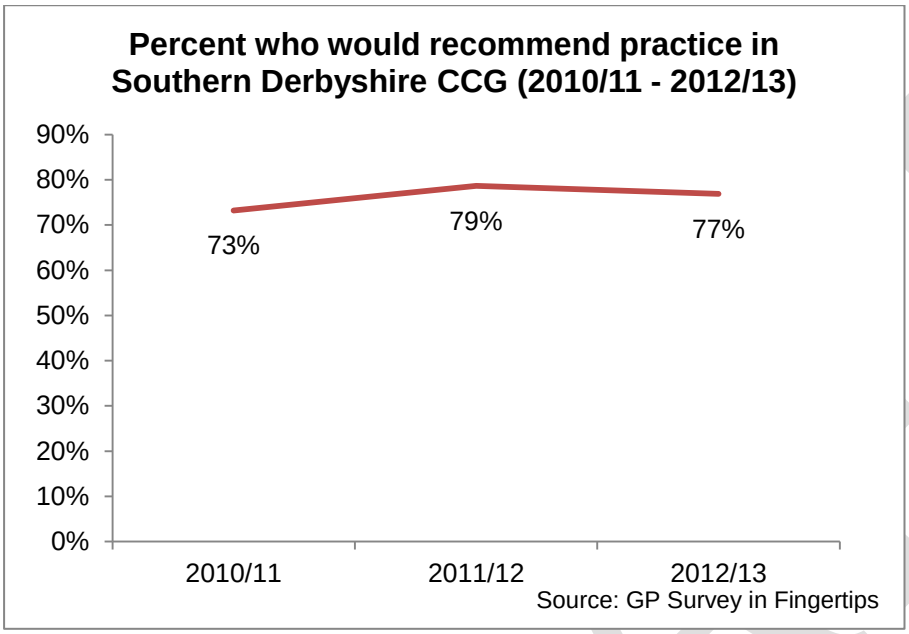


LOCAL CONTEXT – SOUTHERN DERBYSHIRE CCG - WORKFORCE

The CCG has a below average number of GPs over 55 and patients per GP FTE. There are 215 male and 195 female GPs.

SATISFACTION WITH ACCESS TO PRIMARY CARE

The percentage of patients who would recommend their practice has been increasing since 2010/11, but is still slightly below the England average.



Provider Overview for Southern Derbyshire CCG

Provider Overview for SD CCG

- 57 General Practices
- 537,030 Registered Patients
- 9,421 Average per GP practice
- 113 Pharmacies
- 60 Dentists
- 49 Optometrists

SD CCG priorities include

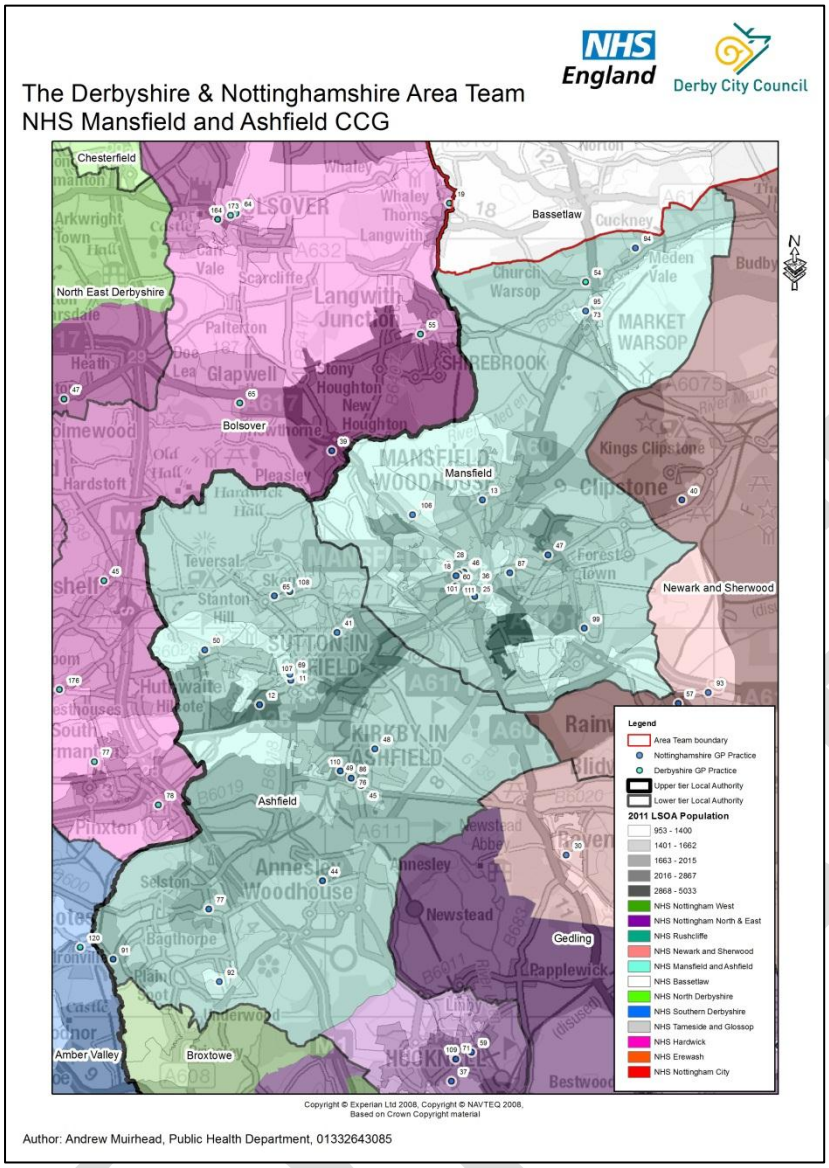
- Promotion of practices working together
- Support practices in care of over 75s
- Develop workforce and strengthen education / training
- Identify areas where quality and performance can be enhanced
- Consistent framework for practice visits, feedback
- Better use of technology solutions
- Implement new commissioning framework and incentivise and reward practices for successful innovation

DN CCG to amend as appropriate

Key Developments for SD CCG

- Improve patient online access to records,
- Improve electronic booking of appointments, registration and prescriptions

LOCAL CONTEXT - MANSFIELD AND ASHFIELD CCG Key themes



LOCAL HEALTH PRIORITIES

Cardiovascular Disease

Hypertension
- Prevalence 14.0%

Strokes
- Prevalence 1.8%

Smoking
- Prevalence 14.8%

Cancers

- Prevalence 1.8%
- 9,741 patients with cancer

Respiratory Disease

COPD
- Prevalence 1.8%

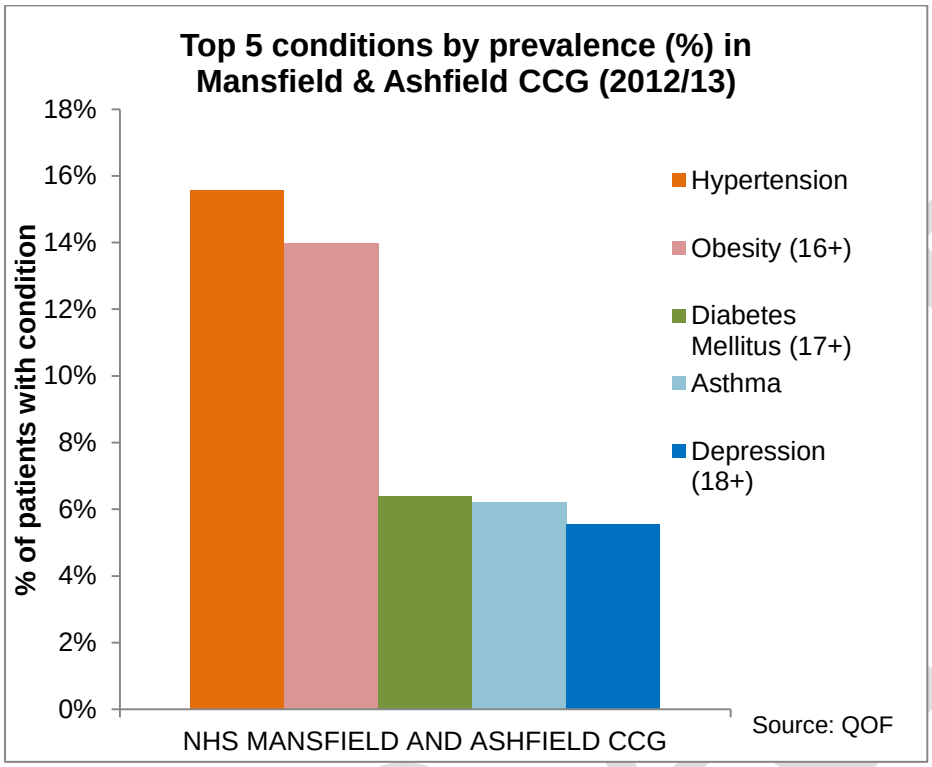
Asthma
- Prevalence 6.4%

Key Developments:

- Develop integrating primary care, community and social care

LOCAL CONTEXT - POPULATION AND HEALTH NEEDS IN MANSFIELD & ASHFIELD CCG

Mansfield & Ashfield CCG has the highest levels of obesity in Nottinghamshire and Derbyshire. Furthermore, the prevalence of smoking is also the highest in the area with 29.4% of population smoking.



Other Key Health Issues

Kidney Disease
- Prevalence 5.1%

Obesity
- Prevalence 14.0%

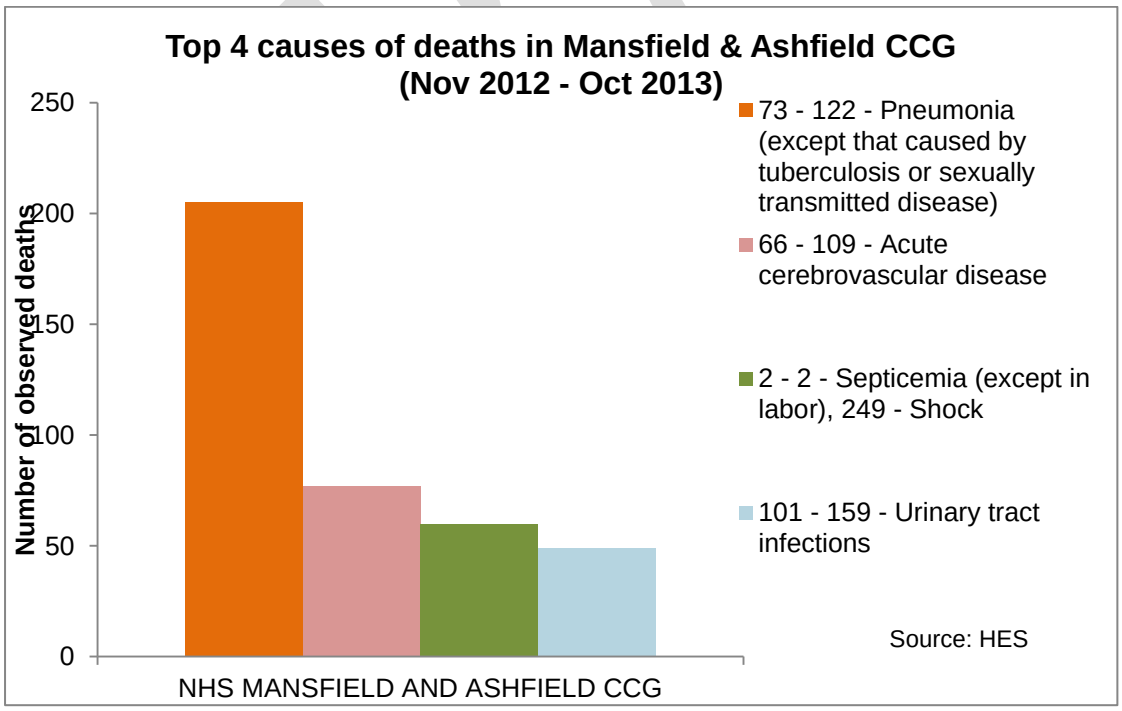
Mental Health

Depression
- Prevalence 5.5% (ages 18+)

Diabetes

- Prevalence 6.4%
- Lifestyle
- Self-care

The most common causes of observed deaths are pneumonia and acute CVD.

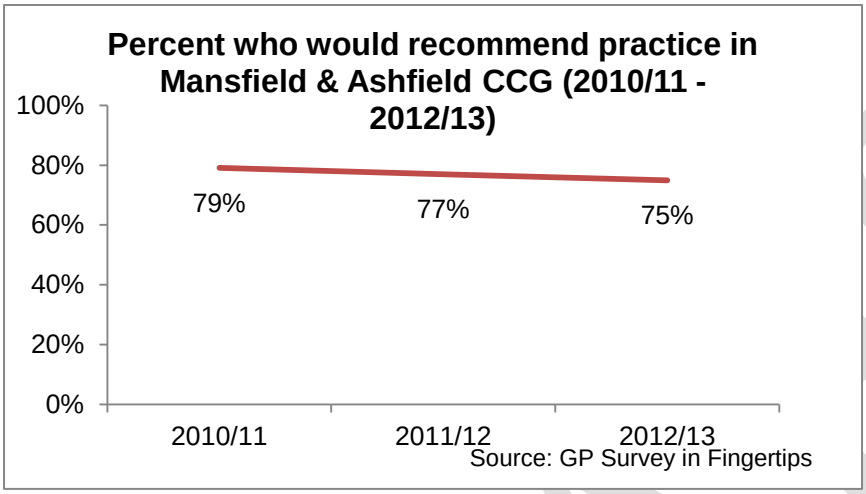


LOCAL CONTEXT MANSFIELD AND ASHFIELD CCG – WORKFORCE

Mansfield & Ashfield CCG has a high proportion of GPs over 55 years old (22%) as compared to the England average (19.8%). The workforce in the CCG is predominantly male, with 71 male GPs and 38 female

SATISFACTION WITH ACCESS TO PRIMARY CARE

The percentage of people who would recommend their practice has been decreasing since 2010/11 and is now 4% below the England average.



Provider Overview for Mansfield and Ashfield CCG

Provider Overview for M & A CCG

- 31 General Practices
- 186,111 Registered Patients
- 6,003 Average per GP practice
- 41 Pharmacies
- 19 Dentists
- 19 Optometrists

M & A CCG priorities include

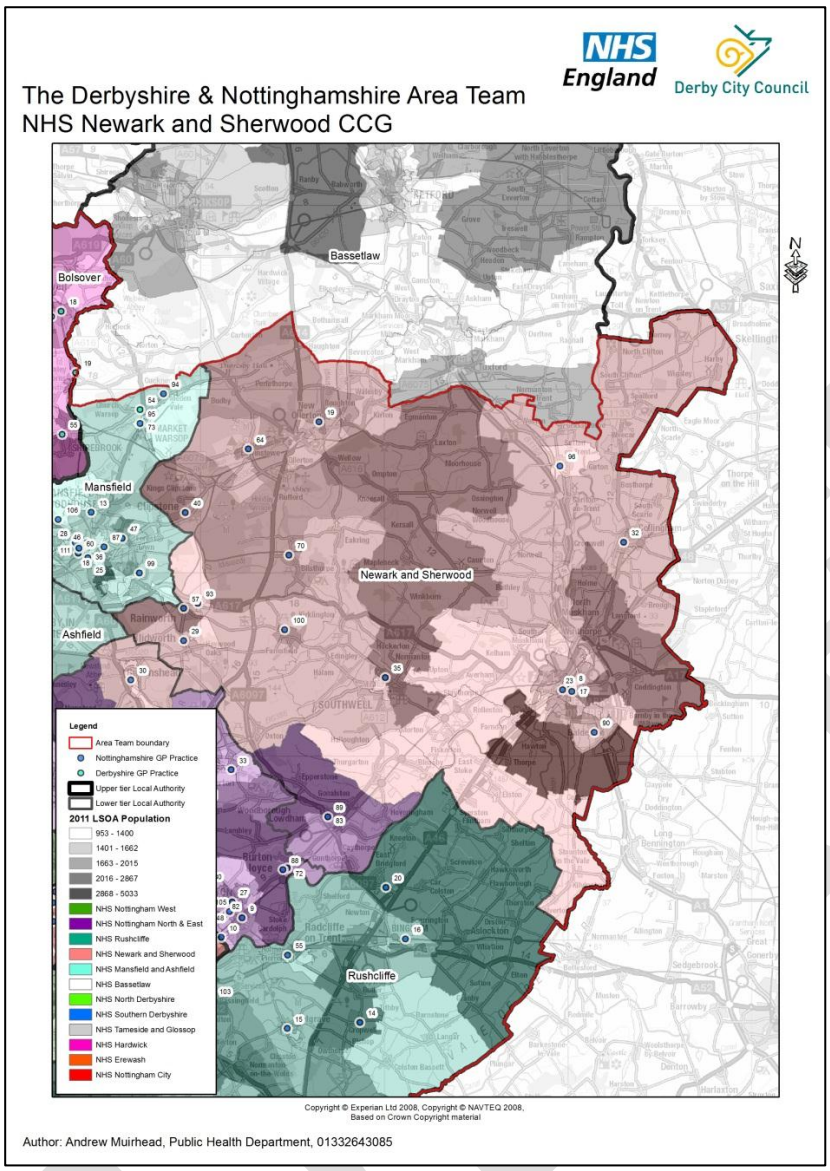
- Build system capacity to manage rising demand
- Develop local priority outcomes for quality premium
- Join up services more to improve care
- Improve the way major causes of ill health and disease are tackled
- Promote wellbeing more

DN CCG to amend as appropriate

Key Developments for M & A CCG

- Integrate in and out of hours urgent care
- Change patient flows to get right clinical decision first time
- Single front door and extended hours
- IT and estates changes

LOCAL CONTEXT - NEWARK AND SHERWOOD CCG Key themes



LOCAL HEALTH PRIORITIES

Cardiovascular Disease

Hypertension
- Prevalence 14.7%

Strokes
- Prevalence 1.9%

Smoking
- Prevalence 20.1%

Cancers

- Prevalence 2.3%
- 2,948 patients with cancer

Respiratory Disease

COPD
- Prevalence 2.0%

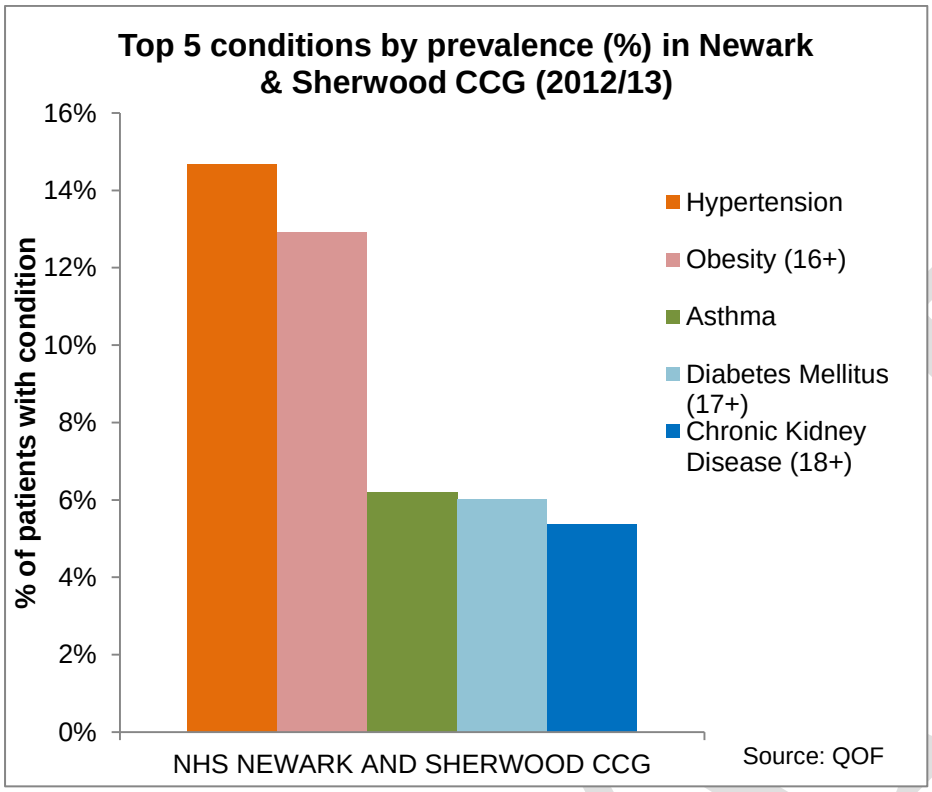
Asthma
- Prevalence 6.2%

Key Developments:

- Develop integrating primary care, community and social care

LOCAL CONTEXT – NEWARK & SHERWOOD CCG Key themes

Newark & Sherwood CCG has one of the lowest prevalence rates of depression and asthma.



Other Key Health Issues

Kidney Disease
- Prevalence 5.4%

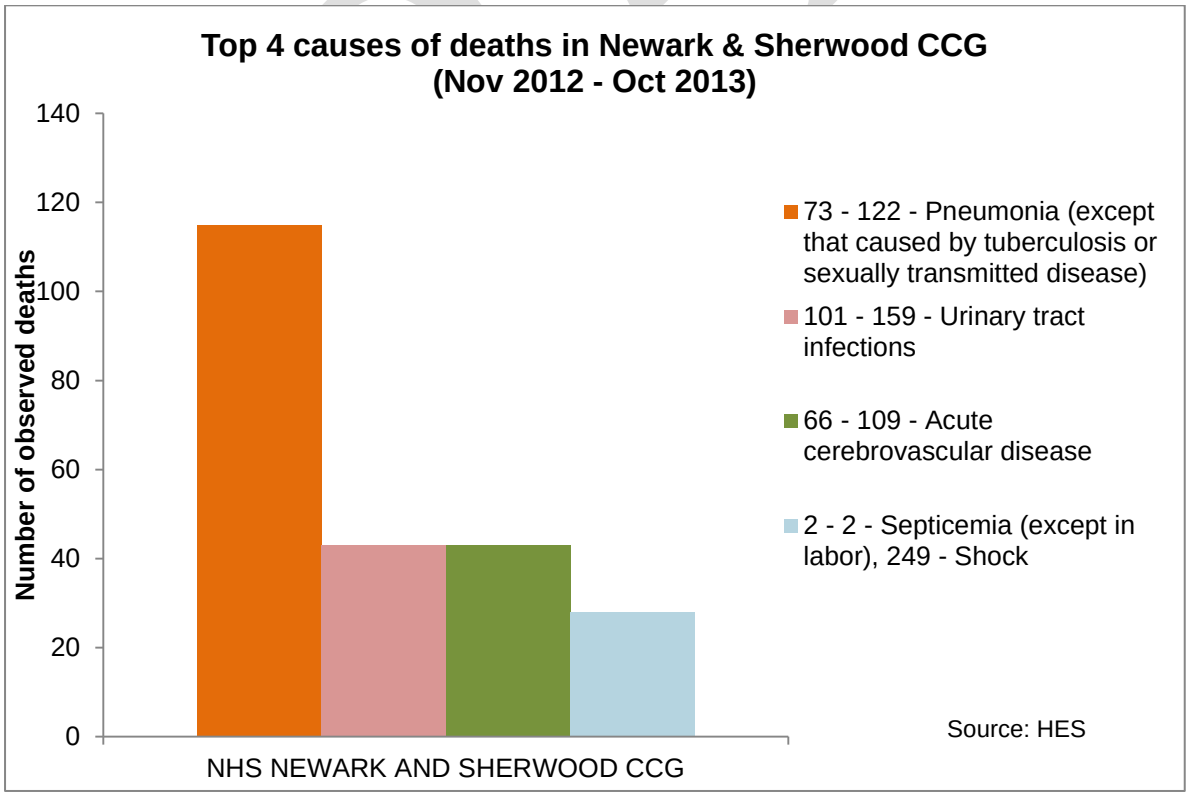
Obesity
- Prevalence 12.9%

Mental Health

Depression
- Prevalence 4.9% (ages 18+)

Diabetes
- Prevalence 6.0%
- Lifestyle
- Self-care

The most common causes of death in the CCG are pneumonia and UTIs.

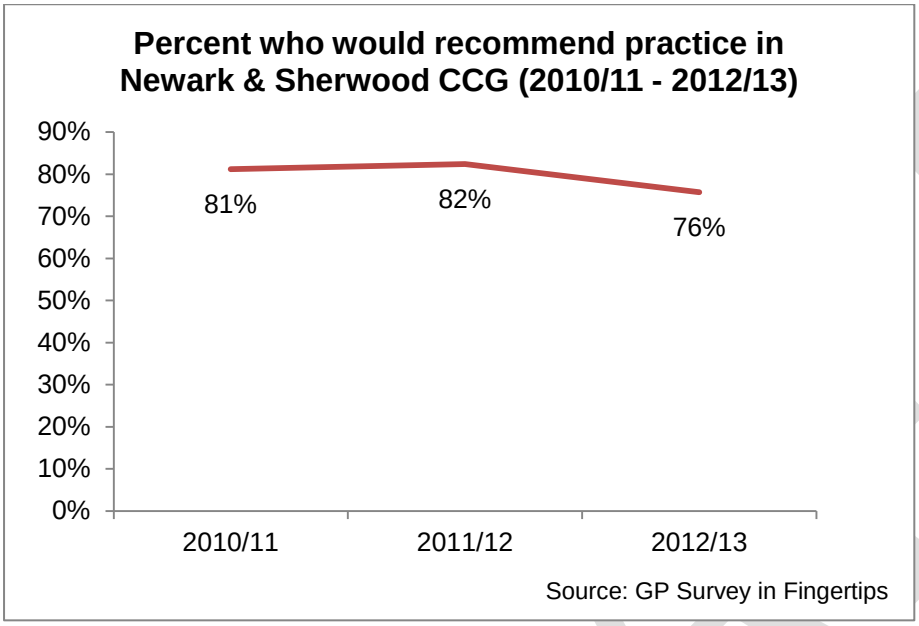


LOCAL CONTEXT NEWARK AND SHERWOOD CCG – WORKFORCE

Newark & Sherwood CCG has a higher than average number of patients per GP FTE. The number of male and female GPs is similar.

SATISFACTION WITH ACCESS TO PRIMARY CARE

The percentage of people who would recommend their practice on the GP Survey has been steadily decreasing over time and is now 3% below the England average.



Provider Overview for Newark and Sherwood CCG

Provider Overview for N & S CCG

- 16 General Practices
- 129,334 Registered Patients
- 8,083 Average per GP practice
- 4 Pharmacies26
- 12 Dentists
- 13 Optometrists

N & S CCG priorities include

- Improve access to primary care services
- Acute episodes of illness managed through primary care in a simpler more responsive way
- Citizens to manage chronic disease proactively
- Citizens have greater control over their care
- Citizens are better connected to family GP / other care
- Improve quality and delivery of primary care

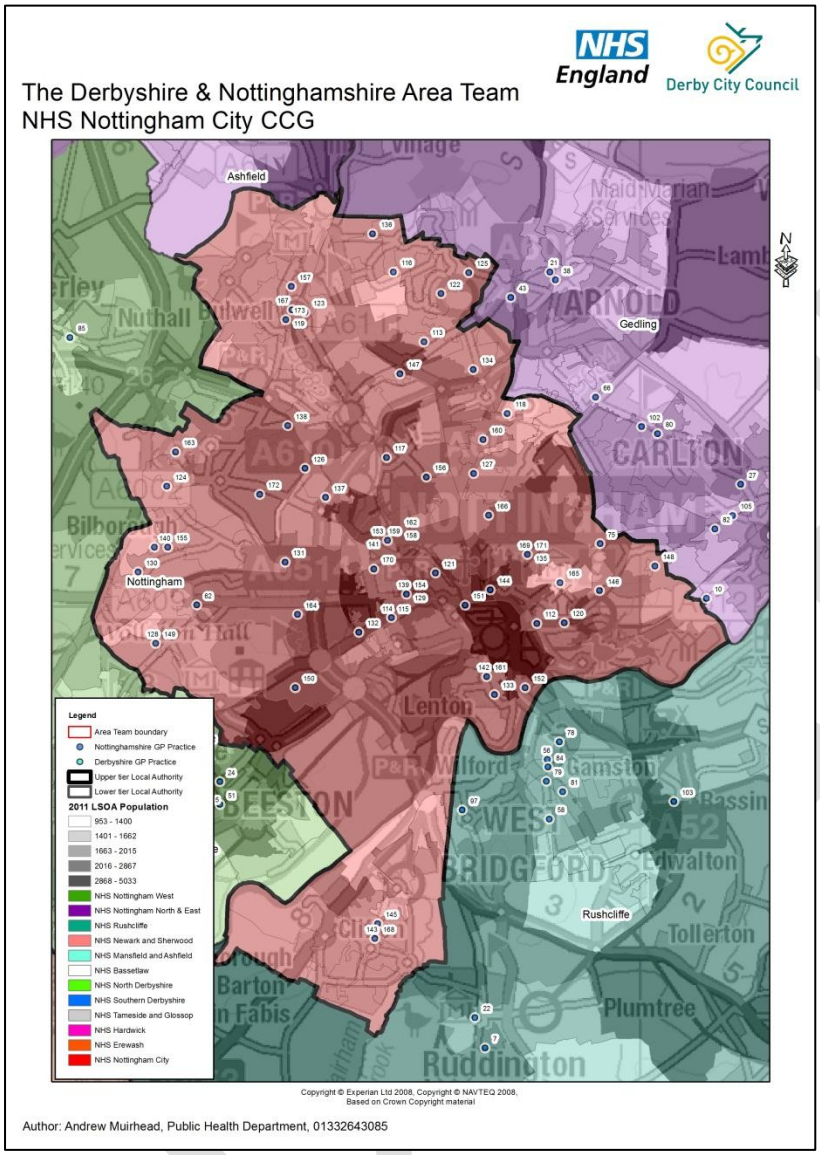
DN CCG to amend as appropriate

Key Developments for N & S CCG

- Integrate in and out of hours urgent care
- Change patient flows to get right clinical decision first time
- Single front door and extended hours
- IT and estates changes

LOCAL CONTEXT – NOTTINGHAM CITY CCG Key themes

Nottingham City's Primary Care Vision is aligned to the Area Team Primary Care strategy to develop sustainable changes by supporting and enabling change to internal systems such as access, workforce and outcomes



LOCAL HEALTH PRIORITIES

Cardiovascular Disease

Hypertension
- Prevalence 10.4%

Strokes
- Prevalence 1.3%

Smoking
- Prevalence 23.3% significantly worse than England average

Cancers

- Prevalence 1.3%
- 3,223 patients with cancer

Respiratory Disease

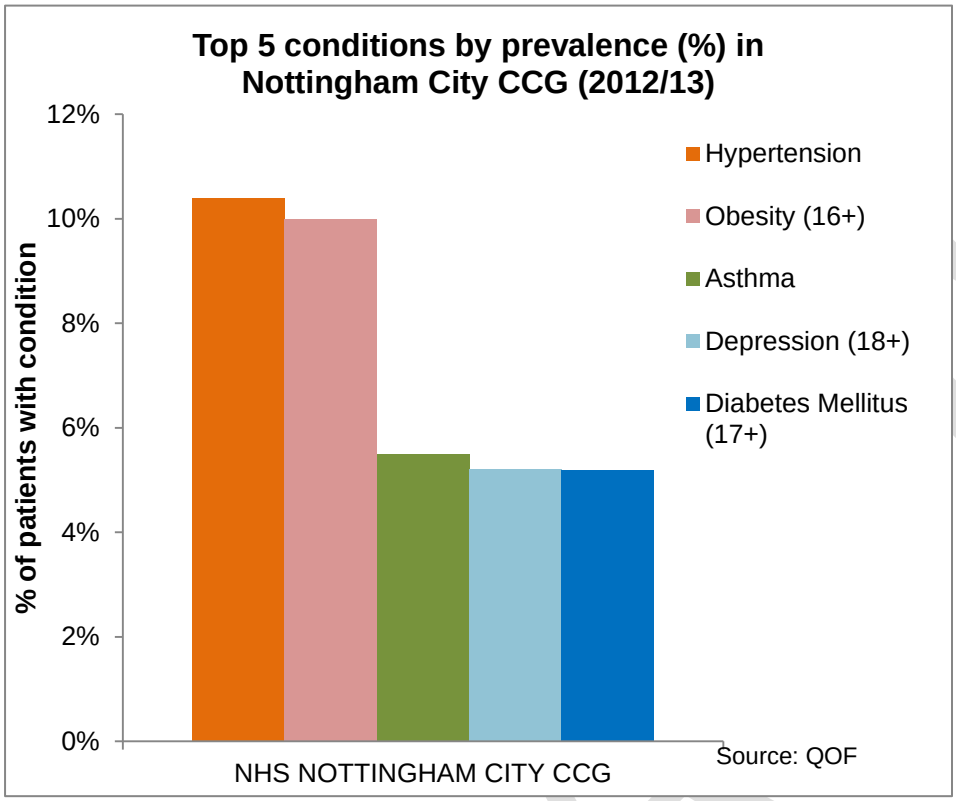
COPD
- Prevalence 1.5%

Asthma
- Prevalence 5.5%

Refer to Appendix CCG plan on a page
DN: Insert links to Primary Care plans

LOCAL CONTEXT – NOTTINGHAM CITY CCG Key themes

Nottingham City CCG has a significantly worse than average percentage of population that smokes.



Other Key Health Issues

Kidney Disease
- Prevalence 4.3%

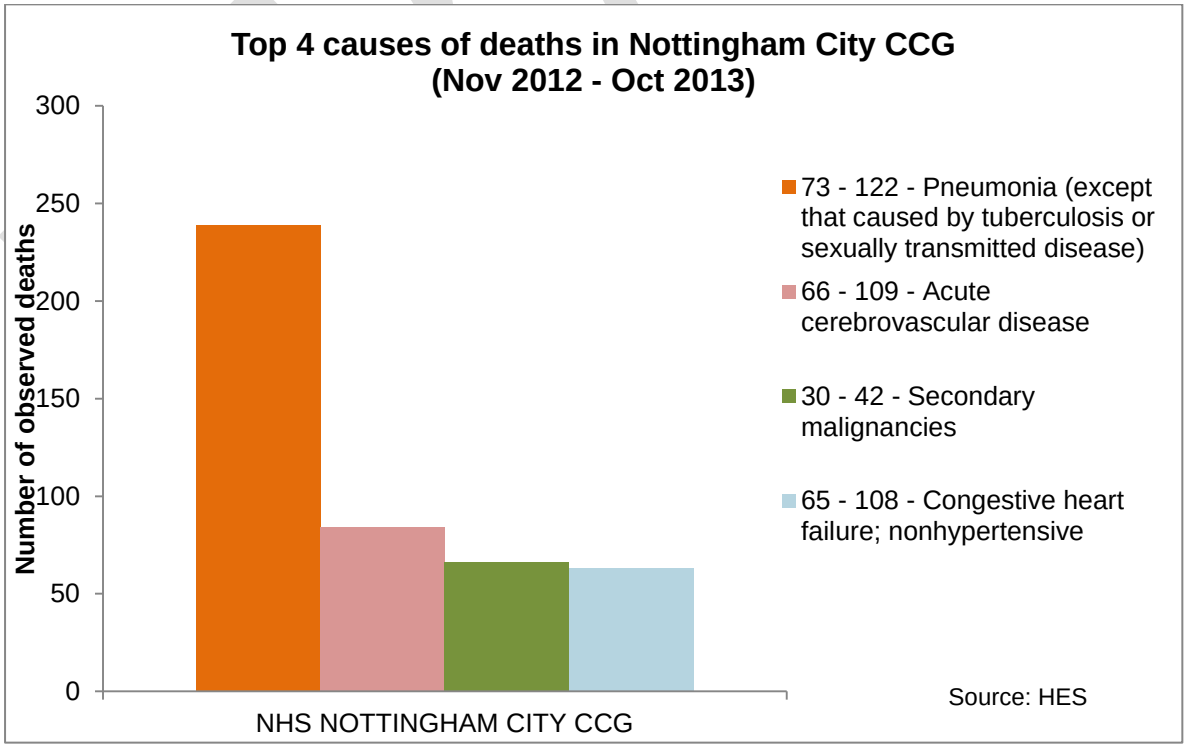
Obesity
- Prevalence 10.0%

Mental Health

Depression
- Prevalence 5.2% (ages 18+)

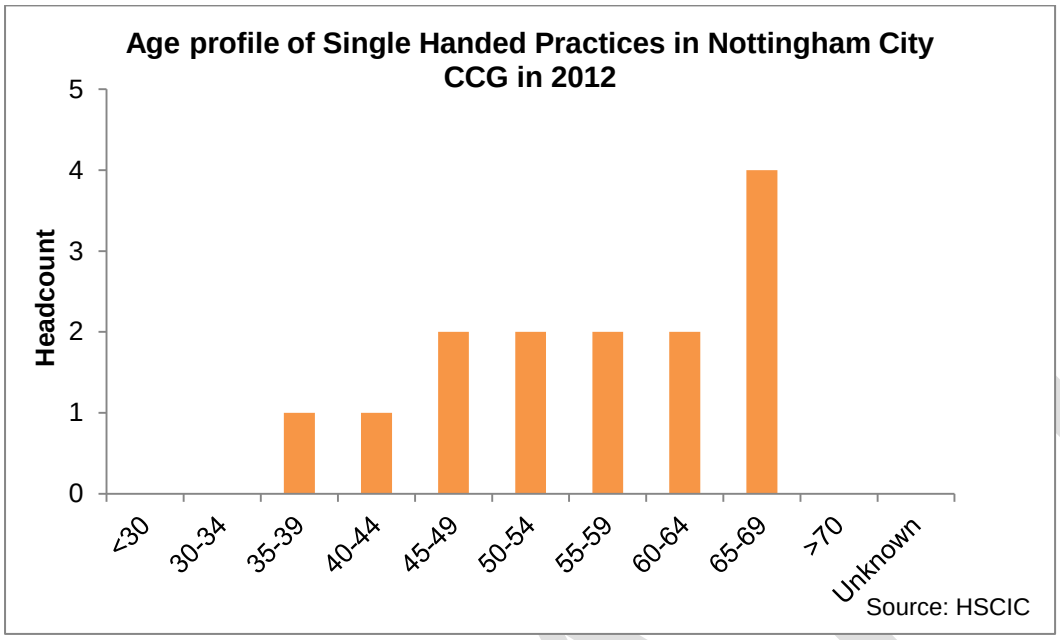
Diabetes
- Prevalence 5.2%
- Lifestyle
- Self-care

The most common causes of observed deaths in the CCG are pneumonia and CVD.



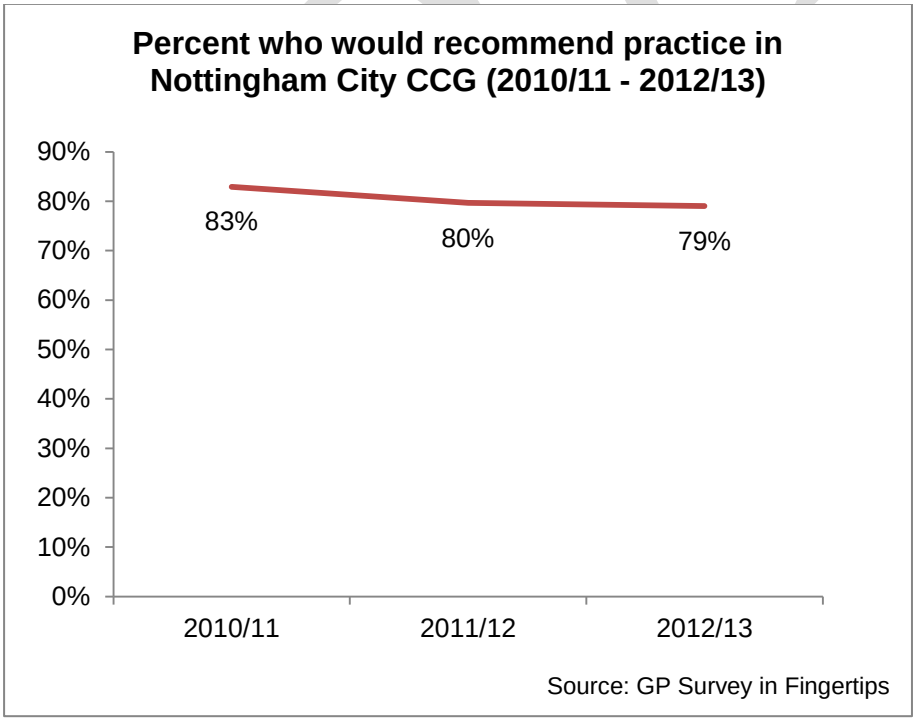
LOCAL CONTEXT – NOTTINGHAM CITY CCG - WORKFORCE

As previously mentioned, the CCG has the highest number of single handed practices in Derbyshire and Nottinghamshire. An analysis of GP age in single handed practices reveals that in four of them the GP is 65 years old or older.



SATISFACTION WITH ACCESS TO PRIMARY CARE

The percentage of patients who would recommend their practice seems to be decreasing since 2010/11. It is currently equal to the England average.



LOCAL CONTEXT FOR NOTTINGHAM CITY CCG

Provider Overview for Nottingham City CCG

Provider Overview for NC CCG

- 65 General Practices
- 357,889 Registered Patients
- 5,505 Average per GP practice
- 65 Pharmacies
- 46 Dentists
- 32 Optometrists

Nottingham City CCG priorities include

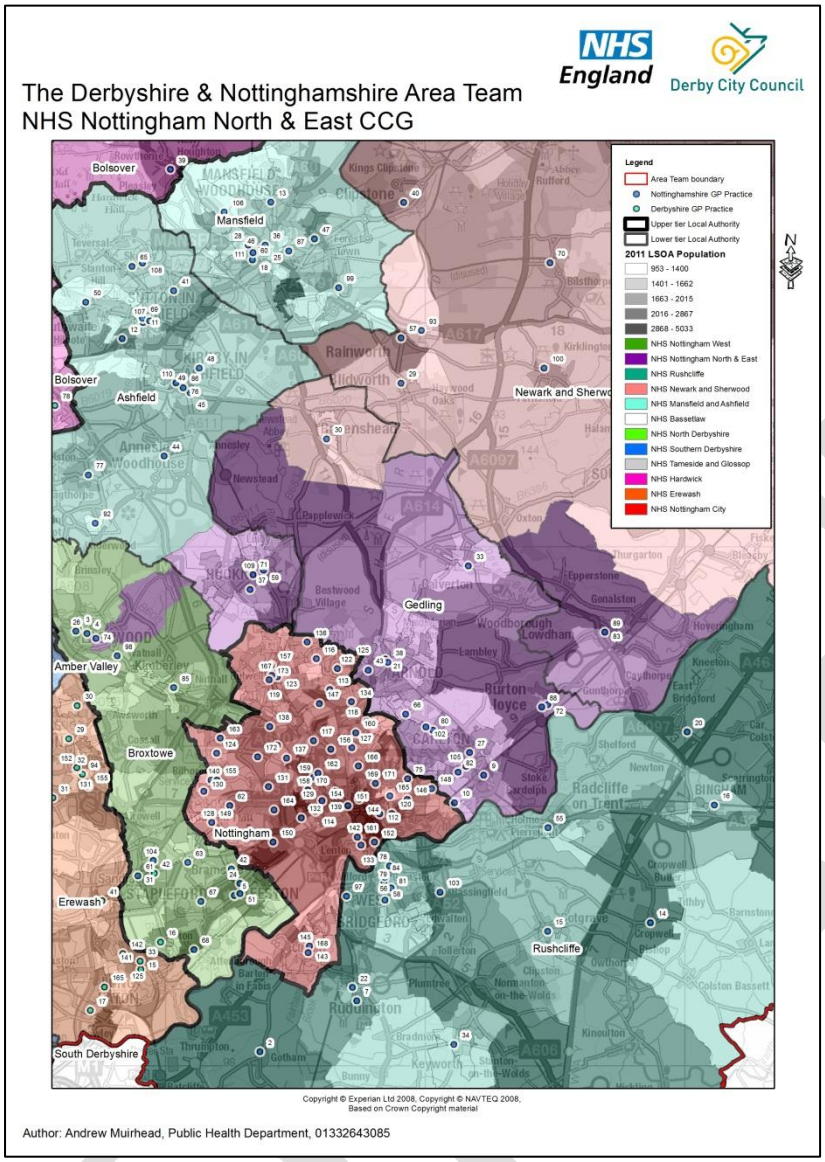
- Integrate primary community and social care
- Standardise and improve access
- Utilise and adapt innovation and best practice
- Develop shared working and workforce
- Promote shared responsibility of health

DN CCG to amend as appropriate

Key Developments for Nottingham City CCG

- Develop 8 health and social Care Delivery Groups integrating primary care, community and social care
- Introduction of neighbourhood teams
- Standardisation of access to primary care, develop 7 / 7 access
- Develop shared working and workforce to make best use of resources
- Focus on patients with long term conditions, vulnerable patients and GP cover in community assessment beds
- Appointment offered within 4 hours to see extended GP team

LOCAL CONTEXT FOR NOTTINGHAM NORTH & EAST CCG Key themes



LOCAL HEALTH PRIORITIES

Cardiovascular Disease

Hypertension
- Prevalence 14.9%

Strokes
- Prevalence 2.0%

Smoking
- Prevalence 15.6%

Cancers

- Prevalence 2.1%
- 3,081 patients with cancer

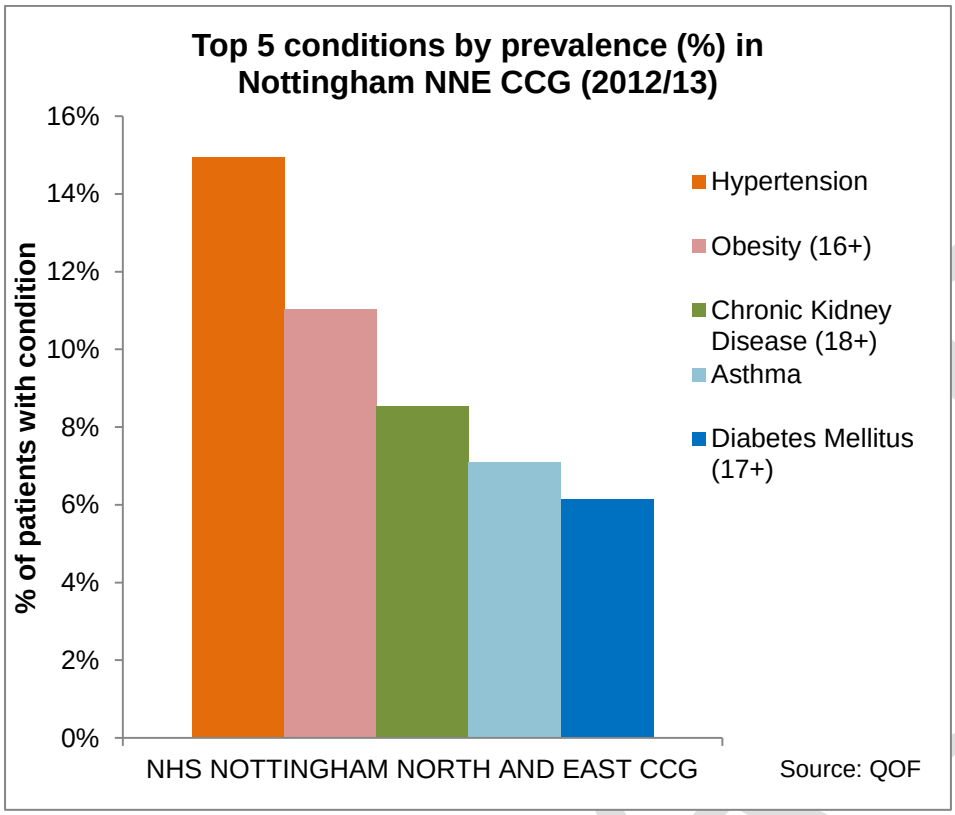
Respiratory Disease

COPD
- Prevalence 1.9%

Asthma
- Prevalence 7.1%

LOCAL CONTEXT – NOTTINGHAM NORTH AND EAST CCG Key themes

Nottingham North and East CCG has the highest prevalence of asthma of all CCGs.



Other Key Health Issues

Kidney Disease
- Prevalence 8.5%

Obesity
- Prevalence 11.0%

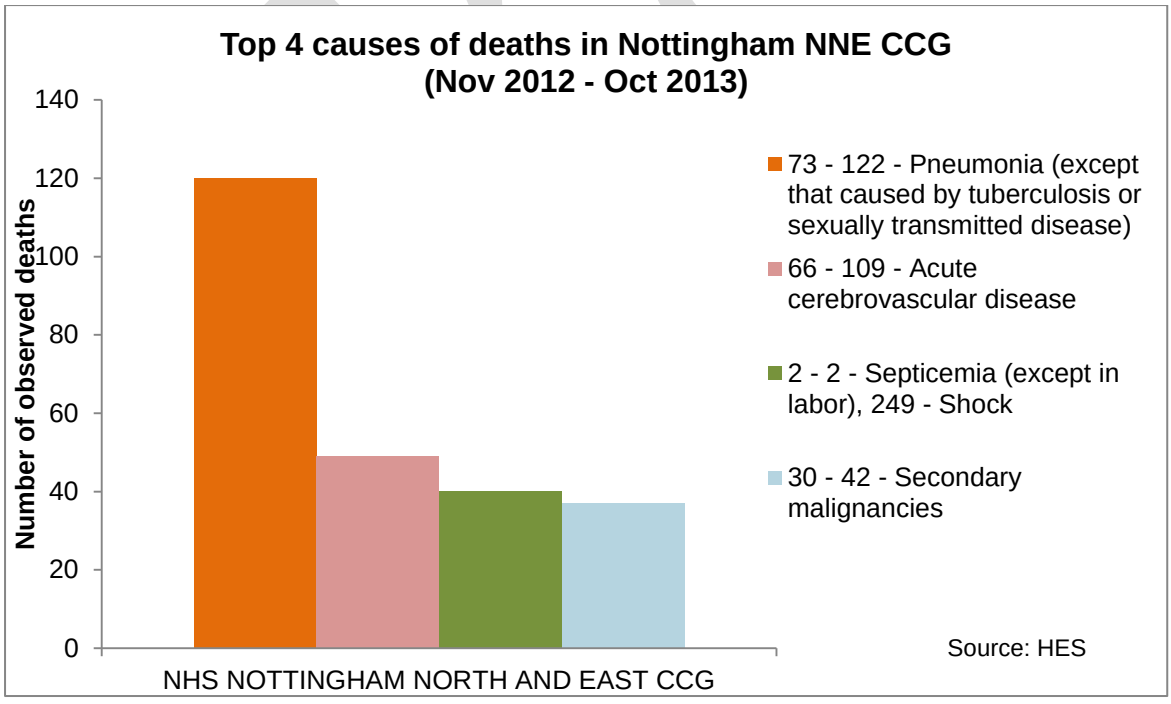
Mental Health

Depression
- Prevalence 5.0% (ages 18+)

Diabetes

- Prevalence 6.1%
- Lifestyle
- Self-care

Similarly to most CCGs in Derbyshire and Nottinghamshire, pneumonia and acute CVD are the major causes of death.

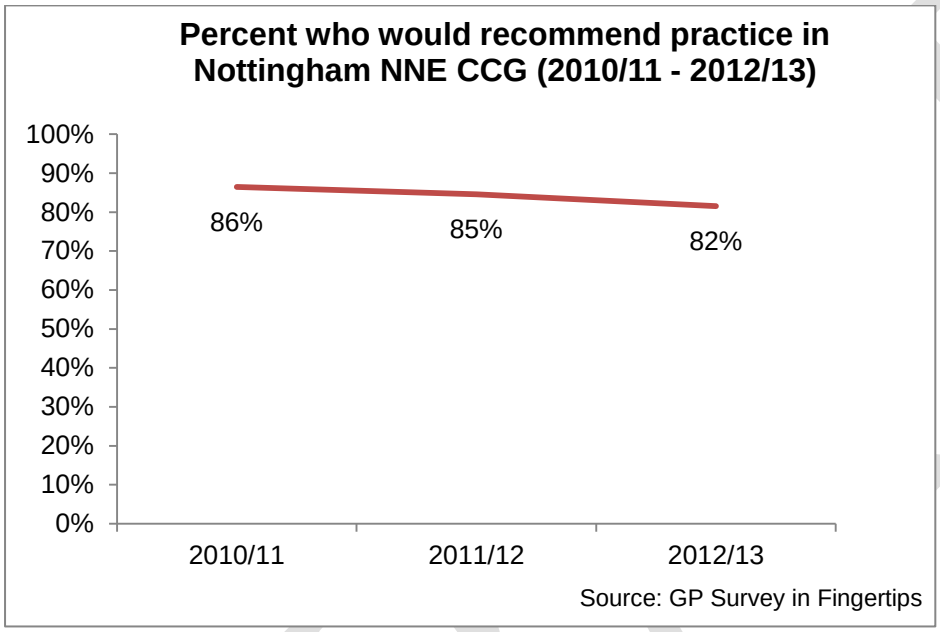


LOCAL CONTEXT – NOTTINGHAM NORTH AND EAST CCG - WORKFORCE

Nottingham North and North East CCG has an above average number of patients per GP FTE. However, the deprivation in the area is below average. The CCG has an equal number of male and female GPs (52 each).

SATISFACTION WITH ACCESS TO PRIMARY CARE

Even though the percentage of people who would recommend their practice has been decreasing, it is still 2% above the England average.



Provider Overview for Nottingham North and East CCG

Provider Overview for NNE CCG

- 21 General Practices
- 147,190 Registered Patients
- 7,009 Average per GP practice
- 28 Pharmacies
- 18 Dentists
- 11 Optometrists

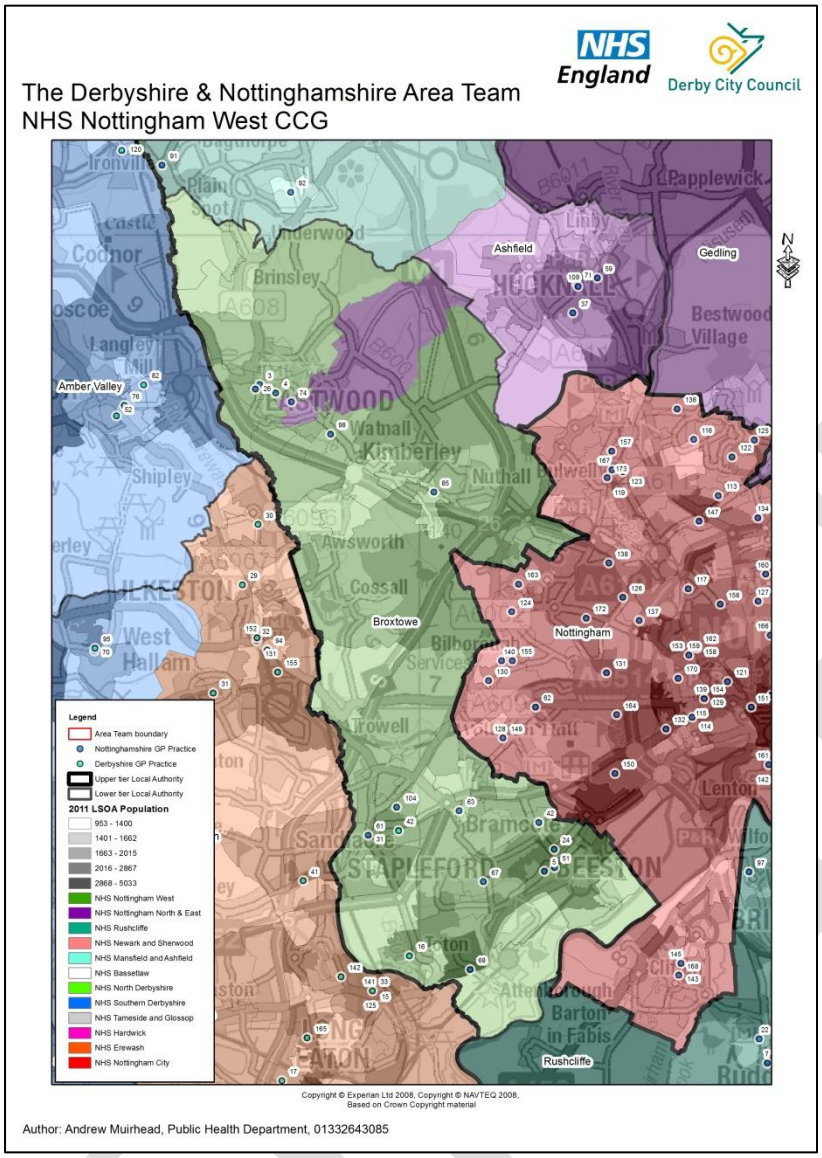
NNE CG priorities include

- Member practices deliver an equitable high quality, efficient and accessible service
- Member practices support each other, be at the heart of more integrated services including other primary, community and secondary care providers to deliver joined up services
- Innovation will be embraced as will new technologies
- Member practices will have a stronger role in improving outcomes by empowering patients to self care.

Key Developments for NNE CCG

- Improve management of same day urgent care
- Release GP time to manage long term conditions more effectively

LOCAL CONTEXT NOTTINGHAM WEST CCG Key themes



LOCAL HEALTH PRIORITIES

Cardiovascular Disease

Hypertension
- Prevalence 14.1%

Strokes
- Prevalence 2.0%

Smoking
- Prevalence 14.8%, significantly better than England average

Cancers

- Prevalence 2.4%
- 2,909 patients with cancer

Respiratory Disease

COPD
- Prevalence 1.3%

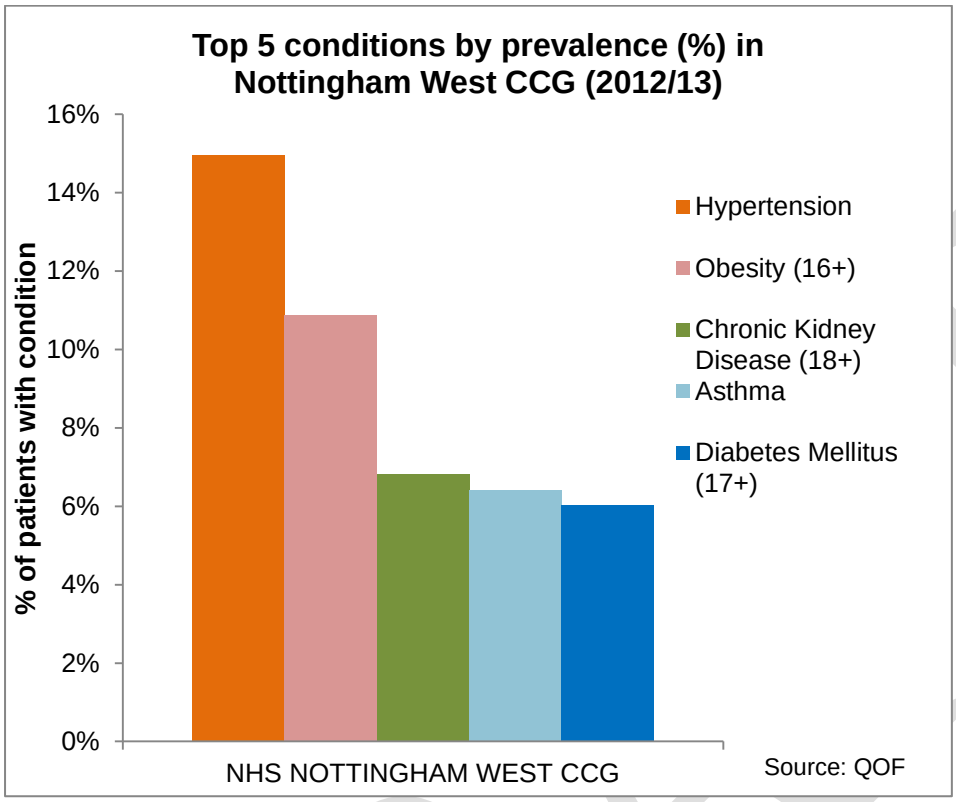
Asthma
- Prevalence 6.4%

Key Developments:

- Develop integrating primary care, community and social care

LOCAL CONTEXT – NOTTINGHAM WEST CCG Key themes

Nottingham West CCG has a higher prevalence of chronic kidney disease and diabetes than the average for Derbyshire and Nottinghamshire.



Other Key Health Issues

Kidney Disease
- Prevalence 6.8%

Obesity
- Prevalence 10.9%

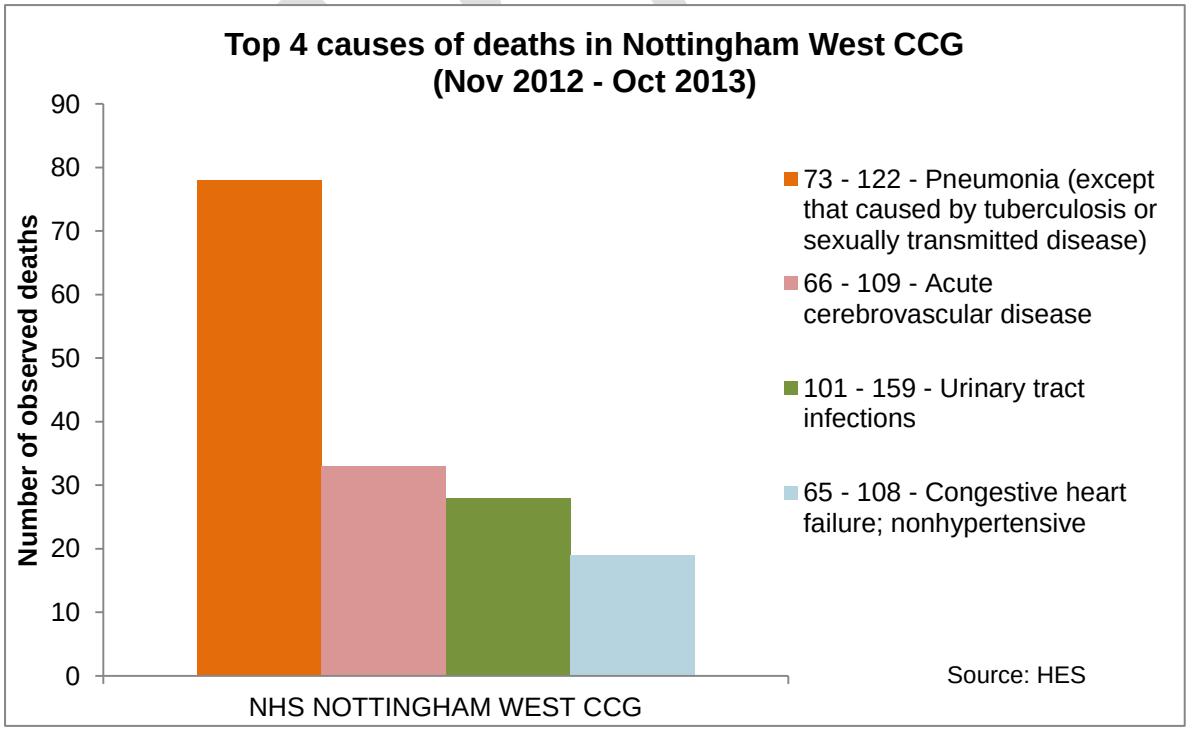
Mental Health

Depression
- Prevalence 5.4% (ages 18+)

Diabetes

- Prevalence 6.0%
- Lifestyle
- Self-care

The most common causes of death are pneumonia and acute CVD.

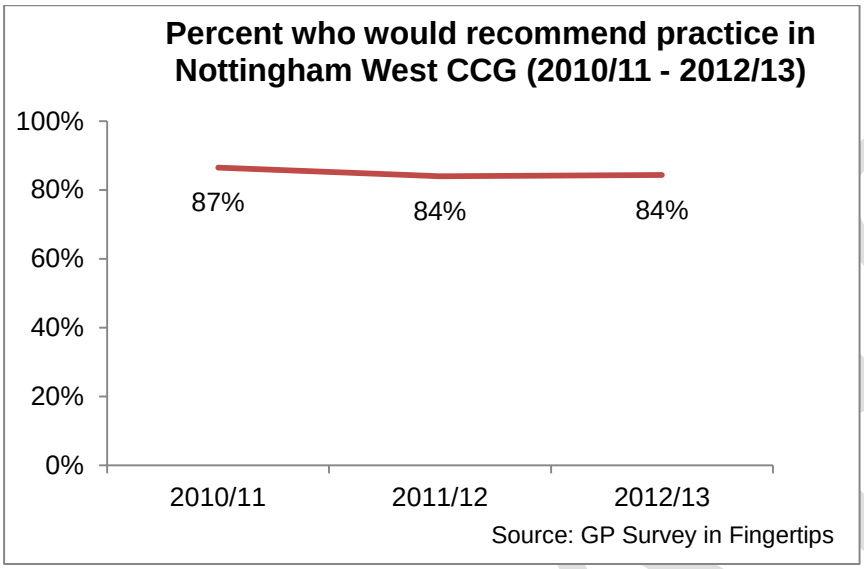


LOCAL CONTEXT – NOTTINGHAM WEST CCG - WORKFORCE

There are 32 male and 38 female GPs in the CCG. The number of patients per GP FTE is above England average.

SATISFACTION WITH ACCESS TO PRIMARY CARE

Together with North Derbyshire, the CCG has the highest percentage of people who would recommend their practice.



Provider Overview for Nottingham West CCG

Provider Overview for NW CCG

- 12 General Practices
- 94,043 Registered Patients
- 7,836 Average per GP practice
- 27 Pharmacies
- 16 Dentists
- 12 Optometrists

NW CG priorities include

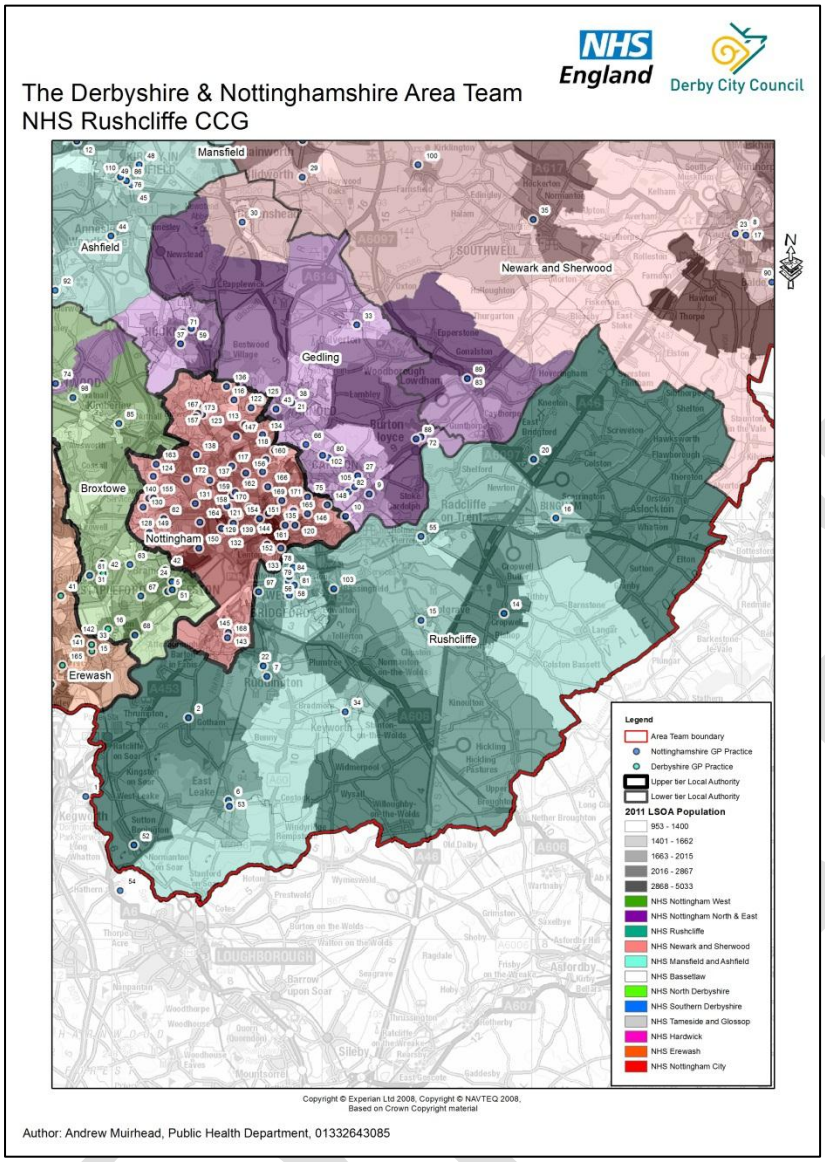
- Responsiveness to local needs
- Develop structures to enable primary care to transform at scale and pace
- Devlop local information systems
- Develop effective local clinical partnerships
- Continue to grow patient and citizen engagement

DN CCG to amend as appropriate

Key Developments for NW CCG

- Define and deliver a common policy for improved access
- Systematic review of all referrals
- Education programmes for clinical and non-clinical staff
- Active promotion of safety culture
- Clinical leadership supporting patient pathways

LOCAL CONTEXT FOR RUSHCLIFFE CCG Key themes



LOCAL HEALTH PRIORITIES

Cardiovascular Disease

Hypertension
- Prevalence 14.1%

Strokes
- Prevalence 2.0%

Smoking
- Prevalence 14.8%, significantly better than England average

Cancers

- Prevalence 2.4%
- 2,909 patients with cancer

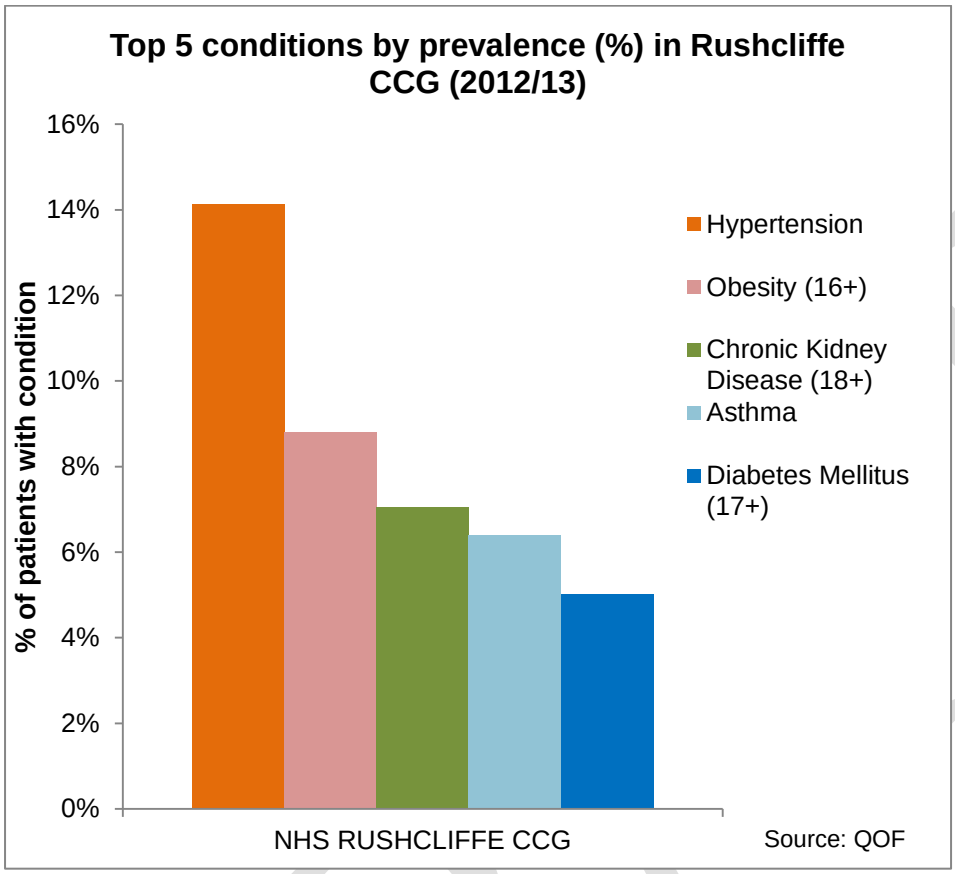
Respiratory Disease

COPD
- Prevalence 1.3%

Asthma
- Prevalence 6.4%

LOCAL CONTEXT – RUSHCLIFFE CCG Key themes

Rushcliffe CCG has the lowest prevalence of obesity and diabetes in Derbyshire and Nottinghamshire, and a very low number of smokers.



Other Key Health Issues

Kidney Disease
- Prevalence 7.0%

Obesity
- Prevalence 8.8%

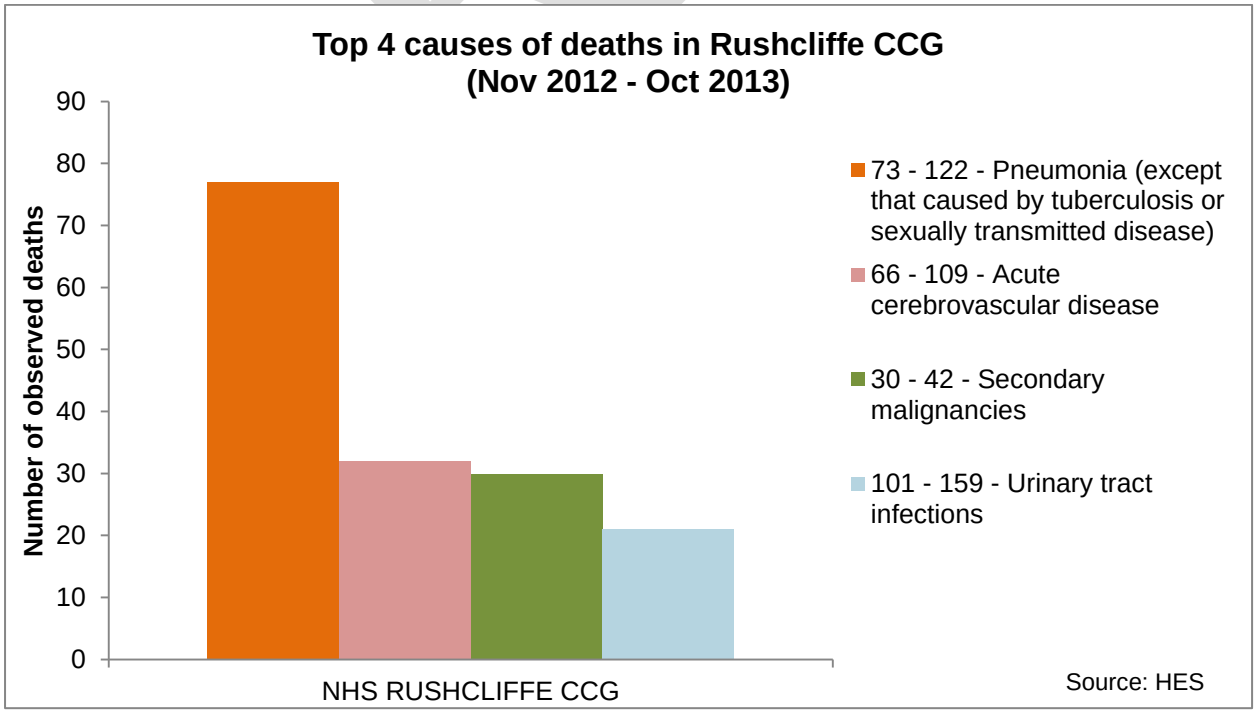
Mental Health

Depression
- Prevalence 4.7% (ages 18+)

Diabetes

- Prevalence 5.0%
- Lifestyle
- Self-care

Despite the fact that there are three CCGs with lower population, Rushcliffe has the lowest number of observed deaths from pneumonia and acute CVD.

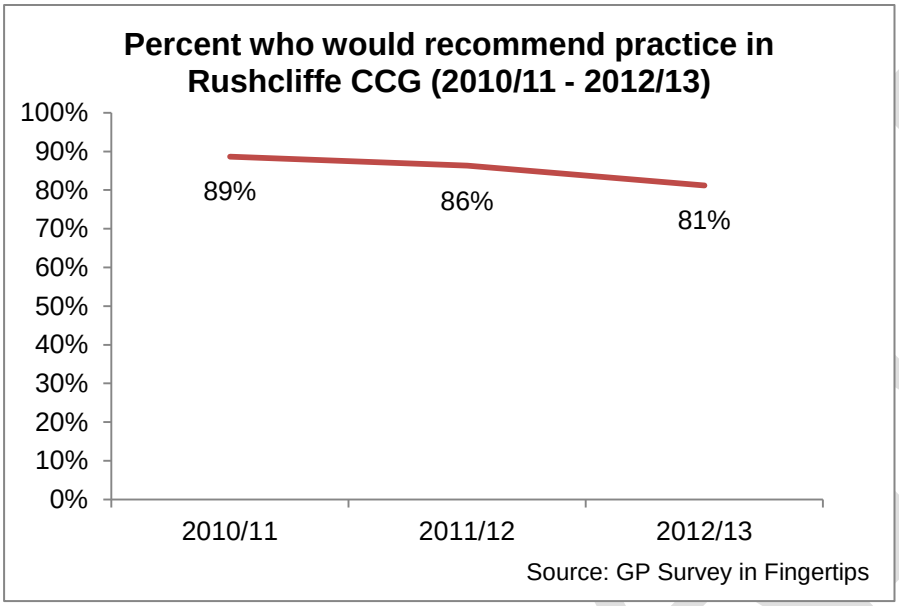


LOCAL CONTEXT – RUSHCLIFFE CCG - WORKFORCE

The CCG has a higher than average number of patients per GP FTE. However, the deprivation in Rushcliffe is also the lowest one in Derbyshire and Nottinghamshire. There are 42 male and 38 female GPs.

SATISFACTION WITH ACCESS TO PRIMARY CARE

The percentage of people who would recommend their practice has been steadily decreasing since 2010/11.



Provider Overview for Rushcliffe CCG

Provider Overview for Rushcliffe CCG

- 16 General Practices
- 122,791 Registered Patients
- 7,674 Average per GP practice
- 23 Pharmacies
- 22 Dentists
- 18 Optometrists

Rushcliffe CCG priorities include

- Develop access and standardise
- Proactive patient services
- Improve information and outcomes
- Develop management and accountability

DN CCG to amend as appropriate

Key Developments for Rushcliffe CCG

- Develop a common set of access standards
- Extend service access to 7 days
- Extend range of accessible services
- Develop my record web space

APPENDIX – 5 Year Plan sand trajectories

Area Team 5 Year Plan Appendix Z

Medical: The following 5 year projections are for scores that are measured through GP survey, the numbers indicated in the 3 tables below reflect an average score against questions within the GP survey:

Satisfaction with consultations

What is the planned satisfaction with the quality of consultation at GP practices throughout 2014/15 to 2018/19?

2014/15	625
2015/16	624
2016/17	624
2017/18	628
2018/19	632

Satisfaction with overall care

What is the planned satisfaction with the overall care received at the surgery throughout 2014/15 to 2018/19?

2014/15	163
2015/16	160
2016/17	160
2017/18	166
2018/19	172

Satisfaction with access to primary care

What is the planned satisfaction with access to primary care throughout 2014/15 to 2018/19?

2014/15	239
2015/16	233
2016/17	236
2017/18	243
2018/19	256

What is the planned level of flu vaccination coverage for those at risk throughout 2014/15 to 2018/19?

	Number of at risk population who have been vaccinated	Total Population at risk	%
2014/15	107214	206180	52.0%
2015/16	107975	207644	52.0%
2016/17	108720	209077	52.0%
2017/18	109449	210478	52.0%
2018/19	110171	211867	52.0%

What is the planned distance between expected depression prevalence and reported depression prevalence from 2014/15 to 2018/19?

	Reported count	Expected count	%
2014/15	90600	79544	87.8%
2015/16	90600	79544	87.8%
2016/17	90600	79544	87.8%
2017/18	90600	79544	87.8%
2018/19	90600	79544	87.8%

Trajectories continued

Dental:

Planned % of population who have seen dentist in past 24 months throughout 2014/15 to 2018/19?

2014/15	56.4%
2015/16	56.4%
2016/17	56.9%
2017/18	57.4%
2018/19	57.4%

Planned number of dental courses of treatments per 100,000 population from 2014/15 to 2018/19?

2014/15	80,000
2015/16	80,000
2016/17	80,400
2017/18	80,800
2018/19	80,800

Secondary dental care

Referral to treatment within 18 weeks

What is the planned level of positive responses on dental services from the GP survey from 2014/15 to 2018/19?

	Number of positive responses to selected questions in GP survey	Total number of responses to selected questions from GP survey	%
2014/15	8760	10371	84.5%
2015/16	8760	10371	84.5%
2016/17	8903	10475	85.0%
2017/18	9001	10527	85.5%
2018/19	9001	10527	85.5%

General Opthalmic services:

How many sight tests are planned to be delivered per 100,000 population throughout 2014/15 to 2018/19?

2014/15	25,623
2015/16	26,121
2016/17	26,919
2017/18	27,117
2018/19	27,615

Trajectories continued

How many tints/photochromic lens supplements per voucher are planned to be delivered from 2014/15 to 2018/19?

	Total number of tints	Total number of vouchers	%
2014/15	2802	175099	1.6%
2015/16	2626	175099	1.5%
2016/17	2451	175099	1.4%
2017/18	2276	175099	1.3%
2018/19	2101	175099	1.2%

How many repairs and replacements per voucher are planned to be delivered from 2014/15 to 2018/19?

	Number of positive responses to selected questions in GP survey	Total number of responses to selected questions from GP survey	%
2014/15	14874	16028	92.8%
2015/16	14874	16028	92.8%
2016/17	14874	16028	92.8%
2017/18	14874	16028	92.8%
2018/19	14890	16028	92.9%

APPENDIX - MONITORING EVALUATION AND RESEARCH, EVIDENCE BASE

The ***East Midlands Collaboration for Leadership in Applied Health Research and Care*** (CLAHRC) has been chosen as our evaluation partner for the wider implementation of our primary care strategy. CLAHRC is a health research collaboration between the University of Nottingham and NHS organisations across the East Midlands, and has significant experience in the evaluation of change programmes in healthcare.

This approach will bring rigour and credibility to the evaluation of our projects and strategy, and will also allow comparative evaluation of the relative success and impact of the different approaches that we are taking across Derbyshire and Nottinghamshire. We believe that this comparative evaluation will give NHS England a unique insight into how to achieve the greatest, sustained and effective spread of primary care innovation.

Furthermore, through using CLAHRC across all of our projects, and linking them in to the Area Team Project Support office, we can achieve economies of scale and better value for money, than would have been the case if each project had been evaluated individually.

In addition to this the ***East Midlands Academic Health Sciences Network*** has offered its assistance in validating these projects and providing linkages across the system/geography in order to facilitate collaboration. We welcome this approach and are confident that it will bring additional benefits to the spread of change across the area.

APPENDIX – GOVERNANCE

Overseen through the following governance arrangements:

- Area Team Corporate Management Group
- Area Team (AT) Strategy Steering Group
- Direct Commissioning Performance Group with Primary Care Assurance and Performance List Decision Panel Sub Groups
- AT Primary Care Work Stream
- Primary Care Panel with professional representatives
- CCG and AT assurance meetings
- CCG Governing Bodies
- Health and Wellbeing boards

DN: Insert governance with NHS England etc in form of a family tree

APPENDIX – RISK AND ISSUES

Clinical Risk (System objective 1)	RAG	Assumptions and Mitigation
There is a risk that failure to establish and maintain effective primary care commissioning capability/capacity, systems, processes and partnerships to successfully drive continuous improvement of quality and efficiency across the four Primary Care contractor groups (General Practice, Community Pharmacy, Dental Practice and Optometry) which would lead to sub optimal quality for patients and / or value for taxpayers.	**Amber / Red (A/R)**	Strong working relationships between AT and Clinical Commissioning Groups (CCGs), local representative committees, local professional networks and CCGs to support effective commissioning. External evidence will include delivery of continuous improvement against the 5 outcomes domains and the national Primary Care assurance framework indicators Detailed annual workplan including QIPP (quality, innovation, productivity, prevention) Area Team implementing Single National Policies to effectively deliver the annual workplan, to achieve a core offer of high quality Primary Care which is continually improving, and to ensure contract compliance.
There is a risk that providers will fail to meet the referral to treatment 18 week wait for secondary care dental services	**A**	Action plans in place to ensure delivery of the target. Family and friends test will be applied and monitored
Clinical Issues	**RAG**	**Assumptions and Mitigation**
There is an issue that Personal Health Plans will not be accepted and that mortality and life expectancy could deteriorate as patient outcomes will not improve with improved access to primary care, in particular General Practice	**A**	The development of Personal Health Plans (PHP) will be clinically led and validated, a task and finish group has been established to progress this development The Patient Association has agreed to develop the PHP in conjunction with clinicians The aim is to have Personal Health Plans will be developed at practice level for all those aged 65 and/or targeted groups by 2016 and for all the population by 2019
There is an issue that patient safety, experience and access could not improve with increased demand on the urgent care system	**A**	Plans for transformation have been designed collaboratively to increase capacity and capability within the primary care system The primary care strategy and implementation plans are aligned to the Units of Planning and the Better Care Fund plans. All CCGs have developed plans to support improved urgent care management in primary care, driven by the Challenge Fund
Patients could be unsure of pathways and default to secondary care	**A**	Improved access will redirect patients to the most appropriate primary care clinician. Clear communication and engagement will educate patients to the access the most appropriate pathway available

The workforce will not be developed at pace and scale as activity and pressures shifts to primary care	**A**	The strategy will develop workforce plans at practice level, collated at CCG level and driven forward through Local Education and Training Committee commissioning process Providers in secondary setting are informed of the plans with ongoing engagement Robust workforce plans commissioned in alignment with secondary to primary care shift of services
Financial Issues	**RAG**	**Assumptions and Mitigation**
There is an issue that QOF payment will not be available to transfer into a local quality incentive scheme	**A**	Task and Finish group established to work up proposal for a local quality incentive scheme to support delivery of the strategy objectives Medical directorate to lead negotiation with CCGs and national team
There is an issue that projects led by CCGs will only deliver CCG efficiencies and savings will not be in line with targets	**A**	Alignment of plans to ensure that efficiencies are gained for the wider health economy
There is an issue that failure to drive through transformational change would impact on the delivery of QIPP	**A**	A financial plan underpins the strategy which has been commercially and financially modelled
There is an issue that baseline information will be lacking or inaccurate	**A**	Establishing baseline position on all primary care activity at locality level
Corporate Risks	**RAG**	**Assumptions and Mitigation**
There is a risk that the Area Team is unable to effect transformational change in primary care which would lead to an unsustainable model of primary care that cannot meet rising demand, costs and patient expectations within the resources available.	**A**	Specific measurements of improvements include improved health outcomes, improved patient experience measured through complaints and surveys; Draft primary care strategy co-developed with key stakeholders for final agreement in June 2014. All CCGs supporting innovation in General Practice via the Challenge Fund with contingency plans in place to secure transformation from 2014 Patient and public involvement includes working with Patient Leaders, Healthwatch and the Patient Association in the development of patient led transformational change High level communication and engagement plan in place to consult with all stakeholders on transformation.
There is a risk that the Area Team recurrent financial position and impact is not fully reflected through NHS England, as non-recurrent mitigating actions are being taken to achieve balance in current year. The recurrence of issues needs to be addressed and captured otherwise NHS England planning decisions will not be based on known pressures, which would lead to NHS	**A**	Internal forecasting arrangements capturing recurrent / forward pressures are in place within the finance team. Key data returns to regional / national teams. Governance guide for budget holders to be developed

England forward plans not being in financial balance		
There is a risk that without implementing a single operating process, delegated authority and internal capacity the Area Team is unable to facilitate decisions to resolve legacy GP premise issues and / or invest to improve GP Premises. This is of particular risk in relation to achievement of CQC compliance. This is leading to operational/quality risks associated with GP Practices delivering services from poor quality premises which are not CQC Managing the 'holding' position is consuming significant capacity with the Primary Care and Finance Team resulting in less focus on other key priorities	**A/R**	Identified temporary resource from within the team to manage this. Developing Primary Care Strategy Escalation to Region where appropriate Working With Stakeholders A Premises Sub Group has been established to provide oversight of the development of the 5 year strategy and operational decisions in relation to GP premises. Primary Care Work Stream Group in place to oversee the delivery of primary care transformation Premises plan aligned with national policy and guidance
There is a risk that the AT will exceed running cost allocation, if running cost expenditure is changed to include FHS and Non-HQ property costs, as Area Team has not been given sufficient budgets to cover these costs. Mitigating actions to cover these overspends were planned within programme spend areas. This change would lead to NHS England not achieving running cost targets.		Area Team executive level reporting: highlighting issues and reports up through to the Regional / National Teams. Finance report to NHS England and regional Directors of Finance
Corporate Issues	**RAG**	**Assumptions and Mitigation**
There is an issue that the Area Team will Insufficiently engagement with CCGs and public/patients and other stakeholders to inform the strategy and agree priorities linked with Call 2 Action	**A**	The Area Team is working in partnership with CCGs to engage with patients, public and stakeholders to co-produce local transformation and communication and engagements plans. The Area Team has established a Patient Leaders groups and is working with the Patients Association and Healthwatch to ensure patient are leading the transformation programme
There is an issue that services transferring from secondary to primary care at would be unable to move pace and scale	**A**	The transformation plan is aligned with provider strategic plans
There is an issue that the strategy focuses attention on general practice which may detract attention away from transformation across PODs	**A**	The Clinical Leadership Advisor and the LPN chairs have co-produced the strategy

APPENDIX EQUALITY AND IMPACT ASSESSMENTS

Equality and Impact assessments will have been conducted by the area team in relation to the implementation of the strategy. These will be supported by equality and impact assessments conducted by Each CCG in relation to their 5 year primary care strategies.

DN Insert EQIA in April

APPENDIX – POPULATION CONTEXT AND HEALTH NEEDS Derbyshire

Population Deprivation Source http://fingertips.phe.org.uk/profile

Table 4:

Criteria	Erewash	Hardwick	North Derbyshire	South Derbyshire	England Comparison	
AGE						
Age 0-4	5432	5558	14504	32239	3,385,305	
Age 5-18	13485	10862	29672	61061	9,578,144	(5-19)
Age 18-64	49770	65412	184928	349678	33,712,500	
Age 65-74	18048	11366	33465	49751	5,063,777	
Age 75-84	8052	6446	19050	29580	3.064,354	
Age 85+	2231	2605	7757	11807	1,239,281	
Total	97018	102249	289376	534116	56,042,361	
DEPRIVATION						
Deprivation Score	**20.6**	**26.7**	**18.2**	**20.4**	21.5	
ACCESS						
% would recommend	**72.5%**	**75.9%**	**83.8%**	**82.6%**	79.9%	
% Satisfied with Phone access	75.0%	**72.9%**	**75.5%**	**76.9%**	75.0%	
% Satisfied with opening hours	**76.3%**	**80.8%**	**83.5%**	**81.2%**	79.6%	
% saw/spoke to nurse /GP same day	**42.7%**	**52.3%**	**54.6%**	**52.9%**	49.4%	
% Report good experience of making appointments	**72.1%**	**74.7%**	**78.4%**	**77.2%**	76.3%	
HEALTH INDICATORS						
% Long standing Health condition	**56.8%**	**57.8%**	**57.2%**	**55.9%**	53.5%	
% with health related problems daily life	**50.0%**	**57.1%**	**51.4%**	**51.0%**	48.7%	

NB Green figures show better than national average and red figures worse than national average

APPENDIX - POPULATION CONTEXT AND HEALTH NEEDS Nottinghamshire

Source: http://fingertips.phe.org.uk/profile

Table 6:

Criteria	Nottingham City	Nottingham West	Nottingham North & East	Rushcliffe	Mansfield & Ashfield	Newark & Sherwood	England
AGE (2013)							
Age 0-4	14837	5442	8261	6577	11555	6968	3,385,305
Age 5-14	23897	9446	15534	13706	19909	14168	9,578,144
Age 15-64	154861	60372	94002	77571	120391	81729	33,712,500
Age 65-74	12587	9958	15432	13016	18494	14319	5,063,777
Age 75-84	8182	6120	9097	7925	10498	8119	3.064,354
Age 85+	3342	2502	3552	3277	4036	3063	1,239,281
Total	217706	93480	145878	122072	184883	128366	56,042,361
DEPRIVATION							
Deprivation Score	**32.7**	**15.1**	**18.2**	**8.1**	**29.2**	**19.8**	21.5
ACCESS							
% would recommend	**79.0%**	**84.4%**	**81.6%**	**81.2%**	**74.9%**	**75.7%**	79.9%
% Satisfied with Phone access	73.5%	**84.2%**	**79.0%**	**79.5%**	**66.9%**	**69.4%**	75.0%
% Satisfied with opening hours	**80.2%**	**83.6%**	**80.9%**	**75.3%**	**79.8%**	**80.0%**	79.6%
% saw/spoke to nurse /GP same day	**50.8%**	**44.3%**	**48.7%**	**45.7%**	**54.0%**	**45.4%**	49.4%
% Report good experience of making appointments	**76.8%**	**85.4%**	**80.8%**	**77.8%**	**71.9%**	**70.1%**	76.3%
HEALTH INDICATORS							
% Long standing Health condition	**53.4%**	**54.2%**	**55.9%**	**50.1%**	**59.0%**	**55.6%**	53.5%
% with health related problems daily life	**49.2%**	**50.6%**	**50.9%**	**43.9%**	**54.9%**	**52.5%**	48.7%

NB Green figures show better than national average and red figures worse than national average.

APPENDIX - KEY METRICS AND OUTCOME MEASURES

No	Metrics	Source
1.	Increase in GP appointments from baseline	Local data set/QOF
2.	% practices providing an urgent appointment/same day	
3.	% practices providing routine appointments within 3 days	
4.	% practices providing an appointment day of patient choice	
5.	Number of patients offered choice of practice	
6.	% patients with on-line access to records	
7.	Number of patients signing up to Electronic Prescribing Release 2	
8.	Percentage of patients referred to the single point of access (SPA) who have received a package of voluntary and community services	
9.	Number of patients on the virtual wards with a package of voluntary / community care from local providers tailored to their needs	
10.	Proportion of complex patients with agreed care plans	
11.	Increase in LTC prevalence due to detection and early diagnosis	
12.	100% at end of life to be asked their Preferred place of death	
13.	Increase in identification and adoption of “gold standard” care at end of life	
14.	% patients with end of life needs actively case managed from baseline	
15.	Increase in Flo (telehealth)	
16.	Practice returns for number of on line registrations	
17.	% practices with booking appointments on line	
18.	% practices using Skype appointments	
19.	% requests v’s GP visits for “acute visits” from care/residential home	
20.	Number of complaints/comments received regarding access	
21.	% patients recommending GP to family and friends	
22.	% patients not accessing services but with inequalities or life issues - parity of esteem	
23.	Reduction in GP OOH attendances and contacts	
24.	% patient with night sitting service	
25.	Voluntary sector directory of services	
26.	Number of referrals to local community and voluntary services	
27.	% patients reporting positive feedback/experience of primary care	GP survey
28.	Reduced inappropriate contacts with the ambulance services	Ambulance and hospital data sets

29.	Improved patient experience and outcomes through simplified access to GPs via A&E	Hospital data and local data sets
30.	Reduction in Minor Injuries Unit attendances	
31.	Reduction in the inappropriate use of A&E attendance 24/7	Hospital data sets
32.	Reduction in inappropriate admissions via A&E 24/7	
33.	Proportion of readmissions within 30 days	
34.	Proportion of expedited discharges	
35.	Length of stay in hospital	
36.	1000 fewer unnecessary outpatients first and follow-up attendances managed by GPs	
37.	200 less elective episodes	
38.	Proportion of residential and nursing home patients case managed increase from baseline	Local authority / public health data sets
39.	Proportion of patient entering long term care	
40.	Proportion of health checks completed	
41.	Proportion of patients on long term sickness notifications	DWP data set
42.	Improved staff satisfaction in practice	Staff survey
43.	Cost effectiveness (avoidance, reduction and savings)	Finance returns

APPENDIX General Practice Implementation Plan Year 2014-2019

Ambition	Action	Date	To be led by	Monitoring
GP1. Improve access to high quality primary care services for all resulting in reduced complaints and increased patient satisfaction with consultation and care	Y1Q1.CCGs and Area Team implement new contract and agree monitoring and evaluation of **change programme to transform General Practice in Derbyshire and Nottinghamshire**, including "mystery shopper" and friends and family test in general practice; access to technologies; development of virtual wards; roll out of Community Organiser role. Roll out transformation plans submitted for Challenge Fund (resources permitting) Y1Q2. Complete initial data collection and commence PDSA cycles; establish Access Clinics; commence home visiting trial; plans developed for all practices to use Flo (telecare) for target population; integration of voluntary sector into virtual wards Y1Q3. Evaluate project outcomes, embed teams and roll out of successful ways of working; finalise succession planning Y1Q4 Roll out with champion practices and CCG/AT management team offering support using design principles and toolkit	June 2014 August 2014 December 2014 March 2015	Dr Doug Black	Project Plan / Transformation/ Challenge Fund Monitoring
	Y1Q1. Develop **Personalised Care** for targeted groups prioritised in areas with the poorest health outcomes Embed modelling of new ways of working, training of staff with the Area Team and CCG using newly developed modelling tool, share tool with other Area Teams Y1Q2 -Q4 Roll out and embed Right Care Plans, pilot different approaches to personalised care from cradle to grave for the healthy, well and targeted population groups, such as Personal Health Plan Apps	April 2014	Dr Doug Black Dr Doug Black Tracy Madge Dr Doug Black	Project Plan and QIPP Plan

Ambition	Action	Date	To be led by	Monitoring
	Y2Q1-Q4 Evaluate and review effectiveness of personalised care approaches, feed into national negiotiations Y3-5 Self-management plans in place as standard,as part of personalised care; Patients involved in assurance and monitoring evaluation; proactive management through public health; more patients actively involved in self care Apply new contractual changes year on year	October 2014 January 2015 April 2016		
GP2. Improve health outcomes for patients with initial focus on those with long term conditions for those aged over 65	Y1Q1-4 See **Change Programme** detail above Agree changes to QOF and agree local quality incentive scheme Y3-5 Personalised care in place for all of the population with named GP/clinician	March 2015	Dr Doug Black	Project Plan / Challenge Fund Monitoring
GP3. Maximise the use of technology to improve access and self-management	Y1Q1-4 See **Change Programme** detail above Y3-5 Access to 7/7 high quality primary care for routine and urgent care; increased application of technology solutions; shared patient records	March 2015	Dr Doug Black	Project Plan / Challenge Fund Monitoring
GP4. Develop and improve our people to be the best healthcare workforce	Y1Q1-4 See **Change Programme** detail above Y1Q1-4 Health Education East Midlands commission **educational programmes; workforce plan developed and collated for all contractor groups**; First contact training completed for GP staff Develop local or implement national clinical leadership programme to foster positive culture Develop joint workforce recruitment plan to attract and keep staff Business case for paying off student loans in exchange for 5 year contract Complete baseline of training places with trajectory to increase	March 2015 March 2015	Dr Doug Black Julie Bolus	Project Plan / Challenge Fund Monitoring

Ambition	Action	Date	To be led by	Monitoring
	Develop joint training programmes Agree baseline and trajectory for research competence for contractor groups Agree trajectory of non medical prescribers Y2Q1-4 Training plans for joint programmes, Clinical leadership programme embedded Non- medical prescribing roll out Y3-5 Plans in place to develop primary care providers with self-sustainable workforce, training and organisational plan	March 2016	Julie Bolus	
GP5 Premises aligned to meet the needs of the population	Y1Q1-4 Produce baseline data set Co-development of plans with CCGs and AT that target equality, inequality and access; include patient and local clinical engagement; all premises CQC compliant, refresh capital plan; baseline information gathered for all primary care contractors Y2Q1-4 Practices/premises numbers are in line with movement of secondary care services and growth in self management; Premises plan developed, implemented and reviewed Y3-5 All current premises fit with strategic direction and demographics. Health and Social Care Plan for premises aligned to community needs and in partnership with commercial and economic planning; increased numbers of mergers and federations	March 2015 March 2016 March 2019	Jonathan Rycroft	
GP6 Develop payments and incentives system to reward improved outcomes and secure value for money	Y1Q1-Q4 **Review of PMS** with financial adjustments Y1Q1–Q4, Y2Q1-Q4 **GP List Size Growth** – savings for growth phased across the year Review of QOF to inform future shape of any local quality incentive schemes Y1Q1-Q3 **Post Payment Verification** – QOF	April 2015 March 2015 October 2014	Jonathon Rycroft Joanne Lunn Tracy Madge	Project Plan Project Plan Project Plan QIPP Plan

Ambition	Action	Date	To be led by	Monitoring
	validation and exception reporting Y1Q1-3 **Post Payment Verification –** Direct Enhanced Services Y1Q1-3 **Convergence of PMS Payment approaches** – OOHs deductions Y1Q1-4 **GP List Validation** Y2Q1-4 Deep dive assurance developed, implemented and reviewed Y3-5 Annual deep dive reviews in place	October 2014 October 2014 March 2015 March 2019	Joanne Lunn Joanne Lunn Joanne Lunn Joanne Lunn	QIPP Plan QIPP Plan QIPP Plan

Detailed Action Plans			By when	By whom	Progress
GP1. Improve access to high quality primary care services for all resulting in reduced complaints and increased patient satisfaction with consultation and care – development of personalised care and local quality incentive scheme					
Developing Personal Health Plans	1	Share proposal with CCGs and key stakeholders	March 2014	Dr Doug Black	Primary Care Panel in Jan and Feb with concern about applicability for all population groups
	2	Approval to pilot	March 2014	Dr Doug Black	Area team director approval required
	3	Establish a task and finish group to progress the work	March 2014	Dr Doug Black	Members currently agreed as Dr Ian Matthews, Dr Avi Bathia, Dr Ian Campbell, Tracy Madge
	4	Agree the task and finish group ToR, including membership and communication plan	April 2014	Task and Finish Group	3 April 2014
	5	Review of the QOF	May 2014	Task and Finish Group	8 May 2014
	6	Develop template for personalised care approaches to all age groups	May 2014	Task and Finish Group	Patients Association and Patient Leaders agreed to support development meeting being arranged for April
	7	Agree the patient cohort eg over 65, over 75, those with most risk factors, Long Term conditions, complex cases etc for fast track personalised care, building on Right Care	May 2014	Task and Finish Group	Not started
	8	Agree the pilot practices	May 2014	Task and Finish Group	Not started
	9	Agree the evaluation	May 2014	Task and Finish Group	CLAHRC support to develop methodology agreed
	10	Evaluation report considered by key stakeholders	September 2014	Task and Finish Group	Not started
	11	Recommendation from the report shared and actions agreed	October 2014	Area Team directors	Not started

Detailed Action Plans	By when	By whom	Progress
GP2. Improve health outcomes for patients with initial focus on those with long term conditions for those aged over 65			
Elements included in Action Plan for **General Practice Transformation** (within Primary Care Strategy) and personalised care for targeted population outlined in GP1 above	March 2015	Dr Doug Black	Project Plan / Challenge Fund Monitoring
Convergence of approach to **Violent Patient Schemes across Derbyshire and Nottinghamshire**. Current variable quality of service for patients removed from mainstream primary medical service provision. Project aims to secure consistent high quality and value for money service with emphasis on re-education and return of patients to mainstream services	March 2016	Jonathan Rycroft	QIPP Plan to be developed
GP3. Maximise the use of technology to improve access and self-management			
Scope and increase potential use of technologies such as telecare, online prescriptions, appointment booking – contained within Primary Care Strategy and Challenge Fund submission – co-produced by Area Team and CCGs. See earlier detail of **change programme for General Practice**	March 2015	Dr Doug Black	Project Plan / Challenge Fund Monitoring
GP4. Develop and improve our people to be the best healthcare workforce			
See earlier detail of **change programme for General Practice** Multi-agency approach with Health Education East Midlands, CCGs and AT to identify strategies to address GP recruitment and retention issues and develop new models of service delivery	March 2016	Julie Bolus	Project Plan / Challenge Fund Monitoring

Detailed Action Plans	By when	By whom	Progress
GP5 Premises aligned to meet the needs of the population			
ACTION PLAN TO BE REVIEWED Aim to maximise shared use of accommodation with partner organisations, identifying opportunities for financial efficiencies through reduction in void costs and non-recurrent savings through recovery of small business rates relief funding for GPs and dental practices Reduction in number of GP contracts and surgery buildings through practice/branch surgeries rationalisation in line with primary care strategy	June 2014	Jonathan Rycroft	QIPP Plan to be developed

Detailed Action Plans			By when	By whom	Progress
GP6 Develop payments and incentives system to reward improved outcomes and secure value for money					
Review of PMS with financial adjustments	ACTION PLAN TO BE DEVELOPED Renegotiation and implementation of national PMS contract review policy as part of primary care transformation and implementation of primary care strategy		June 2014	Joanne Lunn / Jonathan Rycroft	QIPP Plan to be developed
GP List Size Growth	ACTION PLAN TO BE DEVELOPED		May 2014	Joanne Lunn / Jonathan Rycroft	
Review of QOF	ACTION PLAN TO BE DEVELOPED		April 2014	Tracy Madge/Joe Lunn	Meetings commenced with 8 May 2014 for progress report
Workforce planning	3-5 YEAR ACTION PLAN TO BE DEVELOPED Business cases for transformation (Challenge Fund)		April 2014	Tracy Madge with Health Education England	Meetings commenced.
Post Payment Verification – QOF validation	1	Identify NHS England PPV support	Feb 2014	Helen Pledger	
	2	Meet with provider to scope PPV support provider	March 2014	Richard Hobbs Julie Coulson	
	3	Receive proposal for PPV programme	April 2014	Richard Hobbs Julie Coulson	

	4	Estimate potential savings	May 2014	Joanne Lunn	
	5	Commence PPV programme	July – Oct 2014		

Detailed Action Plans			By when	By whom	Progress
GP6 Develop payments and incentives system to reward improved outcomes and secure value for money					
Post Payment Verification – Direct Enhanced Services	1	Identify NHS England PPV support	Feb 2014	Helen Pledger	
	2	Meet with provider to scope PPV support provider	March 2014	Richard Hobbs Julie Coulson	
	3	Receive proposal for PPV programme	April 2014	Richard Hobbs Julie Coulson	
	4	Estimate potential savings	May 2014	Joanne Lunn	
	5	Commence PPV programme	July – Oct 2014		
Convergence of PMS payment approaches – OOHs deductions	ACTION PLAN TO BE DEVELOPED.		April 2014	Joanne Lunn	QIPP plan to be developed
GP List Validation	ACTION PLAN TO BE DEVELOPED		April 2014	Joanne Lunn	

Detailed Action Plans		By when	By whom	Progress
APMS Budgetary Savings	Review to focus on identification of potential efficiencies through standardisation of contracts and robust contract management of KPI delivery	April 2014	Joanne Lunn / Jonathan Rycroft	QIPP Plan to be developed

APPENDIX Optometry Implementation Plan Year 2014-2019

Ambition	Action	Date	To be led by	Monitoring
O1. Understand the needs of our population and keep informed of trends.	Y1 Q1-2 Identify target groups via eye health needs assessment Y1Q3-4 Establish children's screening at an age that allows effective treatment, plus start pilot scheme for providing sight tests for homeless people Y1Q1-4 Review and improve access to care pathways Y2Q1-4 Improve access to hard to reach groups identified Y3-5 link to public health to refine and understand changing patient needs	September 2014 March 2015 March 2016	Jonathan Rycroft	Detailed plan to be developed
O2. Improve and redesign services in line with national eye pathways	Y1Q1-4 evaluate glaucoma refinement schemes and recommend to all CCGs. Explore innovative options to increase sight test numbers Y2Q1-4 Review all existing enhanced services to see if fit for purpose and pilot new schemes Y3-5 roll out successful pilots	March 2015 March 2016	Jonathan Rycroft	Detailed plan to be developed
O3. Improve health campaigns, education and communications	Y1Q1-4 Include importance of sight tests and eye health in all health campaigns – working with public health and other professionals; make contact with all stakeholders and contribute to national assembly work Y2Q1-4 Expand information available to public health and health professionals using multiple channels; implement web based eye health education tool	March 2015 March 2016	Jonathan Rycroft	Detailed campaigns plan to be developed
O4. Establish people plans for training, manpower and leadership	Y1Q1-4 Confirm manpower numbers and complete LETB needs assessment. Education GPs re regular sight tests through the RCGP eye health initiative Y2Q1-4 offer leadership training and other programmes to eye health professionals	March 2015 March 2016	Jonathan Rycroft	Detailed plans to be developed

O5. Review of contracts		Y1Q1-4 Conduct post payment validation of optometry services	October 2014	Joanne Lunn	QIPP Plan
Post Payment Verification – Optometry	1	Identify NHS England PPV support	Feb 2014	Helen Pledger	
	2	Meet with provider to scope PPV support provider	March 2014	Julie Theaker	
	3	Receive proposal for PPV programme	April 2014	Julie Theaker	
	4	Estimate potential savings	May 2014	Joanne Lunn	
	5	Commence PPV programme	July – Oct 2014		

APPENDIX Dental Implementation Plan Year 2014-2019

Ambition	Action	Date	To be led by	Monitoring
D1. Increased access to dental care for low income groups	Y1 Q1-4 Identify target groups via oral health needs assessment Y1Q1-4 Review and improve access to secondary care pathways Y2Q1-4 Improve access to hard to reach groups identified ie elderly, bariatric patients and address anxiety issues	March 2015 March 2016	Jonathan Rycroft	
D2. Review Dental Contract Payments and underperformance	Y1Q1-4 6 month review of contract activity levels Y2Q1-4 12 month review of contract activity levels		Jonathan Rycroft	
D3. Review of dental Out of Hours and Urgent Care	Y1Q1-2 Review of current arrangements Y1Q2-4 Develop a plan to provide a consistent service approach Y2Q1-2 Implement new arrangements Y2Q3-4 Evaluate and reassess	June 2014 March 2016	Jonathan Rycroft	
D4. Develop the dental workforce	Y1Q1-2 Review workforce requirements Y1Q2-4 Develop a plan for future workforce Y2Q1-2 Commission workforce and training plans Y2Q3-4 Review impact Y3-5	June 2014 March 2016	Jonathan Rycroft	

Detailed Action Plans			By when	By whom	Progress
D1. Increased access to dental care for low income groups					
Hard to Reach Groups	ACTION PLAN TO BE DEVELOPED Develop Oral Health Needs Assessment and use to identify health needs for vulnerable patients and ensure services pathway in place and accessible		June 2014	Jonathan Rycroft	
Pathways Review	ACTION PLAN TO BE DEVELOPED Review current pattern of referrals primary and secondary care pathway oral surgery and primary care orthodontic treatment to deliver increased activity and better value for money. Providers to meet RTT 18 week target		June 2014	Jonathan Rycroft	QIPP Plan to be developed
D2. Review Dental Contract Payments and underperformance					
Dental contracts payments and clawback underpayments	1	Refine estimation based on mid year review of 2013/14 and any contract changes made in 2013/14 (as a result of 2012/13)	February 2014	Laura Burns	QIPP Plan
	2	Refine estimation based on end of year review 2013/14	August 2014	Laura Burns	

Detailed Action Plans			By when	By whom	Progress
	3	Action clawback from practices before end of financial year	March 2015	Laura Burns	
Community Dental services – QIPP/CQUIN/Tariff Deflator impacts to be negotiated through the associate contracts	ACTION PLAN TO BE DEVELOPED		April 2014	Jonathan Rycroft	QIPP Plan to be developed
Dental Superannuation Review	ACTION PLAN TO BE DEVELOPED		April 2014	Jonathan Rycroft	QIPP Plan to be developed

Detailed Action Plans		By when	By whom	Progress
D3. Review of dental Out of Hours and Urgent Care				
Convergence of contract across Derbyshire and Nottinghamshirre	ACTION PLAN TO BE DEVELOPED	June 2014	Jonathan Rycroft	QIPP Plan to be developed

Area Team Objective	Year 1-2	Year 3-5

System Objective One **Ensuring patients have access to a core of high quality primary care that is continuously improving and delivers better health outcomes**	• Develop and roll out personalised care using Right Care Plan and bespoke health plans and (PHP) for over 65 and targeted population • Evaluate and review effectiveness of PHP • Review of PMS with financial adjustments • Dental and Eye needs assessment access report	• Self-Management plans for patients using Right Care, health plans and health apps • Patients involved in assurance and monitoring evaluation • Proactive management through public health • More patients actively involved in self care • Pharmacy, Optometry, Dental as first point of contact where appropriate to need
System Objective Two **Develop and improve our people to be the best healthcare workforce**	• HEEM commission educational programmes • Workforce plan developed and collated for all contractor groups • First contact training completed • Training plans for joint programmes, feedback	• High quality primary care workforce, effective and safe, with future leadership identified and growing • Workforce configured to population need working across organisational boundaries, with joint training • Primary care providers with self-sustainable workforce and organisational plan • Increased demand for primary care careers
System Objective Three **Support the processes of transformation by innovation, excellence in monitoring and evaluation, and development at pace and scale across primary care**	• Primary care strategy and implementation plan agreed • Communications and engagement plans agreed, implemented and reviewed • Programme management office established • Dental and Eye needs assessment plans approved • Patient leaders plan developed implemented and reviewed • Refresh implementation plan	• Personalised care in place for all of the population, with named GP / clinician utilising a number of methods e.g. Health Plans, health apps for the well • Access to 7/7 high quality primary care for routine and urgent care • Increased application of technology solutions • Shared patient records

System Objective Four **Our premises will be aligned to meet the needs of the population**	• Baseline information gathered for all primary care contractors • Premises plan developed , implemented and reviewed • Premises plan refreshed	• Health and social care plan for premises aligned to community needs and in partnership with commercial and economic planning • Increased numbers of mergers and federations to improve access and health outcomes
System Objective Five **To develop the payments and incentives system to reward improved outcomes and secure value for money**	• Key performance indicators and targets agreed for all primary care contractors • Payments and contractual arrangements for PHP agreed • Action plans agreed with CCGs for improvement in contractor groups • QOF reviewed with clinical leads for projects • Deep dive assurance developed, implemented and reviewed	• Resources following the patient to reflect the impact primary care can have on reducing inappropriate utilisation • Deep dive reviews continued annually • Rewards for improved outcomes

DN: Timelined 5 year plans from CCGS will need to demonstrate what is expected to be achieved by when from each of their primary care plans.