NHS
Nottingham North and East
Clinical Commissioning Group

Primary Care Development Strategy 2014-2019

Version 1.0, June 2014

Putting good health *into practice*

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Contents

Tables of information

Figures

1. Introduction

Nottingham North and East Clinical Commissioning Group (NNE CCG) has been a statutory NHS organisation responsible for commissioning health services for the population covered by the CCG area since 1 April 2013. NNE CCG is one of seven Clinical Commissioning Groups (CCGs) in Nottinghamshire, including Nottingham City and Bassetlaw. The CCG comprises 21 GP practices covering a population of approximately 147,000, organised collectively to commission health services for the patient population living in Arnold, Burton Joyce, Calverton, Carlton, Colwick, Daybrook, Gedling, Giltbrook, Hucknall, Lowdham, Mapperley, Netherfield and Newthorpe. An area map can be found in Appendix 1.

The CCG is led by general practitioners (GPs) using their knowledge and understanding of patients' needs, with the key principles of putting patients at the centre of the NHS and focussing on clinical outcomes. Pivotal to the success of the CCG is the requirement to continuously improve the quality and safety of care whilst ensuring that the available healthcare resources are used as effectively and efficiently as possible. This is at a time when the CCG, along with the wider NHS, is facing a significant financial challenge.

The key aims for NNE CCG in 2014/15 – 2015/16, as outlined in NNE CCG's Commissioning Plan, are to:

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

The responsibility for primary care commissioning and contracting is overseen by NHS England. However, CCGs have a responsibility to work with NHS England to improve the quality of general practice. This document therefore sets out Nottingham North and East CCG's strategy in respect of primary care development for 2014/15 – 2018/19.

2. The national context

High quality primary care is the foundation of an effective healthcare system. Primary care is the first point of contact for over 90% of patients and service users. Primary care includes general practitioners, pharmacists, dentists, and optometrists – all of whom play an important part in delivering healthcare services. In particular, general practitioners play a crucial role in providing urgent care, coordinating and providing chronic disease management, health promotion, diagnostics and early intervention, and support to patients to manage their own care.

The current government has placed quality at the heart of the NHS, focusing on outcomes rather than process targets, giving power to patients and devolving power and accountability to clinicians via the development of CCGs. The NHS definition of quality (Lord Darzi's 'High Quality Care for All – NHS Next Stage Review Final Report' (Department of Health 2008)) is expressed in terms of three core areas: patient safety, patient experience, and effectiveness of care.

The planning guidance 'Everyone Counts: Planning for Patients 2014/15 to 2018/19' (NHS England 2013) states that 'one of the key aims is to enable general practice, community pharmacy and other primary care services to play a much stronger role, at the heart of a more integrated system of community-based services, in improving health outcomes'.

Nationally, general practice is currently facing a number of challenges:

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

Unwarranted variation: there are unwarranted variations (variations in the utilisation of services that cannot be explained by variation in patient illness or patient preferences) in the quality and range of services that patients receive both locally and nationally, which have a negative impact on health outcomes. There are serious failings in the provision of care in a small minority of practices nationally, although patient satisfaction with general practices services remains high. However, there is increasing concern in respect of patient experience of access to care.

Financial pressures: the NHS faces a projected funding gap of £20 billion by 2021/22, placing pressure on the NHS as a whole, including general practice, to maximise the use of resources and deliver efficiencies where possible.

Workforce: over the last 10 years the number of full time equivalent GPs has risen, but only at half the rate of other medical specialities, and not in line with population growth. There has also been a gradual increase in the number of GPs working part-time, which is creating long-term sustainability issues.

3. The local picture

The national picture in respect of demographic changes, unwarranted variation, and workforce is clearly reflected locally within NNE CCG. The following sections demonstrate the challenges that the CCG will need to address over the next five years.

3.1. The local population

The population of NNE CCG is spread across a mix of urban areas and rural villages. Figure 1 indicates that the Index of Multiple Deprivation (IMD) score for the CCG is 18.8 (UK average is 21.5). The higher the score, the more deprived the area. However, within the CCG there are areas of significant deprivation, particularly around Hucknall. Conversely, there are areas of relative affluence. This variation is reflected across the GP practices in NNE CCG:

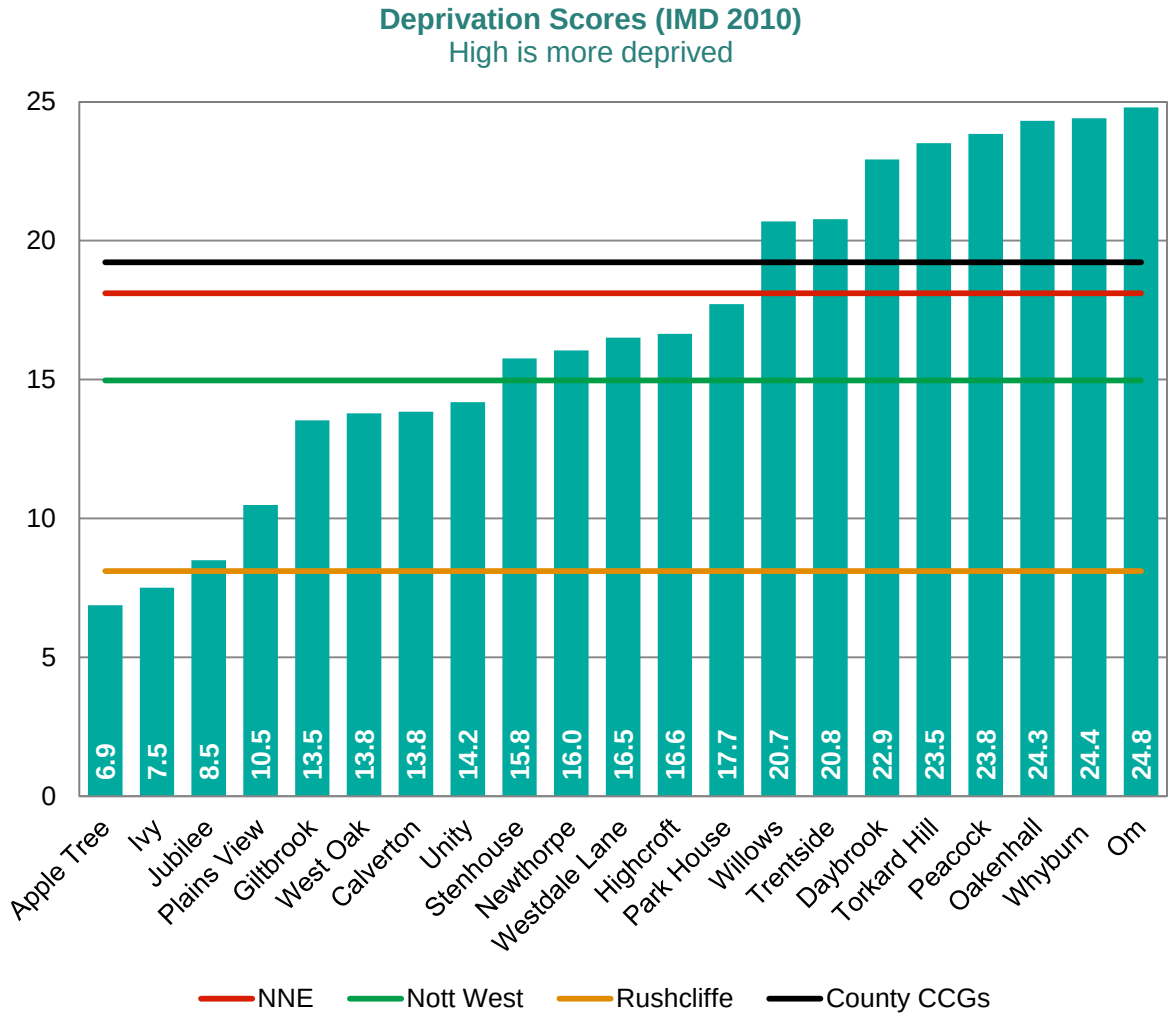


Figure 1. NNE deprivation scores

The population profile for the CCG shows that the population is slightly older than the national average, whereas the proportion of people under 40 is lower than the national average.

Across the CCG area, it is estimated that the population will grow by 11.66% between 2010 and 2025.

3.2. Disease prevalence

Table 1 below (NHS Commissioning Board Outcomes benchmarking support packs: CCG level) shows the prevalence (number and percentage) of diseases covered by the Quality and Outcomes Framework (QOF) for the practices in NNE CCG in 2010/11. The chart shows the distribution of the CCG's practices' prevalence in terms of ranks. Individual practices are shown as vertical bars, with the height of the bar proportional to each practice's population. The blue box shows the range of the middle 50% of practices in the CCG. The large diamond shows the average rank for the CCG, and the dashed blue line shows the England average.

QOF Disease Register	Number (%) and practice ranks chart
Coronary Heart Disease	5,635 (3.9%)
Stroke or Transient Ischaemic Attacks (TIA)	2,902 (2.0%)
Hypertension	21,396 (14.9%)
Chronic Obstructive Pulmonary Disease	2,688 (1.9%)
Hypothyroidism	4,742 (3.3%)
Cancer	2,251 (1.6%)
Mental Health	827 (0.6%)
Asthma	10,158 (7.1%)
Heart Failure	1,088 (0.8%)
Heart Failure Due to LVD	507 (0.4%)
Palliative Care	299 (0.2%)
Dementia	861 (0.6%)
Atrial Fibrillation	2,260 (1.6%)
Cardiovascular Disease Primary Prevention	1,313 (0.9%)
Diabetes Mellitus (17+)	6,741 (5.8%)
Epilepsy (18+)	923 (0.8%)
Depression (18+)	12,044 (10.4%)
Chronic Kidney Disease (18+)	10,540 (9.1%)
Obesity (16+)	13,039 (11.0%)
Leaning Disability (18+)	469 (0.4%)

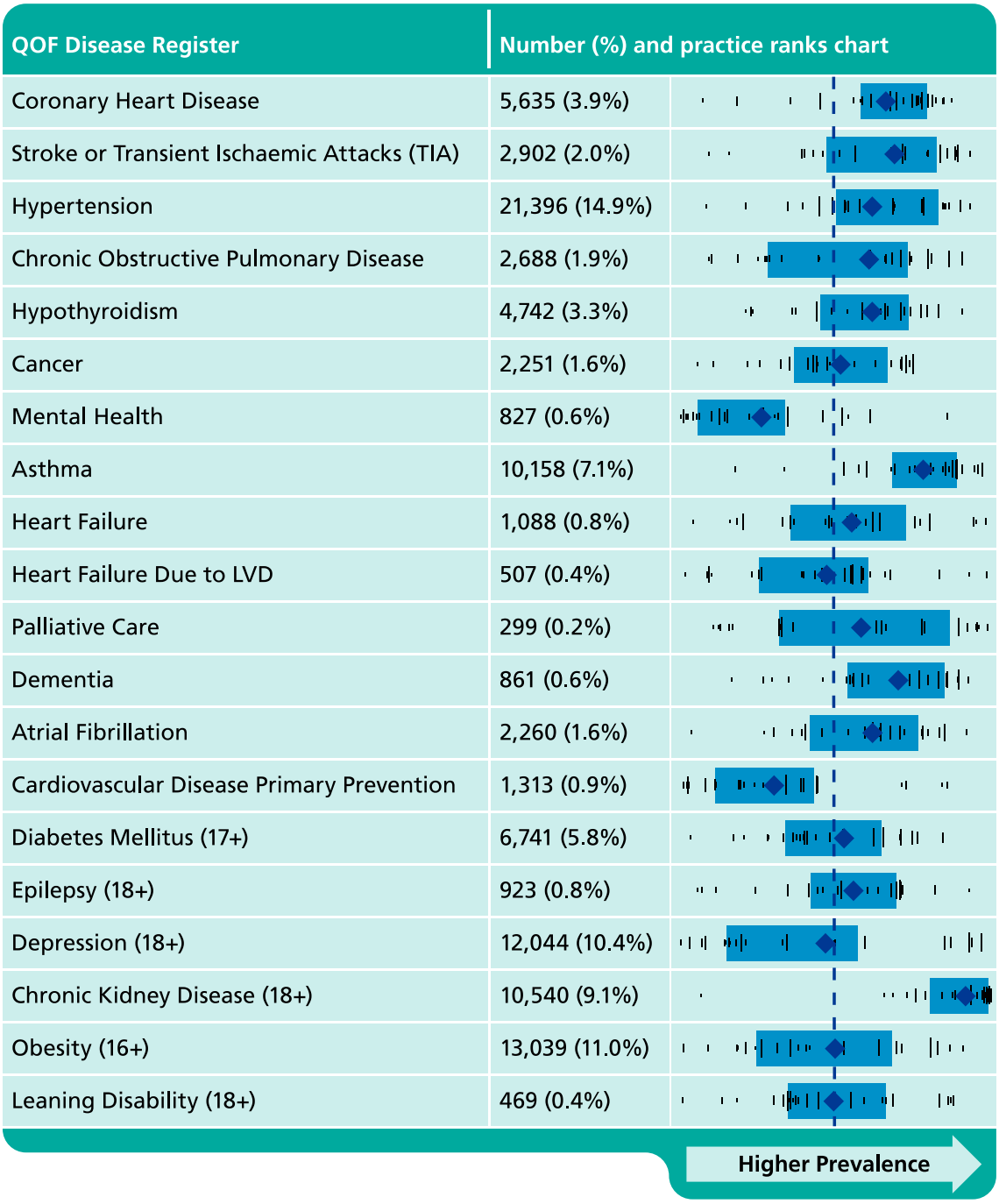


Table 1. Disease prevalence per QOF register

This demonstrates the levels of disease prevalence, and shows not only the variation of prevalence within the CCG, but also the variation from the national average. In particular, there is a high prevalence of chronic kidney disease, asthma, and coronary heart disease, and low prevalence for mental health, which could indicate there is low diagnosis of mental health. There is also wide variation in the prevalence of the individual practices, which could highlight unwarranted variation.

As nationally evidenced ('Improving General Practice – a call to action' (NHS England, August 2013/14)), the prevalence of many diseases is increasing. This is compounded by the fact that the incidence of people having two or more long-term conditions is also increasing.

3.3. Patient outcomes

Figure 2 below shows the performance of CCGs against each outcome indicator. NNE CCG is shown as a red diamond. The yellow box shows the interquartile range and median of CCGs in the same Office for National Statistics (ONS) cluster as NNE CCG. The dotted blue line is the England median. Each indicator has been orientated so that better outcomes are towards the right (light blue).

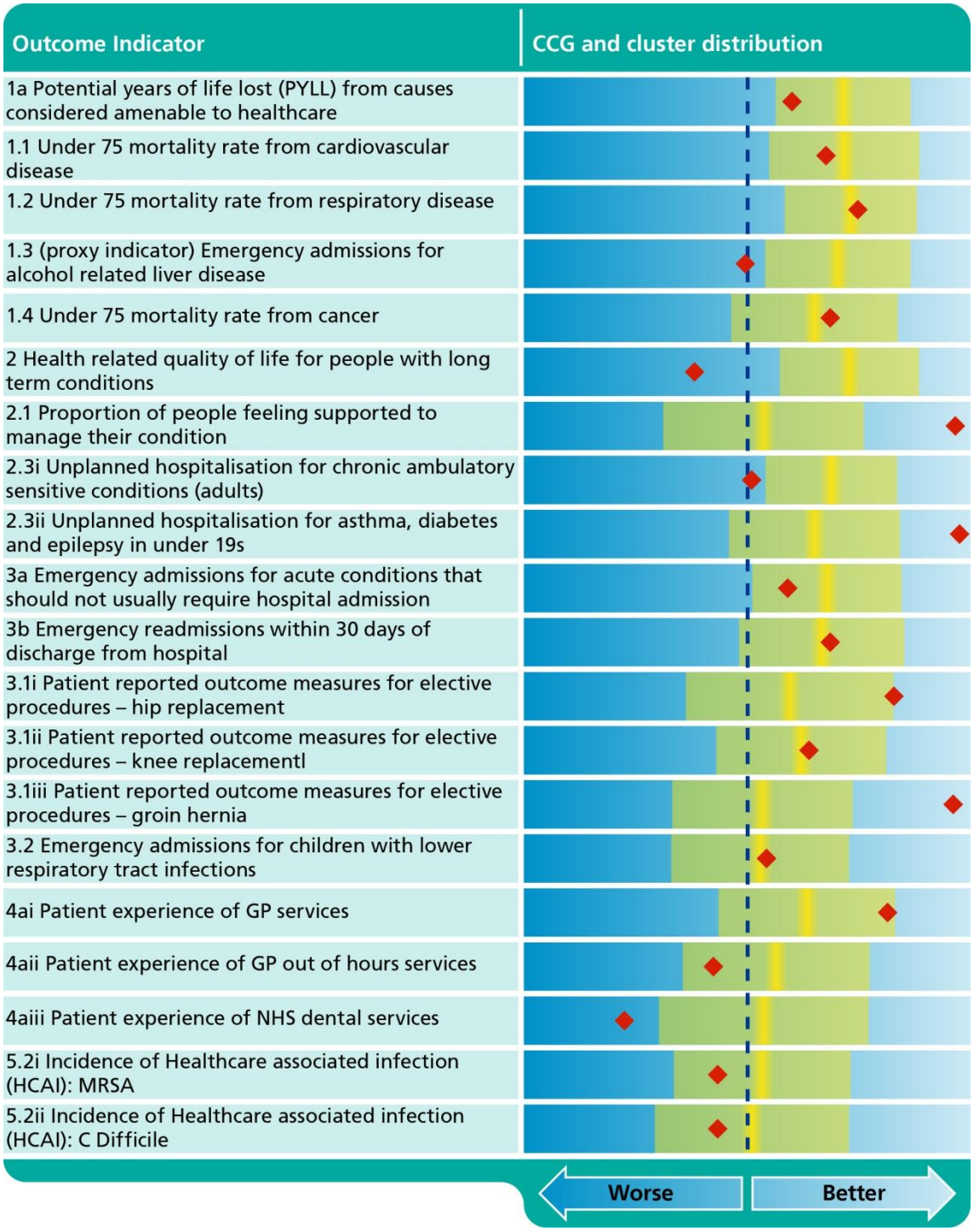


Figure 2. Performance against outcome indicators

The NHS England Outcomes Benchmarking Support Pack (2013) indicates that NNE CCG has particularly good outcomes when compared with the England average and other CCGs in the same ONS cluster, in respect of:

- supporting people to manage their condition
- unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
- patient reported outcome measures for elective procedures – hip replacement and groin hernia.

However, health related quality of life for people with long term conditions is worse in NNE CCG than the average for England and other CCG in the same ONS cluster. Whilst emergency admissions for alcohol related liver disease and unplanned hospitalisation for chronic ambulatory sensitive conditions (adults) are the same as, or above, the England average outcomes are worse than the ONS cluster CCGs.

The NHS England Right Care Commissioning for Value information (2013) for NNE CCG indicates that significant improvements can be made in terms of both spend and quality for cancer, circulation, respiratory, mental health, and neurology outcomes.

3.4. Unwarranted clinical variation

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

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

- Life expectancy
- Childhood vaccinations
- Screening for cancer
- Disease prevalence as recorded in the QOF registers versus expected disease prevalence
- Prescribing

Figures 3 and 4 below (source: Secondary User Services data) highlight some of the variation across the CCG.

First outpatient appointments (April 2013 to March 2014)

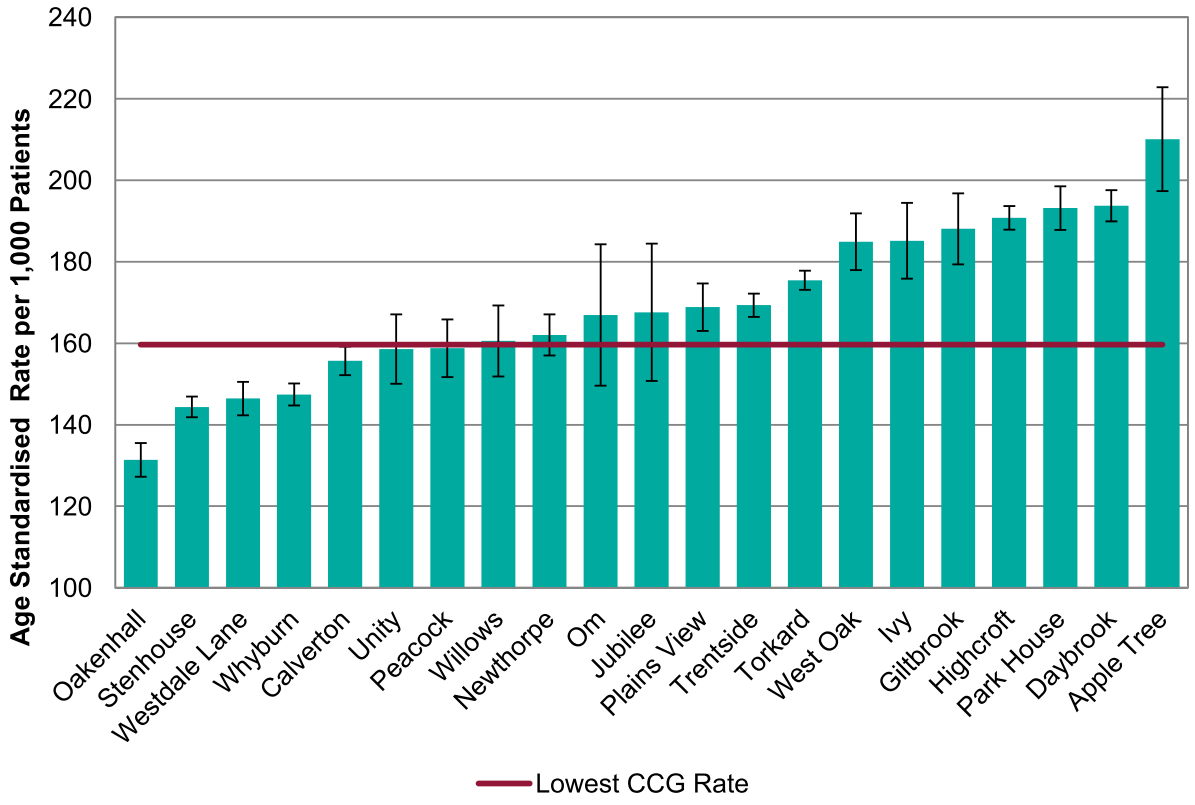


Figure 3. First outpatient appointments (April 2013 to March 2014)

Emergency admissions from GP (April 2013 to March 2014)

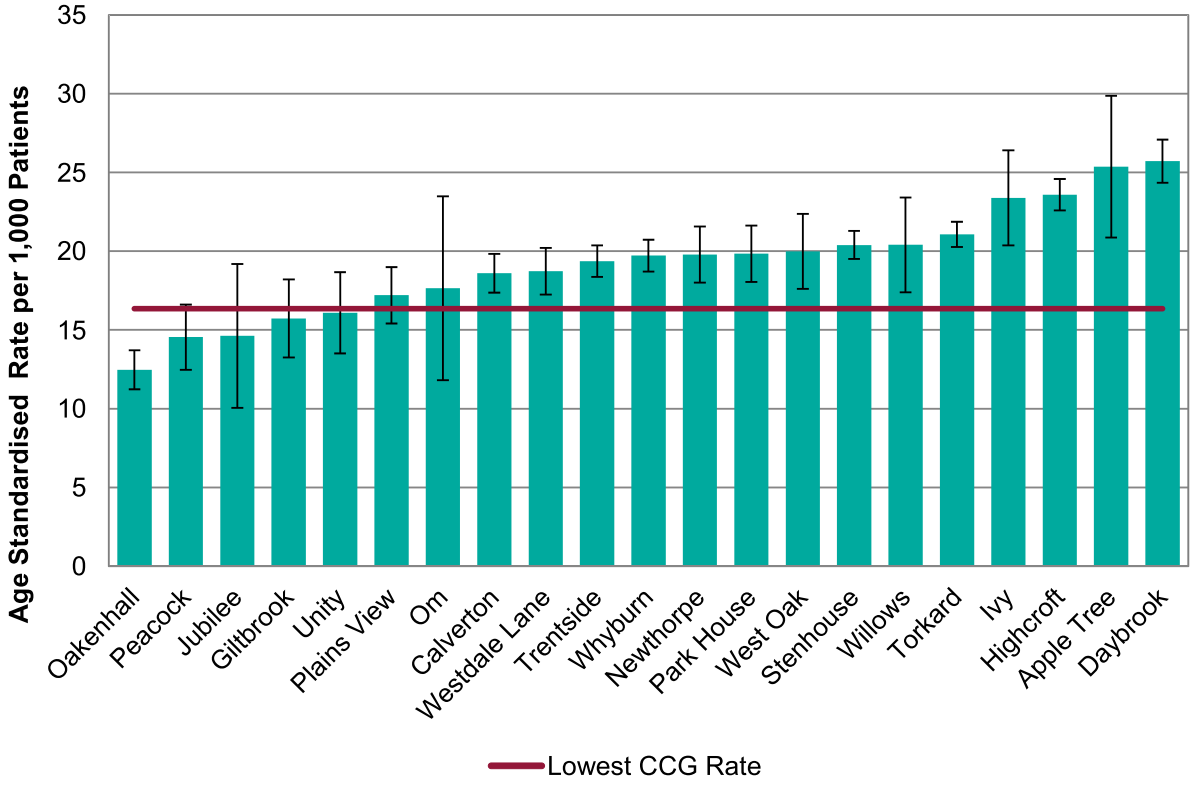


Figure 4. Emergency admissions from GP (April 2013 to March 2014)

3.5. Patient experience

The national Patient Survey (December 2013) results for GP practices in NNE CCG confirmed that for the most part the results reflect the national picture.

Whilst acknowledging that there are shortcomings to the survey, it did highlight that there are significant variations across the CCG area, regarding patient experience and satisfaction in the services offered by GP practices. Figures 5 to 7 below give examples that highlight these variations.

Percentage of patients rating overall experience of GP surgery as very good or fairly good

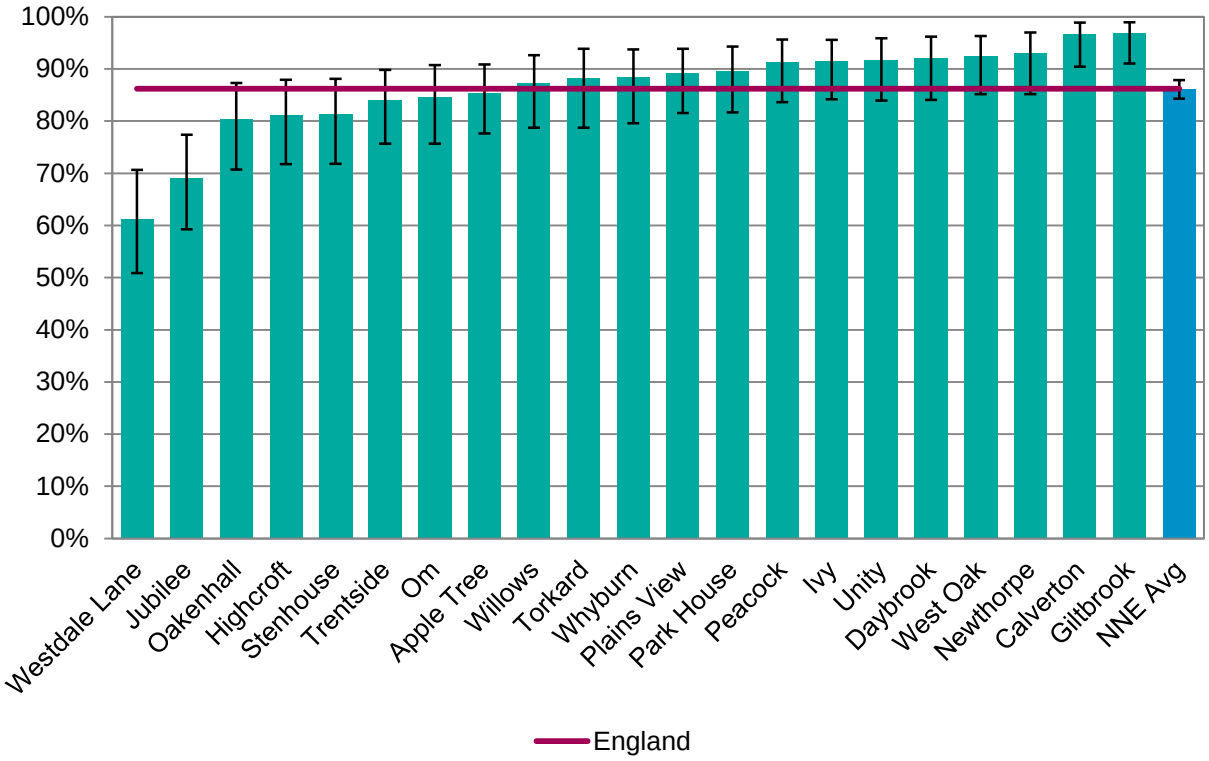


Figure 5. Percentage of patients rating overall experience of GP surgery as very good or fairly good

Percentage of patients rating overall experience of making an appointment as very good or fairly good

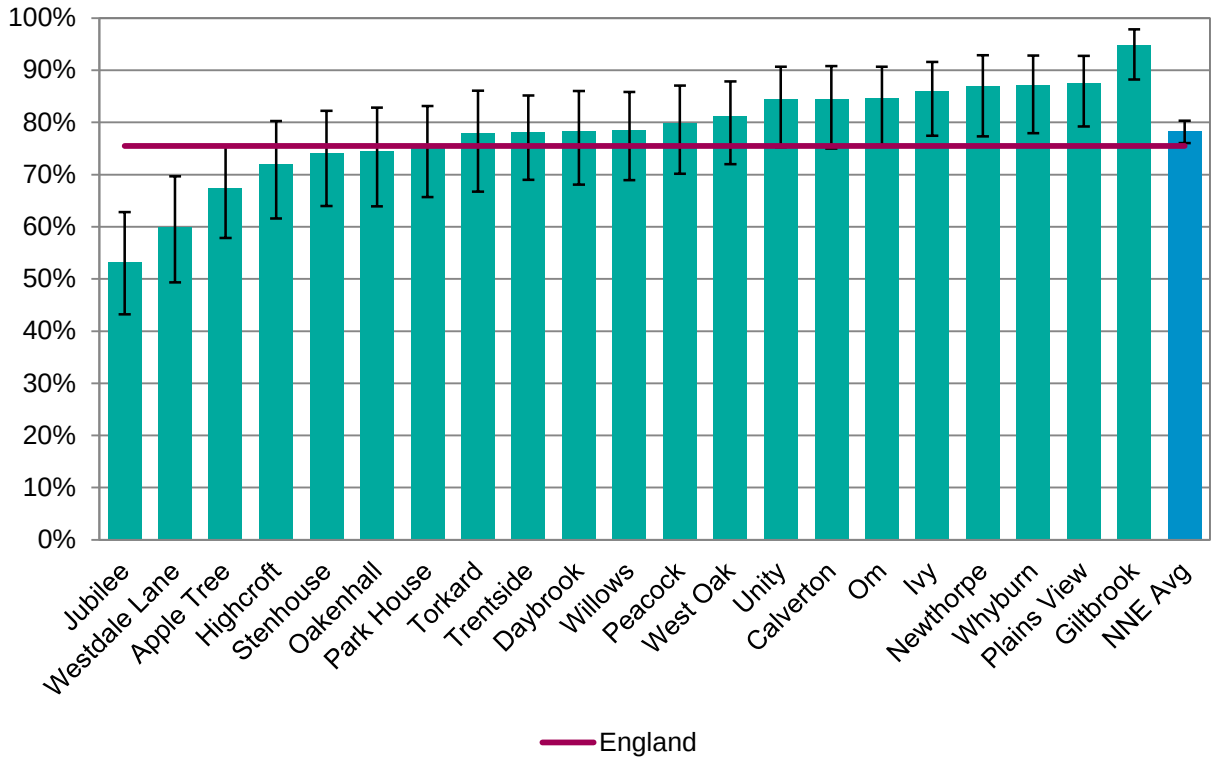


Figure 6. Percentage of patients rating overall experience of making an appointment as very good or fairly good

Percentage of patients rating satisfaction with opening hours as very satisfied or fairly satisfied

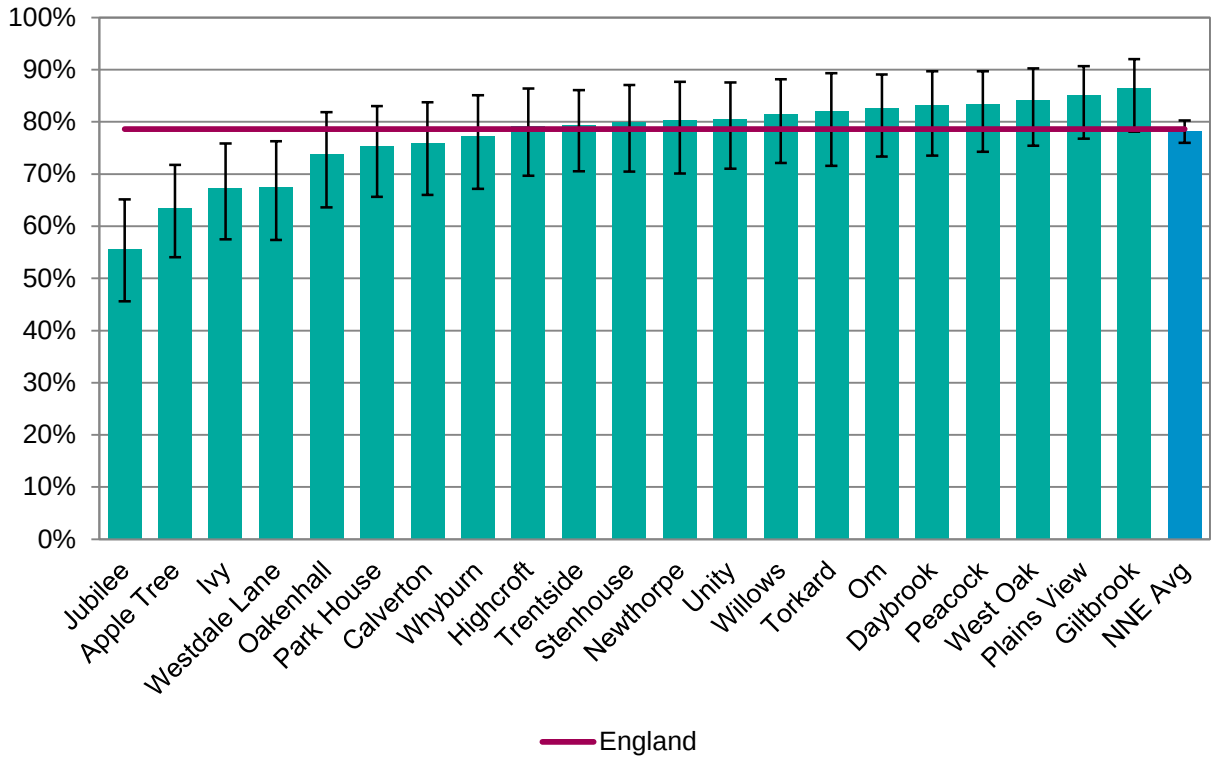


Figure 7. Percentage of patients rating satisfaction with opening hours as very satisfied or fairly satisfied

For those patients who said their surgery is not open at convenient times, 68% of people would like surgery opening after 18:30 and 74% indicated that they would like Saturday opening. 38% favoured opening before 8:00, with only 22% favouring Sunday opening and 9% wanting opening at lunchtimes.

3.6. What patients are telling us

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

A number of key themes relating to primary care have emerged to date, with our patients telling us the following:

- Self-management of diabetes, with the provision of good information and guidance from clinical staff who understand the condition and its complications, is paramount.
- NNE CCG and GP practices need to address the perceived variations in diabetes care across practices, educate more staff to understand the condition, and promote self-management initiatives, to both engage with, and gain more trust from, their patients.
- It is difficult to make an appointment at a GP practice by telephone. It is also difficult to get an appointment within what is perceived as a reasonable time period. In winter it is quicker to call for an ambulance.
- The process for getting a GP appointment needs to improve. Patients shouldn't have to phone at 8.30am and then be asked to phone back later if there are no appointments available.
- More support is required for the older population, who suffer loneliness and are isolated in their own home.
- Communication systems between providers (e.g. the GP and the hospital) need to be improved as the current system of writing letters is inefficient and a waste of money.
- Systems need reviewing to avoid duplication of tests/assessments/treatment between primary and secondary care, which wastes money.
- Local GP surgeries could work together so that if one is at full capacity in terms of appointments, other local surgeries not at capacity could arrange to take the 'overspill of patients'.
- The huge increase in people living longer means early intervention is a key way to address future potential long-term conditions.
- Nurses could be trained to carry out more procedures/duties, to free up doctors who can work on more urgent cases.
- There need to be more GPs.
- Assistive technologies are useful, but consideration needs to be given to the confidence patients (particularly older people) have in using these to support their care.
- Confidentiality and data protection are an issue at GP surgeries. People queuing can hear everything said at reception desk.
- Hucknall West is one of the most deprived wards in terms of health services. Residents are concerned about access to GP services, particularly in light of the new proposed housing developments planned in the area and the increase on demand this will cause.

4. So what are we going to do?

Early in 2013, NNE CCG GP practices and staff met to define the CCG's vision for primary care, gain a clearer understanding of the local challenges, and identify priority areas on which to focus over the next five years. The outcomes of this form the basis of this strategy, and are described in the following sections.

4.1. Our vision

Our CCG vision is for general practices across the NNE CCG area to deliver equitable, high quality, efficient and accessible primary care services that are clinically effective and have the patient at the centre of care. One of the key elements of this will be to improve quality in primary care, where quality is expressed in terms of three core areas: patient safety, patient experience, and effectiveness of care.

4.2. Our priorities

The CCG's priorities in respect of primary care are:

Quality

- To improve quality in general practice to ensure patients have the best possible experience of care
- To increase the number of completed episodes of care within the practice setting
- To develop new models within primary care that provide more proactive, holistic and responsive services for local communities, particularly for frail older people and those with complex health needs
- To develop systems, processes and pathways that empower patients (and their carers) to take more control of their care through self-management
- To ensure patients and carers are more fully involved in the development of primary care services

Unwarranted variation

- To reduce unwarranted variation between general practices in the CCG, both clinical and non-clinical
- To reduce unwarranted variation between practices in terms of health outcomes for patients
- To reduce unwarranted variation between practices in respect of the patient experience
- To reduce health inequalities

Access

- To ensure primary care provision and access across the CCG matches the needs of the population and is available for everyone
- To encourage innovative ways of working and sharing of examples of good practice
- To support the development of services that enable care to be provided closer to home where appropriate
- To reduce the number of unnecessary attendances at Accident and Emergency, and the number of emergency admissions
- To integrate general practice and improve collaborative working across the whole health care system (including other primary care providers, secondary care, community care, social care, 3rd sector, out of hours medical services, ambulance, and 111 services) in order to ensure patient care is delivered in a 'joined up' manner
- To maximise productivity and ensure the sustainability of general practice so that it can continue to support patients in the context of increasing demand and limited resources

Capacity/capability

- To support workforce development/education to ensure general practice has the capability and capacity to deliver high quality care
- To maximise the use of existing and new technology systems to support efficient and effective working, information sharing, and improved co-ordination of patient care
- To explore, develop, and implement new models of working, both in practices and between practices, to support sustainability and improved quality

5. Enablers

The following enablers have been identified that will support the delivery of the CCG's Primary Care Development Strategy.

5.1. Workforce

The workforce of the CCG's member practices is pivotal to the delivery of the CCG's Primary Care Development Strategy. Strategically the CCG will support the development of a workforce that has the capacity and capability to deliver the necessary future transformation of general practice.

Development and training of the GP workforce is primarily the responsibility of the Local Education and Training Council (LETC) and Local Education and Training Board (LETB).

The CCG will work closely with the NHS England Derbyshire and Nottinghamshire Area Team ('the Area Team'), the Local Medical Council (LMC), the LETC, and the LETB to contribute where appropriate to the development of a comprehensive staff development plan which recognises and supports the changing environment in which people are working, the changing ways of working, and changing responsibilities.

The CCG recognises that education and development includes not only formal training but also less formal training, such as that provided by peer support both within practices and between practices. The CCG will therefore continue to support peer review where referral activity indicates this may be beneficial in addressing unwarranted clinical variation.

5.2. Clinical leadership

The effective delivery of this strategy will rely on strong clinical engagement and practices working collaboratively and supportively. The clinical engagement of member practices in the commissioning activities of the CCG is similarly seen as key to the success of the strategy. All GP practices are represented on the CCG's clinical cabinet.

There is a strong locality focus within the CCG and inter-practice relationships are robust. There is also willingness from clinicians to be involved in the work of the CCG. Over the next five years the CCG will continue to maximise the benefits of clinical leadership within the CCG to ensure commissioning is fully embedded into the work of general practice.

5.3. Stakeholders

To ensure general practice is patient centred, and works effectively and efficiently with other providers of care it is vital to have good stakeholder engagement. The CCG remains committed to patient and stakeholder involvement in all its areas of responsibility, including primary care development.

The CCG promotes collaboration between providers and will explore ways to reduce unnecessary processes, reduce duplication, and streamline pathways. It supports the work of Nottinghamshire Health Informatics Service (NHIS) to develop protocols which support appropriate information sharing.

5.4. Premises

In order to improve the quality of care provided in general practice going forward, and to meet the demographic challenges of an aging population, it is essential to have GP premises that are fit for purpose. Premises require the capacity to accommodate not only an increase in the number of patients, but also to be able to deliver an expanded range of services in order to provide more services closer to home.

The Care Quality Commission (CQC) has a mandate for ensuring that essential standards of quality and safety are met in respect of GP premises. NHS England, through its area teams, is responsible for the funding of premises development.

The CCG will work closely with the Area Team and practices to support the development of premises that have the capacity to meet future demands.

5.5. Finance and sustainability

General practice faces significant financial challenges. These are set to continue for the foreseeable future. However, despite these pressures, general practices will need to ensure that quality of care is maintained and that services are clinically effective and safe.

Over the next five years, therefore, the CCG will support practices to identify efficiencies in the way primary care is delivered. The CCG will facilitate the sharing of good practice and build on the experience of Productive General Practice.

To ensure the future viability of general practice it is becoming increasing necessary for practices to explore alternative business models, including, for example, federated working and development of a provider arm. Where appropriate and if required the CCG will support such developments.

5.6. CCG Pharmacy Team

The CCG employs a team of pharmacists who support practices in several ways, including:

- reducing clinical variation in medicines management
- ensuring cost effectiveness of medicines prescribed
- facilitating integrated working with community pharmacies.

6. Implementation of the Strategy - Work Plan 2014/15 – 2015/16

The table below summarises the current and planned work which will support the delivery of the strategy over the next two years.

Table 2. Implementation Work Plan (below)

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Quality				
End of life	Un-coordinated and unplanned end of life care can often result in unnecessary attendances at the Emergency Department and subsequent unplanned admissions to hospital Ensuring choice of preferred place of death is a priority	Commission an Electronic Palliative Care Coordination System (EPaCCS) Increase the number of patients who die in their preferred place of death	Summer 2014	Improved patient experience Increased quality of care More people are supported to die in their preferred place of death Fewer unnecessary attendances at the Emergency Department and unplanned admissions to hospital
Older and complex patients	Many patients who are identified as being at high risk of admission could be better managed in primary care	Gain a greater understanding of the use of healthcare by high risk patient groups Promote the use of eHealthScope, an interactive and responsive system that supports GP practices and assesses the impact of clinical decisions and interventions	On-going throughout 2014/15 and 2015/16	Improved identification and subsequent case management of patients Improved quality of care, patient experience and satisfaction, and increased self-management Proactive care ensures patients receive the care they need in a timely manner Resources targeted more effectively
Personalised care	The need to optimise care for patients most at risk of an admission	Support practices to provide holistic, integrated and co-ordinated care for the over 75 population and those patients with complex needs most at risk of an unplanned admission	2014/15	A reduction in avoidable emergency admissions through systematic and proactive care management of those identified as at risk. Improved quality of care and patient experience Patients supported to manage their own health Standardised approach to care to reduce clinical and outcome variation

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Self-management	More people, particularly those with long term conditions, could be involved in the management of their condition if they were supported to do so	Maximise the use of appropriate Telehealth mediums for people with long-term conditions Work with GP Practices and community services to implement the 'Flo' model of telehealth	Throughout 2014/15	More people are able to manage their own condition and are therefore less reliant on the health system Improved patient experience A reduction in the number of appointments patients require with their GP Reduction in emergency department attendances Reduction in unplanned admissions Reduction in elective admissions Reduction in bed days
Information Sharing	It is recognised that a proportion of patients are transferred to hospital because information about the patient is unknown by the clinician making the decision. This proportion may be reduced if a summary of key information was available	Work collaboratively to develop a system that will allow the sharing of care plans across the wider health community including GP practices, OOH, EMAS, NUH and 111 Work with IM&T in the development of the medical interoperability gateway (MIG) Work with IM&T in the development of portal technology to enable sharing of information across the health community	2014/15	Improved interface between providers leading to improved quality of care for patients Reduction in unplanned admissions Reduction in emergency department activity Improved patient experience
Clinical advisor	The requirement for practices to improve quality, address unwarranted clinical variation, and improve access	Recruit a clinical advisor to work closely with practices to improve quality and access, and reduce unwarranted variation	Sept 2014 onwards	Increased quality of patient care A reduction in the number of patients being referred to hospital unnecessarily Improved patient experience

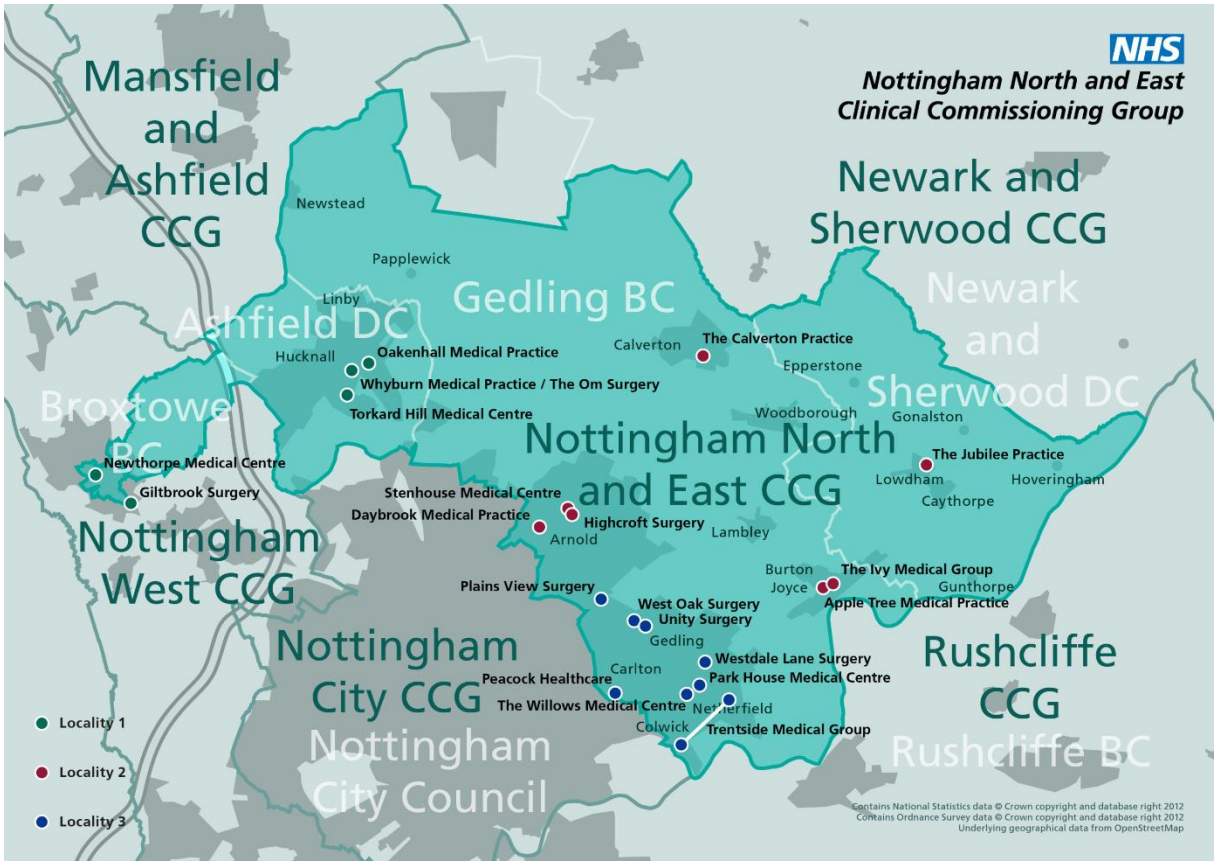
Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Unwarranted variation				
GP referrals	There are significant variations between GP practices in the CCG in respect of the number of patients who are referred to a hospital to receive the care they require, suggesting that some referrals could be avoided	Implement the Right Care programme to reduce unwarranted variation in referrals Consider and implement referral tools such as Map of Medicine	Right Care programme to be implemented via a phased approach during 2014/15 and 2015/16	A greater number of patients will receive care closer to home An increased range of services will be available to ensure patients receive the most appropriate care Fewer patients will need to go to hospital to receive the care/treatment they require
Patient choice	It is believed that if patients are more informed about the treatment options available to them some may choose not to go ahead with the treatment on offer	Develop and Implement a 'shared decision making' approach to referrals	Project to be developed during 2014/15	Patients will be more informed when making decisions about the treatment they are being offered Increased patient satisfaction and improved patient reported positive outcomes following treatment Fewer referrals to hospital for treatment
Clinical thresholds	The CCG needs to prioritise resources and provide interventions with the greatest proven health gain. There is a risk that clinical thresholds for procedures change inappropriately. Maximising value depends on the effective use of shared decision making.	Review the Procedures of Limited Clinical Value/Guidelines Policy Implement a revised policy/guidelines alongside shared decision making	2014/15 2014/15	Reduced rate of first outpatient attendances following a GP consultation
Diagnostic tests	A significant number of diagnostic tests are requested by GP practices each year It is recognised that patients often have diagnostic tests repeated when their care transfers from one provider to another e.g. general practice to hospital	Ensure the availability of a single electronic solution for requests, result and e-documents within GP practices Roll out of the Integrated Clinical Environment (ICE) system across the CCG Monitor the impact of the ICE system Develop Phase 2 of the ICE project to improve electronic transfer of information from the hospital to the practices	2014/15	Reduction in duplication of tests Reduction in the number of tests requested More efficient and effective working Improved patient experience

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Access				
GP access	Analysis of GP appointments, validated by GPs, indicated that 50% of the same day/urgent demand could have been dealt with by another appropriate qualified health and social care professional rather than a GP. There is a need to release general practitioner (GP) time and enable increased proactive management of older patients and those with more complex health needs	To implement an Urgent Care/Same Day Pilot across two GP Practices	April 2014	Improved access to urgent/same day GP appointments A reduction in attendance at the emergency department Improving patient confidence in accessing GP services which will reduce the need for patients to access emergency services for non-emergencies Promotes integration across primary, secondary, community and social care – reduces duplication and reduces the amount of time the patient repeats their story
		To roll out an agreed model of urgent care management across one locality as part of the Prime Minister's Challenge Fund	March 2014	
		To test an approach to achieving seven day working across one locality	Sept 2014	
		To implement a chronic care management approach	2014/15	Improves access and the length of time of appointment for patients with complex needs including housebound patients
	Variation in access to GP services Variation of patient experience	Agreement and implementation of Access Standards	June 2014	Reduction in variation in patient experience
Communic-ation with patients/public	It is recognised that patients often do not receive care in the most appropriate place. In order to ensure patients receive their care/treatment in the most appropriate setting a greater understanding of the health system is required	Develop a communication plan to include a variety of campaigns/approaches etc. to support patients to determine the best place to go to receive the help they need	2014/2015	Increase in patients being seen in the most appropriate setting by the most appropriate clinician
Capacity and capability				
Education and training	To increase the range of services provided in general practice and reduce the number of referrals to hospital, clinical and non-clinical practice staff will require appropriate and on-going training and education, e.g. dermatology, ECG, diabetes year of care, COPD	Consider and plan GP practice training and education into any new service development Support GP practices to access Protected Learning Time events, and ensure these are tailored to meet the education and development needs of local practices	On-going	Increase in GP practice staff skills and knowledge Improved patient outcomes and experience More services offered closer to home

Area	What are the identified issues	What we plan to do	Timescales	Expected outcomes
Professional development	To ensure sustainability, the roles and responsibilities of clinicians working within general practice will need to change. It is therefore necessary to ensure that there is training available for existing staff in order to ensure they are able to meet the requirements of any changes to their roles. There is a need to have suitably qualified and trained staff in general practice to meet future demands and service requirements	Work with the Area Team and Nottinghamshire Local Education and Training Council (LETC) to support and influence any future training plans based on an analysis of existing skills and the identification of gaps	On-going	A trained workforce who have the skills, capability and capacity to deal with changing roles, increasing complexity increasing demand
Practice manager training	It is recognised that the role of the practice manager continues to evolve and is becoming increasingly complex. The role is pivotal in ensuring quality in primary care	Support practice manager training. A training plan will be developed and delivered during 2014/15	2014/2015	
Productive General Practice	General Practice is a complex business and comprises many different sized organisations which operate with a variety of different processes and procedures. In the light of growing demand and complexity it is vital that these organisations operate as efficiently as possible	Six Productive General Practice packages have been commissioned by the CCG to help practices improve efficiency. The CCG will work with those practices and share learning and areas of good practice across the CCG	2014/2015	More efficient practice operations leading to the ability to better manage increasing demand
Premises development	There are identified areas within the CCG where there is a need for premises development either because there is a forecast growth in population or because buildings need to be developed to ensure they are fit for purpose to meet the future challenges	The CCG will work collaboratively with the Area Team and practices to ensure that developments are timely and meet the future needs for the delivery of integrated health care	On-going	General practices will have premises which are fit for purpose and suitable to meet future demands Improved patient experience and satisfaction Improved access

7. Appendices

7.1. Population map



7.2. Locality Structure

Practice	List Size (as of May 2014)
Locality 1	
Newthorpe Medical Centre, Eastwood	6,434
Oakenhall Medical Practice, Hucknall	7,115
Om Surgery, Hucknall	2,088
Whyburn Medical Practice, Hucknall	11,294
Torkard Hill Medical Centre, Hucknall	14,439
Giltbrook Surgery, Giltbrook	4,064
Locality 2	
Calverton Practice	9,214
Stenhouse Medical Centre, Arnold	12,265
Daybrook Medical Centre	9,275
Jubilee Practice	2,224
Apple Tree Medical Practice, Burton Joyce	3,446
Highcroft Surgery, Arnold	12,082
The Ivy Medical Group	4,022
Locality 3	
The Willows Medical Centre, Carlton	3,755
Peacock Healthcare, Carlton	4,646
Trentside Medical Group (Netherfield & Colwick Vale)	11,820
Unity Surgery, Mapperley	3,841
West Oak Surgery, Mapperley	4,925
Westdale Lane Surgery, Mapperley	7,576
Plains View Surgery, Mapperley	5,630
Park House Medical Centre, Carlton	7,069

7.3. Glossary/Abbreviations

Clinical Commissioning Group (CCG)

The term given to a number of GP practices that work together within a defined geographical area to plan and pay (commission) health services for the local population.

Commissioning

Commissioning relates to the purchasing and contracting of health care services. It involves identifying health needs, service planning and design and purchasing services from appropriate providers and subsequently managing the contracts put in place.

End of life

The Department of Health have developed an end of life strategy to ensure that the care people receive at the end of life is compassionate, appropriate and gives people choices in where they die and how they are cared for. The pathway includes health and social care services.

Health and Social Care Information Centre (HSCIC)

Formerly the NHS Information Centre, HSCIC was designed to be England's central, authoritative source of health and social care information.

Health and Wellbeing Board

Local authorities have a responsibility to establish a Health and Wellbeing Board that will lead on improving the strategic co-ordination of commissioning across NHS, social care and related children's and public health services. Clinical Commissioning Groups are represented on the Health and Wellbeing Board.

Health needs assessment

Health needs assessment is a method for reviewing the health issues facing a population, leading to agreed priorities and allocation of resources that will improve health and reduce inequalities.

Health outcomes

Health outcomes are a change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status. Interventions may include government policies and consequent programmes, laws and regulations, or health services and programmes, including health promotion programmes.

Improving Access to Psychological Therapies (IAPT)

IAPT is a Department of Health project. Psychological therapies have been shown to be an effective intervention for people with common mental health problems such as depression and anxiety disorders, including posttraumatic stress disorder and obsessive-compulsive disorder. Within Nottinghamshire the service is called 'Let's Talk Wellbeing' and individuals can self-refer or be referred through their GP.

Joint Strategic Needs Assessment (JSNA)

The purpose of JSNA is to pull together in a single, on-going process all the information which is available on the needs of our local population ('hard' data i.e. statistics; and 'soft' data i.e. the views of local people), and to analyse them in detail to identify: a) the major issues to be addressed re health and well-being, and b) the actions that we as local agencies will take to address those issues.

Locality Group

NNE CCG practices have formed into three groups according to geographic location. These groups meet regularly (quarterly or monthly) and attendance varies depending on the agenda. The groups consider local population needs, local issues, clinical pathways, processes and procedures

in practices. They are chaired by a practice manager who directly feeds back to a wider meeting of practice representatives.

Long term conditions

A condition that cannot be cured but can be managed through medication and/or therapy. There is no definitive list of long term conditions; diabetes, asthma, and coronary heart disease can all be included.

National Institute for Health and Clinical Excellence (NICE)

NICE was set up in 1999 to reduce variation in the availability and quality of NHS treatments and care - the so-called 'postcode lottery'.

NICE evidence-based guidance and other products help resolve uncertainty about which medicines, treatments, procedures and devices represent the best quality care and which offer the best value for money for the NHS. NICE also produce public health guidance recommending best ways to encourage healthy living, promote wellbeing and prevent disease. NICE public health guidance is for local authorities, the NHS and all those with a remit for improving people's health in the public, private, community and voluntary sectors. (NICE site)

Out of hours service (OOH)

Commissioned service to provide primary care medical attention during times when GP practices are closed.

Pathway

A pathway defines a patient's journey through care for a specific health condition. The pathway identifies what care and treatment is required along the pathway and the expected outcomes of that care and treatment.

Patient and Public Reference Group/Patient Participation Group

Patient Reference Groups and Patient Participation Groups bring together groups of patients with the aim of involving them in decisions about the range and quality of services provided and commissioned by their practice through the Clinical Commissioning Group.

Planned care

Planned care is pre-arranged, non-emergency care that includes out-patient appointments and planned operations. It is usually provided by consultants in a hospital setting.

Primary care

Primary care is the care provided by people you normally see when you first have a health problem. It includes services provided by GP practices, dental practices, community pharmacies and high street optometrists.

Registered population

Refers to those people registered with a GP practice, or those people registered with one of a group of practices, for example all the people registered with practices in NNE CCG.

Resident population

Refers to those people residing in a specified geographic area.

Secondary care

Secondary care is defined as a service provided by medical specialists who generally do not have first contact with patients. Secondary care is usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Unplanned care, urgent and emergency care

Unplanned care refers to a patient who is admitted to hospital but not in a planned way from a waiting list, for example the patient would be admitted as an emergency.

Unwarranted variation

The most widely accepted definition of unwarranted variation is:

> 'Variation in the utilization of health care services that cannot be explained by variation in patient illness or patient preferences.' Wennberg JE (2010) Tracking Medicine. A Researcher's Quest to Understand Health Care, OUP.

Variation could be clinical, in terms of quality (and hence outcomes) of clinical practice, or in terms of the amount of service delivered to different populations. Variation could also be due to non-clinical factors such the time it takes to get an appointment, or the ease of access of locations where services are provided.