NHS

Nottingham North and East Clinical Commissioning Group

Putting good health *into practice*

Primary Care Strategy

2015/16 – 2019/20

Version 1 December 2015

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1. Introduction

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

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

In October 2014 the ***NHS Five Year Forward View*** was published, setting out a clear direction for the NHS in respect of whole system integration of services and implementation of alternative care delivery models, such as accountable care organisations, multi-speciality community providers, or prime provider/primary and acute care systems. To support delivery of the *Forward View* a 'new deal' for general practice is included, which builds on existing strengths within primary care and sets out to build a firm foundation for the future, including:

- stabilising core funding for general practice
- improving access to services and supporting new ways of working
- expanding the number of GPs
- providing access to funding to upgrade primary care infrastructure and the scope of services offered to patients.

On 1st April 2015, NHS Nottingham North and East Clinical Commissioning Group (NNE CCG), in response to NHS England's invitation to become more involved in the commissioning of primary care services, took on full delegated responsibility for commissioning the majority of GP services under co-commissioning arrangements.

This document therefore sets out NNE CCG's five year strategy in respect of general practice in response to the *NHS Five Year Forward View*, the CCG's role as co-commissioners of primary care services, and the challenges highlighted above. It describes the CCG's vision for general practice, and also its plans to improve quality in primary care whilst ensuring its future sustainability. For clarity, all references to primary care in this strategy relate to general practice. Commissioning of pharmacy, dental, and optical services is currently the responsibility of NHS England.

1.1. What is NHS Nottingham North and East Clinical Commissioning Group?

NHS Nottingham North and East Clinical Commissioning Group has been a statutory NHS organisation, responsible for commissioning health services for the population covered by the CCG area, since 1st April 2013. The CCG is led by general practitioners 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. NNE CCG is one of seven clinical commissioning groups in Nottinghamshire, including Nottingham City and Bassetlaw. The CCG comprises 21 GP practices covering a population of almost 150,000, organised collectively to commission health services for the patient population living in and around Arnold, Burton Joyce, Calverton, Carlton, Colwick, Daybrook, Gedling, Giltbrook, Hucknall, Lowdham, Mapperley, Netherfield, and Newthorpe. An area map and locality structure can be found in Appendices 1 and 2.

NNE CCG's vision is:

"Putting Good Health into Practice"

This vision will be delivered through:

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

1.2. Our aims

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

For 2015/16-2019/20, NNE CCG's key aims will continue to be to:

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

1.3. Our vision for primary care

Our CCG vision is for general practice to be the bedrock of healthcare for the population of NNE, delivering equitable, high quality, efficient, accessible, and sustainable primary care services that are clinically effective and patient-centred. With collaboration a key element, our aim is to integrate care across primary, community, secondary, and social care, with general practice at the heart of this, coordinating care across the health and care system. With a focus on prevention and proactive care, our mission is to ensure care is provided in the most appropriate setting, with people cared for at home whenever possible and admission to hospital viewed as a last resort. In delivering this vision, the CCG is committed to redirecting resources towards primary care to support the shift of services out of the acute sector.

The CCG believes that its recently-acquired responsibilities for commissioning GP services under delegated co-commissioning arrangements will support delivery of the CCG's vision for primary care. Co-commissioning will facilitate improved performance, access, and quality in primary care, and enable primary care commissioning to be more responsive and sensitive to local needs and priorities. In addition, co-commissioning will strengthen the CCG's ability to deliver the ambitions set out in the *Five Year Forward View.*

More specifically, co-commissioning will enable the CCG to work with its member practices as providers, to explore, develop, and implement new ways of working, both within and between practices, to ensure the sustainability of general practice so that it can continue to support patients in the context of increasing demand and limited resources.

2. The national context

The *NHS Five Year Forward View* makes explicit the need for the NHS to adapt in order to meet the challenges posed by an aging and growing population. People are living longer and often with complex health issues, sometimes because of the impact of poor lifestyle choices. The *Forward View* sets out a clear direction for the NHS over the next five years, including:

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

The *Forward View* confirms the central role of the NHS as caring for people with long-term conditions and also confirms the direction of travel as follows:

- More care needs to be provided out-of-hospital
- Services need to be integrated around the patient
- Examples of best practice need to be adopted more widely
- New models of in-reach support for people in care homes

In addition, 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'.

2.1. General practice

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

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

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

Financial pressures: the NHS faces a projected funding gap of £30 billion by 2021/22, placing pressure on the NHS as a whole (including general practice) to maximise the use of resources and deliver efficiencies where possible.

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

3. The local picture

The national picture as described above is clearly reflected across the NNE CCG area. The following sections highlight the challenges the CCG will need to overcome during the next five years.

3.1. The local population – deprivation and demographic changes

The population of NNE CCG is spread across a mixture of urban areas and rural villages. The Index of Multiple Deprivation (IMD) 2010 shows a wide variance in overall deprivation across the NNE area. Higher scores mean greater deprivation, and, while the CCG average (18.2) is below the England average of 21.5, there are areas of significant deprivation in the area, particularly around Hucknall. Figure 1 below shows the IMD scores for NNE GP practice populations. (All scores use Public Health England 2012 population data to determine the areas in which practice and CCG populations reside.)

Index of Multiple Deprivation (IMD) 2010 scores

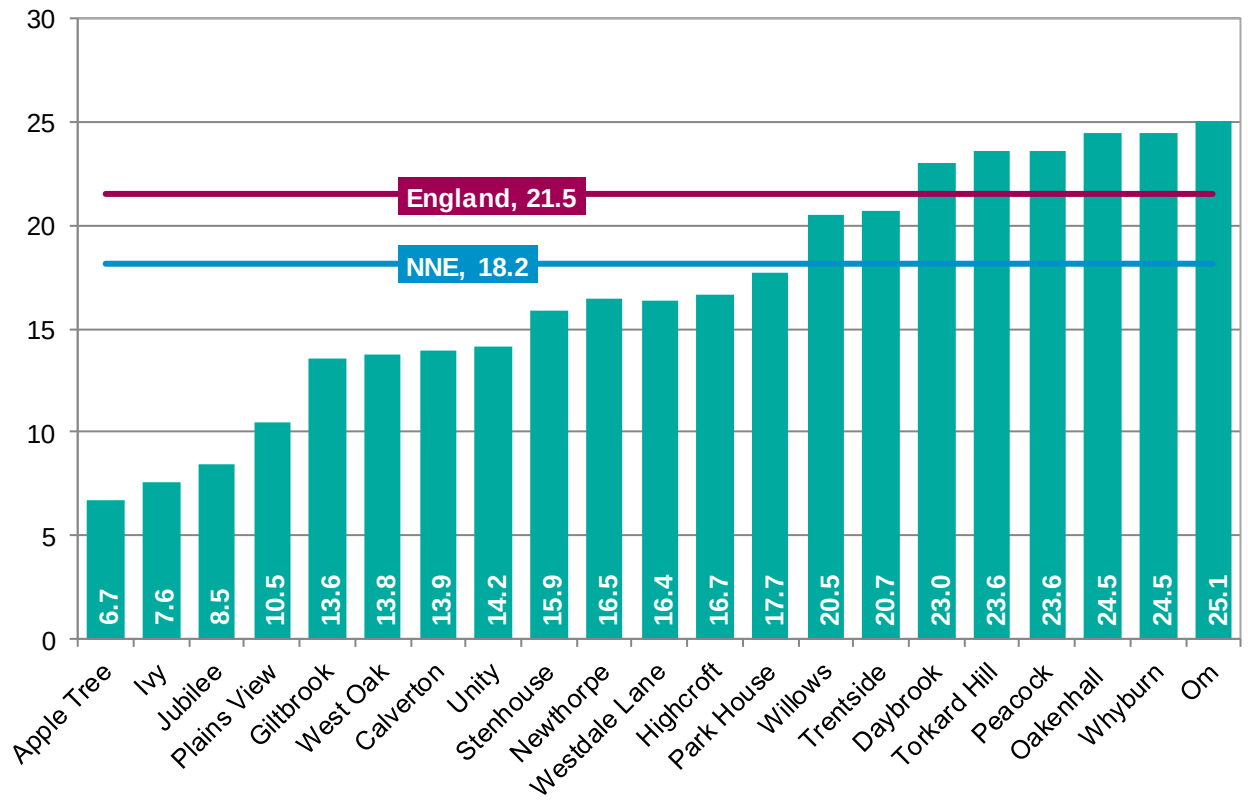


Figure 1. NNE deprivation scores (IMD 2010 – fingertips.phe.org.uk/profile/general-practice/data)

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.

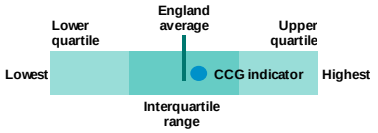
Across the CCG area, it is estimated that the population will grow by 11.66% between 2010 and 2025.

3.2. Disease prevalence

Figure 2 below shows the prevalence (number and percentage) of diseases covered by the Quality and Outcomes Framework (QOF) for NNE CCG in 2013/14.

Disease prevalence

- Significantly higher than England average
- Not significantly different from England average
- Significantly lower than England average
- No significance can be calculated



	Indicator	Pop-ulation	Rate	Eng Avg	Eng Low	England Range	Eng High
1	AF - Atrial Fibrillation	2532	1.7%	1.6%	0.4%		2.8%
2	CHD - Coronary Heart Disease	5561	3.8%	3.4%	1.4%		5.3%
3	CVD-PP - Cardiovascular Disease - Primary Prevention	3507	2.4%	2.9%	1.7%		4.1%
4	HF - Heart Failure	1016	0.7%	0.7%	0.3%		1.4%
5	HYP - Hypertension	21888	14.9%	14.0%	7.9%		18.0%
6	PAD - Peripheral Arterial Disease	859	0.6%	0.6%	0.2%		1.2%
7	STIA - Stroke and Transient Ischaemic Attack	2955	2.0%	1.8%	0.8%		2.6%
8	AST - Asthma	10002	6.8%	6.1%	3.5%		7.7%
9	COPD - Chronic Obstructive Pulmonary Disease	2828	1.9%	1.8%	0.8%		3.6%
10	OB - Obesity 16+	12477	10.3%	9.7%	4.3%		14.6%
11	CAN - Cancer	3521	2.4%	2.2%	0.7%		3.2%
12	CKD - Chronic Kidney Disease (18+)	8386	7.1%	3.9%	1.6%		8.1%
13	DM - Diabetes Mellitus (17+)	7502	6.3%	6.3%	3.5%		9.2%
14	PC - Palliative Care	378	0.3%	0.2%	0.1%		0.8%
15	THY - Hypothyroidism	5161	3.5%	3.3%	1.4%		5.0%
16	DEM - Dementia	1099	0.7%	0.6%	0.3%		1.2%
17	DEP - Depression (18+)	6647	5.6%	6.6%	3.1%		12.4%
18	EP - Epilepsy (18+)	977	0.8%	0.8%	0.4%		1.1%
19	LD - Learning Disabilities (18+)	562	0.5%	0.5%	0.2%		0.9%
20	MH - Mental Health	941	0.6%	0.8%	0.5%		1.5%
21	OST - Osteoporosis (50+)	156	0.3%	0.4%	0.1%		0.7%
22	RA - Rheumatoid Arthritis (16+)	817	0.7%	0.7%	0.4%		1.2%

Figure 2. Disease prevalence (QOF data 2013/14)

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

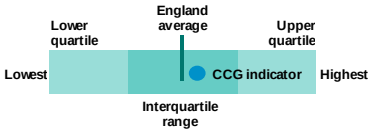
As nationally evidenced in *Improving general practice – a call to action* (NHS England, August 2013), the prevalence of many diseases is increasing. This is compounded by the fact that the incidence of people having two or more long-term conditions is also increasing.

3.3. Patient outcomes

Figure 3 below shows the performance of CCGs against each outcome indicator.

Performance against outcome indicators

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



	Indicator	Pop-ulation	Rate	Eng Avg	Eng Low	England Range	Eng High
1	1.1 Potential Years of Life Lost amenable to h/c (f)	73994	1648	1853	976		3287
2	1.1 Potential Years of Life Lost amenable to h/c (m)	1647	2124	2202	1266		4070
3	1.2 Under 75 mortality from CVD	88819	66	66	39		125
4	1.6 Under 75 mortality from respiratory disease	66615	25	27	10		59
5	1.8 Emergency adm. for alcohol released liver disease	115491	24	23	3.4		69
6	1.9 Under 75 mortality from cancer	88819	124	121	85		176
7	1.10 One year survival - all cancers combined		68	68	62		76
8	1.7 Under 75 mortality from liver disease	88819	15	16	6.8		35
9	1.4 MI, stroke & stage 5 kidney disease in diabetics	6815	2.0	1.9	1.2		4.0
10	1.11 One yr survival - breast, lung & colorectal cancers		68	69	62		76
11	1.17 Record of stage of cancer at diagnosis	930	58	58	24		83
12	2.2 % LTC pts feel supported to manage their condition	634	65	65	52		75
13	2.6 Unplanned adm. chronic ACS conditions	813	780	804	166		1492
14	2.7 Unpl. hosp. for asthma, diabetes & epilepsy, <19s	38	187	300	62		683
15	2.1 Health related quality of life for people with LTC		0.75	0.75	0.66		0.80
16	2.15 Health-related quality of life for carers	346	0.79	0.80	0.72		0.85
17	3.1 Em. adm. acute conds not usually requiring hosp.	1001	997	1182	263		2313
18	3.2 Emergency readm. < 30 days of hospital discharge	1644	11	12	8.1		14
19	3.3 Hip replacement casemix adjusted health gain		0.40	0.42	0.35		0.50
20	3.3 Knee replacement casemix adjusted health gain		0.33	0.32	0.20		0.38
21	3.3 Groin hernia casemix adjusted health gain		0.09	0.09	0.01		0.14
22	3.4 Em. adm., children w/ lower resp. tract infections	69	357	376	78		662
23	4.1 Patient experience of GP out-of-hours services		64	65	49		86
24	4.2 Patient experience of hospital care		76	77	70		83
25	4.5 Responsiveness to Inpatients' personal needs		62	68	59		79
26	5.4 Incidence of healthcare-associated infection - C.Diff	37	25	24	8.3		51
27	5.3 Incidence of healthcare-associated infection - MRSA	0	0.00	1.5	0.00		5.7

Figure 3. Performance against outcome indicators (most recent data available for each indicator, to 2013/14)

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

- childhood vaccinations
- screening for cancer
- disease prevalence as recorded in the QOF registers versus expected disease prevalence
- prescribing.

Figure 4 and Figure 5 below (source: Secondary User Services data) highlight some areas of variation across the CCG.

GP referrals to outpatients – all specialties

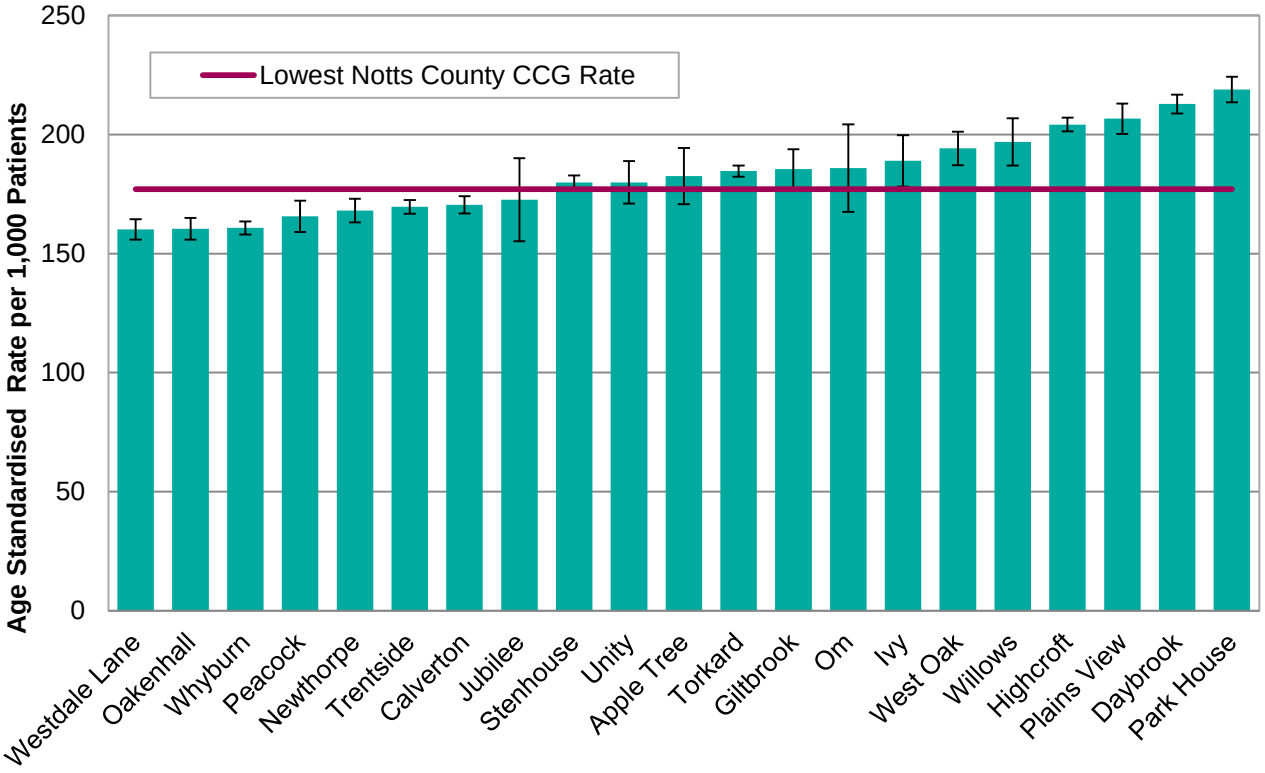


Figure 4. GP referrals to outpatients, April 2014 to March 2015 – all specialties (SUS data)

Emergency admissions from GP

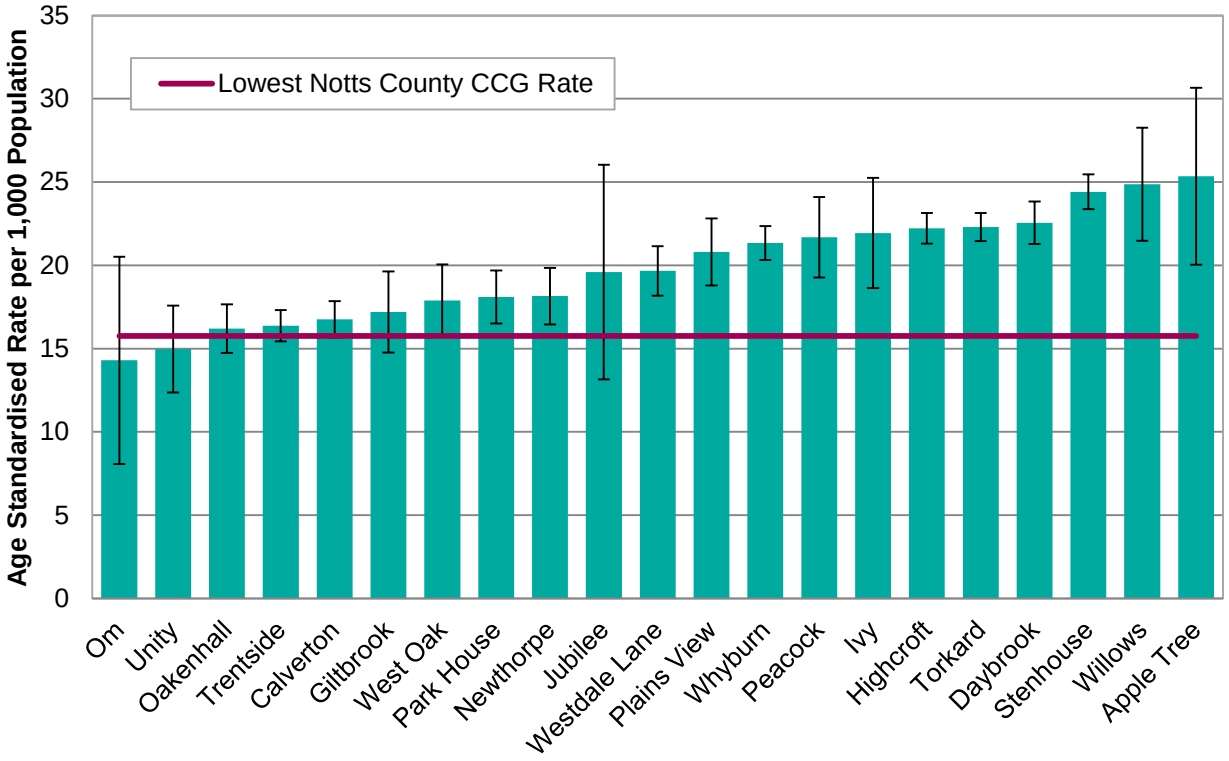


Figure 5. Emergency admissions from GP, April 2014 to March 2015 (SUS data)

3.5. Workforce

Across the CCG, GP practices are increasingly reporting facing workforce-related issues which, if not addressed, have the potential to impact on the quality of care provided. The CCG is acutely aware that practices:

- are struggling to recruit both salaried GPs and partners on a permanent basis, particularly GP partners, because of national workforce issues; given the number of GPs anticipated to retire over the next 5 years, practices are concerned that this will further exacerbate existing workforce challenges and pose risks to continuity of provision locally
- are concerned that a reduction in the number of general practice trainees will result in an increased risk to workforce capacity over than next 5-10 years
- often have to manage vacancies through the use of temporary or locum GPs
- are finding it increasingly difficult to source locum medical cover for gaps in frontline general medical services provision
- are finding it challenging to maintain continuity of care and clinical quality with the need to use more temporary locum medical staff
- find it difficult to maintain a work/life balance due to increased workload demands, with increasing workload contributed to by the diminishing workforce, and also by increasing patient demand, ageing population, and increased prevalence of long-term conditions
- are experiencing higher rates of stress-related sickness
- are very concerned about the future sustainability of general practice
- struggle to meet the competing time demands placed on them as a result of their dual role as both commissioners and providers
- are concerned that financial austerity and further contract funding cuts to primary care (PMS and GMS-MPIG) over the next five years to <8.4% of the NHS budget will introduce further financial challenges to sustaining frontline services
- are finding it difficult to cope with the increasing levels of management, administration, and bureaucracy they are required to undertake as a result of the need to engage with external agencies such as the Care Quality Commission.

3.6. Patient experience

The national GP patient survey (July 2015) results for practices in NNE CCG confirm that, for the most part, the patient experience in the CCG reflects the national picture.

Whilst acknowledging that there are shortcomings to the survey, it does highlight that variations continue to be seen across the CCG area regarding patient experience of, and satisfaction with, the services offered by GP practices. Figure 6 to Figure 8 below give examples that highlight these variations.

Patients rating overall experience of GP surgery as very good or fairly good

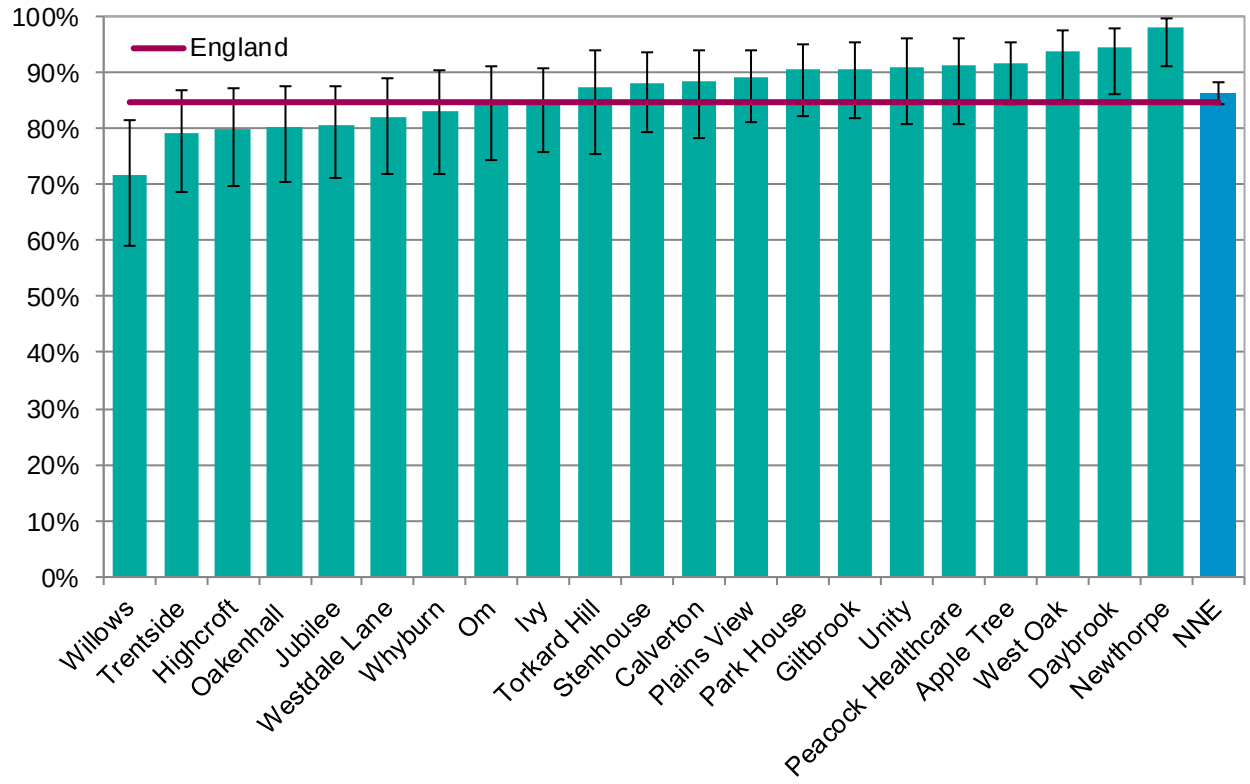


Figure 6. Percentage of patients rating overall experience of GP surgery as very good or fairly good (GP patient survey, July 2015)

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

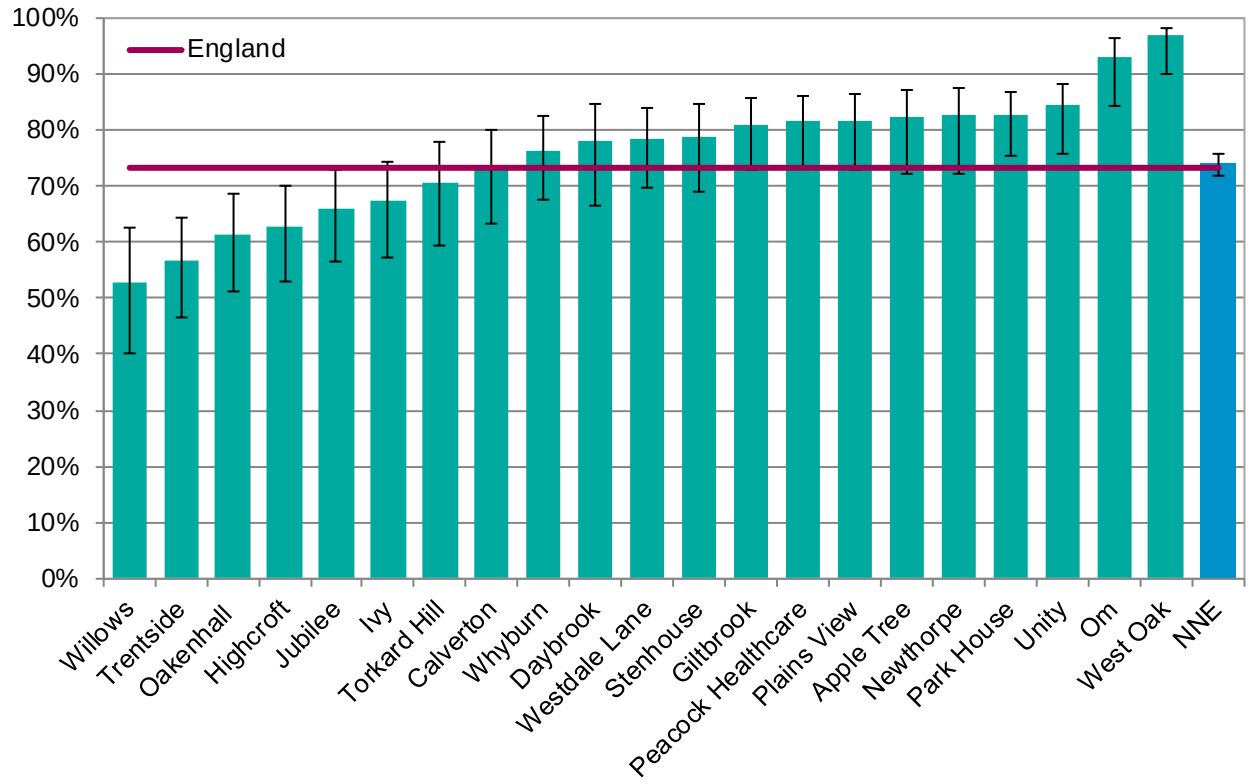


Figure 7. Percentage of patients rating overall experience of making appointment as very good or fairly good (GP patient survey, July 2015)

Patients rating satisfaction with opening hours as very satisfied or fairly satisfied

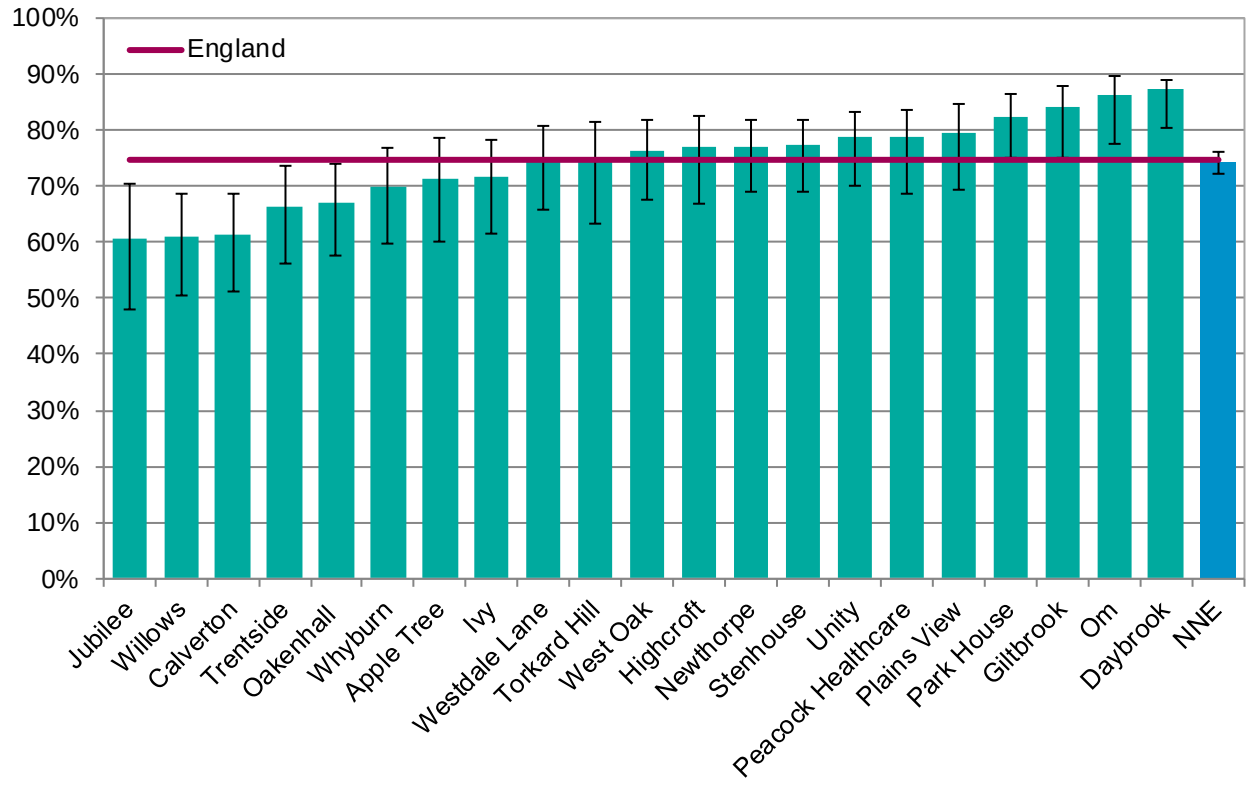


Figure 8. Percentage of patients rating satisfaction with opening hours as very satisfied or fairly satisfied (GP patient survey, July 2015)

3.7. What patients are telling us

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

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

- There appears to be variation in how patients perceive the quality of care they receive. Some patients describe having high levels of confidence and trust in their GP. They feel fully involved in decisions about their care, with GPs taking time to discuss, explain, and provide information about their illness/condition. Some GPs have specialisms in certain areas, e.g. dermatology, thereby removing the need to see a specialist at the hospital, which is considered to be good. Others report not being as involved in the planning of their care as they would like, or believing their GP lacks the necessary knowledge and experience to be able to ensure quality of care, e.g. regarding mental health, alcohol, and drugs.
- Some patients report that GPs and practice nurses are good at providing information to enable them to manage their conditions at home, thereby reducing the number of visits they need to make to hospital. This is often supported by practice staff providing information regarding self-help groups not only to support patients to self-care but also to provide opportunities for them to socialise, e.g. Juggle, Breathe Easy, Nottingham Hospice. At the same time, other patients feel that their GP has a lack of awareness of services into which they could be referred, particularly self-help and third sector services. In addition, it has been suggested that GPs need to provide more information about the side-effects of drugs they are prescribing, so that the patient has a greater understanding of what is happening should side effects be experienced.
- It seems that there is significant variation between practices in respect of access. Some patients tell us that their practice operates a very effective telephone triage system, with GPs calling back quickly and same-day appointments being arranged if required. Online booking systems have been praised as convenient and time-saving. Patients commended the Urgent Care Pilot service in terms of how quickly they were seen by a GP/advanced nurse practitioner for an urgent same-day appointment. The role of advanced nurse practitioners has been praised more generally as it is believed they can free up GP time to see patients with more serious conditions. However, other patients report the appointment system and opening times in their GP practice to be inflexible, particularly for those who work. It can be difficult to make an appointment at a GP practice by telephone. It is also difficult to get an appointment within what is perceived as a reasonable time period. In winter it is quicker to call for an ambulance. In addition, the approach and attitude of some reception staff has negatively affected some patients' perception of their practice. Automated phone systems are not always considered to be helpful, particularly to those who do not speak English as their first language. The use of locums within practices has been commented on as having a negative impact on continuity of care.

In addition, our patients have told us the following:

- GPs and practice staff need to be more visible in their local community promoting health awareness, especially to schools. Practice staff are respected and are therefore listened to when they are out of the context of their practice.
- Patients who have had a long-term condition for several years (and are aware of self-management techniques) feel they could save their own time and the NHS's time and money if prescribed medication for two months at a time, instead of every week/two weeks.
- There should be more use of information technology in healthcare, including patient access to Wi-Fi in practices. However, although assistive technologies are felt to be useful, consideration needs to be given to the confidence patients (particularly older people) have in using these to support their care
- Self-management of diabetes, with the provision of good information and guidance from clinical staff who understand the condition and its complications, is paramount.

- NNE CCG and GP practices need to address the perceived variations in diabetes care across practices, educate more staff to understand the condition, and promote self-management initiatives, to both engage with, and gain more trust from, their patients.
- More support is required for the older population, who suffer loneliness and are isolated in their own home.
- Communication systems between providers (e.g. the GP and the hospital) need to be improved, as the current system of writing letters is inefficient and a waste of money.
- Systems need to be reviewed to avoid duplication of tests/assessments/treatment between primary and secondary care, which wastes money.
- Local GP surgeries could work together so that if one is at full capacity in terms of appointments, other local surgeries that are not at capacity could arrange to take the 'overspill of patients'.
- The huge increase in people living longer means early intervention is a key way to address future potential long-term conditions.
- There need to be more GPs.
- Confidentiality and data protection are an issue at GP surgeries. People queuing can hear everything that is said at reception desk.

4. So what are we going to do?

4.1. Priority areas

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 priority areas identified formed the basis of the CCG's Primary Care Development Strategy 2014-2019. These have subsequently been reviewed in the context of the CCG taking on additional responsibilities under delegated co-commissioning arrangements, the publication of the *Five Year Forward View,* and also the on-going development of the South Nottinghamshire five year strategy. The CCG's updated vision and priorities for primary care are therefore described in the following sections.

In order to achieve our vision for primary care, the CCG will focus on the following areas over the next five years:

Quality

The CCG will:

- improve quality in general practice in three core areas: patient safety, patient experience, and effectiveness of care, with shared decision-making being the norm
- increase the number of completed episodes of care within the practice setting
- 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
- develop systems, processes, and pathways that empower patients (and their carers) to take more control of their care through self-management
- ensure patients and carers are more fully involved in the development of primary care services
- ensure the patient voice is heard in respect of initiatives to improve primary care quality including using patient stories and complaints, and feedback from the CCG's People's Council, GP practice Patient Participation Groups, the GP Patient Survey and the Friends and Family Test.

Unwarranted variation

The CCG will:

- reduce unwarranted clinical and non-clinical variation between general practices in the CCG and between the CCG and other CCGs in England
- reduce unwarranted clinical variation between practices in terms of health outcomes for patients
- reduce unwarranted variation between practices in respect of the patient experience
- reduce health inequalities.

Access

The CCG will:

- ensure primary care provision and access across the CCG matches the needs of the population and is available for everyone
- encourage innovative ways of working and sharing of examples of good practice
- support the development of services that enable care to be provided closer to home where appropriate

- reduce the number of unnecessary attendances at the Accident and Emergency Department, and the number of emergency admissions
- integrate general practice and improve collaborative working across the whole health care system (including other primary care providers, secondary care, community care, social care, third sector, out of hours medical services, ambulance, and 111 services) in order to ensure patient care is delivered in a 'joined up' manner
- 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
- develop and implement models of care that offer patients extended access to GP services, e.g. full in-hours opening on weekdays as well as provision of services in the evenings and weekends
- work with practices to re-model the provision of GP primary care services in order to improve access.

Capacity/capability/sustainability

The CCG will:

- support workforce development/education to ensure general practice has the capability and capacity to deliver high quality care
- work with practices to increase/improve service integration across localities and providers in order to increase capacity
- maximise the use of existing and new technology systems to support efficient and effective working, information sharing, and improved coordination of patient care
- explore, develop, and support the implementation of new models of working, both in practices and between practices, to ensure sustainability and improved quality
- work with practices to improve access and quality through sharing resources
- support practices to set up responsive systems and processes to ensure patients with urgent needs are seen in a timely manner by a clinician with the appropriate skills; this could be at both individual practice level but also across a number of practices
- work closely with the Local Medical Committee (LMC) to support practice mergers and federations where these meet the strategic objectives of the CCG and support improvements in the quality of patient care
- support collaboration between practices in order to provide a more efficient, resilient and sustainable model for primary care
- develop opportunities for integration with other primary care providers e.g. community pharmacists to maximise capacity across primary care.

Workforce

The CCG's member practice workforce is pivotal to delivery of the Primary Care Strategy.

The workforce of the CCG's member practices is pivotal to the delivery of the CCG's Primary Care Development Strategy. The CCG will therefore:

- support the education and development of a workforce that has the capacity and capability to deliver the necessary future transformation of general practice
- work closely with the Local Education and Training Council (LETC), the Local Education and Training Board (LETB) and the LMC to contribute, where appropriate, to the development of a comprehensive staff development plan that recognises and supports the changing environment in which people are working, the changing ways of working, and changing responsibilities
- continue to support peer-review where referral activity indicates this may be beneficial in addressing unwarranted clinical variation.

Clinical leadership

Clinical leadership, engagement, and collaboration are essential.

The effective delivery of this strategy will rely on strong clinical leadership and engagement, and on GP 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, and as such all GP practices are represented on the CCG's Clinical Cabinet.

There is a strong locality focus within the CCG but opportunities to strengthen inter-practice and locality relationships exist. There is also willingness from some clinicians to be involved in the work of the CCG, but again there is significant potential to increase the number of clinicians engaging in this.

Over the next five years, the CCG will:

- maximise the benefits of clinical leadership and engagement within the CCG to ensure commissioning is fully embedded into the work of general practice
- support practices to develop clinical leadership in order to address the challenges facing general practice.

Stakeholders

Good stakeholder engagement is vital for effective service provision.

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 that support appropriate information sharing.

Premises

GP presmises must be fit for purpose to meet changing demand.

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.

To support delivery of this Primary Care Strategy, the CCG will develop a primary and community care estates strategy which will clearly identify premises priorities for the next five years based on a number of factors, including emerging service models and increases in the size of the population as a result of significant housing developments.

The Care Quality Commission (CQC) has a mandate for ensuring that essential standards of quality and safety are met in respect of GP premises. The CCG will therefore work closely with practices and NHS England to support the development of premises that meet the required standards in terms of quality and safety, whilst also having the capacity to meet future demands. The CCG will also support practices to determine premises solutions where the existing premises are no longer fit for purpose for whatever reason.

Information technology

The CCG will aim to:

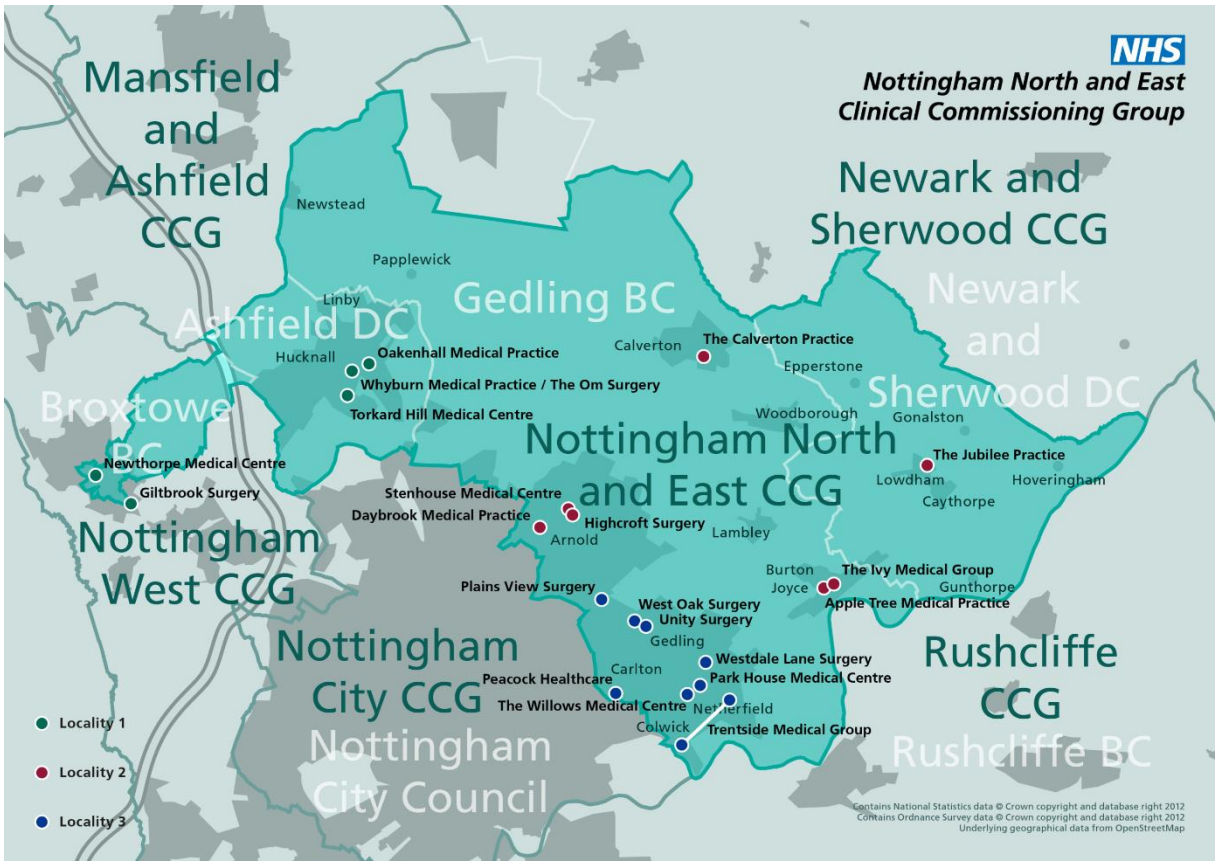
- work with practices to maximise the use of IT to enable patients to consult with their GP without necessarily having to visit the surgery e.g. video consultations, e-mail consultations
- ensure IT systems are in place that support communication between practices, and between practices and other providers to enable sharing of information to support the delivery of care
- support practices to maximise the use of IT to enable patients to view their own health care records, make and change appointments, and order repeat medications
- encourage practices to maximise the use of assistive technologies to support patients to self-manage.

4.2. Outcomes and benefits to patients

Delivery of the CCG's Primary Care Strategy will be supported by the development and implementation of an annual primary care operational plan. During 2015/16 the CCG will identify outcomes relating to each of the priority areas against which progress will be monitored and reported back to the CCG's Governing Body and Primary Care Commissioning Committee in future years. Patients and the public will be involved in the development of outcomes where these relate to patient experience.

5. Appendices

5.1. Population map



5.2. Locality Structure

Locality/practice	List Size (June 2015)
Locality 1	
Giltbrook Surgery, Giltbrook	4,243
Newthorpe Medical Centre, Eastwood	6,717
Oakenhall Medical Practice, Hucknall	7,163
Om Surgery, Hucknall	2,050
Torkard Hill Medical Centre, Hucknall	14,545
Whyburn Medical Practice, Hucknall	11,730
Locality 2	
Apple Tree Medical Practice, Burton Joyce	3,437
Calverton Practice, Calverton	9,418
Daybrook Medical Practice, Daybrook	9,358
Highcroft Medical Centre, Arnold	12,715
Ivy Medical Group, Burton Joyce	3,831
Jubilee Practice, Lowdham	2,300
Stenhouse Medical Centre, Arnold	11,912
Locality 3	
Park House Medical Centre, Carlton	7,507
Peacock Practice, Carlton	5,049
Plains View Surgery, Mapperley	5,928
Trentside Medical Group, Netherfield	11,651
Unity Surgery, Mapperley	3,842
West Oak Surgery, Mapperley	5,185
Westdale Lane - The Surgery, Gedling	7,643
Willows Medical Centre, Carlton	3,656
	149,880

5.3. 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 for (i.e. 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, purchasing services from appropriate providers, and subsequently managing the contracts that are put in place.

End of life

The Department of Health has 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 regarding where they die and how they are cared for. The pathway includes health and social care services.

Forward View

See *NHS Five Year Forward View.*

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.

Index of Multiple Deprivation (IMD)

The IMD is the official measure of relative deprivation for small areas (Lower-layer Super Output Areas/LSOAs) or neighbourhoods in England, published by the Department for Communities and Local Government. The IMD ranks every LSOA in England from 1 (most deprived) to 32,844 (least deprived).

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, e.g. statistics; and 'soft' data, e.g. 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.

Local Medical Committee (LMC)

LMCs are the statutory representative bodies for GPs and their practices. Nottinghamshire LMC represents all GPs and practices in Nottinghamshire.

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 long-term condition 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.

NHS Five Year Forward View

The *Five Year Forward View* is a planning document produced by NHS England in October 2014, setting out proposed changes to care models, such as prioritising prevention, and allowing local health communities to choose from amongst a small number of new care delivery options. The document claims that significant annual savings can be delivered over the five-year period to 2020, but makes clear that increased funding would be required to maximise these savings.

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 the people who patients normally see when they first have a health problem. It generally includes services provided by GP practices, dental practices, community pharmacies and high street optometrists. For the purposes of this document, 'primary care' refers specifically to care provided by GP practices.

Registered population

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