NHS
Nottingham North and East
Clinical Commissioning Group

Operational plan 2017-2019

Putting good health *into practice*

Version control

Document purpose: This document is the operational plan for 2017 – 2019 for NHS Nottingham North and East Clinical Commissioning Group
Title: NHS Nottingham North and East Clinical Commissioning Group Operational Plan 2017 – 2019
Editor: Sharon Pickett
Publication date: December 2016
Target audience: NHS England
Circulation list: NHS North Midlands, Nottinghamshire Clinical Commissioning Groups, Nottingham North and East Clinical Commissioning Group's People's Council
Cross ref:
Superseded documents: None
Action required: Note
Contact details: Sharon Pickett Deputy Chief Officer NHS Nottingham North and East Clinical Commissioning Group Civic Centre Arnot Hill Park Nottingham NG5 6LU
For recipient's use
Version control: Draft Version 0.1 November 2016 Draft Version 0.32 November 2016 Draft Version 0.42 23 November 2016 – submitted to NHS North Midlands Draft Version 0.43 8 December 2016 – updated following feedback from NHSE

Contents

Introduction

This Operational Plan has been developed by NHS Nottingham North and East Clinical Commissioning Group (NNE CCG) in response to the NHS Five Year Forward View, Delivering the Forward View: NHS planning guidance 2016/17-2020/21 and NHS Operational Planning and Contracting Guidance 2017-2019. It should be read in conjunction with the Nottinghamshire Sustainability and Transformation Plan 2016-2021 and the CCG's finance and activity plans for 2017-2019.

The plan is reflective of the CCG's strategic objectives, which are as follows:

#	NHS NNE CCG objective	Link to NHSE IAF domain
1	The CCG has effective and appropriate financial management including stretching itself financially, efficient financial controls and processes and good governance.	3. Sustainability
2	The CCG has comprehensive and achievable plans as both a CCG and as part of a wider system	4. Leadership
3	The CCG demonstrates that it is planning effectively providing a basis for transforming services, improving outcomes while ensuring that patients receive the high quality, timely care that they have a right to expect today	1. Better Health
4	To ensure effective and efficient management of delegated functions and high quality primary care	2. Better Care
5	To ensure a well-led organisation including strong leadership and good governance resulting in delivery of all statutory functions and duties, partnership working and a strong workforce	4. Leadership

Delivering the Forward View: NHS planning guidance 2016/17-2020/21 included nine national 'must dos'. These priorities, which remain for 2017-2019, are to:

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

This plan describes NNE CCG's approach to delivery against the requirements as detailed in the aforementioned documents across a number of key areas during 2017-2019. In particular this plan focusses on:

- delivery of the nine 'must-dos'
- how the CCG will support implementation of the local STP.

A key priority for the CCG during 2017-2019 will be to support delivery of the Nottinghamshire STP. The CCG is therefore committed to delivery of the key aims of the STP, which are to:

- organise care around individuals and populations – not organisations – and deliver the right type of care based on people's needs
- help people remain independent through prevention programmes and offering proactive rather than reactive care
- support and provide care for people at home and in the community as much as possible and ensure that hospital, care home beds, and supported housing are available for people who need them
- work in multi-disciplinary teams across organisational boundaries to deliver integrated care as simply and effectively as possible
- minimise inappropriate variations in access, quality, and cost, and deliver care and support as efficiently as possible so that we can maximise the proportion of our budget that we spend on improving health and wellbeing
- maximise the social value that health and social care can add to our communities.

It is acknowledged that in some areas this plan will need to be updated over the next few months as local provider contracts are negotiated and agreed and as more guidance is released at a national level. Specifically the plan will be refreshed to reflect the on-going development of the Nottinghamshire Sustainability and Transformation Plan (STP), the system-wide roll-out of best practice care delivery models, and the outcome of the detailed design work currently underway in support of the creation of an integrated Accountable Care System across the Greater Nottingham area (see below).

Delivery of the nine national priority areas

1. Sustainability and Transformational Plan (STP)

Commissioners and providers from health and social care across Nottingham and Nottinghamshire (excluding Bassetlaw) have come together to develop and deliver a Sustainability and Transformation Plan (STP) in accordance with national guidance. This is in the context of ensuring the system remains both sustainable and affordable over the next five years, requiring a programme of change on a scale and of a complexity never previously undertaken.

The STP outlines the locally relevant implementation of the Five Year Forward View by addressing the Nottinghamshire health and wellbeing, care and quality, and finance and efficiency gaps. The STP confirms an intention to implement the majority of initiatives at a local system level through two place based delivery units within the footprint – Greater Nottingham and Mid-Nottinghamshire – with accountability for delivery, allocation of resources and tracking of impact at that level. These units are based on patient flows, and have existing delivery plans in differing stages of implementation:

- Mid-Nottinghamshire has a Primary and Acute Care Systems Vanguard
- Greater Nottingham Health and Care Partners have a high level strategy which was completed in June 2016 and has informed the development of the STP. Greater Nottingham also has a number of underpinning plans including the Principia Multi-Specialty Community Provider Vanguard; the Nottingham City Support to Care Homes Vanguard; and the Greater Nottingham Urgent Care Vanguard. Greater Nottingham also has the Nottingham and Nottinghamshire Better Care Fund Integration Care Pioneers

The Partners in the Greater Nottingham delivery unit are:

- NHS Nottingham North and East Clinical Commissioning Group
- NHS Nottingham City Clinical Commissioning Group
- NHS Nottingham West Clinical Commissioning Group
- NHS Rushcliffe Clinical Commissioning Group
- Nottingham City Council
- Nottinghamshire County Council
- Nottingham University Hospitals NHS Trust
- Nottinghamshire Healthcare NHS Foundation Trust including County Health Partnerships
- Nottingham CityCare Partnership
- Circle Partnership
- East Midlands Ambulance Service NHS Trust.

Greater Nottingham's three gaps are quantified as:

- **Health and wellbeing:** healthy life expectancy is too low compared to the broader East Midlands population
- **Care and quality:** mortality rates are too high for patients with long term conditions; older people, people with cancer and musculoskeletal conditions spend more time in hospital than is good for them; the flow in our urgent care pathway is not good enough; people are diagnosed relatively late, often in crisis, leading to avoidable hospital-based care and worse outcomes
- **Finance and efficiency:** at the end of 2015/16, Greater Nottingham had a £47m funding gap by 2020/21 this is projected to grow to £314m unless radical change is made to how organisations work to deliver services.

In addressing these gaps, partners have come together with the ambition of achieving a future state where:

- people are supported to develop the confidence and skills to be as independent as possible, both adults and children
- people remain at home whenever possible; hospital, residential and nursing homes will only be for people who appropriately need care there
- resources are shifted to preventative, proactive care closer to home
- organisations work seamlessly to ensure care is centred around individuals and carers
- we address health and care needs of population collectively making the best use of the public purse.

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

High impact	Supporting	Enablers
Promote wellbeing, prevention, independence and self-care	Improve housing and environment	Future proof workforce and organisational development
Strengthen primary, community, and social care and carer services	Strengthen acute services	
Simplify urgent and emergency care	Drive system efficiency and effectiveness	Maximise estates utilisation
Deliver technology enabled care		Proactive communications and engagement
Ensure consistent and evidence-based pathways in planned care		

NNE CCG is committed to and actively contributing to the delivery of this change programme and will continue to do so going forward. Examples of high impact initiatives that will be taken forward over the course of the next two years and therefore featured in this operational plan and contractual round include:

High impact theme	Agreed change initiatives
Strengthen primary, community and social care and carer services	Co-ordinated primary, community, mental health and social care support for people with high and emerging risk through multi-disciplinary teams (MDTs) Enhanced care to people in care homes through extended primary and community support
Simplify urgent and emergency care	System redesign to enable reduction of 200 beds in acute hospitals over two years in NUH that are currently occupied by people who are medically fit for discharge Operate single front door at ED with streaming to primary care and ambulatory care pathways, including redirecting ambulance to primary/urgent care centre Improve capability to discharge from ED and hospital settings

High impact theme	Agreed change initiatives
Ensure consistent and evidence-based pathways in planned care	Standardise elective care pathways with an initial focus on gastro, cardiology, ophthalmology Develop a new integrated multidisciplinary model for MSK, improving experience, aligning pathways and reducing duplication and waste costs Reduce unnecessary attendances and provide alternative ways of providing follow up care in local GP surgeries or the community where clinical appropriate

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

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

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

The second stage of the process, in developing the ACS, has focused on a period of detailed design work from July to mid-November 2016 inclusive. This design phase was supported by Centene Corporation and Ribera Salud, international organisations that have successfully brought about well managed integrated health and care systems in the United States and Spain.

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

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

Greater Nottingham has confirmed that its plans for 2017/18 and beyond will be iterated in accordance with the outputs of this design work and resulting locally agreed next steps. These will be shared in the form of refreshed Vanguard Value Propositions which confirm plans to replicate and scale-up successes to date. In addition a Greater Nottingham ACS value proposition is being developed with support from and submission to the New Care Models Programme and wider arm's-length bodies stakeholders by the end of December 2016. This Greater Nottingham Value Proposition will provide:

- an overview of the Greater Nottingham area
- the case for change
- the accountable care system future state
- required investment
- delivery of the accountable care system
- implementation plan and expected impact
- enablers
- logic model and evaluation
- governance

At this stage the Greater Nottingham delivery unit has an ACS Oversight Group which is the overarching, strategic governing group for the delivery unit. This group is reporting into the STP Executive Group. All partner organisations have a named Executive Lead on ACS Oversight Group, with these named leads collectively forming the Network of System Leaders for the Greater Nottingham Delivery Unit and ACS development.

Update 8 December 2016 – it is recognised that this Operational Plan may need to be updated in response to changes to the STP going forward. Specifically at this time, with the merger of Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust no longer being progressed the impact of this will need to be reflected in the CCG's Operational Plans (including finance and activity plans).

2. Finance

The CCG works alongside other commissioners, providers, and local authorities under the Greater Nottingham Health and Care Partners arrangement (GNHCP) in recognition of the financial and efficiency challenges facing the health and social care system over the next planning period. The transformational schemes developed via this partnership, including the three Vanguards – Urgent Care, Multi-speciality Community Provider, and Care Homes - have fed into the wider Nottingham & Nottinghamshire Sustainability and Transformational Plan (STP). The Five-Year STP, which includes the Mid-Notts Caring Together alliance, demonstrates how the CCG will work together to improve the quality of care, the population's health and wellbeing and NHS finances.

The CCG's individual financial plans, which form part of the bigger financial picture across the STP, includes compliance with commissioner business rules:

- Minimum cumulative/historic underspend 1%
- Contingency minimum 0.5%
- Non-recurrent spend 1%
- Admin costs remain within admin allocation
- Quality premium must be applied to programme spend
- Specialised co-commissioning joint working gain share
- Transparency obligations met re information on source and use of MRET etc. to relevant stakeholders
- National policy commitments met e.g. mental health investment standard, better care fund contributions

The plans also meet the requirement for the CCG to be in financial balance in both 2017/18 and 2018/19 and to start 2017/18 with 50% of the 1% non-recurrent requirement remaining uncommitted.

In terms of 2017/18, the published national allocations, the CCG's control total, planning guidance and tariff assumptions along with anticipated growth assumptions have been modelled through the CCG's financial plan model, together with all additional anticipated cost pressures (including no additional funding assumed for Vanguard schemes) and a prudent risk reserve. The recurrent impact brought forward from 2016/17 which includes the on-going local price review with NUH, the

Continued Healthcare continued growth and the Free Nursing Care mandated cost inflation impact has also been factored into the 2017/18 recurrent position. This has resulted in a very challenging efficiency requirement of £14m in 2017/18. The savings schemes, which had been developed with the main acute provider services/directorate, are being worked through as part of the contract negotiation process with providers to ensure both the finances and activity model are aligned.

QIPP schemes are in development and include the full year effect of 2016/17 schemes started part way through the year, local schemes including Vanguard savings and the CCG's elements of the STP's solutions. These schemes will achieve savings of £8.5m and work is on-going to develop additional schemes to achieve financial balance.

3. Primary care

Greater Nottingham vision for general practice

There is a local and national necessity to optimise the general practice workforce to ensure a sustainable system of care for our patients and citizens. In the Greater Nottingham system this will be achieved by developing a delivery model based around 'clusters' of practices working together, supported by federations or alliances that will facilitate practices to achieve the benefits of operating at scale. Geographical clusters of GPs may maintain their independence, but will be encouraged to work closely with other primary and community care providers in a bid to flex their existing capacity co-located from estates that are fit for purpose, located centrally and easily accessible. This will result in a responsive service that delivers access to general practice services outside of core hours Monday to Friday, and on Saturdays and Sundays. Aligned working encourages open dialogue, shared best practice, clinical mentorship and support as well as the obvious administrative benefits such as back-office function support and clinical cover.

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

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

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

In the past, over-specified contracts have had a detrimental impact on delivery, resources, and efficiencies. The model for the future will be based around outcomes and delivery.

Responding to the General Practice Forward View

NNE CCG's vision is for general practice to be the bedrock of healthcare for the local population, delivering equitable, high quality, efficient, accessible, and sustainable primary care services that are clinically effective and patient-centred. The CCG is currently updating its primary care strategy in order to reflect the requirements of the General Practice Forward View. This will be completed during Quarter 3 of 2016/17 and will be considered for approval at a future meeting of the CCG's Primary Care Commissioning Committee. The CCG will also work collaboratively with other CCGs to implement the GPFV and as part of this is developing a joint plan for delivery and this is attached in Appendix 1.

The CCG's emerging primary care strategy for 2017-2019 will focus on the key areas described below.

Workforce

The CCG recognises the workforce pressures that currently exist in general practice and therefore increasing capacity is a key priority. During 2017/18 and 2018/19 the CCG plans to:

- continue to support training practices to expand their capacity with a view to increasing the number of placements by 2019. This will not only increase the overall number of GP trainees working locally but support GP recruitment within the CCG area. In addition, the CCG will enhance education opportunities by offering trainees the opportunity to obtain greater knowledge of CCG commissioning functions.
- encourage practices to review skill mix within their workforce. One practice within the CCG is already participating in a GP pharmacy transformation pilot to examine the benefits of utilising a community pharmacy independent prescriber. The outcomes of this work will be shared to encourage other practices to adopt this approach.
- incentivise practices to promote Improved Access to Psychological Therapies and increase referrals. During quarter 1 of 2017/18, the CCG will engage with practices to review how practice based mental health therapists can add capacity and value to both practices and patients.
- Work with other local CCGs, the LMC and HEE to utilise the funding available to support training for care navigators and medical assistants (£23k in 2017/18 and £25k in 2018/19).
- ensure training is made available for practice staff around signposting and clinical record management. In 2017/18, the CCG will also ensure that training on the management of mental health is made available to GPs and other practice based clinical staff.

In addition, during 2017-2019 the CCG will:

- support the implementation of national recruitment and retention initiatives, including the NHS GP Health Service
- work with partners in the local community to develop recruitment and retention strategies for example, portfolio working, incentives, rotational opportunities, collaborative campaigns, sharing specialist staff
- work with partners to review the impact of wellbeing initiatives targeting general practice during 2017/18 and roll them out in a sustainable model during 2018/19, for example, supported appraisals, coaching and mentorship.
- continue to work with Health Education England (HEE) to ensure that the primary care workforce across the East Midlands is sustainable and has the right skills, values, and behaviours, at the right time and in the right place. In working directly with HEE the CCG is well placed to highlight the particular needs of the primary care workforce in NNE CCG while future planning workforce needs, retention and development.

Workload

The CCG has secured resources via the GP Resilience Programme and is working with the Local Medical Committee to roll out a programme of support to all practices that will enable them to

assess their requirements and then provide them with the practice specific support required. The initial assessments will take place by January 2017 and tailored support delivered by 31st March 2017.

Practices will be encouraged to participate in the 'Releasing Time to Care' programme to support them to implement 'Ten High-Impact Changes' that are appropriate. The CCG will identify a champion to lead on the promotion of this programme and to share best practice.

During 2017-2019 the CCG will continue to support practices with workload pressures in a number of other areas:

- Implementation of a quality dashboard to enable practices to identify issues early and pro-active support for practices to help them prepare for inspections and respond appropriately to any issues that are raised
- Implementation of Map of Medicine to provide a central resource on approved standardised pathways of care, referral forms and patient information
- Investment in practices to enable them to enhance the pro-active support they provide to care homes. This aims to reduce the demands currently placed on practices that provide medical cover for patients residing in care homes
- Development of a clinical hub that is linked to NHS 111 and which, it is hoped, will reduce the number of face to face contacts being requested from general practice following calls to NHS 111
- Implementation of 'care delivery groups' within the CCG and a developing work programme around multi-disciplinary population health management which will have a positive impact on practice workloads

Infrastructure

During 2017-2019 the CCG will continue work to maximise estates utilisation and support practices to make premises improvements in order to meet existing and future demands on capacity and to ensure high quality premises are available to support the delivery of care. A number of schemes have already received approval in principle to receive funding from the Estates and Technology Transformation Fund. These are:

- Calverton Medical Practice – extension and redevelopment of existing premises
- Hucknall – funding at the level required for the proposed new development is currently not available, therefore the available funding will be used to undertake a feasibility study and options appraisal for the area.

The CCG is also working closely with the local district and borough councils to ensure that section 106 funds are identified and applied for.

As well as the resources identified above, increased joint working between practices and between practices and other community providers will help facilitate the co-location of providers and consolidation of estate but there remain challenges in progressing the CCGs vision for primary care estate:

- The lack of availability of sufficient capital funding to support an expansion in capacity required in response to increases in practice list sizes as a result of new housing developments in some areas e.g. Hucknall
- The willingness of GP partners to change existing premises arrangements

During 2017/18 the CCG will incentivise practices to increase uptake of online bookings and the use of remote care technology. Utilising technology and information patients in NNE CCG will have the ability to book online appointments, re-order prescriptions and access their GP medical records.

In addition during 2017-2019 the CCG will continue work to empower patients by ensuring they are provided with the tools to support their own self-care as well as offering telephone advice/video consultation appointments. Specifically, the CCG will ensure that the funding to support the

implementation of on-line consultations (£39k in 2017/18 and £52k in 2018/19) is identified and available to support the implementation of the guidance and specification as and when it is available. We will also significantly increase the sharing of information across the health community to facilitate improved patient care.

Care redesign

RightCare

The NHS England RightCare Commissioning for Value packs indicate that significant improvements can be made in NNE CCG in terms of both spend and quality in the following areas: cancer, cardio-vascular disease, respiratory disease, mental health, musculoskeletal conditions and neurology. The CCG will work with practices and the wider health community to re-design services and pathways in these areas and in addition will incentivise service improvement work within general practice. The main focus of activity during 2017/18 will be on improving the detection and management of cardio-vascular disease (including diabetes); the focus for 2018/19 will be discussed and agreed with practices during the second half of 2017/18.

New model of primary care

During the remainder of 2016/17 and into 2017/18 the CCG, along with the Local Medical Committee will continue work already commenced supporting its GP practices to determine, develop and implement a new model for primary care in NNE. This will build on the Primary Care Home initiative which is supported by the National Association of Primary Care and is currently being developed by a small number of practices within the CCG. It will also be informed by other local approaches to primary and community care redesign such as the Rushcliffe MCP Vanguard and the Nottingham City GP Alliance. The overarching aim is to improve patient care by improving access and greater integration of primary, community, and social care services. In addition the redesign of general practice will need to support the sustainability of general practice going forward with practices being able to maximise the benefits of operating at scale. This might include the sharing of best practice, enhanced clinical mentorship and support as well as the obvious administrative benefits such as shared back office functions support and clinical cover.

During 2016/17 the CCG has funded a GP practice development facilitator to progress this work. The CCG is currently working with GP practices to identify their support requirements going forward into 2017/18. Once these have been confirmed the CCG will consider its plans for utilisation of funding to support practice transformation. This might include:

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

In parallel with the development of this new model of care, the CCG will assess the level of demand at a locality level for appointments in the evenings and at weekends. In the latter part of 2017/18 the CCG will co-design its model of extended access to general practice with practices and patients. During 2018/19 the CCG will use the £3.34 per head funding provided to support the implementation of 8am to 8pm and weekend access in each of the CCG's three localities where this is achievable; implementation will be via a phased roll out ensuring that additional consultation capacity equates to 30 minutes 1000 population.

Urgent and emergency care

Simplify and improve urgent and emergency care

The CCG's priority for 2017/18 and 2018/19 is to ensure that at least 95% of our citizens attending A & E at any given time will wait less than 4 hours from arrival to be seen, treated, admitted or discharged. This will be achieved through the rapid implementation of the system recovery and improvement plan developed from the five elements of the A & E improvement plan and ECIP recommendations. Successful delivery will be supported by the Emergency Care Improvement Programme (ECIP) and overseen by the local A & E Delivery Board. The CCG is also committed to working with system partners to improve ambulance response times through supporting a significant reduction in ambulance handover delays and increasing the use of both hear and treat and see and treat in order to reduce 999 conveyances.

In Greater Nottingham urgent care situations will be dealt with in the least acute setting possible, navigating citizens directly to the most appropriate, urgent mental and physical health services. The approach will avoid the emergency department and core hospital provision being the default option, supporting a more sustainable system; improving patient and staff experience and clinical outcomes.

What will be achieved in the first two years?

Over two years system redesign will enable a reduction of 200 beds in NUH that are currently occupied by patients who are medically fit-for-discharge by putting in place both more effective processes for admitting and discharging people from hospital.

There are four key areas of work. These are to:

1. Develop system leadership to enable a shared understanding of problems and coherence of actions
2. Improve capability to discharge from A&E and hospital settings
3. Operate a single front door at A&E with streaming to primary care and ambulatory care pathways, including redirecting ambulances to primary / urgent care centre
4. Establish a clinical hub for patient navigation, linking to 111, OOH, signposting and booking into local service, increase hear and treat and see and treat

How will the 5-year vision be delivered?

Over the next five years simplification and improvement of the urgent and emergency care system in Greater Nottingham will focus on:

- Improving the quality of information available to people with urgent care needs
- Increasing citizens' awareness of how and when to best deal with their urgent care needs, by providing them with education and tools to support self-assessment and self-care, and by encouraging them to use an enhanced 111 service able to provide them with the right advice about how to respond to their urgent care needs (e.g. self-care, pharmacy, GP or urgent care centre)
- Improving the current 111 service by establishing a clinical hub in 2017 that will operate across Greater Nottingham, offering a booking service for local urgent care services, and able to provide greater clinical input to decision making, including for people requiring mental health services. The implementation of the clinical hub as recommended in the Urgent and Emergency Care Review will support reducing NHS 111 referrals to A & E and 999
- Building on the existing 'Call for Care' and mental health triage services, further develop a community based professional navigation service for staff across the system to access when clinical input into decision making is needed, or when advice is required about the availability of physical, mental health or social care services. This will improve services for mental health patients prior to presentation in A&E
- Improving access to urgent care beyond A&E
- Operating a 'single front door' at A&E, able to direct citizens to co-located primary care, ambulatory care or urgent care services, including those who arrive by ambulance

- Integrating crisis response support with community services in order to provide a 24/7 rapid response service that is able to support people with urgent mental or physical needs at home or in community settings and prevent avoidable hospital admissions
- Making sure there is timely and safe care for those who require hospital based urgent and emergency care
- Ensuring that staff providing urgent and emergency care (particularly in A&E) have access to patient's records and care plans in order to ensure patients receive the most appropriate care for their needs
- Ensuring access to a senior opinion before patients are admitted to hospital via A&E in order to ensure that a hospital admission is required (this links to timely consultant review standard for 7 day hospital services)
- Making sure there is access to relevant specialist opinion or assessment and diagnosis e.g. for patients admitted with mental health needs or frailty syndromes (this links to timely consultant review and improved access to diagnostics across 7 days).
- Improving patient flow in A&E and through the hospital by implementing the SAFER patient flow bundle and the Red and Green day daily operational planning at wards across acute and community hospitals
- Implementing more effective processes for discharging people from hospital
- Building on recent successes in Mid Nottinghamshire and advice from ECIP, commence discharge planning by multi-disciplinary teams as soon as patients are in a stable condition after being admitted to hospital and ensure that people are discharged back home or for a period of short-term assessment and diagnosis or further recovery in community beds as soon as they are medically fit
- Enhancing and scaling-up schemes to provide specialist intermediate care in citizens' homes to reduce re-admission by providing home based support or rapid access to community based assessments

5. Referral to treatment times and elective care

Referral to treatment times

The CCG and its major providers have provided a sustained high level of performance to its patients in respect of the delivery of the RTT standards set out in the NHS Constitution. This has been achieved through a number of mechanisms including innovative pathway design, strong relationships, close performance management, and the shared understanding of a projected demand.

These principles will continue for the life of the CCG's plan and so the CCG is confident these standards will be maintained. It is acknowledged that the revised national RTT policy, which became operational in October 2015, introduces additional risks to the number of very long-waiting patients due to their ability to decline offers of treatment on an on-going basis. This has been managed well during 2016 but remains a risk to the proportion of patients choosing to wait extremely long times.

Many of the planned efficiency savings, such as QIPP schemes, will support acute trusts in utilising their capacity to greater effect. The reduction of follow-up rates for elective pathways will minimise outpatient attendances where suitable alternatives or early discharge is appropriate releasing clinical and estate capacity for acute provider organisations.

The provision of patient choice is engrained into the ethos of the CCG and all practices offer this to patients. The current high utilisation of electronic systems will continue as an enabler and to enhance the opportunities provided to patients through other primary care on-line services. E-referrals will be fully utilised for all referrals by April 2018 in line with the national ambition.

Elective care

Throughout 2017-2019 planned care transformational change will continue to be delivered by NHS Nottingham North and East CCG as partners in the Greater Nottingham health and care system, building on momentum created in 2016/17 through the Elective Care Workstream. This provides the opportunity to develop consistent pathways across the wider population into and out of secondary care. Increasingly, the CCG will focus on the opportunities for learning, collaboration, and standardisation across the broader footprint with links to the Mid Nottinghamshire system in light of work developed for the STP.

Greater Nottingham and Mid-Nottinghamshire have agreed a joint intent for planned care within the STP. The ambition is to provide planned care with minimum avoidable variations in timeliness, quality, and cost, ensuring early diagnosis, information, and support to patients and developing new models of elective care with increased activity in the community rather than secondary care setting. Collectively, the aim is to improve the utilisation of specialist services by focusing on complex care, coupled with a reduction in duplicated activity and follow-ups that do not add clinical value.

The CCG will continue to use the Right Care Commissioning for Value insight packs to identify priority areas which offer the best opportunities to improve healthcare for the local population. This is both in terms of improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system.

The October 2016 insight packs show there is opportunity for improvement in:

- cancer services
- MSK
- neurological conditions (specifically in relation to pain management)
- gastro-intestinal.

Work commenced in 2016/17 will start to address these priority areas as detailed below. In addition, mental health has been identified as a priority in terms of outcomes and spend. Plans for this priority area will be developed early in 2017/18.

MSK

Maximising outcomes and efficiency in MSK continues to be a priority for NNE CCG and the Greater Nottingham system as the single greatest programme budgeting spend with a value of £89 million in 2014/15.

A new model for delivery has been developed by the Greater Nottingham MSK Clinical Group, building on knowledge and experience from other systems nationally such as Pennine, Bedford and Sheffield.

This care model is a multidisciplinary integrated MSK service that includes orthopaedics, sports and exercise medicine, pain management, physiotherapy and rheumatology. An integrated triage and assessment service will co-ordinate and manage the healthcare pathways of patients with MSK issues to deliver high-quality care, good clinical outcomes, and excellent patient experience.

This care model builds on existing community based services within individual CCGs. Existing contracts will be subject to contract negotiation and variation to move toward a single, consistent pathway delivered by all providers by the end of 2017/18. This will happen on a phased approach with early implementation in NNE CCG and Nottingham West CCG in April 2017.

A single minimum dataset for referrals will be agreed across Greater Nottingham to ensure that patients are triaged to the most appropriate service to meet their needs in a timely and responsive way. This will be developed and socialised during the remainder of 2016/17 to realise the impact in April 2017.

It is anticipated that the new MSK clinical pathway will deliver the following:

- Improved patient experience
- Reduction in 1st outpatient attendances
- Reduction in outpatient follow ups
- Reduction in emergency admissions
- Reduction in planned admissions
- Reduction in acute bed days

Neurological conditions: pain management

Deep dive analysis has indicated that there is opportunity to improve outcomes and spend in pain management with differential opportunity across the Greater Nottingham CCGs. Spend on the pain pathway in 2015/16 was £13.1m. Based on the RightCare Commissioning for Value packs, there is a potential financial opportunity of £687k.

A task and finish group has developed a pain management pathway that embeds the evidence base for effective treatments and interventions. This will form the basis of a service specification that will be procured in early 2017 for implementation in July 2017.

The objectives of the proposed redesigned pathway are to:

- act as a single point of access for patients with chronic pain
- provide a biopsychosocial assessment and management approach for patients with chronic pain
- support patients living with chronic pain to manage their own condition and make decisions about self-care and treatment that allow them to live as independently as possible, e.g. through Shared Decision Making
- educate and support other care professionals in the early intervention of pain management techniques
- reduce elective care activity within an acute hospital setting.

Implementation of the new pathway will be monitored throughout the remainder of 2017/18 in order to understand and monitor its impact from both a quality and financial perspective.

Gastro-intestinal

The pathway for all routine and urgent non-two week wait referrals to gastro-intestinal and hepatology has been redesigned to improve patient access to care and to manage the rising demand in referrals. Referrals will be reviewed by consultants funded on a PA basis, to support a focus on a model for service delivery to meet population need, rather than an activity driven tariff based approach.

A triage process will be undertaken, using a minimum dataset for referrals, reviewing clinical data, considering a patient completed questionnaire and ordering diagnostic tests as required. This will be undertaken in a community setting with the tracking of tests and information being undertaken by a Clinical Assessment Service.

Following receipt of all required diagnostic tests and other clinical information, the consultant will undertake a case review of the patient and decide on the clinical management required.

The proposed benefits of the service are:

- Faster access to a clinical review: a non-face-to-face clinical review will take place on the pre-assessment pathway within 7 to 14 days of the GP referral.
- Earlier access to diagnostic testing: tests will be ordered at the pre-assessment phase rather than the outpatient appointment.
- Improved patient experience: unnecessary outpatient appointments will be avoided and patients will have quicker access to diagnostic testing and results.

- Reduced outpatient attendances: face to face outpatient appointments will only occur when clinically necessary. Pilot work indicates there is a 23% reduction in first outpatient appointments.

GP education is an intrinsic part of the pathway, with a link consultant role to be developed providing a named link for practices in a given CCG. This will support the longer term objective of developing the service to be delivered in primary care wherever possible, including GPs having direct access to key diagnostic tests.

Stakeholder engagement has been undertaken through the Elective Care Workstream and with clinicians from the main providers of gastro-intestinal and hepatology services. Patient engagement is being undertaken as part of the evaluation of the pilot service to understand the experience of the service delivery approaches.

Implementation of the service commenced in November 2016 with a phased approach to support providers to manage the capacity required to deliver diagnostics earlier in the pathway. The service will be fully implemented across Greater Nottingham by 1st April 2017 with the impact in the reduction of follow-ups being measurable from 1st July 2017.

The pathway model will be rolled out to other specialties such as cardiology and respiratory during 2017/18 and 2018/19.

Follow-up care

There is significant clinical variation in outpatient follow up care, with feedback from clinicians and patients of differing expectations in the value of continuing secondary care follow up. Over the last few years, the principle has been agreed that follow up outpatient appointments should occur only when they add genuine value to the patient pathway. For NNE CCG and the Greater Nottingham health system the challenge is now to extend, embed and sustain this culture across all specialties and all providers.

Benchmarking data for Nottingham University Hospitals (NUH) demonstrates there is opportunity to improve the way in which outpatient follow care is delivered. There is considerable variation in the first to follow up ratio between trusts and specialties. Whilst some of this is clinically warranted, further work is required to understand the opportunity to improve value in follow up care at a specialty level.

During the remainder of 2016/17, specialty and sub-specialty pathways for follow-up care will be agreed across primary and secondary care, clearly articulating the clinical responsibilities across the pathway. This will support more follow-up care being undertaken in the community and allow secondary care to remove capacity at scale.

The pathway redesign work will:

- Embed an approach of risk stratification for follow up care in all specialties through greater integration between primary and secondary care to deliver optimum outcomes for patients.
- Use technology to deliver review and follow up care, building on the work that has happened around telephone clinics at NUH, teledermatology at Circle and using new technology and information sharing such as the MIG to deliver a modern system of care, as well as developing the opportunity provided by the Advice and Guidance service.

This approach will be supported by local payment reform enacted through the contract with NUH, replicating the approach taken with other providers.

From 1st April 2017, follow up care will start to be delivered according to the new risk stratified pathways. A phased approach for agreeing the pathways has been taken given the scope and scale of the work which covers 21 specialties. All pathways will be operational by 31st July 2017. This will have an estimated saving to commissioners of £7.2 million in 2017/18 and 2018/19. Provider costs will be reduced through the removal of waiting list initiatives and a reduction in outpatient clinics, in particular consultant PAs and other outpatient clinic staff.

Maternity care - Implementing the national maternity services review, Better Births

A multi-agency Better Births Implementation Group (chaired by commissioners) has been established to develop the local vision, including plans for community hubs within the local maternity system (LMS). Closer working across the LMS, which covers two maternity units within the STP footprint, will facilitate embedding of consistent clinical care and care pathways, adoption of best practice from each unit and learning lessons to improving practice. Maternity services have benchmarked their position against the recommendations of Better Births and the elements in Saving Babies' Lives, providing a baseline. Working with key stakeholders, including mothers and families, plans will be developed and implemented during 2017/18 and 2018/19 in line with the timelines outlined in Better Births.

6. Cancer

During 2017/18 and 2018/19, NNE CCG will work collaboratively with partner organisations to deliver against a number of priority areas in respect of cancer. Across both the Greater Nottingham and Mid-Nottinghamshire areas, the priority areas have been agreed as the following:

- Preventing cancer:
  - Addressing risk factors of cancer, particularly smoking, but also obesity and alcohol
  - Strengthening existing tobacco controls and smoking cessation services in line with reducing smoking prevalence to below 13% nationally by 2020
  - Pilot prescribing of e-cigarettes within smoking cessation services (City CCG but consideration to be given to rolling this out in the remaining Greater Nottingham CCGs)
  - Increasing the number of smoke free areas (Nottinghamshire Healthcare Foundation Trust has been smoke free since October 2016 and NUH is working to be smoke-free from 2017/18)
  - Making every contact count, particularly on physical activity and weight loss.
- Early diagnosis:
  - Programme to implement fully NICE referral guidelines NG12, in particular GP direct access to diagnostics; to include faecal immunochemical test (FIT) for colorectal cancer, oesophago-gastroduodenoscopy (OGD) for upper GI cancer, MRI for brain cancer, CT for pancreatic cancer
  - Pilot non-specific cancer symptoms pathway (Danish model) across the STP area for patients that don't meet the 2WW referral criteria, but where a GP is highly suspicious of cancer.
  - Piloting community prostate clinics in BME populations.
  - Pilot and evaluate lung MOT service in City CCG, with view to roll out across populations with high risk of lung disease including cancer i.e. high smoking rates
  - Increase uptake of breast, bowel and cervical screening programmes
  - Breast and cervical screening – work with NHS England to support GP practices to increase uptake rates where these are low
- Performance:
  - Commission sufficient capacity to ensure 85% of patients continue to meet the 62 day standard and to begin to meet the 28 day faster diagnosis by identifying any diagnostic capacity gaps for 2017/18 and improving productivity or implementing plans to close these gaps
  - Capacity and demand analysis undertaken using IST tools across all tumour sites, the results of which have been fed into activity plans for 2017-2019. Acute trusts working to achieve seven day diagnostic waits

    - NUH has commissioned additional private sector capacity alongside internal plans to increase capacity. The Better For You Redesign Team is working with diagnostic teams to improve productivity
    - Monitoring of 28 day diagnostic standard by tumour site now in place at NUH. This is to be rolled out to Circle.
    - Tumour site pathway redesign to achieve current waiting time standards and to move towards new 28 day referral to diagnosis standard: programme of redesign to reduce delays in diagnosis and treatment, focusing particularly on diagnostic part of the pathway.
    - Forecast achievement of 75% one year survival by 2020
- Improving cancer treatment and care:
    - All parts of the recovery package to be available to all patients, namely: Holistic Needs Assessment (HNA) and care plan at the point of diagnosis and at the end of treatment; ensuring a treatment summary is sent to the patient's GP at the end of treatment; ensuring a cancer care review is completed by the GP within six months of diagnosis, and health and wellbeing clinics
    - eHNAs are being rolled out across tumour sites as part of the NUH Cancer Pathways Project
    - Programme of work underway to roll out standard template summary across tumour sites
    - Commission personalised stratified follow up pathways: this has been completed for breast cancer but will be piloted across a small number of pathways prior to being rolled out to all pathways. This will be implemented for colorectal cancer during 2017/18
    - Continue to ensure all patients have access to a clinical nurse specialist or other key worker
    - Community pharmacies dispensing antiemetic and other supportive medicine regimes.
    - End of life: maximise utilisation and benefits of EPaCCS (Electronic Palliative Care Co-ordination Systems) to enable the recording and sharing of people's care preferences and key details about their care at the end of life.

7. Mental health

During 2017/18 and 2018/19 NNE CCG will work collaboratively with other Nottinghamshire CCGs to implement the requirements as set out in the Five Year Forward View for mental health. Specifically this will focus on improving access to mental health services for people of all ages, developing community services and thereby reducing the pressure on inpatient facilities, and ensuring people receive integrated holistic care that addresses both their mental and physical health needs.

A number of key priorities and actions for 2017/18 and 2018/19 are identified below:

Access to psychological therapies

The CCG is currently undertaking modelling work in order to establish appropriate trajectories in respect of improving access to psychological therapies for those with anxiety and depression. The current proposal is for a 2.5% incremental rise each year for 2017-18 and 2018-19. Work is also underway to explore the logistics of IAPT services to sit within physical care outpatient departments and also to be integrated into pain pathways across Nottinghamshire by April 2017.

During 2017/18 and 2018/19 work will continue to increase access to 'core' IAPT services. Actions will include on-going promotion via GP practices, consideration of opening up referral pathways to other healthcare professionals, encouraging more effective/cohesive relationships between IAPT and other mental health support services, CCG specific campaigns to raise awareness of IAPT services.

Mental health services for children and young people

NNE CCG is working with other Nottinghamshire CCGs and local partners to implement a transformation plan for children and young people's emotional and mental health. The plan focuses on the five themes identified through Future in Mind that will lead to improved outcomes for children and young people with emotional and mental health needs.

During 2017-2019 the key priority areas for action include:

- resilience, prevention, and early intervention – embedding online counselling services and ensuring that children's emotional resilience is developed through evidence based programmes in schools
- improving access, a system without tiers – increasing access to evidence based therapeutic interventions, increasing capacity of services.
- caring for the most vulnerable – further developing support to children and young people in urgent need of mental health support, whether in community or hospital settings

As part of the Nottinghamshire Children and Young People's IAPT programme NNE CCG is working alongside other local CCGs and providers to improve access, implement evidence based intervention, and use routine outcome measures. Work is underway to baseline the numbers of children and young people currently accessing treatment, and compare with expected levels based on prevalence data. This will inform future service planning and development. Additional investment into children's mental health services has already made an improvement on access in terms of waiting times for treatment.

Treatment for psychosis

The CCG recognises that it particularly needs to improve mental health crisis services and Early Intervention in Psychosis (EIP) services.

The Crisis service has been enhanced following the closure of two inpatient wards which provide support to patients 24 hours a day and seven days a week. In addition to this Crisis House has also been developed in order to provide an alternative to inpatient admission. Commissioners continue to work with the Trust to ensure the crisis service meets local population needs. CCGs recently commissioned HealthWatch to undertake a review of the crisis service and the findings are being addressed in order to inform service developments.

During 2016/17 commissioners have worked closely with the provider to improve operational processes and data recording in the EIP service; improvements in performance have been seen and performance was at 100% for the CCG in October. The current model for Early Intervention in Psychosis was commissioned for 18-35s as this is the age range when First Episode Psychosis (FEP) is most commonly experienced. Commissioners recognise that those outside of this age range are receiving a different service at this point in time, and are considering what service model will be required going forward to ensure they have access to a service compliant with access standards and NICE quality standards. Any funding implications associated with delivering the increased targets over the next 5 years will need to be assessed and considered. A baseline self-assessment of NICE compliance has been completed by Nottinghamshire Healthcare Trust. This work is coordinated by a joint CCG steering group.

In-patient services

The CCG is committed to improving access to placement support for people with severe mental illness and will work with STP partners to develop local plans for improvement in response to the national baseline audit for in-patient services to be undertaken on Q3-Q4 2016. This will require support from transformation funding a bid for which the CCG will make along with STP partners by December 2017.

Eating disorders

A CAMHS Community Eating Disorder Service has been commissioned and work is currently underway to meet the published access and waiting time standards (95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases by 2020). Data from Q1 and Q2 2016/17 indicates that children and young people are not always yet able to access treatment within the required timeframe. For the remainder of 2016/17 and into 2017/18 NNE CCG will therefore work with other CCGs and the service provider to develop a plan to improve access to treatment to meet the required target.

Suicide

During 2017/18 and 2018/19 NNE CCG will continue to work with partners in both Nottinghamshire County and Nottingham City to implement an approved suicide prevention strategy. This will be supported by improving access to staff training on suicide prevention for primary care and provider staff.

Crisis response services

In advance of the publication of guidance by NHS England in April 2017 the CCG is planning to undertake a review of crisis response services to inform future service development and ensure the local model of care meets the needs of service users. This is with the aim that by 2020/21 all Crisis Response and Home Treatment Teams in Nottinghamshire will be delivering in line with best practice standards as described in the CORE fidelity criteria.

Key milestones

November 2016:

- Amendment of existing specification

December 2017:

- Specification and measures CV'd into the contract

January 2017:

- Crisis service review scheduled – including review of CORE fidelity model
- NHFT to report bi-monthly as per reporting requirements

February 2017:

- Crisis service feedback to be shared at IPG- actions to be agreed

April 2017:

- NHS England publish further guidance and formal review begins
- Out of area information to be reported by provider

Key deliverables

- • Reduced number of patients receiving OOAT
- • Improved clinician and patient reported outcome measures
- • Patients receiving treatment closer to home
- • Evidence of working towards Core fidelity model

Meeting the waiting time standard for urgent care for those in crisis

During 2017-2019 the CCG will continue to work with system partners to prepare for the forthcoming waiting time standard for urgent care for those in a mental health crisis. This will include a focus on ensuring parity between mental and physical health urgent care responses and

will include the development of mental health liaison teams and crisis teams. Work will also be undertaken in respect of health-based places of safety.

Mental health liaison teams

Key milestones

November 2016:

- Mental health liaison teams commissioned to provide 24 hour coverage and urgent response (within 1 hour of ED referral)
- Current staffing levels obtained from the trust
- NHS England to provide further staffing on Core 24 levels and gap analysis to be undertaken.
- Trust to undertake work to implement FROM LP outcome reporting (due April 2017)

December 2016:

- Enhanced Core 24 model to be developed in collaboration with key stakeholders
- Evaluation of non-recurrent pump prime monies to be completed
- Business case to be developed

April 2017:

- Agreed service enhancement model to be agreed and implemented

Summer 2017:

- Business case to be submitted in order to secure transformation funding for mental health liaison teams

Key deliverables

- Urgent referrals responded to within one hour of receipt by the mental health liaison teams (supporting overall response time of four hours)
- Mental health liaison teams providing 24 hour ‘all age cover’ as per Core 24 requirements

Crisis

Key milestones

December 2017:

- Specification and outcome measures CV’d into the contract

January 2017:

- NHFT to report bi-monthly as per reporting requirements

April 2017:

- Implement new local model (baseline allocations for crisis have increased)
- NHS England publish further guidance and formal review begins

Key deliverables

- Mental health liaison to respond to urgent referrals within 1 hour of receipt by the mental health liaison teams- (supporting overall response time of 4 hours)
- Mental health liaison teams to provide 24 hour ‘all age cover’ as per Core 24 requirements
- Crisis teams- to provide 4 hour and 24 hour response

HBPoS (Health-based place of safety)

Jasmine and Cassidy suites are already taking patients under S135 as well as S136.

Key milestones

- **Q4 2016/17:** Analysis to be undertaken to understand the impact of the new Police and Crime Bill, i.e. increase in S135 & S136 and a reduction in the time spent in a HBPoS
- **April 2017:** Patients will only remain in a HBPoS for up to 24 hours as per Police and Crime Bill.
- **Summer 2017:** works completed to make suites more robust and therefore less likely to be damaged and out of commission for periods of time.

Key deliverables

- Robust and effective HBPoS in operation
- Patients are assessed and referred on within 24 hours

Dedicated MH conveyance vehicle (as above) will ensure a more timely conveyance to the HBPoS.

Street triage

During 2017/18, the CCG will continue to commission a street triage service.

Key milestones

- **Q3/Q4 2016/17:** complete evaluation of Control Room Pilot to inform future commissioning.

Maternal and perinatal mental health

Maternal mental health is a priority in the NHS 5 Year Forward View; in Future in Mind: promoting, protecting, and improving our children and young people's mental health and wellbeing; and in Better Births: the national maternity transformation programme. During 2017-2019 there will continue to be a focus on improving maternal mental health, recognising that between 10 and 15% of women develop mental illness in the perinatal period and our local maternity providers identify up to 20% of their caseloads with mental health issues.

Perinatal mental health services in Nottinghamshire benchmark well overall. However there are opportunities for improvement, including strengthening support for women with mild, moderate, or emerging mental health needs and improving information sharing across the pathway.

Scoping work identified five key areas for action, namely:

- Commissioning
- Assessment tools, thresholds and self-help materials
- Training
- Information sharing
- Medicines and prescribing

Work will be led across Nottinghamshire by a multi-agency Perinatal Mental Health Steering Group, focusing on improving care and delivering the Better Births recommendations.

Nottinghamshire CCGs have been successful in their application to NHS England for additional funding. Over the next 3 years this funding will be utilised to ensure all elements of the perinatal 5YFV target are met. The project will go live in January 2017 and key deliverables will be CV'd into the Nottinghamshire Healthcare Foundation Trust's contract to ensure achievement.

Key milestones

November 2017:

- Attend National event for successful applicants

December 2017:

- Translate application into project plan
- CV agreed reporting measures into the contract (including targets specifically relating to waiting times, training, outcome measures and number of contacts)

January 2017:

- Enhanced service goes live
- Quarterly reporting provided to NHS England

The project to be monitored on an on-going basis as per the project plan.

Key deliverables

- Expansion of the current service in both staffing and geography covered
- Achievement of the 2 week waiting time target (referral to treatment) by 2020/21
- Additional mothers are supported –based on NHFT current baseline (as per National target- 30,000 additional women to be receive treatment in England)
- Perinatal mental health training delivered to universal services (midwifery and health visiting)
- Reduced number of DNAs

Dementia

NNE CCG currently achieves dementia diagnosis targets and aims to continue to meet this requirement in 2017/18 and 2018/19. To support this, the CCG has identified both a clinical and organisational lead for dementia. The CCG's Dementia Communication Plan 2016 provides a framework for improving dementia diagnosis rates during 2017/18 and 2018/19. In addition the CCG has created a practice performance summary on the intranet to improve practice awareness of their relative performance and throughout 2017/18 and 2018/19 will promote the use of this as a way to support achieving the dementia diagnosis target.

To support carers the CCG commissions compass workers who provide practical and emotional support for individuals with moderate to severe dementia. The CCG also has a web-site specifically for dementia carers and supports care groups.

Out of area placements

NNE CCG is committed to ensuring that by 2020/21 no service users requiring non-specialist acute care receive their treatment in an out of area placement setting. As a first step towards eliminating OATs the CCG will review the data released in April 2017 in order to understand the nationally agreed definition of OATs and to gain a more accurate understanding of the scale and challenges locally

Reducing conveyances to A&E

During 2017/18 and 2018/19 the CCG will continue work to identify and implement initiatives that reduce the number of people with a mental illness that are unnecessarily transported to A&E following a 999 call. Two such initiatives are described below:

Dedicated conveyance vehicle

This is a bespoke vehicle for EMAS funded by capital money. It provides an additional resource to EMAS to support the appropriate conveyance response for MH patients.

Key milestones

- **Q4 2016/17 to Q2 2017/18:** identify revenue funding for staffing

- **Q1 2017/18:** develop and sign off operational plan to include most appropriate base location to ensure equitable response times across the county.
- **Q3 and Q4 2017/18:** roll this service out.

Deliverables

- Mental health patients are conveyed to the most appropriate place in a timely manor
- A&E attendances by mental health patients in crisis are reduced

Crisis café/sanctuary

The CCG is currently considering commissioning a Crisis Café service. This is an out of hours voluntary sector led service for people experiencing MH crisis which will prevent inappropriate use of blue light services and A&E attendance. Also, provide a service for blue light services to take people out of hours who need some level of intervention. If approved, the CCG will work collaboratively to deliver as follows.

Key milestones

- **Q1 and Q2 2017/18:** Develop model, identify revenue funding and determine commissioning process i.e. CCG procurement or subcontracting arrangements
- **Q3 and Q4 2017/18:** Develop spec and procure
- **Q1 2018/19:** Service to start

Key deliverables

- Appropriate out of hours provision is available for people experiencing crisis who don't require an immediate response from crisis services
- Blue light services time isn't occupied inappropriately by patients requiring mental health support

8. Learning disabilities

As a fast track site Nottinghamshire's plan to transform services 'Transforming Care for People with Learning Disabilities and/or Autism Spectrum Disorders in Nottinghamshire' was submitted to NHS England in September 2015. The Transforming Care Programme (TCP) footprint is as outlined within 'Building the Right Support' and is made up of seven CCGs, two local authorities, and the NHSE Specialised Commissioning Hub for Midlands and East.

Delivery of the Transforming Care Programme in Nottinghamshire is managed and driven by five work streams, an Operational Committee and a Board. The Board has overall responsibility for ensuring implementation of the programme. Regular reports on the progress of the programme, including monthly milestone reports that capture risks and mitigations, are provided by programme management team to the Operational Committee and the Board as well as to NHS England. In addition, trackers containing information on inpatients, admissions, and discharges are submitted weekly to NHS England by each CCG within the partnership.

As the TCP plan aims to ensure that people can be safely cared for in the community, with hospital only being used when there is no other less restrictive option that is suitable, a range of measures have already been implemented designed to help prevent admissions to hospital. These include having an 'at risk of admission' register and pre admission and 'blue light' Care and Treatment Reviews (CTR) process. A robust process is also in place across the partnership for post admission and on-going CTRs to ensure that people are not remaining in hospital for longer than they need to. In addition, there are plans to commission a number of services to help manage and reduce inpatient numbers as detailed in the key milestones and deliverables below.

The Finance work stream is working on the development of a pooled budget, releasing investment from CCG and specialised commissioned inpatient services, and increasing the uptake of Personal Health Budgets to the Transforming Care cohort.

Key milestones

- **28/2/2017:** complete an independent review of the local Assessment and Treatment Unit
- **31/3/2017:** commission a crisis service that can provide an alternative to hospital admission for up to 3 people.
- **31/3/2017:** commission a respite service that can provide for up to 2 people with challenging behaviour
- **31/3/2017:** commission a step-down service in the community for people leaving hospital, particularly secure services.
- **31/3/2017:** enhance the Intensive Community Assessment and Treatment Team to provide the expertise to care for the TC cohort in the community and to work with the crisis, respite and step-down services.
- **31/3/2017:** Reduce the inpatient numbers of people that meet the Transforming Care criteria from to 65 from 73 on 31/3/2016.
- **31/3/2018:** Review the outcome of the crisis/respite pilot model and re-commission a longer term service model accordingly.
- **31/3/2018:** Review, and where required re-commission, the provision of step-down placements for people leaving secure hospitals, to ensure that placements offer re-enablement and rehabilitation that allow people to exit the hospital system safely, and reducing risk of re-admission.
- **31/3/2018:** Review commissioned services within NHS Trust block contract including community teams and inpatient unit, in line with reducing capacity in the inpatient unit and increasing capacity of the community teams, issuing notice periods and/or commissioning intentions as required.
- **31/3/2018:** Reduce the inpatient numbers of people that meet the Transforming Care criteria in the TCP area to 53 from 73 on 31/3/2016.
- **31/3/2019:** Review the provision of carer support, planned respite, training and referral routes into services, ensuring that adjustments are made that enable people that meet the Transforming Care criteria to access physical, mental and emotional treatment and support when required.
- **31/3/2019:** Reduce the inpatient numbers of people that meet the Transforming Care criteria in the TCP area to 36 from 73 on 31/3/2016.

Key deliverables

- Reducing numbers of people that meet the Transforming Care criteria who are in inpatient beds in line with expectations included within BRS
- Increasing the number of people with LS/ASD that receive treatment in a community based placement.
- Increasing the number of complex people with LD/ASD who are living in accommodation with security of tenure, in order that their accommodation doesn't have to change if there is a change in their care and support needs.
- Reducing the number of spot purchased / commissioned inpatient beds, resulting in a smaller acute assessment and treatment unit, and a reduced use of locked rehabilitation beds.
- Increasing the number of people, who when requiring an inpatient admission, are cared for within Nottinghamshire Increasing the ability of the workforce to support new ways of working and improving the competence, capability and capacity of staff providing health and social care and support.
- Increasing the number of staff who have the relevant skills, knowledge, and values to deliver high quality care and support.

- Development and implementation of a pooled budget, releasing investment from CCG and specialised commissioned inpatient services.
- Increasing the uptake of personal health budgets and direct payments for the Transforming Care cohort.
- Increasing the number of service users / their carers who say that they felt they had some choice in the nature of the health and social care they received.
- Increasing the number of people aged 14 and over that have a learning disability accessing annual health checks.
- Increasing the number of people aged 14 and over that have an autistic spectrum disorder accessing an annual health check.

Reducing in-patient bed capacity

The Nottinghamshire TCP has committed to reducing its usage of inpatient services in line with the national planning assumptions set out in 'Building the Right Support' (Oct 2015). For Nottinghamshire this translates to the use of no more than 13 CCG and 23 specialised beds by the end of 2018/19. Nottinghamshire envisage that the majority of the 36 people still requiring inpatient services in 2019 will be in beds already provided in Nottinghamshire.

Capacity planning has already been completed and submitted to NHS England. This identifies the expected reduction in in-patient bed capacity for each of the financial years (2017/18 to 2018/19). As most inpatient beds commissioned by both CCGs and the specialised hub are commissioned on a spot purchase basis from provider framework contracts it will not be necessary to serve notice on these. Despite this, all providers delivering in-patient care within Nottinghamshire have had the opportunity to respond to as part of a formal consultation.

For the Assessment and Treatment Unit (part of a block contract with Nottinghamshire Healthcare Foundation Trust) it is the intention to reduce these beds by 50% by March 2019. The provider has been made aware of this intention since the publication of the plan in September 2015, and the programme management team continue to work closely with the provider in terms of timescales and formal commissioning intentions.

Health checks

Whilst commissioning NHS health checks is not a direct or delegated responsibility of CCGs, the TCP recognises the important contribution they can make to the health and wellbeing of people with a learning disability/ASD. At an average of 55%, current performance for the CCGs in the TCP is above the 2016/17 national average of uptake of health checks which is 48%. However, in order to reach the target of 75% of people on a GP LD register by 2020, there are a number of actions required which will be overseen by the TCP. These are as follows:

- Establish timely monitoring of data by March 2017
- Understand data issues and work with GPs to improve data accuracy by March 2017
- Encourage GPs to participate in the scheme and to engage with data improvement during Q3-Q4 2016/17
- Review the role of primary care liaison nurses with regard to encouraging take-up of health checks during Q1 2017/18
- Establish a TCP-wide task and finish group to understand the data and operational issues with annual health checks. This will include a comparison of commissioning models and outcomes between CCGs within the TCP footprint which may lead to a change in specifications / methods of delivery by end of Q4 (2016/17)
- Oversight and monitoring of performance and progress at the Operational Committee. This has already commenced and will continue during 2017/18 and 2018/19

Nottingham North & East CCG is committed to supporting patients with learning disabilities and recognises the need to increase the number and quality of health checks that are delivered within Primary Care. The CCG will be undertaking an audit in each practice with a view to 100% of

patients being invited to attend a health check during 2017/18. The CCG will continue to work closely with the learning disability community nurse.

Reducing premature mortality

A National Learning Disabilities Mortality Review programme has been launched (LeDeR Programme) following the publication of the 'Confidential inquiry into premature deaths of people with learning disabilities' (CIPOLD) (2013). A key recommendation of CIPOLD was for on-going mortality surveillance in the LD population. Nottinghamshire will be participating in workshops which will launch local LeDeR steering groups, the aim of which will be to drive improvement in the quality of health and social care service delivery for people with learning disabilities, and to help reduce premature mortality and health inequalities in this population. Following these workshops the TCP will agree plans to establish the local arrangements for the LeDeR programme.

The measures to improve the uptake of annual health checks for the LD population are linked to the premature mortality review. Evidence suggests that people with a learning disability are less likely to seek assessment, diagnosis, and treatment of long term conditions, which in part, contributes to the inequality in mortality statistics. Ensuring that people have an annual health check is in part aimed at engaging the population in discussion about their physical health, detecting early signs of physical health conditions, and assessing other contributory factors such as mental health and wellbeing.

The TCP in Nottinghamshire is working closely with wider programmes of change in Nottinghamshire that aim to improve outcomes, and reduce health inequalities for people with learning disabilities and autism, including the special educational needs (SEND) reform programme, and the 'Whole Life Disability Review' programme. In both Nottingham City and County, specialist LD nurses are employed as 'health facilitators' who work closely with primary care services, service users, families and carers, in order to ensure that people with learning disabilities attend physical health appointments, treatment, follow up and aftercare, in relation to their health conditions, and that all reasonable adjustments are made to facilitate this where required. In addition to this, the CCGs fund a number of specialist LD nurses who are based at acute hospitals in both the City and County working as 'acute liaison nurses' who provide specialist assessment, support, advice, and signposting for people with LD and ASD who are accessing either inpatient or outpatient services within acute general hospitals.

Special educational needs and disabilities, children and young people (0-25)

During 2017-2019 the CCG, via the Children's Integrated Commissioning Hub will work in partnership with Nottinghamshire County Council to deliver the statutory duties for children and young people aged 0-25 with special educational needs and disability in line with the Children and Families Act 2014 and the requirements of the OFSTED and CQC inspection framework, including:

- continuation and development of the designated clinical officer (DCO) and associate designated clinical officer roles
- development of the Educational Health and Care Plan (EHCP) pathway to be more streamlined and person centred
- further development of the local offer
- establishment of new approaches to commissioning of services to meet health needs identified in EHCPs
- development of individual personalised commissioning for children and young people (Personal Health Budgets)
- further development of quality assurance of the EHCP pathway and continuing care
- mobilisation of the Integrated Children and Young People's Community Health Services transformation programme, to deliver better health services for children and young people with the most complex health needs.

9. Improving quality

During 2017/18 and 2018/19 the CCG's shared quality team will continue to work with providers (across all sectors) to identify areas for development and support them in the production and implementation of plans and strategies to make sustained improvements. This will involve triangulation and analysis of a wide range of information including clinical outcomes, workforce/ staffing indicators, and patient and staff safety and experience measures supplemented with quality visits and other intelligence sharing e.g. from NHSI, CQC inspections, HealthWatch feedback and cancer peer review.

The team will continue to use contractual levers such as CQUINs and increasingly Quality Outcome Frameworks to incentivise continual improvement. Quality schedules and quality scrutiny panels will be utilised to ensure that providers have robust mortality and morbidity review processes in place and comply with requirements to publish avoidable mortality rates, acting as a critical friend confirming and challenging information and monitoring completion of improvement action plans. The quality assurance framework for primary care introduced in 2016/17 (comprising a quality dashboard, risk stratification matrix, primary care quality groups and escalation process), will be further developed in light of learning from CQC inspections in particular those where ratings of inadequate were found either overall or in any domain. The team will also continue to build on the harm review processes developed during 2016/17 to enable continued monitoring of the impact of performance on quality (in particular safety) e.g. cancer and ED breaches, ambulance and diagnostic delays. Particular areas of focus during 2017-2019 will be aligned to national and local priorities as follows:

- Improving 4 hour ED access performance and ambulance response times by implementing system transformation to reduce attendances and improve timely discharge
- Reducing cancer and diagnostic waits by ensuring that capacity and demand is matched and efficient systems are in operation
- Reducing the number of patients with learning disabilities admitted to hospital by undertaking regular care and treatment reviews, provision of crisis intervention services and alternative community based provision
- Improving staff health and well-being by ensuring that initiatives are implemented that support musculoskeletal and mental health and healthy eating
- Supporting safe and proactive discharge by developing transfer to assess services and improving provider to provider communication and collaboration
- Reducing impact of serious infections (in particular sepsis) by ensuring appropriate use of early warning tools, staff training and antibiotic therapy
- Improving services for patients with mental health needs who attend ED by supporting mental health and acute hospital providers, working together and with partners (primary care, police, ambulance, substance misuse, social care, voluntary sector) to ensure that people presenting at ED with primary or secondary mental health needs have these needs met more effectively through an improved, integrated service offer
- Reducing avoidable emergency admissions by ensuring effective advice and guidance is available to referring clinicians and improved GP access
- Maximising choice by ensuring that all first outpatient referrals are able to be received through ERS
- Preventing ill health by risky behaviours (alcohol and tobacco in particular) by ensuring that staff have appropriate training and confidence to assess and where appropriate offer brief intervention training and onward referral or treatment
- Improving the assessment of wounds that not healed within 4 weeks by implementing full wound assessments
- Improving access to and transitions between mental health services for children and young people by supporting sending and receiving services to work collaboratively and ensuring that individual transitions meetings are held

- Increasing personalised care and support planning by staff training to support increased patient activation
- Increasing the uptake of personal health budgets and integrated personal commissioning by working in collaboration with our local authority colleagues to maximise the sustainability of the care market, in particular appropriately trained personal assistants
- Reducing the number of 999 calls that result in conveyance to ED and increasing the number of 111 calls that result in referral to services other than ED by appropriate training and support for frontline staff and provision of effective alternative pathways
- Reducing clinical variation by using intelligence from RightCare and Centene to identify opportunities for improvement
- Improving early cancer and dementia diagnosis by appropriate staff training and access to diagnostics and specialist services
- Reducing mortality and improve quality of life for people with long term conditions by early diagnosis, a proactive approach to prevention and targeted support for individuals and communities at highest risk

Appendix 1

NHS Operational Planning and Contracting Guidance – General Practice Forward View: summary of schemes released

Introduction

The General Practice Forward View (GPFV) was published in April 2016 and sets out a plan with significant investment to support and transform general practice. The NHS Operational Planning and Contracting Guidance requires CCGs to submit a GPFV plan to NHS England by 23 December 2016 encompassing specific areas outlined in the GPFV. Plans must reflect local circumstances and as a minimum set out:

- how access to general practice will be improved
- how funds for practice transformational support will be created and deployed to support general practice
- how ring-fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, will be deployed

NHS England conducted a number of roadshows over the summer to engage with organisations in respect of the GPFV and to ensure organisations are aware of the roll out of the 82 schemes that form part of the GPFV. An update on the release and progress of these schemes was provided and a clear focus on improving access to GP services and delivering the GP Resilience programme was identified. It was also confirmed that for many of the other schemes further detailed guidance and specifications are awaited.

In addition the Planning Guidance suggests that “in their GPFV plans, CCGs will want to include a general practice workforce strategy for the local system that links to their service redesign plans”. For example, the plans could include:

- a baseline that includes assessment of current workforce in general practice, workload demands and identifying practices that are in greatest need of support
- workforce development plans which set out future ways of working including the development of multi-disciplinary teams, support for practice nursing and establishing primary care at scale
- commitment to develop, fund and implement local workforce plans in line with the GPFV and that support delivery of STPs
- initiatives to attract, recruit and retain GPs and other clinical staff including locally designed and nationally available initiatives
- actions to ensure GPs are operating at the top of their license, for example through use of clinical pharmacists in a community setting and up-skilling other health care professionals to manage less complex health problems
- actions which facilitate an expanded multi-disciplinary team and greater integration across community services to optimise out of hospital care for patients including access to premises, diagnostics, technology and community assets

Given the complex nature of many of the schemes outlined above, further complicated by differing timescales for delivery and varying funding mechanisms, and the amount of work involved, the CCG plans to work with other local CCGs to progress implementation of the GPFV. A working group has been established for this purpose which reports to the Primary Care Strategic Advisory Group.

The draft plan below outlines the relevant schemes and the CCG’s/local approach to delivery of the GPFV.

Summary of schemes

2016/17

Lead organisation for coordination/delivery	Scheme	Funding (£)	Information	Progress/action	Next steps	Deliver by
NHSE	**GP indemnity review**	£33m nationally (included in contract inflation rises in 2016/17 to reflect rises in the previous year – figure based on population)	To cover the associated increases for in-hours indemnity insurance with MDUs	Co-ordinated by NHS England First payment of scheme made in April 2016 to address inflation in 2016/17 (already in practice baselines)	Scheme to be reviewed in two years	N/A
NHSE/ CCG	**Vulnerable Practice Scheme**	£10m North Midlands = £601,337k Not applicable to any practices in NNE CCG	Programme of support to practices identified as 'vulnerable'. Vulnerable GP practices are identified as those rated by CQC as 'inadequate', those rated as 'requiring improvement' where there is greatest concern, those assessed by local commissioners in need of support in view of local intelligence; or practices that self-declare.	N/A	N/A	N/A
NHSE/CCG	**GP Resilience Programme**	£2.579m over four years from 16/17 for North Midlands £1.453m across Derbys/Notts NNE CCG 2016/17 allocation = £42k Next 3 years £21k per annum	Same criteria as vulnerable practice scheme and no match funding required, although practices must provide 'matched commitment' Support can be delivered by local resilience teams or pools of experienced clinical and managerial staff to help practices implement changes that will support practices to become more sustainable and resilient	1. Application submitted to NHSE Nov 16 and supported 2. Programme of support to be developed to be delivered to all NNE CCG practices in response to practice-identified need 3. MoU and reporting mechanisms developed for practices to agree	1. Await funding release from NHSE 2. Implement programme of support	March 17

Lead organ-isation for coordinat-ion/delivery	Scheme	Funding (£)	Information	Progress/action	Next steps	Deliver by
				and sign		
NHSE/CCG	**Estates and Technology Transformation Fund (ETTF)**	Over £900m national capital investment (over 4 years)	Local ETTF schemes prioritised and submitted by CCGs on central portal 1. Hucknall - new build and extension £9,320,000 incl VAT 2. Calverton - extension £1,133,850 incl VAT 3. Giltbrook - new build £1,200,000 incl VAT 4. Lowdham - reconfiguration £540,000 incl VAT	1. NHSE 1st cohort approval in principle received for Calverton - £720,000 2. NHSE 2nd cohort approval in principle for Hucknall - £400,000	1. Due diligence process to be completed 2. Calverton scheme to be considered at the CCG's PCCC meeting on 1 December 2016 to secure approval to progress revised business case 3. Work to continue to identify optimum solution for Hucknall 4. Reporting to be advised by NHS England	March 17
NHSE/CCG	**Training for reception and clerical staff**	£45m over five years 2016/17 allocations made directly to CCGs NNE CCG allocation = £13k	Supporting reception and clerical staff to undertake enhanced roles in active signposting and management of clinical correspondence	1. Liaised with neighboring CCGs to ascertain potential to collaborate 2. Established an NNE Practice Managers task and finish group to identify training requirements and delivery options	1. CCG leads liaising to explore opportunities to collaborate to maximise investment 2. Develop detailed training programme for delivery	Proposal by Dec 16
NHSE/The Hurley Clinic	**NHS GP Health Service**	£19.5m (nationally)	The Hurley Clinic Partnership has been appointed provider of a NHS GP Health Service. The service is to improve access to mental	Commissioned by NHS England 1. Awaiting details to	Awaiting confirmed launch	Launch January 2017

Lead organisation for coordination/delivery	Scheme	Funding (£)	Information	Progress/action	Next steps	Deliver by
			health support for general practitioners and trainee GPs who may be suffering from mental ill-health including stress, depression, addiction and burnout.	determine delivery plan		

2017/18

Lead organisation for coordination/delivery	Scheme	Funding (£)	Information	Progress/action	Next steps	Delivery Timescale
CCG - Wave two site	**Improving access to general practice**	NNE CCG not receiving additional national funding for 2016/17 or 2017/18 but practices incentivized to review access through the CCG funded Care and Quality in General Practice service	The CCG will be working with GP practices during 2017/18 to ensure readiness to meet the access requirements as detailed in the planning guidance. This will include: 1. Working with practices to undertake an access audit of current delivery 2. Undertaking patient engagement to gain greater understanding of access needs locally 3. Developing a plan to meet the delivery requirements from 2918/2019 in partnership with GP practices 4. Reviewing existing approaches to improving access and learning from good/best practice models	1. Service specification in place to enable practices to monitor current access delivery (Care and Quality in General Practice) 2. Patient engagement commenced in Hucknall with roll-out to be scheduled	1. Review practice activity 2. Review patient feedback 3. Work with practices to develop a plan for delivery	April 2018
CCG/ Connected Notts	**Online general practice consultation software systems**	£45m over three years, from 2017/18	'Online consultation systems' to be purchased and deployed, starting in 2017/18.	1. Specific plans not required at this stage. 2. CCG has looked at 'AskMyGP' and 'WebGP' systems	1. Awaiting further details, including funding rules and system specification	2017/18 onwards

CCG	**Training care navigators and medical assistants**	£45m over five years NNE CCG allocation 2017/18 - £23k 2018/19 - £25k	Supporting reception and clerical staff to undertake enhanced roles in active signposting and management of clinical correspondence Developing and piloting medical assistant roles that support GPs **Care navigators also included in "Ten high impact changes" within GP Development Programme**	1. Notts CCGs are jointly scoping delivery of medical assistants to ascertain joint working with HEE, PCSET & LMC to develop and deliver (medical assistants)	1. Awaiting details of specification and monitoring arrangements in relation to medical assistants	Building on progress from 2016/17

Delivery timescale to be confirmed

Lead organ-isation for coordinat-ion/delivery	Scheme	Funding (£)	Information	Progress/action	Next steps	Delivery Timescale
NHS England/Regional Pilots	**Targeted investment in recruiting returning doctors pilot 2016 (TIRRDs)**	Approximately £15k per participating practice	Targeted at practices that have struggled to recruit to GP vacancies that they have held for over 12 months. Not applicable to NNE CCG at this stage	Co-ordinated by NHS England 15 pilots identified across region, 5 prioritised in North Midlands and approved.	Ongoing monitoring	NHS England to advise (monthly/ quarterly)
NHSE/CCG	**General practices development programme**	£30m nationally over three years	Tailored programme linked to releasing 'Time to care' – delivering the 10 High Impact Actions, freeing up time for GPs and improving care for patients (10 high impact actions includes care navigators)	CCG to identify a champion to lead on the promotion of this programme and to share best practice	Practices to be encouraged to apply/participate in this initiative	NHS England to advise (monthly/ quarterly)
NHSE	**Retained doctors scheme (2016)**	Bursary scheme based on annualised sessions	Incentives to support GPs who might otherwise leave the profession to remain in clinical general practice (clarity provided that can be a mentor within existing practice – does not need to move to another practice)	1. NHS England communicating with practices 2. CCG communication circulated to GPs 3. Dr Mclachlan proposing establishment of Senior GP Fellowship scheme to HEE	Awaiting feedback of take up	NHS England to advise (monthly/ quarterly)