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NHS
Rotherham
Clinical Commissioning Group

# Rotherham response to the General Practice Forward View



Your life, Your health

## 1. Our vision for general practice within Rotherham

Plans and services of all commissioners and health and social service providers in Rotherham are prioritised by needs identified in our Joint Strategic Needs Assessment and the five key Rotherham Health and Wellbeing (H & WB) Strategic aims:

All children to get the best start in life
Children and young people achieve their potential and have a healthy adolescence and early adulthood
All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life
Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing
Rotherham has healthy, safe and sustainable communities and places

The CCG will work with practices to transform services over the next 3 years to achieve the following key outcomes:

- Improved consistency in access to general practice – aspiring to within 24 hours for an urgent appointment, within 5 days for routine appointments and the ability for working patients to have appointments at weekends
- A combined, collaborative workforce across primary, secondary and community care providing a seamless pathway for patients with GPs as the linchpin for care
- Patients able to self manage their conditions from home utilising technology to connect with healthcare professionals
- 200 additional years of life
- All patients will be able to access equivalent services
- We will increase the wider workforce within general practice to improve consistency in patient experience

## 2. Introduction

Rotherham Clinical Commissioning Group (CCG) is responsible for commissioning the majority of health services for Rotherham patients, its overall strategy is available on the following link:

Primary care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing ongoing mental and physical health conditions and helping recovery

from episodes of ill health and injury (Ref: NHS mandate 2013). General practice plays a significant part in primary care and Rotherham CCG is committed to adhering to the principles of the NHS and how these are applied locally to best meet the needs of our population.

**The CCG has an overall vision of working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities. Primary care, defined for this purpose as care that can be provided out of hospital by GPs and the teams they employ, is at the heart of the NHS and will play a central role in achieving this aim by ensuring a co-ordinated service for patients, centred on the needs of the people that we serve and not silo organisations.**

We have fantastic examples of care in Rotherham but as our population increases and ages, it is critical that we respond by providing services in different ways to ensure we continue to sustain and improve during challenging times. Our key challenges within GP services include our own ageing workforce. Over 33% of GPs in Rotherham are due to retire in the next 5 years with limited availability of trainees to fill vacancies.

Rotherham CCG believe a significant step forward in this journey included bringing back, the commissioning of primary care (GP services) to Rotherham, this was achieved in April 2015. We are already seeing the benefits of being able to respond to local issues with local knowledge as often it is difficult to understand and respond to our population from afar but with our dedicated resources we are able to ensure this is achieved. To ensure good governance is maintained, the CCG has created an additional committee, Primary Care Committee which is chaired by a Lay member of the CCG and meets monthly in public to discuss all issues affecting general practice. Healthwatch, NHSE and a representative from the Health and Wellbeing Board are all committee members. The CCG will continue to work with NHSE who commission other primary care services i.e. pharmacy, optometry and dental to ensure these services complement each other and a section has been included in relation to how these services will work together.

This strategy is a key component to ensure we continue to mould our journey to deliver our priorities and what we will do to make the vision a reality. The strategy aligns with the Health & Wellbeing board priorities, the CCG's commissioning plan and the General Practice Forward View (GPFV) which recognises the pressure general practice is under following years of relative under investment and sets out a national programme to invest £2.4bn by 2020/21, tackling workload, building the workforce and stimulating care

redesign. The strategy should also be considered as an enabler for, and read in conjunction with the RCCG Better Care Fund (BCF) plan which is a pooled budget of £23 million for health and social care.

There are some considerable challenges to be overcome as we move towards delivery of our vision. 56.8% of our population live with health-related problems. More people are living longer with more chronic diseases and medical treatments are getting more complex and expensive. We have to deliver healthcare differently as funds are not growing to deliver in its current format which could increase inequity in funding if it is not managed effectively.

We have developed our strategy by reflecting on feedback from our patients and the wider primary healthcare teams at market place and development events held in June 2015, November 2015 and July 2016, as well as considering the challenges facing general practice. The following ten key principles have been identified to form the main elements of the general practice strategy and have been reviewed in light of the publication of the GPFV:

1. **Quality driven services** – providing high quality, cost effective, responsive and safe services
2. **Services as local as possible** - teams working in community in conjunction with GPs, in-reaching into secondary care where possible
3. **Equality of uniform service provision** - addressing inequalities in Rotherham's life expectancy – we will focus on health prevention and education to support these areas along with 'baskets' of services to ensure equality across Rotherham
4. **Increasing appropriate capacity & capability** – as well as continuing to recruit to our workforce, we will develop new roles to support the GP and nursing workforces to ensure patients are well managed along with innovative models to manage patients conditions e.g. telephone support and extended use of pharmacists. We will also educate the public to feel confident in using different health professionals for their care.
5. **Primary care access arrangements** – ensuring our access to general practices meets the needs of our population
6. **Maximised use of integrated / aligned care pathways** – new models of care, taking a lead from the new Vanguard models and other good practice across the NHS

7. **Self care** – improved information including patient health portals, ability to monitor conditions at home/link to appropriate service when 'abnormal'
8. **Robust performance management** to provide assurance that safe and cost effective care is being delivered
9. Continuing our programme to **improve medicines management** with appropriate prescribing and reducing waste
10. **Engaging patients** to ensure patient pathways are optimised – to date engagement has been varied and the CCG is committed to finding alternative ways to ensure the patient voice is heard

Our interim strategy was developed in March 2015 and significant progress has been made in implementing these ten key principles. The GPFV however provides an excellent platform for implementing change at increased pace as funding streams are being identified to enable delivery of the programme. The 10 High Impact actions (actions contained within blue boxes) from the GPFV have been referenced in this document to make clear where these are incorporated.

## 3. Executive summary

Over the course of the next 4 years, RCCG will continue its strategy to invest in primary care as follows:

- Support the development of a Federation/LLP structure to enable practices to work at scale and ensure a sustainable general practice infrastructure - £94k has been released this financial year and will be invested in supporting this infrastructure.
- Continue to reinvest £1.94m monies released from PMS changes in the form of a quality contract for general practice and new local enhanced service schemes
- We will continue our strategy to support practices with increasing telephone consultation and delivering new methods of consultation
- We will continue to invest (current £3.4m) in local enhanced schemes, delivering care closer to home and improving the management of patients to avoid admission
- We have commenced and will facilitate the Productive General Practice Programme for all Rotherham practices by the end of March 2017
- Subject to funding, we will ensure practices are offered the opportunity to continually develop their nursing workforce and feel able to utilise new roles within

the practice e.g. pharmacists, physiotherapists, emergency care practitioners, associate physicians, mental health workers

- We will utilise resilience monies to ensure GP leaders are identified and upskilled to support their clinical colleagues in radical changes within practices
- We will ensure arrangements are in place for a 3 year programme to upskill reception and administrative staff to feel able to care navigate and deal competently with medical documentation
- The CCG will improve weekend access in 2017/18 by implementing a hub approach for routine appointments and clear standards within the quality contract specify practice requirements for availability of appointments. This will be built on as funding is released.
- We will continue our pilot of integrated working within one locality to inform the roll-out across 5-7 hubs during 2017/18
- We will implement our key IT enablers including, the local digital roadmap, telehealth, e-consultation, increasing uptake of patient online
- We will continue enhancing our social prescribing offer as this has evidenced significant improvements for patients and savings in practice time

RCCG interim general practice strategy comparison and actions following publication of the GP Forward View

| | Priority Area | RCCG delivery | GPFV | NHS England deliver | Additional RCCG expected actions |
|---|---|---|---|---|---|
| 1 | **Quality Driven Services** | • 4 year reinvestment plan<br>• Benchmarking<br>• Comparing practice quality and productivity<br>• Delegated responsibility for general practice<br>• New models of delivery | Investing £2.4 billion per year into primary care by 2020/21 – 14% real terms increase<br>Capital via the transformation fund<br>Review of Carr Hill<br>Consult re. indemnity costs by July 2016<br>£56m for practice resilience<br>£246m to support redesign of services in practices<br>Completing electronic prescribing<br>All clinical correspondence to be electronic and coded by 2020 | Anew national service for GP mental health<br>New workforce 2020 oversight group<br>Streamlining CQC oversight – reducing inspections<br>Successor to QOF – review 16/17<br>Simplified system for how GP data and info is requested<br>Improved payment systems<br>Accelerating paper free<br>Promoting best practice<br>Review of mandatory training and the impact of Increase | Facilitating practice resilience support<br>Facilitating redesign of practices |
| 2 | **Services as local as possible** | • New ways of managing patients:<br>➢ Telephone consultations, skype video consultations<br>➢ Utilising our wider workforce<br>➢ Integrating out of hours and urgent care | £900m investment for GP estate and infrastructure<br>18% increase in allocations to CCGs for IT and technology<br>£45m national programme for online consultations | New rules from Sept 2016 to enable NHS England to fund up to 100% of the costs of premises development with relevant caveats | 3 year bid for estate and infrastructure by end of June 2016 |
| | | Seamless services | IT actions to enable collaborative working including full interoperability across systems<br>IT to facilitate shared care planning, telephone<br>Enable appointments to be booked in different practices using different systems<br>Allows healthcare professionals to inform and update a practice through the sending and management of tasks<br>Advice & guidance platform on e-referral to allow 2-way conversations | Funding for wi-fi<br>Ability to access data and tools to understand and analyse demand, activity and gaps in service provision<br>National framework for cost-effective procurement of telephone and e-consultation tools | |
| 3 | **Equality of service provision** | • 'Baskets' of services<br>• Providers working together<br>• Focused health prevention measures<br>➢ Working with public health | At scale working in larger practice groupings | Roll out of access to summary care record to community pharmacy by Mar 2017 | Supporting LLP/practices to work together |
| 4 | **Increasing appropriate capacity and capability** | • Workforce plan<br>➢ Sufficient capacity and an appropriately skilled workforce<br>• Effective succession planning<br>• New workforce models<br>➢ More effective use of different | £206m for workforce measures<br>Targeted £20k bursaries in hard to recruit areas<br>250 new CCT fellowships<br>500 GPs attracted back to England<br>Minimum 5000 other staff working -3000 | 5000 additional doctors for general practice by 2020<br>Recruitment campaign<br>International recruitment campaign<br>Improving nurse training capacity<br>Measures to improve retention of | Supporting/facilitating transition to new models |

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| | | professions e.g clinical pharmacists, admin and clerical<br>➢ Engaged and empowered workforce<br>• Recruitment strategy<br>➢ Improved profile of Rotherham as a place to work<br>➢ Improved fill rates | mental health therapists, 1500 pharmacists<br>Pharmacy integration fund<br>Practice nurse development strategy<br>£45m to training current reception and clerical staff to navigate patients and free u GP time<br>New medical assistant roles<br>£6m in practice manager development<br>£3.5m for MDT hubs to develop wider workforce in GP<br>Flexible working incentives to reduce locuming<br>£30m releasing time for patients development programme | nurses<br>New standard contract measures to stop work shifting – access policy changes, onward referral relaxation, electronic discharges within 24 hours, outpatient letters no later than 14 days after appointment, responsibility remaining with hospital to discuss results post discharge, 7 days medication on discharge<br>Rapid testing programme in 3 sites to review ways of better managing OPD demand<br>New automation software from 2017/18 | |
| 5 | **Primary care access arrangements** | • Review of arrangements and to pilot extended opening<br>• Provision of wrap-around services to support GPs | £500m by 2020/21 to enable extra capacity to GP services, including routine appointments at evenings and weekends alongside effective access to OOH and urgent care<br>Greater use of technology<br>Primary care access hubs<br>Implementation of 10 high impact changes | Automated appointment measuring interface to support capacity and demand modelling by 17/18<br>Minimum requirements –pre-bookable and same-day appointments | Await clarity of funding but hub direction of travel is the way forward. £3 per head is being identified as within CCG baselines to facilitate this in 2016/17 |
| 6 | **New models of care** | • Collaborating groups of practices to deliver care in the community<br>• New emergency centre<br>➢ Secondary and primary care clinicians working together | Nurses supporting LTCs<br>Mental health support in GP practices<br>Social workers in GP practices<br>GPs providing services in care homes<br>Social prescribing<br>MCP model – single whole population budget for primary and community services<br>Working at scale – practice groups or federations | Fit for work to reduce dependence on GPs for fit notes and advice<br>National champion for Social prescribing<br>Voluntary Multispecialty Community Provider contract from April 2017 to integrate general practice with community and wider healthcare<br>MCP care model framework<br>New blended quality & performance sceen to replace CQUIN and QOF at MCP level | Evaluate 'perfect locality' and roll-out if successful<br>Population based budget |
| 7 | **Self care** | • Education<br>➢ Patients confident to manage their condition(s)<br>• Social prescribing<br>➢ Signposting & support to manage their condition(s)<br>• Technology<br>➢ Proactive monitoring to enable fast response | Assisting patients in managing minor self-limiting illness themselves<br>National programme for supporting people with LTCs to self-care | National programme by Sept 2016<br>National enabling work to provide some functions at a national level & stimulate development of the market<br>Digital primary care maturity index<br>10% of patients using one or more online services by Dec 2016<br>Funding to support education and support for patients to utilise digital services from Dec 2017 | Implement the national programme |

| | | | | | |
|---|---|---|---|---|---|
| | | • Case management<br>➢ Clear plans of care | | Apps library to support self-care | |
| 8 | **Robust performance management** | • Performance dashboard to collate data<br>• RAIDR to ensure consistency | • | • | • |
| 9 | **Continued improvements to medicines management** | • 6 service redesign projects to improve prescribing<br>• Prescribing Local Incentive Scheme | • | • | • |
| 10 | **Engaging patients to ensure patient pathways are optimised** | • Effective Patient Participation Groups<br>• Condition specific focus groups | • | • | • |

## Steps to Make the Vision a Reality

There are the key enabling strands of work that underpin the strategy. These tackle the main issues and challenges facing general practice and will allow the CCG to turn the vision into reality. More detailed consideration of them is required in the short term to translate them into an implementation plan.

# 4. Context

## 4.1 Profile of Primary Medical Care in Rotherham

90% of all NHS contacts are with general practice.

There are around 1.5M GP consultations every year in Rotherham with each patient seeing their general practice 6 times per year on average.

Rotherham's resident population is estimated at 261,000 who are cared for by a total of 31 GP practices (as at September 2016) alongside a centrally based walk-in centre providing 14 hour/7 day access. At the present time, four GP practices in Rotherham are singlehanded compared to 27 practices with multiple GP partners or which are alternative providers.

| | |
|---|---|
| National average list size | 6287 |
| Rotherham average list size | 7182 |
| Number of patients per WTE GP | 2450 |

The CCG currently has 15 training practices and all Rotherham training places have been filled this year. This is important as training practices play a significant role in supporting new GPs and encouraging them to stay in the area once they are qualified.

With regard to type of contract there are:

23 Personal Medical Services (PMS) practices

7 General Medical Services (GMS) practices

1 Alternative Provider Medical Services (APMS) practices (covering 3 practices)

A Limited Liability Partnership (LLP) is in place which enables all 31 practices to work collectively and be able to respond to the demands facing general practice. The LLP currently has a GP leading on a very part-time basis and a one day per week Practice Manager supporting its administrative arrangements primarily. It is not currently equipped to support the delivery of the GPFV and work is ongoing in consulting GPs with the shape of a structure which can ensure Rotherham develops primary care to deliver.

At minimum, the LLP needs to create a community interest company or identify a host practice which would be able to hold contracts on its behalf, the LLP needs legal support to determine and agree the right vehicle for Rotherham. We anticipate that this would consist of a session with GPs (November PLT) and supporting the management team to put the legal arrangements in place.

**The LLP requires a management structure which is currently lacking of at least a 1 day per week GP to provide clinical leadership, 1wte Band 8b Project Manager (to deliver the direction of travel identified by the GP lead and its members), 1wte Band 7 Development Nurse (supporting practices with identifying and responding to nurse development requirements. In the longer term, the LLP will need to fund these roles on a substantive basis.**


## 4.2 Current General Practice

Whilst media attention is often focused on the challenges facing the heath service, it must be acknowledged that there is excellent work taking place in general practice, day in, day out to ensure patients receive high quality care. As a principle, it was agreed that these should be protected and preserved when thinking about any future model of care. They included:-

- GPs holding longer term contracts that build real commitment to the local Community and/or configuring under different forms e.g. multi-specialty community Providers, accountable care organisations
- Registered list that leads to continuity of relationships and care•
- GP acting as the coordinator of care between other health and social care settings
- Appetite for innovative ways of working
- Keen to learn new skills through educational programmes designed by local GPs
- Practices beginning to work together to share good practice and learning

- Secondary to primary care Local Enhanced Service agreement where practices have agreed to work together to provide services for all patients when individual practices have not got capacity
- The delivery of high quality care e.g. anticoagulation, where the increased service quality being delivered is outstanding.

General practice incorporates the essential values of personal care, continuity of care, generalist skills and a holistic approach to patients. Prevention and the treatment of ill health both have equal priority.

It is also important to acknowledge the teams that support the clinical professionals such as practice managers, reception staff and apprentices without whom our services would not be fully functional.

### 4.3 Changes to Contractual Arrangements

NHS England have nationally lead changes to the payment arrangements for general practice to apply the principles of equitable funding. The aim of which is to by move to a position where all practices (whether GMS, PMS or APMS) receive the same core funding for providing the core services expected of all GP practice. The review of PMS funding, determined that any additional funding above this must be clearly linked to enhanced quality of services or the specific needs of a local population. Also that practices should have an equal opportunity to earn premium funding if they meet the necessary criteria.

On a positive note, the funding released from the PMS review has remained within Rotherham and will be reinvested back into Rotherham primary care over the 4 year period described to achieve the following:

- Reflect joint area team/CCG strategic plans for primary care – supporting an integrated approach to delivering community based services
- Secure services or outcomes that go beyond what is expected of core general practice – ensuring premium funding is tangibly linked to providing a wider range of services or providing services to higher quality standards
- Help reduce health inequalities
- Give equality of opportunity to all GP practices

- Support fairer distribution of funding at a locality level

The GMS monies released from MPIG removal will not remain within Rotherham and it is understood that they will be reinvested into the 'global sum' for general practice (equitable funding level).

The Rotherham approach to PMS reinvestment has included the development of a quality contract which consists of 14 standards:

Improving access to General Practice
Demand management
Health improvement
Screening
Health Protection
Cancer Referral
Best Care Long Term Conditions
Exception reporting
End of life care
Patient safety
Membership engagement
Mental health, learning disability and military veterans
Carers
Patient experience

The quality contract is being phased in to the timescale of the PMS disinvestment and will therefore be fully in place by April 2018.

## 5. Our Key Priority Areas

### 5.1 Quality Driven Services

A high-quality service can only be delivered if there is a focus on three key quality dimensions: clinical effectiveness, safety and patient experience. It is crucial that the economic challenge does not change this focus. We will, therefore continue to support innovation in clinical practice and develop pathways that improve effectiveness and that

enhance the patient experience as well as providing value for money. The CCG already supports protected learning time every 2 months, for all GP practices and sufficient time for localities to ensure they are clinically and professionally updated. There are four core components to this focus: quality, innovation, prevention and productivity. The CCG will continue to review benchmarking and learning from peers to support this agenda.

Funding for all practices should be equitable for delivery of service and also demonstrate value for money. Core contract activities will be remunerated in line with national agreements. Benchmarking information using nationally available data, comparing practice quality and productivity within our area and externally, will be used to ensure value for money.

We will look to achieve best value for money, driving efficiencies in the way general practice is delivered. The quality contract also provides the platform for defining more clearly the quality requirements from practices and relevant training and support is being provided (for example diabetes specific PLT, reception team training in relation to customer care, carers and dementia) to ensure practices feel sufficiently competent. Local practices have already embraced the opportunities to be more efficient in medicines management and prescribing with £1.8m savings in 2014/15, are fully supporting a waste campaign which includes practices taking more control of what is dispensed to their patients.

The CCG already undertakes quality peer review visits to all GP practices and has developed a framework to support practices where there are quality concerns co-commissioning principles. The Care Quality Commission (CQC) are undertaking quality visits of all GP practices during 2015/16 and as at September, only 6 practices have not been visited. The majority of practices have received a 'Good' rating, 4 practices to dates have received 'requires improvement', no practices have been identified as inadequate. On a revisit to one of the four practices, the CQC have amended their rating to 'Good'. The CCG will work collaboratively with practices where any required improvements are identified.

### 5.2 Services as local as possible

Our main aim is for general practice to sit at the heart of a patients care. Currently, when a patient requires secondary care intervention, care is handed over to the 'specialist' and

handed back once treatment is complete or where protocols exist for care to continue in the community. Often patients could be more appropriately managed by their GP who has a holistic understanding of the patient and therefore increasing used of shared care protocols is a key aim of this strategy. This fits well with planning guidance which identifies changes to outpatient follow-up to encourage discharge back to primary care as soon as is feasible. This is difficult to achieve when there are capacity issues therefore patient management will take on a variety of forms e.g. skype and telephone consultations and utilising our upskilled nursing workforce (cross reference to workforce 5.4 page 17).


Three important local plans which will impact on general practice are the community transformation plan (which will improve and expand out of hospital care provided by teams from Rotherham NHS Foundation Trust), Rotherham Mental Health Transformation plan which will increase the locality focus of mental health services provided by RDASH and the Emergency Centre which will provide state of art facilities for those requiring urgent care but will also redirect patients to using primary care where this is deemed more appropriate.

General Practice in Rotherham is already delivering a number of services which traditionally have been provided by secondary care. These include:

DMARD monitoring
Anti-coagulation monitoring
CEA monitoring
Suturing and complex dressings following procedures in secondary care

The intention is to continue this journey with a desire that with the practices having continuing responsibility for the patient, the requirement for follow-up care within secondary care, particularly after surgical procedures will significantly diminish. This is a significant change for both primary and secondary care and links to the requirement to ensure that primary care is sufficiently resourced to manage this commitment. Section

5.4, in relation to workforce describes how the CCG is working with providers to upskilled and have sufficient numbers to ensure the service is robust.

The CCG has also committed to the provision of 'social prescribing' to support patients requiring healthcare which enables GPs and other clinicians within practices to refer patients to other appropriate services for issues which whilst not directly clinical and have impact on their health and wellbeing. These include housing, debt, loneliness. Rotherham CCG was also provided with additional funding over the winter period to increase these schemes to families and carers.

## 5.3 Equality of Service Provision – Enhanced Services

GPs are contracted to provide "core services" (essential and additional) to their patients. The extra services they can provide on top of these are called "enhanced services" which are voluntary but, if taken up, often add to the quality of care. The CCG is committed to maximising the uptake of enhanced services and as part of the quality contract arrangements, it will be mandatory for practices (or to have appropriate sub-contract arrangements in place) to undertake all the local enhanced services considered core quality.

Enhanced services address gaps in essential services or deliver higher than specified standards, with the aim of helping the CCG to reduce demand on secondary care and other health services. Enhanced services expand the range of services to meet local need, improve convenience and extend choice. The total investment by the CCG in 2014/15 was £3.4m. The number and variety of schemes has increased over the years as local enhanced services have been developed and the local enhanced services which will be available to the whole Rotherham population from April 2017 are:

- Case management
- Anticoagulation
- Aural care
- DMARDs (Rheumatology monitoring)
- PSA
- Testosterone
- Suture removal

- Dementia
- CEA monitoring

During 2015/16, the CCG also encouraged practices to align with care homes across Rotherham to reduce the number of GPs visiting and improve the quality of care patients receive in care homes. All care homes are now aligned and weekly clinic/ward visits take place in order to manage patients conditions proactively. Early indications are showing a reduction in non-elective admissions from care homes.

In addition to this the CCG also has Local Incentive Scheme (LIS) which ensure that practices remain up to date with current practice. Rotherham CCG spends on average £4 per head of population. Rotherham is looking to utilise the funding opportunities from GPFV to increase this spend via additional educational and support in the form of:

The Productive General Practice programme for every practice
A programme of education for reception teams which will include care navigation and enhanced medical documentation support for every practice
Releasing GP leaders to make this significant change within practices
Developing Practice Managers to lead different business models in the future
Work with the ATP programme to support practices to host and then employ Physician Associates

The CCG is responsible for providing services for all Rotherham patients so developing the capacity to help all eligible patients will be an important consideration when planning future expansions of general practice services.

## 5.4 Increasing Appropriate Capacity and Capability


Fewer trainees are choosing general practice when they qualify and more GPs are choosing to retire earlier than normal retirement age. Rotherham has a good track record of attracting trainees, predominantly due to a good reputation for education but also the proximity to Sheffield. The latest workforce report for Rotherham is attached however this

is not fully inclusive as 7 main sites are missing and 4 practices within the report are branch sites.


NHS Rotherham CCG
GP Workforce Q1 April

Overall the report identifies that whilst currently we are slightly better than the Yorkshire and Humber average in relation to numbers of GPs and qualified nurses, we have a very worrying age profile of 26% of GPs, 22% of Practice Nurses and 34% of Practice Management being aged 55 or over.

Until fairly recently, practices were almost exclusively run on a GP partner basis, with occasional use of locums to cover study, sickness or holiday absence. More recently, there has been a significant growth in locum and salaried GPs, with fewer being attracted to the partnership model. The primary care workforce is changing. An increasing number of GPs are working outside the traditional model with more sessional and locum GPs and utilisation of different professions, more typically nursing to undertake traditionally GP roles. The gender balance between male and female doctors is also changing which is also impacting on workforce availability as traditionally female GPs have chosen to work part-time.  The success of the CCG will be dependent on its ability to embrace, utilise and develop potential across its whole clinical and non-clinical workforce. It will also work with provider organisations and the local authority to harness the skills of the wider primary care health and social care teams including district nursing, social work, pharmacy, podiatry, physiotherapy and others. A workforce plan is in place and incorporates the national 10 point plan – Building the workforce – new deal for GPs. This includes our plans for training administrative staff, upskilling unqualified staff and developing our Practice Managers to have the skills to lead new organisational formats.  Rotherham participates in the South Yorkshire and Bassetlaw Workforce Group and is committed to the STP plan for primary care which has been co-produced by the group and Health Education England.


Workforce plan
updated September 2(

10 practices have committed to the student nurse training scheme and 8 practices now have apprenticeships. 10 practices have shown an interest in mentoring newly qualified student nurses as there is commitment to capturing the workforce early in their career instead of general practice being seen as somewhere secondary care or community nurses go later in their career. Unfortunately a bid for funding support for clinical pharmacists was rejected in 2015. Four practices have already directly employed clinical pharmacists in their new workforce models, undertaking medication reviews and long term condition management and we will support the LLP to bid for a further opportunity this year to be able to extend this workforce into more practices who are keen to adopt these new roles.

Whilst some practices have recognised the need to continually train and develop staff to enable nurses and other clinicians to feel empowered and competent to take on new roles, there are practices who have not felt able to fund and/or release time for training to the level required for the cascade of duties from GPs. All practices in Rotherham recognise that the traditional GP practice model has to change and many are already embracing the benefits of skill mix changes to fully utilise the skills of qualified and unqualified nurses. However, there are practices who require support with this both financially and physical presence as primary care does not have the benefit secondary care has of education teams co-ordinating training. It is therefore proposed to use GPFV funding for the LLP to employ a Band 7, experienced Practice Nurse to provide leadership and ensure General Practice nursing teams across Rotherham are equipped to deliver the current and future primary care agenda. This role will also provide an initial point of contact for future work developing stronger links between all nursing teams across the Borough. It is recognised that collective leadership is not present across general practice nursing teams and the value of experienced able leadership is widely recognised and well documented. The workforce report details the current risk we have of 22% of the workforce who are able to retire and have the most knowledge, it is critical that we ensure the current workforce is upskilled along with the work already taking place to attract newly qualified nurses into general practice. As detailed above, we have 10 practices providing placements for student nurses to develop the primary care workforce of the future and also intend to extend training to offer opportunities to secondary care nurses who longer term would wish to work within primary care but as they are normally specialty specific, do not meet the criteria for application. As our plan as an STP is to reduce bed bases and manage patients more within an integrated community environment, we need to start to enable

current secondary care staff to access training as in reality it takes at least 2 years for staff to be fully confident in primary care as there is such a breadth of knowledge to gain. It is proposed that the Band 7 nurse takes responsibility for this longer term plan.

Whilst the CCG provides regular learning events and release time, it is considered that this will not be sufficient for the upskilling described above. Whilst the CCG would like nursing staff to aim for diploma level it is acknowledged that this may not always be feasible and therefore the Band 7 would work with each practice's Lead Nurse to ensure there was a skills matrix for their team which includes succession planning. The role would support closer working between practices to share resources and other initiatives and support practices nurses through nurse revalidation together with nurse development. Additionally the role would be expected to contribute to the short, mid and long term planning for the development of primary care. The CCG requires funding for 1 WTE B7 nurse plus course and release time.

We already have a significant number of high quality, committed and dedicated administrative staff who support and care for our patients. But we recognise that their roles could be enhanced to provide more support whilst also enabling this workforce to be more empowered and therefore more likely to be retained. We will utilise GPFV monies to facilitate training sessions in relation to care navigation and medical documentation along with customer care, dementia and carer awareness. After exploring different options, we are working with colleagues across the STP footprint to deliver this training at scale to provide the most benefits.


**The CCG has considered piloting the use of Emergency Care Practitioners within its model but this would presently mean ceasing one scheme to commence another and there is no agreement to ceasing any of the current schemes which are working hard to reduce admission to hospital (social prescribing, care co-ordination centre, rapid response service). The Emergency Care Practitioner model provides a home visiting service on behalf GPs/ANPs to release capacity in practice and also**

**undertake visiting much earlier in the day to ensure patients requiring admission are admitted timely as currently most home visits take place at the end of morning surgery therefore there is a pressure point in the system for ED and the ambulance service in transporting patients. There are successful pilots running locally and Rotherham would wish to participate in a pilot for the Emergency Care Practitioner model. It is anticipated that the cost of such a pilot will be in the region of £100k.**

**The CCG is also keen to pilot 'Physio First' to release GP capacity. There is already an established MSK service within Rotherham who could quickly mobilise a 12 month pilot which is estimated would free up 105 GP/ANP appointments per week in a locality. Patients would be redirected by reception teams to the in-house MSK clinic which will assess, treat (joint injections and physiotherapy if patient requires only 1 appointment), refer where appropriate. It is considered that this could make a significant difference to working arrangements within practices, making workload significantly more manageable. There is scope to mobilise this pilot by December 2016 if approval to go ahead can be achieved by the end of October. The cost of the pilot will be in the region of £90k to mobilise 'immediately' £75k to mobilise by the new financial year.**

The CCG has met with local universities regarding physician associate training and promoted this with practices. Key concerns remain in relation to the roles being paid at the same or even higher level than Advanced Nurse Practitioners who it is currently considered require less direction and are able to prescribe and order x-rays. The CCG undertook a workforce development session in 2015 with practices and an externally facilitated session with all GPs took place in September 2016. The CCG is also an active member of the Primary Care Workforce Group (South Yorkshire and Bassetlaw) and the STP plans for workforce. It is proposed that the CCG will work with the ATP regarding opportunities to support practices with training and recruiting to these new roles.

At the moment, health and wellbeing support within general practice is provided on an informal basis and needs to improve. The CCG is keen to implement the resources identified in GPFV to support GPs in relation to their health and wellbeing. The CCG will work with the LMC/LLP to understand the need for this support within Rotherham and actively pursue funding as it becomes available.

The CCG has training leads and spends time with new trainees identifying and promoting the different opportunities for work within Rotherham. These include portfolio careers enabling new GPs to have more varied roles by also working in secondary care or having a particular specialised interest developed.

Rotherham commenced a whole-scale programme of Productive General Practice in September 2016 via 3 cohorts of 10/11 practices receiving intensive support to release 'Time to Care'


| Cohort 1 | Thursday | Thursday |
|---|---|---|
| Week | 22/09/2016 | 29/09/2016 |
| Input | Group based learning session | Group based learning session |

Then there is a 12 week delivery model.* (extra week for half-term/Christmas / new year)

| Week | 1 w/c Mon 03/10/2016 | 3 w/c Mon 17/10/2016 | 5 w/c Mon 31/10/2016 | 6 Thursday 10/11/2016 | 7 w/c Mon 14/11/2016 | 9 w/c Mon 05/12/2016 | 11 w/c Mon 09/01/2017 | 12 w/c Mon 31/01/2017 |
|---|---|---|---|---|---|---|---|---|
| Input | Practice hands on session 1 | Practice hands on session 2 | Practice hands on session 3 | Group based learning session | Practice hands on session 4 | Practice hands on session 5 | Practice hands on session 6 | Group based learning session |

| Cohort 2 | Thursday | Thursday |
|---|---|---|
| Week | 13/10/16, 6 weeks in advance | (17/11/16) 2 weeks in advance |
| Input | Group based learning session | Group based learning session |

Then there is a 12 week delivery model.* (extra week for half-term/Christmas / new year)

| Week | *1 Friday 28/10/2016 | 3 w/c Mon 12/12/2016 | 5 w/c Mon 02/01/2017 | 6 Tuesday 17/01/2017 | 7* w/c Mon 30/01/2017 | 9 w/c Mon 13/02/2017 | 11 Thursday 09/03/2017 | 12 Thursday 23/03/2017 |
|---|---|---|---|---|---|---|---|---|
| Input | Practice hands on session 1 | Practice hands on session 2 | Practice hands on session 3 | Group based learning session | Practice hands on session 4 | Practice hands on session 5 | Practice hands on session 6 | Group based learning session |

| Cohort 3 | Tuesday | Thursday |
|---|---|---|
| Week | 1/11/16, 6 weeks in advance | 24/11/16, 2 weeks in advance |
| Input | Group based learning session | Group based learning session |

Then there is a 12 week delivery model.* (extra week for half-term/Christmas / new year)

| Week | 1 w/c Mon 05/12/2016 | 3 w/c Mon 09/01/2017 | 5 w/c Mon 30/01/2017 | 6 Tuesday 07/02/2017 | 7 w/c Mon 20/02/2017 | 9 w/c Mon 06/03/2017 | 11 w/c Mon 20/03/2017 | 12 Thursday 30/03/2017 |
|---|---|---|---|---|---|---|---|---|
| Input | Practice hands on session 1 | Practice hands on session 2 | Practice hands on session 3 | Group based learning session | Practice hands on session 4 | Practice hands on session 5 | Practice hands on session 6 | Group based learning session |

From previous programmes, this releases on average 10% of practice time as well as


supporting individuals to consider their individual practices to ensure they are as efficient as feasible.

Practice size and sustainability is an important consideration. Rotherham has historically benefitted from having high quality services provided by practices of different sizes. In May 2015 the CCG Governing Body took the view that as opportunities arise the CCG will work to encourage small practices to work closer together in order to provide more sustainable services. Since January 2015 to number of practices has reduced from 36 to 31 and work continues with the LLP to support practices unable to deliver certain services because of their scale. As detailed in section 4.1, the LLP requires more development and possibly to change its organisational form in particular to be able to contract on behalf of practices when a scheme is required across providers.

## 5.5 Primary Care Access Arrangements

Primary care access arrangements are set out in the GMS contract. This defines core hours as the period beginning at 8am and ending at 6.30pm on any day from Monday to Friday, except Bank holidays. The contractor must provide essential services at such times within core hours, as are appropriate to meet the reasonable needs of its patients. Practices offer a variety of systems for walk in access, telephone triage, same day and pre-booked appointments. Some practices close for one afternoon a month in order to have protected learning time however many increase their capacity during that week to ensure the same number of appointments are offered and our ambition is to ensure consistency across practices. Where practices are closed, arrangements are in place for patients to access the out of hour's service during this period.


All practices are able to text remind patients of their appointments and RCCG is currently trialling increased functionality with MJOG for patients to report blood pressure readings which has also enabled access for patients to text cancellations direct to the clinical system which is having significant success in the practices which are piloting this arrangement. A significant number of practices are achieving the target for online services.

It is acknowledged that access is one of the most significant concerns for the general public. As detailed below, the area requiring most focus is patient experience of making an appointment. From triangulating this data, we have commenced work with practices about their capacity for patients contacting their surgeries along with the service received once their call has been answered.

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Access / Satisfaction | | | | | | | | | | ED 3 | ED 2 | ED1 Clinical | | | | | | | | | |
| | Easy to get thru by phone | Usually see or speak to pref GP | Able to get speak / see s'one last time tried | Last app was conv-enient | Recep-tionists helpful | Exp of making an app as good | Usually wait 15mins or less after their apt to be seen | Satisfied with surgery's opening hours | Would rec'mend this surgery | Don't normally have to wait too long to be seen | Exp of making an app as good | Describe overall exp of surgery as good | Last GP saw/spoke to gave enough time | | Last GP saw /spoke to was good at listening to them | | Last GP saw /spoke to was good at exp' tests / t'tment | | Last GP saw/spoke was good at in'ving them in decisions about their care | | Last GP saw/ spoke to treat them with care / concern | |
| | | | | | | | | | | | | | GP | Nurse | GP | Nurse | GP | Nurse | GP | Nurse | GP | Nurse |
| National Avg | 73 | 59 | 92 | 92 | 87 | 73 | 65 | 76 | 78 | 58 | 73 | 85 | 87 | 92 | 89 | 91 | 86 | 90 | 82 | 85 | 85 | 91 |
| CCG Avg | 70 | 59 | 92 | 92 | 87 | 70 | 70 | 76 | 77 | 63 | 70 | 85 | 88 | 92 | 90 | 91 | 88 | 89 | 84 | 85 | 87 | 90 |

As can be seen above, Rotherham are in line with the national average for ED1 and 2 but continuing to have difficulty with ED3, experience of making an appointment. We have focused on improving this area and access is a key standard in the new quality contract and from April 2017 all practices have committed to the following:

1. Practices will offer sufficient capacity to achieve
    a. Urgent access within 1 working day
    b. An appointment for patients within 5 days when their condition is routine.
    c. Follow-up appointments within a two day window of when the clinician identified i.e. if a 1 month follow-up, the appointment offered will be no more than 1 month and 5 working days.
2. It is a requirement that there is a minimum of 75 contacts per 1000 patients per week. Contacts may be provided by a GP (or training GP) and/or Nurse Practitioner (who is qualified to diagnose) and may be face to face or by telephone (triage followed by face to face consultation will be deemed as one episode).
3. Practices are required to have reviewed their capacity and demand and to ensure they are resourcing to meet this demand. This includes:
    - provision of capacity in alternative ways e.g. virtual (telephone) and using alternative roles.
    - 10 bookable sessions (am/pm)
    - offer access to both male and female clinicians.
4. Offer pre-bookable appointments 1 month in advance at main sites where clinically required.
5. Ensure acutely ill children under 12 are assessed by a clinician on the same day
6. Accept deflections from Yorkshire Ambulance Service (YAS).
7. Provide an in hours home visiting service for those patients presenting with an urgent clinical need requiring a home visit who live within the practice boundary but are registered with a practice outside of Rotherham CCG Boundary in accordance with GP choice requirements with associated payments (currently £60 per home visit). It is not anticipated that demands for such visits will exceed one per month.
8. Improve on patient survey measures

Mobilisation meetings took place individually with practices in June and July to ensure they will be able to meet these requirements in the required timescale. This standard will enable us to have the platform for using the Apollo tool in future to ensure capacity is increased

beyond the requirements detailed in the quality contract to ultimately deliver 30 minutes additional general practice availability per 1000 population.

Integration with GP out-of-hours providers and other urgent care services will help to reduce duplication and confusion about how best to access urgent care. Rotherham CCG has committed to capital funding to build a new emergency centre on the Rotherham Hospital Foundation Trust site. Building work has commenced with a completion date in July 2017, along with significant pathway work between primary and secondary care clinicians to ensure pathways are as seamless and effective as possible. Currently, Rotherham has 7 day access to general practice via the Walk-in Centre. This arrangement will be continued for patients requiring urgent primary care within the new Emergency Centre arrangements however it is acknowledged that there is a gap of provision of routine access at weekends presently and in the future Emergency Care model. As part of this, work is ongoing in relation to the creation of three hubs (North, South and Central) to enable patients with commitments within the week, to access general practice at the weekend in addition to the current arrangements of extended access (morning and evening weekday**). It is proposed to have this arrangement in place in time for Winter 2016 utilising the £3 per head funding identified within baseline and enhancing the directed enhanced service which is currently 21 practices provide 91.3 additional hours outside of core working. The proposal for additional working at weekends will provide an additional 21 hours per week.**

Work is also continuing to improve the escalation arrangements across Rotherham and ensure there is clarity of the required actions which can be taken in primary care to support e.g. supporting escalated discharge, ensuring all alternatives to admission are explored.

### 5.6 New Models of Care

In October 2014, an alliance of NHS organisations published the Five Year Forward View (5YFV). A significant element of this strategy is to review the local healthcare system to consider different models of delivering healthcare. Different variations of the models are now being piloted. Greater Manchester health and social care budgets are now devolved to the region's councils and health groups enabling local control over how budgets are allocated and with a main purpose to pool resources to improve out of hospital care. In March? 2016 NHS England announced that as part of the 5YFV a sustainability and

transformation plan on a wider than place footprint to understand the major local challenges, how these are expected to evolve in the next 5 years and emerging hypotheses for what is driving the gaps and action required. Rotherham is included within the South Yorkshire and Bassetlaw footprint for this plan. Primary care is clearly fundamental within the plan.

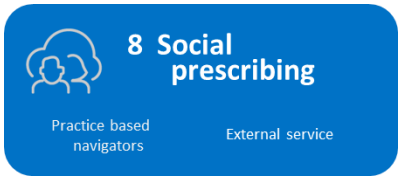
As outlined in 5.5, the CCG has already committed to a new emergency centre which is based on a partnership between urgent care providers in Rotherham and best utilising the different skills of clinicians with primary and secondary care training. The CCG has also committed to transforming community services and already seen significant improvement to out of hospital care, focus is currently on the following:

- Better quality community nursing services
- Supported discharge and admission prevention
- Enhancing the Care Co-ordination Centre
- An integrated out of hours service

We have commenced a pragmatic pilot in July 2016 of integrating community, mental health, social care, palliative care and social prescribing teams further and also includes the availability of secondary care specialists in primary care settings. This enhanced care will be provided in the home setting regardless of place of residence meaning those people who live in care homes will be able to access enhanced community and home based care. An effective case management Local Enhanced Service is already in place providing effective management of more than 12,000 patients who are at highest risk of hospital admission. Rotherham has also aligned care homes in Rotherham with general practices to strengthen relationships and improve continuity of care. Almost all care homes are aligned with 1 practice although the bigger homes have more than 1 as it would not be feasible for 1 practice to manage on their own. Practices are required to provide additional input to the care home to ensure there is a proactive instead of reactive management of patients which in the early stages is starting to show reduced admissions to hospital. Those practices with access to clinical pharmacists are also using these new roles to review medicines with the care homes and support the management of long term conditions.

### 5.7 Self Care

The aim of self care is to prevent patient's conditions from deteriorating to facilitate them being able to remain at home, in familiar surroundings but with the knowledge that their condition is well managed. As well as the changes outlined above, which facilitate the most effective arrangements for long term care, patients and carers will be supported to take control of their long-term conditions through a variety of different ways. Case management and social prescribing are already in place to support patients. Community transformation projects will also refocus community nursing and social work time to input into patient reviews so all the patients needs are considered.




The CCG is also piloting the use of technology to assist patients to manage their conditions for example blood pressure monitoring at home with results reported directly into the GP to take action where results are abnormal. The results of the pilot are currently being evaluated and it is hoped to roll-out self-monitoring by the end of the financial year.


Education will be a key component to self care, to empower patients and their carers to manage their conditions and to take a more active role in consultations and decisions about their care. Practices are able to access Health Trainers but we know that to date, success in improving patient attendance and adherence has been patchy e.g. uptake for cardiac rehabilitation and we must work harder to devise innovative ways of reaching our population. This area is also now being considered as part of the wider work of the STP as detailed in section 6.3.

Rotherham is keen to implement e-consultation and bid for funds in the ETTF however since bidding it has been announced that an alternative funding scheme will be released in the near future. This scheme will be prioritised to this timescale.

As detailed in Appendix 1, Rotherham has bid for funds to enable remote consultations with patients and enable patients to gain confidence in managing their conditions.

Rotherham is also always horizon scanning and exploring smart inhaler concepts which has current positive evidence of reducing eacerbations and 50% improvement in inhaler useage.

### 5.8 Robust Performance Management

As a CCG with delegated responsibility for GP commissioning, we have agreed trajectories for patient survey results with NHS England for the following three outcomes:

1. ED1 Satisfaction with quality of consultation at the GP practices
2. ED2 Satisfaction with the overall care received at the surgery
3. ED3 Satisfaction with accessing primary care

In addition to this, the CCG has developed a performance dashboard that provides the primary care committee with an effective tool for high level monitoring of general practice key performance indicators. Data alone is not an indication of poor service provision however this enables the primary care committee to focus attention on practices that are outlying to ensure that the primary care team are triangulating with other local intelligence to take the necessary steps and provide the committee with an appropriate level of assurance.

As each practice has been quality visited by the CQC during 2015/16, the programme of quality visits normally undertaken was suspended in 2016. Instead, as part of the quality contract work, mobilisation meetings have taken place with each practice to understand practice readiness for implementing the standards. The standard of mobilisation plans received has been very good. The baseline data for the standards is being added to the performance dashboard as it becomes available (ie as each standard is signed off). There are clear key performance indicators for the quality standards and an action plan within the mobilisation plan for addressing any shortfalls.

This also supports the published commissioning and quality principles for primary care. These identify the processes which will be followed in circumstances where the key performance indicators are not being achieved.

### 5.9 Continued Improvements to Medicines Management

The CCG is responsible for all GP prescriptions issued by its member practices. In 2014/15, the CCG spent £45.2 million on prescriptions and on commissioned services (nutrition and continence). The CCG is focused on ensuring all patients are receiving the right medications, at the right time, to date efficiency savings of over £1.8m have been achieved. A Prescribing Local Incentive Scheme commenced in 2014/15 and is reviewed regularly to ensure more effective practice is achieved.

The CCG also has a minor ailment scheme in place which will be reviewed again this year and provides the ability for patients to be redirected to pharmacies for medicines not requiring prescription. It is also the intention to invest in technician support for practices to release GP time and ensuring patients medications are regularly reviewed to prevent wastagel

### 5.10 Engaging Patients to Ensure Patient Pathways are Optimised

Rotherham CCG is committed to active and meaningful engagement with all its patients and potential patients Link to engagement and communications plan.

Patient Participation Groups (PPG) have been in existence for several years; the changes to primary care commissioning will mean that the CCG can more effectively:

- Work with practices to ensure that wherever possible, practices have an active PPG, operating to acknowledged good practice (Link to NAPP website)
- That PPGs are supported through the PPG Network with information, shared good practice, and the opportunity to consider wider, cross Rotherham issues

However, PPGs are only one mechanism for patient and public engagement and experience. The CCG also aims to extend engagement, and work with a variety of organisations to improve the patient voice for specific communities, both geographical

and communities of interest, for example people with specific long term conditions. If the CCG is to develop new ways of working; it will be vital to ensure that patient experience actively and meaningfully informs new systems and processes. This cannot be done in one way, and may involve any of the following:

- Condition specific focus groups
- Patient interviews and/or diaries
- Patient experience – from survey work, consultations, and other feedback (ie social media, complaints and issues raised with other bodies such as Healthwatch)

# 6. Enablers to Delivering our Strategy

## 6.1 Development of the primary care model( Federation/LLP)

As identified in section 4.1, Rotherham currently has a Limited Liability Partnership (LLP) in place which enables all 31 practices to work collectively and be able to respond to the demands facing general practice. The LLP currently has a GP leading on a very part-time basis and a one day per week Practice Manager supporting its administrative arrangements primarily. It is not currently equipped to support the delivery of the GPFV and work is ongoing in consulting GPs with the shape of a structure which can ensure Rotherham develops primary care to deliver.

At minimum, the LLP needs to create a community interest company or identify a host practice which would be able to hold contracts on its behalf, the LLP needs legal support to determine and agree the right vehicle for Rotherham. We anticipate that this would consist of a session with GPs (November PLT) and supporting the management team to put the legal arrangements in place.

The LLP requires a management structure which is currently lacking of at least a 1 day per week GP to provide clinical leadership, 1wte Band 8a Project Manager (to deliver the direction of travel identified by the GP lead and its members), 1wte Band 7 Development Nurse (supporting practices with identifying and responding to nurse development requirements. In the longer term, the LLP will need to fund these roles on a substantive

basis. It is hoped that once the benefits of federation working are realised that this will be extended to ensure general practice across Rotherham continues to develop by having central access to skills and resources to support practices.


## 6.2 Primary Care Estates and Premises

The CQC has a mandate for ensuring that essential standards of quality and safety are met.

However, the CCG undertakes quality visits which encourage practices to offer premises that:

- Deliver care in the right place with the right access
- Provide the patient with an environment that is fit for purpose
- Ensures easy access with clear sign posting
- Meets all statutory and mandatory requirements including compliance with all relevant disability, fire, health and safety legislation

Rotherham Metropolitan Borough Council are currently reviewing all ‘government’ estate to ensure it is fit for purpose and utilised appropriately across all services. Whilst this is welcomed by the CCG, many general practices are privately owned by partners in the practice and will not therefore be captured under this review. NHS England have recently procured site surveys of all GP practices to provide CCGs with an assessment of the current estate suitability for primary care. Whilst some estate issues have been identified, the estate is in fairly good order and other than a planned development there are no identified requirements for new healthcare premises. A strategic plan for Rotherham estates has been developed:

Rotherham Strategic Estates Plan - revised

The strategic direction is towards larger practices and configurations of practices, able to provide a range of general medical services, enhanced services and community based healthcare and on this basis the CCG has bid for funding to create seven neighbourhood/community hubs to enable fully integrated working arrangements. The outcome of this bid should be known in November 2016. The CCG has also bid for a number of other schemes detailed in Appendix 1 which will support the delivery of GPFV if successful.

## 6.3 Information Management and Technology

Technology emerging through our flag ship Sheffield City Region Testbed programme will drive innovation and act as a primary delivery vehicle for identifying, implementing and evaluating new technologies which meet local need. Other leading initiatives across South Yorkshire and Bassetlaw have included the significant collaboration between our local provider organisations, developing innovation in the way they work together across key clinical areas. The following planning assumptions and objectives have been defined by the technology workstream:

| Planning Assumptions | Objectives |
|---|---|
| 1. New Models of Care (NMC) will increase care delivered across provider networks/chains | 1. Implement an integrated digital health record, paper free at the point of care where information is captured only once only and widely available. |
| 2. Patients will experience care in more locations out of hospital, including home | |
| 3. Current paper based information will significantly limit implementation of NMC | |
| 4. Use of wearable tech to manage personal health and wellbeing will grow significantly over the next 5 years. | 2. Support citizens to use digital technologies to manage their own health and wellbeing and develop capability to connect information sharing with the primary care team |
| 5. The SCR Testbed and other leading technology pilots in SY&B will drive a significant increase in the number of people using digital technology to manage their own care | 3. Develop a culture with providers of working with innovators to embed technology as a key enabler to independence and reduce the risks of avoidable admissions, particularly for citizens with multiple LTC's |
| 6. As a consequence of all of the above, considerably more data will be generated than at present. | 4. Establish an advanced data analytics capability to support improvements in population health planning, risk stratification, at risk patient management and provide real-time analysis and decision support. |
| 7. Investment will use the outputs of the Digital Roadmaps and digital maturity assessment to inform investment needs that will have a net positive ROI and reduce/avoid costs | 5. Improve system wide operational efficiency, safety, patient experience and reduce duplication and waste by improving digital maturity to a level that supports care delivery as part of a more distributed healthcare system |

Rotherham is leading the way with a Clinical Portal (the Rotherham Health Record) supporting primary, acute and secondary care clinical information to be accessible from any web connected device and integrated into clinical systems. This requires further development time to ensure it is fit for purpose across the system and extend the portal to have to functionality which includes live updates of patient in secondary and urgent care settings, integration with the primary care systems, patient alerts to enable quicker response by primary care, supporting transfer of care, improving safeguarding arrangements, sharing case management plans. To undertake this additional work an investment of £136k will be required.

This enables community teams to support early discharge, locality management of patients, and GPs to have a detailed view of hospital information about their patients. Rotherham's Clinical lead for IT will also help drive forward the following STP wide projects:

- Synthesised health and wellbeing data could provide early warning alerts to patients and their GP's to allow early intervention avoiding hospital attendance and more costly treatment.
- Interoperability and data sharing between providers will improve the effectiveness of primary care with a full medical record and test results available at every consultation.
- Better integration of care provided across the patient pathway but with particular benefits in community care.
- Access to shared care records will revolutionise in and out of hours care, supporting access to relevant intelligence about patients when needed not when services are 'open for business'.
- Self care and better coordinated care, particularly for people with chronic disease and long term conditions, will mean more people will be managed in their homes or in the community without the need to attend hospital for admission or in outpatients.
- Digital health supporting new forms of consultation including phone, text message, e-consultation, video consultation and in some cases group consultations that could include other relevant health professionals and experienced patients for LTC management. This includes the development of accessibility to more senior/expert decision makers for support and advice as and when needed in order to maintain patient care outside a hospital environment.

- Greater integration for all the primary care team through coordinated administration systems, real time information exchange and single integrated healthcare record.
- Further support for sharing of sensitive information and speeding up referrals between public sector and voluntary, charitable and other community based agencies to meet the needs of individuals including police, fire, and employment agencies for example.
- Promotion of mobility of our workforce through increased deployment of mobile devices as well as supporting software in combination with Wi-Fi to support truly agile working within the patient's home as well as across health and care settings (e.g. comprehensive access to NHS Roam across all health and care sites within the SYB footprint).
- Active signposting of available services including on-line, telephone, video, better reception navigation and one to one consultation through on-line portals.
- Reducing DNA's through easy access to GP booking systems, reminders, patient self-recording.
- A reduction in paper work and other non-digital data transport will mean gains in operational efficiency.
- There are benefits from improved access to services for patients and citizens. This ranges from access to community services (e.g. via e-booking, telephone consultations, skype consultations, patient online) to access to secondary care via e-referrals.
- Better access to patients of expert decision support systems and help to navigate to lower cost health advice and delivery channels could reduce demand for primary care services.
- Supporting working across emerging GP federations through the integrated digital care record, shared practice administration systems etc. supporting greater efficiencies in the management as well as delivery of community based services.
- Greater integration of care means that it is more likely A&E or hospital admission will be avoided as deteriorating patients are picked up earlier with an appropriate intervention at that time.
- Remote monitoring linked to intelligent alerts means that patients, their carers as well as community based teams can focus on priorities knowing that they will be alerted if a patient starts to deteriorate. Alerts will enable specialist outreach teams (e.g. cardio, oncology, vascular) to be auto alerted on their patient events, such as

hospital admission, or deterioration. Local community/locality/hospice teams can be alerted if patients attend unscheduled care etc. which can support care planning, especially in relation to End of Life care pathways.

- Better tracking and scheduling of staff resource through geographical tracking technology used extensively by distributed service providers.

The CCG has also developed its IT strategy through consultation with GPs, RMBC and providers and the following identified the key areas where IT development will support the general practice agenda:

Practices should be able to access electronic information relating to their patients when they are treated in other parts of the health system. This particularly includes discharge and out patient summaries, pathology, diagnostics and care delivered in community settings. The Local Digital roadmap for Rotherham was submitted to NHS England on 30 June 2016, this sets out the five year vision and plans to achieve the ambition of 'paper free at the point of care' by 2020.

The CCG is supporting the roll-out of SystmOne to practices as the system of choice. At present 8 practices use a different system, EMIS web which to date has caused a barrier to linking practices. EMIS web and SystmOne have now agreed to facilitate interoperability between the 2 systems which will significantly support the CCG's strategy to facilitate the exchange of information between practices and other local providers, dissemination of guidelines, audit etc. whilst ensuring patient confidentiality is maintained, there are appropriate levels of data protection and access will be undertaken only on a need to know basis.

The CCG is also supporting practices to utilise the Electronic Palliative Care Co-ordination Systems (EPaCCS) which enables the recording and sharing of patient's preferences and key details about their care with those delivering their care. The systems support co-ordination of care and the delivery of the right care, in the right place, by the right person, at the right time. EPaCCS is the most effective way of providing an EOLC register for patients in Rotherham, enabling information to be seen and shared by all parties involved in a patient's care. A template has been developed and IT solutions put in place to enable the sharing of this information across primary care. GPs have a key part in the roll-out of an electronic EOLC register in Rotherham and linking this to the PMS premium will provide

an excellent incentive for the EPaCCS to be fully implemented and for patients to get real benefits from a co-ordinated and well informed approach to their care

The CCG is committed to ensuring that all patients have equal access to internet based services, in particular the ability to book appointments online and order repeat prescriptions which are then automatically forward to pharmacies for collection. 68% of practices are now live with EPS Release 2 functionality and 82% of pharmacies. Many general practices in Rotherham already offer the facility to online book but it is not well publicised and websites are not easy to navigate therefore the CCG has bid for funding to optimise websites and also enable provision of e-consultation.

Rotherham CCG had commenced roll-out of a primary care system (RAIDR) which supported risk stratification and also enabled practices to better understand their patient flows and compare their activity with their peers. The tool had a range of Dashboard covering areas such as emergency admissions, patients who regularly attend hospital, risk stratification, linkages between prescribing and activity data. There are also screens that will help practices with tasks such as flu vaccination, dementia diagnosis and data quality. Over time it will be possible to develop screens that will make reporting for Locally Enhanced Services to become less onerous. Unfortunately with provider changes at CSU level, Rotherham will no longer be able to access RAIDR after 2016 however work is ongoing with the new provider (EMBED) to utilise Dr Foster tools to deliver these requirements as a minimum and preferably an enhanced system.

During 2016, access to SystmOne from Care homes has been piloted with one GP practice and one care home to support the work which has been undertaken to align the practices with homes.

All GPs have been provided with laptops to support remote working.

GP to community e-referrals are currently being piloted and it is anticipated that roll-out will commence in Winter 2016.

We are working to achieve paper-light status with all practices by December 2016

We are working with practices to increase referrals via the E-referral service. System and capacity issues had meant that GPs within Rotherham had become frustrated with the

system and resorted to paper based referral. This has been addressed via mobilisation discussions and training and support offered.

15 practices are currently achieving the target of 10% of registered patients registered for 1 or more of the patient online services. NHS England representatives have been supporting practices and CCG representatives to increase use.

### 6.4 Access to GPFV funding

Rotherham is keen to increase the pace of delivering its interim strategy along with the commitments identified in the GPFV and recognises that funding is now being released to support delivery. As Rotherham had already embarked on setting up the Productive General Practice programme with the lead delivery partner for the North, this placed us in an excellent position to extend this across all Rotherham practices. We are also well positioned, from the work taking place in relation to the quality contract to quickly operationalise training for receptionists and prepare for 7 day working. Appendix 2 details clearly, Rotherham CCG requirements to be able to deliver this at pace.

### 6.5 Wider primary care contribution

The CCG is working with NHS England to ensure services both compliment and collaborate with each other. 7 day dental services are in operation via NHS 111, a number of emergency care attendances relate to dental care therefore these services are essential. The CCG will work with NHS England to develop Enhanced eye care services such as Ocular Hypertension monitoring, Low vision services, Minor Eye care Conditions (MECS/PEARS) Schemes in primary care providing care closer to home. We will also liaise with the LEHN on developing better services for patients with short waiting times and reducing cost.

As detailed in section 5.9, the CCG already works in collaboration with local pharmacies and the minor ailment scheme is currently under review to ensure it is as effective as feasible. A number of pharmacies also support the flu campaign across Rotherham.

## 7. Governance arrangements

The primary care committee is responsible for ensuring delivery of this strategy. The primary care committee programme of work has been updated to reflect the timescales and commitments detailed in this strategy. The programme of work is timetabled for quarterly review at the committee to ensure timescales are being achieved and also

support where there are any difficulties being encountered.  The programme of work is included at Appendix 3.

Appendix 1

| | Name of Bid | Date of Bid | What it is about | £ | Source of Funds | Outcome? |
|---|---|---|---|---|---|---|
| 1 | **Local Digital Roadmap (LDR) - *Various delivery bids ( names and schemes to be confirmed)*** | Expect to make bids in Autumn 2016. | *To support delivery of the Local Digital Roadmap (LDR) . Partners to the LDR are RCCG, TRFT, RDaSH, RMBC, Rotherham Hospice and Rotherham GP Practices. The LDR sets out a 5 yr. vision and plans to support the Rotherham health and care community in achieving the ambition of working "paper free at the point of care" by 2020. The bids put forward in Autumn 2016 will be for agreed programmes of work to support delivery of the LDR (subject to it being approved by NHSE) . The LDR was submitted to NHSE 30-6-16. Prioritisation and development of the delivery bids will be managed by the Interoperability Group.* | Not known at this stage. There is £1.4bn over 5 years nationally. [RCCG indicative 'fair share' would be c £6.3m/5yrs = £1.26m pa] | Driving Digital Maturity Investment Fund | Not known at this stage |
| 2 | **Connection of GP Practices to the CCG Network** | Jul-16 | *To implement network connectivity to the remaining GP practices that are without a connection to the CCG network was approved in July. These practices will be connected up using the Public Sector Network. We will also replace existing GP practice network connections with the same technology, which will decrease the overall cost of our current network provision.* | £100k | NHSE GP IT Capital | Bid was approved August 2016 |
| 3 | **Local Area Network Replacement Scheme** | Jul-16 | *The aim of this project is to replace local area network equipment (cabinets and data switches) in 20 general practice sites where the equipment is 'end of life', has run out of support and presents a risk to operation of IT Services in the GP Practice* | £211k over 2 years | NHSE GP IT Capital | Bid was approved August 2016 |
| 4 | **PC Replacement Scheme** | Jul-16 | *The aim of this project is to replace the PCs which will run out of warranty during 2016/17 and that are approaching the end of their useful life. The replacement PCs (100 units) cover 15% of the PCs currently deployed in General Practice in Rotherham.* | £509k over 5 years | NHSE GP IT Capital | Bid was approved August 2016 |
| 5 | **E-consultations** | Jun-16 | *Ability to provide sign-posting and electronic consultations* | £163k recurrent | NHSE Estates & Transformation Technology Fund (ETTF) although it has also been announced that there will be a separate fund for this so likely to be excluded from this bid | Late November 2016 - then will have 12 months from decision date to commit funds unclear of decision dates re. new e-consultation funds |
| 6 | **Remote Consultations** | " | *Ability to use video consultations with patients* | £35k Year 1 and then £24k recurrent | NHSE Estates and Transformation Technology Fund (ETTF) | Late November 2016 - then will have 12 months from decision date to commit funds |
| 7 | **Tele health** | " | *Supporting remote consultations within care homes* | £178k recurrent | " | " |
| 8 | **Web optimisation** | " | *Updating websites to help sign-post patients* | £30k | " | " |
| 9 | **Improved telephony** | " | *Improving telephone systems to improve access for patients and enable practices to stream calls more efficiently* | £107k | " | " |
| 10 | **Integrated hubs** | " | *Enabling works and IT requirements to create 7 integrated hubs across Rotherham* | £700k | " | " |
| 11 | **Clinical portal** | " | *Penetration testing, web security, stress testing and hardware to support clinical portal development.* | £30k | " | " |
| 12 | **Targeted investment scheme** | " | *Each CCG was allowed to put forward the practice which has been attempting to recruit GPs for the longest period - we put forward Woodstock Bower* | £14k plus recruitment support | NHSE GP Forward View | Approved 8 August 2016 |
| 13 | **Sustainable practice funding** | " | *12 practices identified interest in sustainable interest funding and the CCG bid for funding to undertake productive general practice* | £120k | " | Unofficially approved in July awaiting formal approval |
| 14 | **General practice development funding** | Aug-16 | *NHSE have approached RCCG to bid for early funding to enable all practices in Rotherham to receive productive general practice support during this financial year* | £133k | " | Imminent as the programme is expected to commence in September 2016 |

Appendix 2 - GPFV bids/funding requirements

| | Name of bid/funding requirement | Date of bid | What is it for and how does it help deliver the STP | Outcome | £ |
|---|---|---|---|---|---|
| 1 | Clinical Pharmacists | Anticipated December | To support practices to recruit and train pharmacists to undertake traditionally GP roles. Without the support monies it is difficult for practices to train the pharmacists as they require significant support (at least 6 months) to start to make an impact in the practice. | Without funding, it is difficult to get practices to commit to new models of workforce and they will continue to try for traditional GP roles | |
| 2 | Mental health staff | | To support practices to recruit mental health expertise to be able to redirect patients. Without the support monies, patients with mental health needs will continue to be seen by GPs. | Without funding, it is difficult to get practices to commit to new models of workforce and they will continue to try for traditional GP roles | |
| 3 | Associate Physicians | | To support practices to recruit and train associate physicians to undertake traditionally GP roles. Without the support monies, it is difficult for practices to commit to these roles as they require significant support (at least 1 year) to start making an impact in the practice. | Without funding, it is difficult to get practices to commit to new models of workforce and they will continue to try for traditional GP roles | |
| 4 | Receptionist training | Sent to baseline in September | To support practices to upskill reception teams to care navigate and/or manage medical correspondence on behalf of the clinical team | Awaiting further information in relation to delivery partners and will then set up a programme of events across Rotherham | £23k in budget |

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| 5 | Practice manager development | STP | To support practices to ensure Practice Manager are receiving appropriate development to manage practices in the longer term. Without these monies, it will be increasingly difficult and challenging for Practice Managers as the environment is changing so quickly. | Without funding, it is difficult to engage with practices to see the benefits of upskilling their workforce | **Monies for the programme** |
| 6 | GP development | Individuals apply | To provide leadership development to GPs | GPs are feeling overloaded and unable to engage in developments in the system | |
| 7 | GP 'stress' support | | Stress management support to improve retention and reduce absenteeism. At present, as independent contractors it is difficult for GPs to invest in such schemes and therefore their own health needs are not properly considered | It is understood that this will be received via NHSE performers route | |
| 8 | 7 day services | STP | Easier and more convenient access to GP services, with the option to book after 6.30pm weekdays and weekends. As GPs are not used to working weekends, it has been difficult to negotiate to date. Using learning from PM challenge fund schemes, it is hoped that additional funds will support engagement. | CCG commits to using £3ph for the remainder of the financial year to commence transition on the basis of £6ph from 2017/18 £7ph from 2018/19, £9ph from 2019/20 | **£6ph 2017**<br>**£7ph 2018**<br>**£9ph 2019** |
| 9 | Resilience/development funding | STP | Federation development /new models of care including staffing, legal requirements and supporting delivery of GPFV<br>GP leadership, enhanced Productive general | Without funding Rotherham is unlikely to have a functioning 'collective' of GPs | **£100k/2 years required**<br><br>£120k |

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| | | | practice package including release time to ensure delivery. There is already acknowledgement that the CCG needs a provider(s) to work on schemes to deliver these new arrangements. Support for embedding federation arrangements will be key to the delivery of the strategy. | | approved |
| 9 | General practice development funding | Aug 16 | A programme of embedding skills within practices to use 'lean' techniques to increase time for care and enable sustainable practices<br>Pilot of the Emergency Care Practitioner to understand the impact on time released from practices to concentrate on long term conditions<br>Extending and improving the clinical portal<br><br>Physio First pilot to release GP/ANP capacity within practices | Agreed – programme commences September 2016 | £214k approved<br><br>**£100k required**<br><br>**£136k required**<br>**£90k/75k dependent on mobilisation timeframe** |
| 10 | Nurse development strategy | National team | Upskilling practice nurses to manage long term conditions and undertake roles traditionally undertaken by GPs Without this support, the current divide between developing nurses and business as usual requirements is likely to increase. | Without funding and with practices stretched, it is unlikely that nurse development will be given the priority required to ensure we have a fit for purpose workforce. | |

| Key lead/s | Objective | Workstream and current RAG rating | 2015/16 | | | | 2016/17 | | | | 2017/18 | | | | 2018/19 | | | | 2019/20 | | | |
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| | | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Dawn Anderson | Quality driven services | CQC reviews - action plans, peer reviews | | | | | | | | | | | | | | | | | | | | |
| | | Continue PLT support | | | | | | | | | | | | | | | | | | | | |
| | | Benchmarking | | | | | | | | | | | | | | | | | | | | |
| | | Safeguarding actions | | | | | | | | | | | | | | | | | | | | |
| | | Devise and implement a local quality contract | | | | | | | | | | | | | | | | | | | | |
| | | Mobilisation meetings with practices | | | | | | | | | | | | | | | | | | | | |
| | | Support following CQC inspections | | | | | | | | | | | | | | | | | | | | |
| Jacqui Tuffnell & Rachel Garrison | Services as local as possible | Introduction of new LESs i.e. Phlebotomy, Minor Surgery, Joint Injections, Ring Pessary, CEA Monitoring, Dementia | | | | | | | | | | | | | | | | | | | | |
| | | Continued movement from secondary to primary care; Denosumab, Testosterone | | | | | | | | | | | | | | | | | | | | |
| | | Diabetes care; increased primary care involvement | | | | | | | | | | | | | | | | | | | | |
| | | Pilot of integrated working at locality level | | | | | | | | | | | | | | | | | | | | |
| Rachel Garrison | Contracting | Contracting of LESs for General Practice and Optometry | | | | | | | | | | | | | | | | | | | | |
| | | Review and update of LES service | | | | | | | | | | | | | | | | | | | | |

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| | | specifications | | | | | | | | | | | | | | | | | | | | | | |
| | | Contract Variations | | | | | | | | | | | | | | | | | | | | | | |
| Jacqui Tuffnell, Dawn Anderson & Rachel Garrison | Equality of service provision | Basket review and implementation | | | | | | | | | | | | | | | | | | | | | | |
| | | Care home alignment | | | | | | | | | | | | | | | | | | | | | | |
| | | Productive General Practice Programme | | | | | | | | | | | | | | | | | | | | | | |
| Jason Page, Jacqui Tuffnell & Dawn Anderson | Increasing appropriate capacity & capability | Workforce plan | | | | | | | | | | | | | | | | | | | | | | |
| | | Pharmacists | | | | | | | | | | | | | | | | | | | | | | |
| | | Associate Physicians; encouraging practices to provide training places | | | | | | | | | | | | | | | | | | | | | | |
| | | Technology | | | | | | | | | | | | | | | | | | | | | | |
| | | Supporting practice sustainability | | | | | | | | | | | | | | | | | | | | | | |
| | | Student nurses; encouraging practices to provide training places | | | | | | | | | | | | | | | | | | | | | | |
| | | Newly qualified nurses; encouraging practices to provide posts | | | | | | | | | | | | | | | | | | | | | | |
| | | Supporting the LLP to bid for 2nd round funding for clinical Pharmacists | | | | | | | | | | | | | | | | | | | | | | |
| | | Organising receptionist training for care | | | | | | | | | | | | | | | | | | | | | | |

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| | | navigator and medical documentation roles | | | | | | | | | | | | | | | | | | | | | |
| | | Supporting Practice Manager development | | | | | | | | | | | | | | | | | | | | | |
| Jason Page & Jacqui Tuffnell | Primary care access arrangements | Weekend / Bank Holiday pilot | | | | | | | | | | | | | | | | | | | | | |
| | | New full access arrangements; pilot ahead of EC opening | | | | | | | | | | | | | | | | | | | | | |
| Jason Page & Jacqui Tuffnell | New models of care | Collaborating practices | | | | | | | | | | | | | | | | | | | | | |
| | | LLP / Federation Structure | | | | | | | | | | | | | | | | | | | | | |
| | | LLP development | | | | | | | | | | | | | | | | | | | | | |
| | | Community transformation programme | | | | | | | | | | | | | | | | | | | | | |
| | | Social prescribing extension | | | | | | | | | | | | | | | | | | | | | |
| Jason Page & Chris Barnes | Self-care | Pilot of anticoagulation, Diabetes, BP COPD, self-management | | | | | | | | | | | | | | | | | | | | | |
| | | Review of case management arrangements to incorporate care home patients | | | | | | | | | | | | | | | | | | | | | |
| | | Patient education | | | | | | | | | | | | | | | | | | | | | |
| | | Roll-out of Telehealth | | | | | | | | | | | | | | | | | | | | | |
| | | Web optimisation | | | | | | | | | | | | | | | | | | | | | |

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| | | Local digital roadmap submitted | | | | | | | | | | | | | | | | | | | | | |
| | | Implementation of local digital roadmap | | | | | | | | | | | | | | | | | | | | | |
| | | Use of EPaCCs | | | | | | | | | | | | | | | | | | | | | |
| | | Use of online services | | | | | | | | | | | | | | | | | | | | | |
| | | EPS implementation | | | | | | | | | | | | | | | | | | | | | |
| | | Increasing the use of e-referral | | | | | | | | | | | | | | | | | | | | | |
| | | Ability of use e-referral for community services | | | | | | | | | | | | | | | | | | | | | |
| | | Connecting care homes to SystmOne | | | | | | | | | | | | | | | | | | | | | |
| | | E-consultations | | | | | | | | | | | | | | | | | | | | | |
| Jacqui Tuffnell, Dawn Anderson, Rachel Garrison & Chris Barnes | Robust performance management | Performance dashboard development roll out | | | | | | | | | | | | | | | | | | | | | |
| | | Procedure in place for managing commissioning / quality issues | | | | | | | | | | | | | | | | | | | | | |
| | | Performance management arrangements being reviewed as part of the quality contract work | | | | | | | | | | | | | | | | | | | | | |
| Stuart Lakin | Continued improvements - medicines management | Waste campaign | | | | | | | | | | | | | | | | | | | | | |
| | | Supporting practices with clinical Pharmacist development | | | | | | | | | | | | | | | | | | | | | |

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| Helen Wyatt | Engaging patient-optimised pathways | PPG development; LIS audit and recommendation | | | | | | | | | | | | | | | | | | | | | |
| | | Co-production of pathways | | | | | | | | | | | | | | | | | | | | | |
| | | Carers support | | | | | | | | | | | | | | | | | | | | | |
| Jacqui Tuffnell, Chris Barnes, NHS England & NHS Property Services | Estates | Approve Waverley build | | | | | | | | | | | | | | | | | | | | | |
| | | Waverley build (January 2017 to January 2018) | | | | | | | | | | | | | | | | | | | | | |
| | | Procurement of provider required during 2017 | | | | | | | | | | | | | | | | | | | | | |
| | | Estates strategy produced | | | | | | | | | | | | | | | | | | | | | |
| | | Approve Canklow move | | | | | | | | | | | | | | | | | | | | | |
| | | Canklow move (actual) | | | | | | | | | | | | | | | | | | | | | |
| | | GP main practice surveys | | | | | | | | | | | | | | | | | | | | | |
| | | Management of required actions from practice surveys | | | | | | | | | | | | | | | | | | | | | |
| Andy Clayton & Wendy Lawrence | IT | All GPs have a laptop to enable remote working | | | | | | | | | | | | | | | | | | | | | |
| | | All practices have Wi-Fi enabled | | | | | | | | | | | | | | | | | | | | | |
| | | Remote consultation implementation | | | | | | | | | | | | | | | | | | | | | |
| | | STP schemes | | | | | | | | | | | | | | | | | | | | | |

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| | | All care homes have Wi-Fi enabled | | | | | | | | | | | | | | | | | | | | | |
| Garry Charlesworth, John Heney, Dawn Roberts | NHS England | Collaborating with community pharmacies | | | | | | | | | | | | | | | | | | | | | |
| | | Optometry support to practices - direct cataract referral | | | | | | | | | | | | | | | | | | | | | |
| | | 7 day dental arrangements | | | | | | | | | | | | | | | | | | | | | |
| | | Optometry secondary to primary transfer | | | | | | | | | | | | | | | | | | | | | |

## Glossary

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| A&E | Accident & Emergency |
| APMS | Alternative provider of medical services |
| BCF | Better Care Fund |
| CCG | Clinical Commissioning Group |
| CQC | Care Quality Commission |
| DES | Directed Enhanced Service |
| FyFV | Five year forward view |
| GMS | General Medical Services |
| GPs | General Practices |
| LES | Local Enhanced Service |
| LIS | Local Incentive Scheme |
| MPIG | Minimum practice income guarantee |
| NES | National Enhanced Service |
| NHS | National Health Services |
| NHSE | NHS England |
| PMS | Personal Medical Services |
| QIPP | Quality, innovation, productivity and prevention programme |
| RMBC | Rotherham Metropolitan Borough Council |
| STP | Sustainability and transformation plan |