Nottingham and Nottinghamshire Integrated Care System (ICS)

2019/20-2023/24 Primary Care Strategy

Version Control

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1.5	28/05/2019	Jon Singfield	First draft shared for comments with stakeholders
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4.0	28/06/2019	Jon Singfield	Final version incorporating additional content, appendices and feedback from NHSE

Authorisation

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1 Executive Summary

In April 2016 Simon Stevens Chief Executive of NHS England announced the *General Practice Forward View* (GPFV): a roadmap for Primary Care for the next five years. It committed to increased funding and a national sustainability and transformation package to support GP practices.

The GPFV pledged an extra £2.4 billion a year to support general practice services by 2020-21, so that spending will rise to reach £12 billion every year by 2021 – an increase of nearly 15% in real-terms.

This pledge reversed the trend that had seen general practice receive an increasingly smaller percentage of the NHS budget over the previous decade. The extra funds were allocated to increase capacity to meet local demand and support practices to become more resilient (including supporting GPs suffering with stress), as well as to boost the medical and non-medial workforce and provide support for practices to redesign services. The GPFV outlined plans to relieve the workload of GPs as well as steps to employ more people in General Practice, alongside harnessing technology to modernise the delivery of care.

We are now over half-way through the period described in the GPFV and so this strategy offers the chance to reflect on what we've achieved to date and what we still have to deliver.

Locally across Nottingham and Nottinghamshire we have embraced this roadmap and made significant progress. Over the past three years we have achieved the following:-

- Workforce
    - Clear ownership, leadership and governance in place of the Primary Care Workforce Group with both the ICS Strategic Workforce Group and ICS Primary Care Delivery Board
    - Strong delivery of GPFV workforce plan during 18-19, creating a solid base to move to engagement and workforce planning with the newly established Primary Care Networks. The key aspects of the plan have been about supply, recruitment and retention which have focused on general practitioners but with success in the uptake of clinical pharmacist programme, approval of more CCT fellowships than other STPs, creating a lead to deliver GPN 10 point plan and latterly the creation of an overarching programme to manage all the GP retention strategies that is a model that can be rolled out for wider workforce. All this has been developed through excellent working relationships between LMC, RCGP, HEE, NHSE(Programme teams) CCG and emerging PCNs
    - STP/ICS has made the most of the NHSE and HEE allocations and

funding opportunities securing funding to move from small non recurrent schemes into coordinated and connected delivery programme with measurable impact and one that supports the 2019-20 GPFV allocations and spending plan plus the development of Primary Care Networks
- The workforce plan has a strong alignment with the long term plan in looking to develop and embed new roles, develop flexible roles that meet individuals' career aspirations but also addresses developments to match population health needs with digital champions identified within the GP, nursing and practice manager roles across all Primary Care Networks.
- Within the infrastructure of the ICS has developed capabilities around workforce modelling and will further develop the Alliance Training Hub to provide workforce planning that includes the identification and delivery of training and educational needs

- Workload
  - Invested £3 per patient in 2017-18/2018-19 to support the development of 'at scale' and sustainable general practice through implementation of schemes such as the General Practice Enhanced Delivery Scheme and the Primary Care Patient Offer.
  - Enabled practices to access GP Resilience Funding to support sustainability and resilience. This funding has been used to undertake 'diagnostic' work to identify areas for improvement and further support, for specialist advice and guidance e.g. human resources, for rapid intervention and management support for practices at risk of closure, to align back office functions such as policies and procedures, to support practices to prepare for CQC visits, to implement a standardised approach to health and safety across practices, and to facilitate GP engagement events to support the development of federations.
  - Supported the development of Practice Managers using GPFV funding to provide training around change management, effective leadership, building personal resilience, developing coaching skills and supporting, and the establishment of Practice Manager Forums
  - Used GPFV funding to provide training to GP receptionists and clerical staff to enhance their skills around care navigation and signposting and to provide sessions aimed at increasing the confidence of receptionists to deal effectively with patients. Practices also benefitted from training to improve correspondence management and workflow optimisation

- Infrastructure –
  - The Estates Transformation and Technology Fund (ETTF) funding has been used to improve and extend existing buildings
  - ETTF has also been used to support business cases for capital investment on new developments, particularly in areas of housing and population growth, including Cotgrave and East Leake
  - Invested (or in the process of investing) over £4m in building, extending and improving primary care estate, targeted at boosting capacity in primary care.

- Care Redesign -
  - Primary Care Networks (PCNs) have been established and configured across the ICS
  - Our overarching aim is that PCNs will be at the heart of health and care provision; improving the wellbeing of our local populations through proactive, accessible, coordinated and integrated health and care services
  - An integrated and collaborative primary care workforce, will deliver proactive population health management with a combined focus on prevention and personalisation of care, with shared and improved qualitative health and care outcomes
  - There will be a strong commitment and voice from partners working collectively to describe how clinical, social and financial drivers are aligned and focused
  - The PCNs will work in neighbours to collectively deliver localised care, and also with the ability of at scale working as part of the wider system
  - Patient ownership, activation and strengthened local communities will play an ever increasing vital role to ensure a comprehensive care offer to our population

However, when we set out on this journey we knew this was just the start and there is still more to do. Feedback from our citizens tells us that it is still too hard for patients to get a GP appointment when they need one, and that there is still variation in how patients experience the quality of care they receive.

We know there is still more opportunity to involve patients (as experts in their conditions) in the planning of their care, increase their ability to self-care, provide greater continuity in the care received and improve communication between health and care professionals. Key to this is continuing to tackle the challenges faced in recruiting doctors and nurses, particularly those in the most deprived populations and also through the harnessing of new digital technologies.

General Practice and Primary Care are now at a crossroads and this strategy represents the next stage of the journey. The creation of Primary Care Networks across all of Nottingham and Nottinghamshire gives a once-in-a-generation chance to transform the care that patients receive, where they live and when they want it.

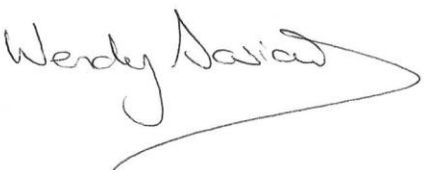
In line with the *NHS Long Term Plan*, over the next five years we will invest more than £60 million in primary and community services (ensuring that our investment in primary care and community services will grow faster than our allocation), structured around our Primary Care Networks, to drive five changes to create a new care model for the 21st Century.

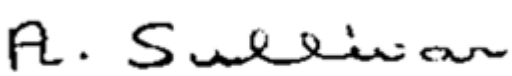
- **Boost out of hospital care** – GP practices will work together more to deal with pressures in primary care and extend the range of convenient local services, creating genuinely integrated teams of GPs, community health, social care and other staff whose work impacts on the health of our citizens. This will include the introduction of new staff in GP surgeries including clinical pharmacists, physician associates, physiotherapists and social prescribing link workers.
- **Reduce pressure on emergency hospital services** – Capacity and responsiveness of community and intermediate care services will be increased. This will help prevent unnecessary admissions to hospitals and residential care, as well as ensure a timely transfer from hospital to community. Urgent response and recovery support will be delivered by flexible teams working across primary care and local hospitals including GPs, allied health professionals, district nurses, mental health nurses, therapists and reablement teams. We will also fully implement the Urgent Treatment Centre model: these Centres will provide a locally accessible and convenient alternative to A&E freeing up that service for people who really need it.
- **More personalised care** – We will drive a fundamental shift in how primary care works alongside patients and individuals to deliver the care and support that each individual wants. The evidence shows that when the care delivered by doctors and nurses is guided by individual patient preference the uptake of high-risk, high-cost interventions is reduced. Creating genuine partnerships requires professionals to work differently, including a commitment to engaging patients in decisions about their health and wellbeing. We will support and help train staff to have the conversations which help patients make the decisions that are right for them. We will also support people to take control themselves of their health condition with expert advice and peer support. This will include ‘social prescribing’ to connect patients to local voluntary groups and support services.

- **Digitally enabled primary care** – Digital primary care will mean every patient will have the option to have an online consultation with their doctor if they want one. This is now being offered by some practices across the country and proving popular with patients and also GPs. Patients benefit by being able to talk to a doctor at a time and place convenient to them and doctors report that the flexible model means they are more likely to continue working as GPs. There is also a benefit in joining up the data and information about patients between GPs and the hospitals and other NHS and Social Care Services.
- **Increased focus on population health** – Primary Care will have a pivotal role in working together to make shared decisions with other parties on how to use resources, design services and improve population health. By working together with all the public bodies and services that have an impact on peoples' health we can make the right joined-up decisions about things like transport, employment, parks and open spaces, housing and education. This will mean that people stay well for longer and we ultimately save money in the long run.

Our Primary Care Networks will be at the heart of delivering this new care model, improving the wellbeing of our local populations through proactive, accessible, coordinated, and integrated health and care services. Through this approach we will:

- Make practical changes to help address the biggest challenges facing general practice, including workforce and workload.
- Provide more proactive and personalised care, join up urgent care services and enable patients to benefit from digital technologies.
- Deliver improvements in care quality and outcomes in line with the ICS outcomes framework.





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2 Vision

2.1 Context

This Primary Care Strategy aligns to the overarching vision for the Nottingham and Nottinghamshire Integrated Care System (ICS). The ICS vision, informed by what our population communicates to us and which has full endorsement from key stakeholders, is as follows:

Figure 2-1 - ICS Vision Statement

Our Overall ICS Vision

Across Nottinghamshire, we seek to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age

The vision for the ICS includes three priority areas which are essential in order to improve outcomes for the population of Nottingham and Nottinghamshire. These include:

- health and wellbeing
- independence, care and quality
- effective resource utilisation

2.2 Primary Care Vision

Our vision for primary care is aligned with the ICS Five Year Strategy which has been developed in order to deliver against the requirements of the NHS Long Term Plan. The vision is built on the foundations of Primary Care Networks (PCNs) which will enhance integrated care and which will deliver a person-centred (holistic) approach to continuous and proactive lifetime care, rather than the traditional disease focused management.

Our vision for primary care delivers:

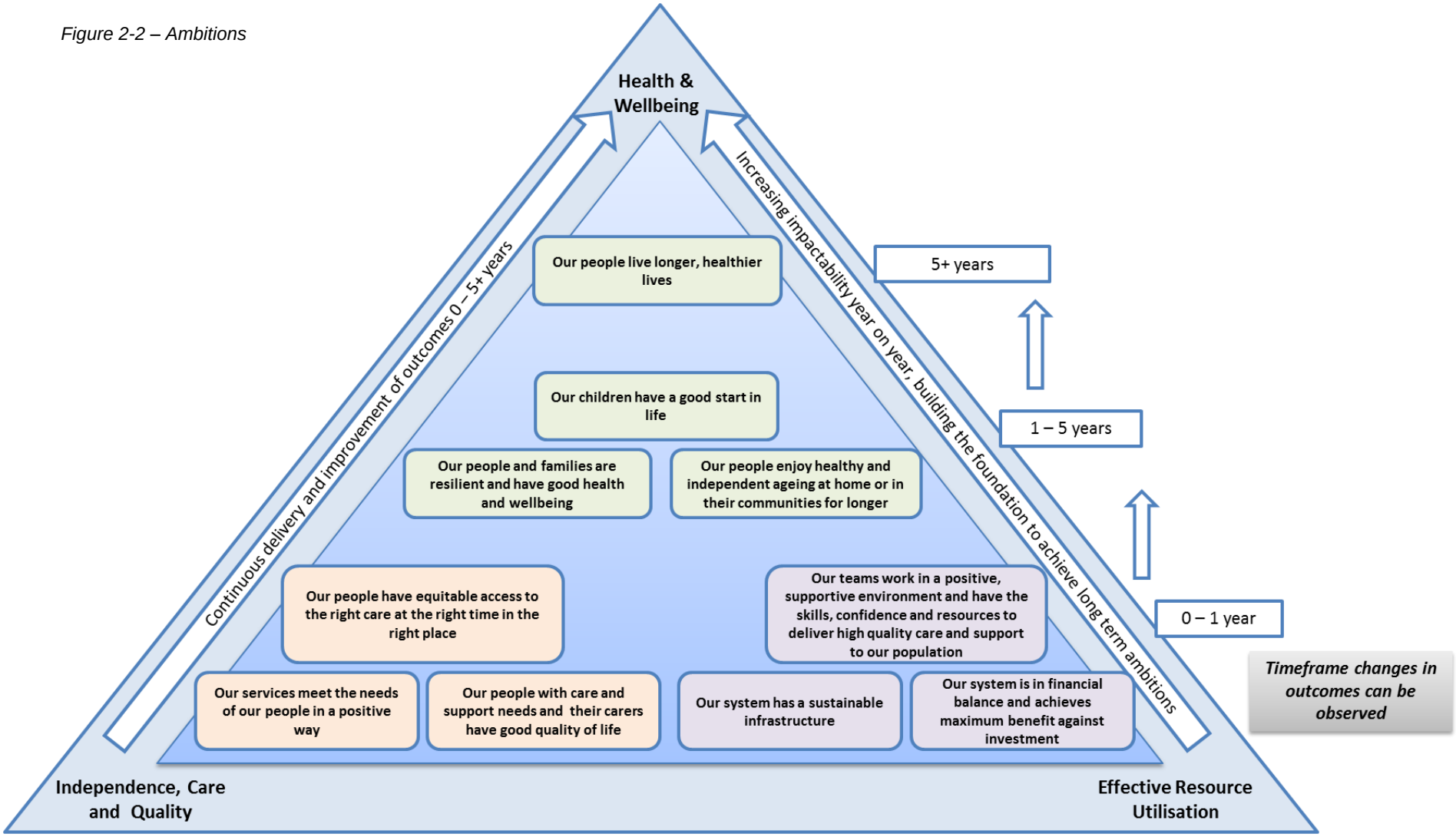
- **Effective Resource Utilisation** - fully integrated, primary and community based healthcare, successfully incorporating new models of care and multidisciplinary teams with wide ranging clinical and social care skills and capabilities whilst improving workforce sustainability and resilience
- **Independence, Care and Quality** - care organised around populations, individuals and their carers, as opposed to organisations. Delivering the right type of care, in the right setting, based on people's needs
- **Proactive and Community-Based Health & Wellbeing** - providing models of health and care that are more proactive and preventative, ensuring more

people are looked after at home, and closer to home, thereby reducing the rising demand for hospital-based care.

Delivery of the ICS vision is based on ten ambitions and these have been used to frame the priorities for Primary Care.

The ambitions are illustrated in the diagram overleaf.

Figure 2-2 – Ambitions



In order to deliver our vision and ambitions, the priorities for Primary Care are as follows:

i. Delivering clinical and service consistency including access

- Improved choice and convenience of GP appointments both in-hours and outside core hours, including the use of digital advancements.
- Localised and centralised clinical services which put care in communities where possible, but concentrate care where clinically necessary to improve patient outcomes and efficiency
- Excellent care plans and pathways developed by clinicians and supported by improvement science
- Integrated community–based mental health services, which recognise the personal, societal and economic importance of mental health
- A scaled-up primary-care system with access to speedy diagnostics and therapeutics provided in suitable facilities and supported through integrated community and pharmacy health teams

ii. Workforce resilience, capacity and wellbeing

- Workforce motivation and development that looks at the sensible delegation and demarcation of skills from the patient's perspective and not just the producer's

iii. Establishment and development of Primary Care Networks to deliver population health and wellness management

- Strong health promotion and illness prevention
- A health system that treats patients as active partners in their care (and communities as carers), and allows individuals and carers control over their life, and ultimately, their death
- Integrated health and social care provided seamlessly in the home

iv. Delivering digital transformation

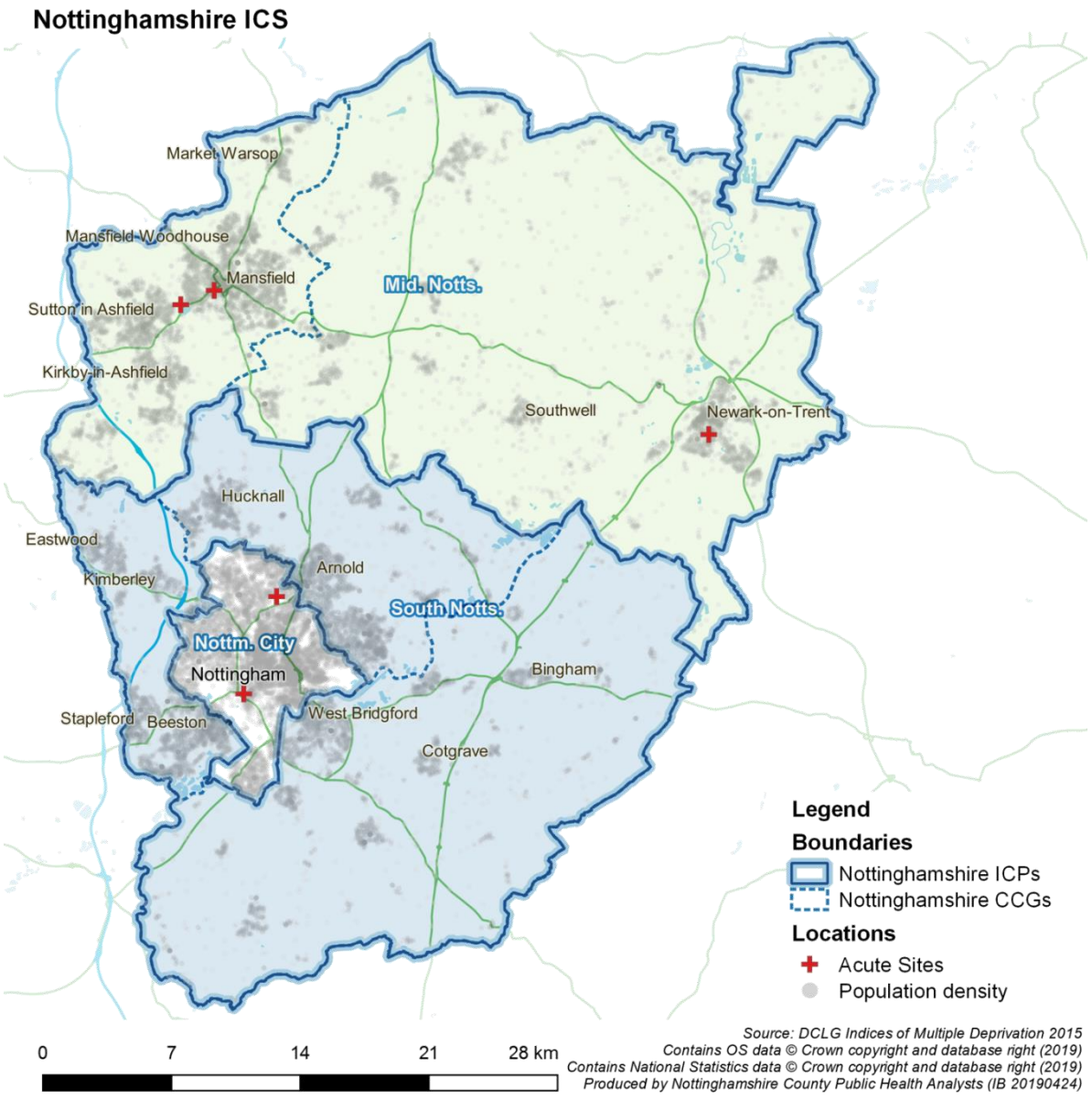
- Excellent population and patient segmentation and stratification techniques to encourage and support citizens and patients to live actively, all supported by the latest technology

3 Introduction

Nottingham and Nottinghamshire has a resident population of 1.1m people. The NHS annual budget is approximately £2.8bn, with a budget of £677m for social care and public health.

3.1 Map of Nottingham and Nottinghamshire ICS

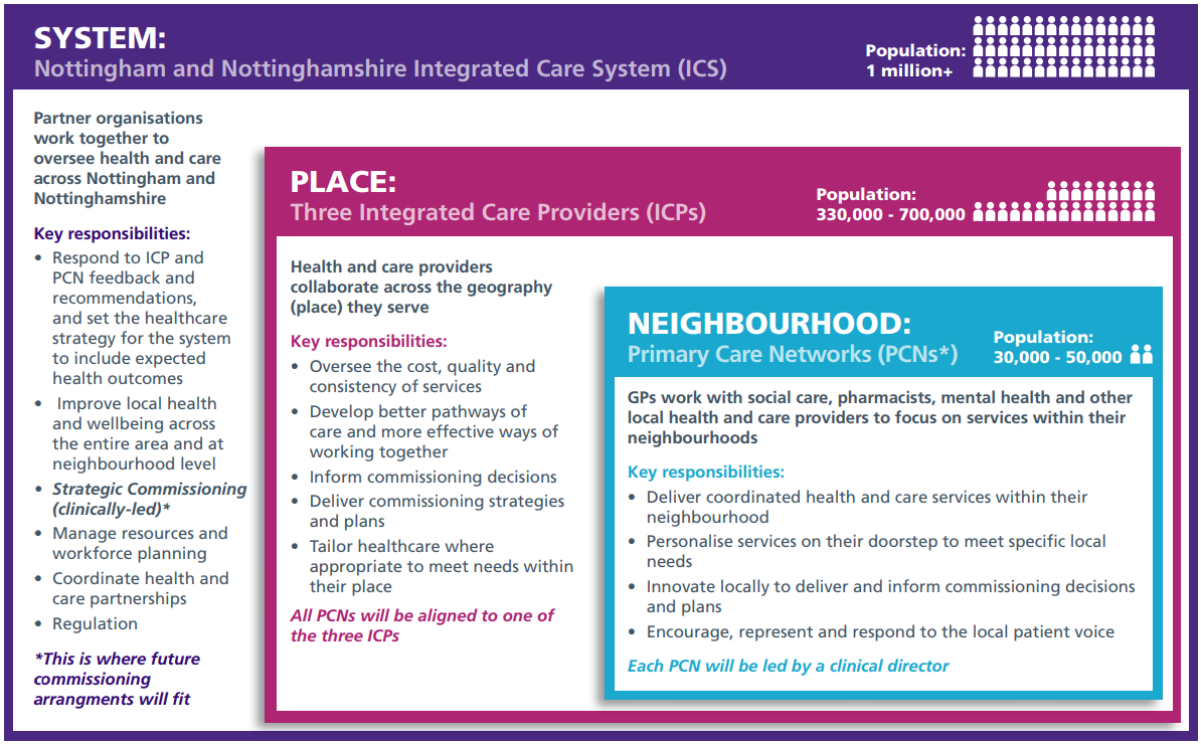
Figure 3-1 - Map of Nottinghamshire ICS showing ICP and CCG boundaries



3.2 Composition of System, Place & Neighbourhood

As part of the move to the new system architecture, Nottingham and Nottinghamshire have established three Integrated Care Partnerships (ICPs) and 20 Primary Care Networks (PCNs). The diagram below provides an illustration of responsibilities in relation to working as a system.

Figure 3-2 - Nottinghamshire ICS- What should happen where



3.3 Primary Care Network Configuration across Nottingham and Nottinghamshire

PCNs provide the local infrastructure that will deliver a person-centred (holistic) approach to continuous lifetime care, rather than the traditional disease focused approach. They comprise integrated, cross organisational and cross professional groups of staff who come together as an integrated community offer.

133 GP Practices have been aligned to 20 PCNs across the ICS, as shown in the map and table overleaf. Each PCN has a designated Clinical Director who will provide strategic and clinical leadership for the ongoing development of their network.

Figure 3-3 - Map of Nottinghamshire ICS showing PCN Boundaries

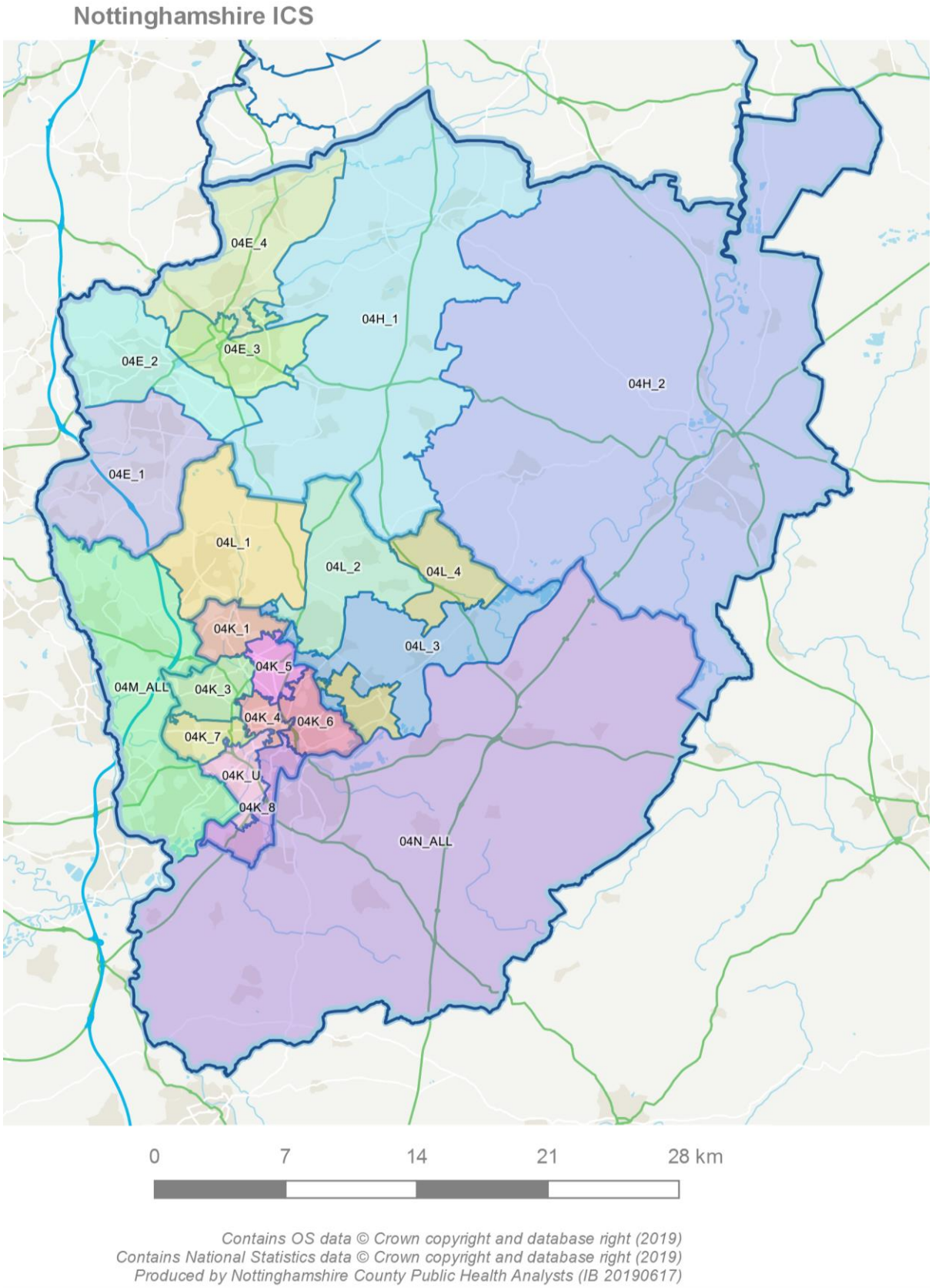


Figure 3-4 - PCNs, Practices and Population by CCG area

CCG	PCN	No of practices	Population
Mansfield & Ashfield	Ashfield South	8	38,794
	Ashfield North	5	51,705
	Mansfield South	5	46,587
	Mansfield North	8	58,425
	4	**26**	**195,551**
Newark & Sherwood	Sherwood	7	59,627
	Newark	7	76,147
	2	**14**	**135,004**
Nottingham City	1 – Bulwell & Top Valley	8	44,571
	3 – BACHS	11	59,168
	4 – Radford & Mary Potter	6	49,503
	5 – Bestwood & Sherwood	8	49,390
	6	8	66,474
	7	4	36,390
	8	5	31,662
	U - Universities	2	51,549
	8	**52**	**388,707**
Nottingham North & East	1 - Hucknall	4	36,715
	2 – Arnold & Calverton	3	33,778
	3 – Carlton & Villages	6	40,969
	4	4	29,647
	4	**17**	**141,109**
Nottingham West	Nottingham West PCN, comprised of the following 'neighbourhoods': • Beeston • Eastwood / Kimberley • Stapleford	12 5 4 3	106,473* 47,476 37,159 21,337
	1	**12**	**106,473**
Rushcliffe	Rushcliffe PCN, comprised of the following 'neighbourhoods': • North • Central • South	12 3 5 4	128,389 39,770 48,129 40,490
	1	**12**	**128,389**
TOTAL	**20**	**133**	**1,095,233**

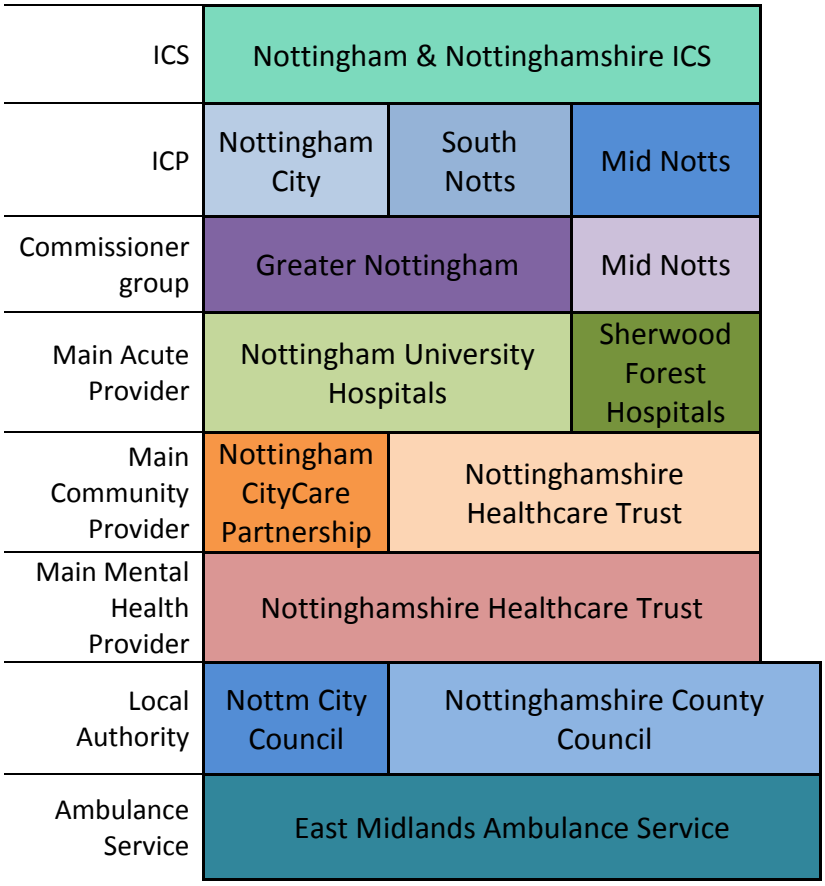
***** Total includes 501 patients not re-registered from practice closure

3.4 ICS Key Partners

Our partners are:

- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospital NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham CityCare
- NHS Mansfield and Ashfield CCG
- NHS Newark and Sherwood CCG
- NHS Nottingham City CCG
- NHS Nottingham North and East CCG
- NHS Nottingham West CCG
- NHS Rushcliffe CCG
- East Midlands Ambulance Service
- Nottingham City Council
- Nottinghamshire County Council
- 6 District/Borough Councils
- Voluntary Sector Organisations

Figure 3-5 - Key system organisations by footprint



4 The Case for Change

4.1 Demographics and Health Inequalities

The populations of Nottingham and Nottinghamshire require health and care services that are of the highest quality and delivered as locally as possible. Our citizens have told us that they want to be supported to take more responsibility for their own health and that if they become ill they want to be cared for at home where-ever possible with a proactive support system wrapping services around them.

We have made great strides in improving the health and care that our population receive, but to continue to improve outcomes, meet the rising level of demand and stay within the funding available we recognise we need a transformation programme which will require all sectors – NHS, social care, local authority services, private and voluntary sectors to work collaboratively with our citizens to radically redesign the way we deliver our services.

There are a number of reasons why our services need to be re-focused to ensure we can maximise the health and well-being of our population within the available resources. These include;

Changing Demographics

There are currently 1.1m people in the Nottingham and Nottinghamshire ICS which is set to increase by 3% by 2024 and by 10% by 2039.

The age profile of our populations in Nottingham and Nottinghamshire are relatively similar to that of the England average, whilst our Nottingham City population has a smaller proportion of those aged 50+ and a higher proportion of younger people even when we discount for its large student population. People are living far longer with 13% of the ICS population currently aged 70+ which is set to rise to 18% by 2039.Deprivation is a strong driver of illness and poor levels of health. Our ICS has large variations in the levels of deprivation, for example Nottingham City and Mansfield and Ashfield are some of the most deprived districts in England compared to Rushcliffe which has significantly lower levels of deprivation.

Deprivation and socio-economic factors significantly affect a person's life expectancy. Nottingham City and Mansfield & Ashfield are affected by higher levels of unemployment, lower qualifications and less healthy lifestyle choices (healthy eating, smoking, overweight/obesity, low physical exercise) resulting in poorer health and wellbeing outcomes. Across the ICS we have a

differential pattern in overall life expectancy with male life expectancy ranging between 77yrs – 80.7yrs and females ranging between 81.1yrs - 83.4yrs.

The healthy life expectancy, i.e. the number of years a person lives in 'good health', also shows a pattern of inequity – a male in Nottingham City lives 57 years in good health compared to a male in the rest of Nottinghamshire who lives 62.5 years. The pattern is similar for females with 53.3 years compared to 61.6 years.

The number of people living with multi-morbidity prevalence will also rise dramatically across our population significantly increasing the complexity of those people who do need health and care support. The number of people with 4 or more diseases will more than double in the next 20 years and 2/3 of these will have mental ill-health as well as physical ill-health. By 2039 moderate frailty will increase by 96% and severe frailty by 117%.

Childhood obesity is a further key indicator of the impact our lifestyle choices have on the health of our population. It is associated with a higher chance of premature death and disability in adulthood. Overweight and obese children are more likely to stay obese into adulthood and to develop long term health (LTC) conditions such as diabetes and cardiovascular diseases at a younger age.

For most LTCs resulting from obesity, the risks depend partly on the age of onset and on the duration of obesity. Obese children and adolescents suffer from both short-term and long-term health consequences. The most significant health consequences of childhood overweight and obesity, that often do not become apparent until adulthood, include cardiovascular diseases (mainly heart disease and stroke); diabetes; musculoskeletal disorders, especially osteoarthritis; and certain types of cancer (endometrial, breast and colon).

At the age of 4-5yrs Nottingham City children are already significantly less likely to be a healthy weight that those in Nottinghamshire and the rest of England. By age 10-11yrs the gap has grown further with only 57.8% of Nottingham City children being a healthy weight compared to 64.3% in England as a whole. By 10-11yrs 2 in 5 children and 1 in 15 children in Nottingham City are severely obese and this is increasing year on year for both age categories.

Changing Public Expectations

We therefore have a growing population with increasingly complex care needs and changing expectations, placing different demands on health and care services. In addition citizens also want to be able to receive services in a very different way to that which their parents and grandparents did. Feedback from

our citizens tells us that there is variation in:

- Access to primary care services, with concerns expressed in respect of the flexibility of GP appointment systems and opening hours, difficulties making an appointment by telephone and/or making an appointment within a reasonable time period
- How patients perceive the quality of care they receive in primary care.
- Involvement in the planning of their care
- Continuity of care, with the use of locums within GP practices commented on as having a negative impact on this
- The effectiveness of communication between providers (e.g. the GP and the hospital) resulting in duplication of tests/assessments/treatment between primary and secondary care
- The use of technology to enable them to take greater control of their health and well-being.

Much of our estate was established over 50 years ago to meet a very different health need. Our health and care services need to adapt and change to provide high quality care for people at home or in the community (where appropriate) and to ensure everyone can benefit from modern day medicine, technological advances, and new models of care.

Clinical Sustainability

The current healthcare system is clinically unsustainable driven by demand pressures, insufficient levels of out of hospital services and staff shortages.

From an activity perspective we have seen:

- Increase in demand for primary care appointments
- **Outpatient appointments** have increased by 15% in the last 3 years (17/18 vs 14/15) with a 20% increase in age 70+ Outpatient appointments.
- **A&E attendances** have seen a 4% increase in the last 3 years (17/18 vs 14/15) with a 17% increase in age 70+ A&E attendances in last 3 years.
- **Inpatient episodes** have increased by 7% over the last 3 years but we have seen a corresponding decrease in bed days by 9% and an increase in day case activity of 10%. There has been a 17% increase in inpatient episodes in those aged 75+.
- Currently 13% of the ICS population is aged 70+ and this population accounts for;
- 20% A&E attendances,
- 27% outpatient appointments,
- 31% of emergency inpatients,
- 33% of elective and 33% of day cases

Circulatory disease (including stroke, coronary heart disease), cancers and respiratory diseases currently account for 60% of the diseases that cause the gap in life expectancy between the most and least deprived areas in Nottingham and Nottinghamshire and these are set to rise. For example over the next 20 years stroke will increase to 84%, respiratory diseases to 101% and cancer to 179%.

Evidence has confirmed that these diseases can be prevented by improving lifestyle choices. For example;

- 9 out of 10 strokes are caused by risk factors that can be modified
- 40 - 45% of cancers are caused by risk factors that can be modified

Current data suggests that we still have significant areas of unhealthy lifestyle choices as demonstrated below;

Smoking	• Mansfield and Ashfield > 1 in 5 people • Rushcliffe 1 in 12 people
Exercised for 30 mins for 12 out of 28 days	• Nottingham City and Mansfield and Ashfield - 1 in 3 people • Rushcliffe - 1 in 2 people

With the population growing, ageing and spending a higher proportion of time in poor health, there will be an ever increasing need for carers. Informal carers need more support, they are 2.5 times more likely to experience psychological distress than non-carers; working carers are two to three times more likely to suffer poor health than those without caregiving responsibilities. Dementia carers particularly struggle and dementia is due to increase 86% in the next 10 years.

The pressures on our current services are unsustainable and require a radical re-think in not only how and where services are delivered to ensure efficient and effective delivery, but also how we shift to a more proactive model of care that focuses on preventing the population developing the disease burden in the first place.

Clinical sustainability also requires us to review and consider how and where we deliver services from. Treatments are becoming increasingly specialised offering the potential to improve quality of care further by enabling access to the latest treatments and techniques. This will enable specialist staff to build their skills and capabilities, and to ensure all patients have access to specialist skills and equipment.

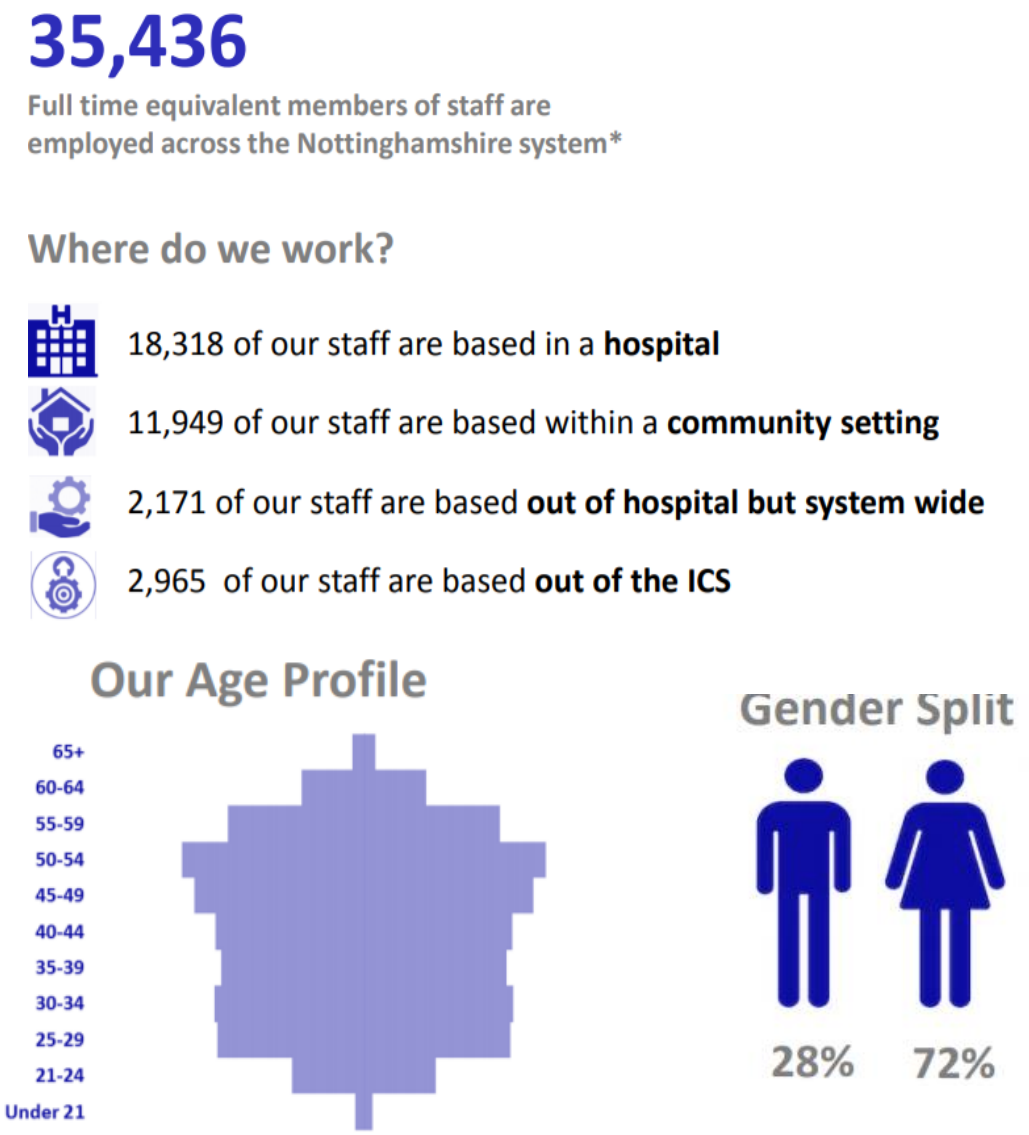
4.2 Workforce Challenges

Across the ICS

Workforce is a key driver for change within our system. Having staff with the right skills and expertise in the right locations is fundamental if we are to achieve our goals and ambitions as a system and we currently face a number of significant challenges in being able to achieve this.

The ICS has developed a 10 year People and Culture strategy which articulates the challenge and puts forward some of the mitigations in terms of recruiting and retaining high quality staff to deliver the care needs of our population. We employ a wide range of talented and dedicated staff across our system who provide excellent care and services to our populations. The profile of staff is as follows:

Figure 4-1 - Workforce key facts and figures



Our local analysis indicates that based on current demand trajectories our ICS will have a shortage of at least 1,500 clinical staff over the next five years. Our system is currently running with a high vacancy rate at 18.19% with turnover at 11.4%. This is exacerbated by a reduced supply of graduates and an ageing workforce with a significant number of staff reaching retirement age.

In terms of primary care, modelling has highlighted significant workforce challenges including a shortage of General Practitioners (77 FTE short by 2020) along with a general shortage of practice nurses and other primary care based staff.

Additionally, there are 2000 (9%) social care/ residential care staffing vacancies, with turnover in Nottingham and Nottinghamshire in line with the England average of 30.1%.

Our People and Culture strategy outlines a range of initiatives and actions that need to be taken for us to address this significant workforce challenge. These are aligned to four strategic workforce objectives:

- Recruitment & retention supporting our current workforce;
- Supporting and retaining our students;
- Developing and supporting emerging new roles;
- Preparing the workforce for new ways of working.

Staff engagement is a key enabler to delivery of both our People and Culture strategy and to this Primary Care Strategy. It is essential that we listen and respond to our workforce to shape the delivery of our priorities. Evidence tells us that an engagement and committed workforce leads to improved patient outcomes and increased staff satisfaction which will assist with recruitment and retention challenges.

Developing our Primary Care Strategy will also identify where we will deliver services differently and how we can use enablers such as technological advances to mitigate some of the workforce challenges. We need to ensure that staff are empowered to work at the top of their licence and that we maximise their valuable contribution by developing new and innovative roles where appropriate to ensure we continue to focus on high quality patient outcomes.

Additionally, we recognise that the current roles and workforce structures are not fit for purpose. We need to develop a flexible workforce that is not constrained by organisational or professional boundaries. In order to achieve this we will need to link with education providers and review the approach to training our future workforce to focus on the skills we need rather than the roles themselves.

Primary Care and GP Practices

In engaging with our GP Practices across Nottingham and Nottinghamshire GP practices they have outlined that they:

- are struggling to recruit both salaried GPs and partners on a permanent basis, particularly GP partners. Given the number of GPs anticipated to retire over the next 5 years, practices are concerned that this will further exacerbate existing workforce challenges and pose risks to continuity of provision locally
- are concerned that a reduction in the number of general practice trainees will result in an increased risk to workforce capacity over than next 5-10 years
- are concerned that difficulties in recruiting doctors and nurses is reducing available capacity within the system, compounded by closing practices
- often have to manage vacancies through the use of temporary or locum GPs
- are finding it increasingly difficult to source locum medical cover for gaps in frontline general medical services provision
- are finding it challenging to maintain continuity of care and clinical quality with the need to use more temporary locum medical staff
- have concerns that financial austerity will introduce further financial challenges to sustaining frontline services
- recognise particular challenges in recruiting to practices that serve our most deprived populations, where workload is typically higher and more challenging whilst pay is often lower
- are aware of the need to develop and support primary care leadership and to encourage more inclusivity and greater diversity of leaders.

4.3 Estates & Infrastructure

The quality of the existing primary care estate provides both a challenge and an opportunity. Across the ICS area there is £168m of backlog maintenance required across the key provider organisations much of it critical for ongoing service delivery.

The healthcare estate infrastructure in the ICS costs circa £172 million per annum of which £78 million p/a is Private Finance (PFI) or LIFT payments.

Nottingham & Nottinghamshire Estate (Health) has:

- High number of NHS Property Services inherited from Nottingham City and Nottinghamshire County PCTs
- LIFT and PFI Estate across the system – high quality, commercial estate

Key challenges and issues:

- We do not have a single system long-term plan, historically estates plans produced at an organisational level for short/medium term
- There is underutilisation of high quality, commercial estate i.e. PFI and LIFT
- Clinical space is used for administrative purposes in many of these buildings.
- We have an aging primary care estate with growing levels of backlog maintenance and inadequate space to meet future requirements.
- There are 316 health buildings across the ICS including 115 GP owned buildings
- £171 million annual running costs
- £168 million backlog maintenance requirement (£110 million is high risk)

It is therefore essential that our strategy for primary care estates over the next five years supports and enables

- Better use of our primary care estate, especially PFI and LIFT building where there are long term contractual commitments, using the estate more effectively for the whole health and care system, looking beyond traditional organisational boundaries.
- The development of new primary care estate where required in order to deliver against the requirements of the NHS Long Term Plan.

4.4 Financial Sustainability

The Nottingham and Nottinghamshire ICS currently spends £3.2 billion on health and care services and for a number of years has been spending more money than it receives. Without change, the situation will get worse.

The system faces a gap of £159.6 million in 2019/20 representing 4.9% of the total system resources. This gap is expected to increase to in excess of £500 million by 2023/24 for NHS services alone if we do not change the way in which we design services and work with our populations to improve their health and well-being to prevent them entering ill-health in the first place.

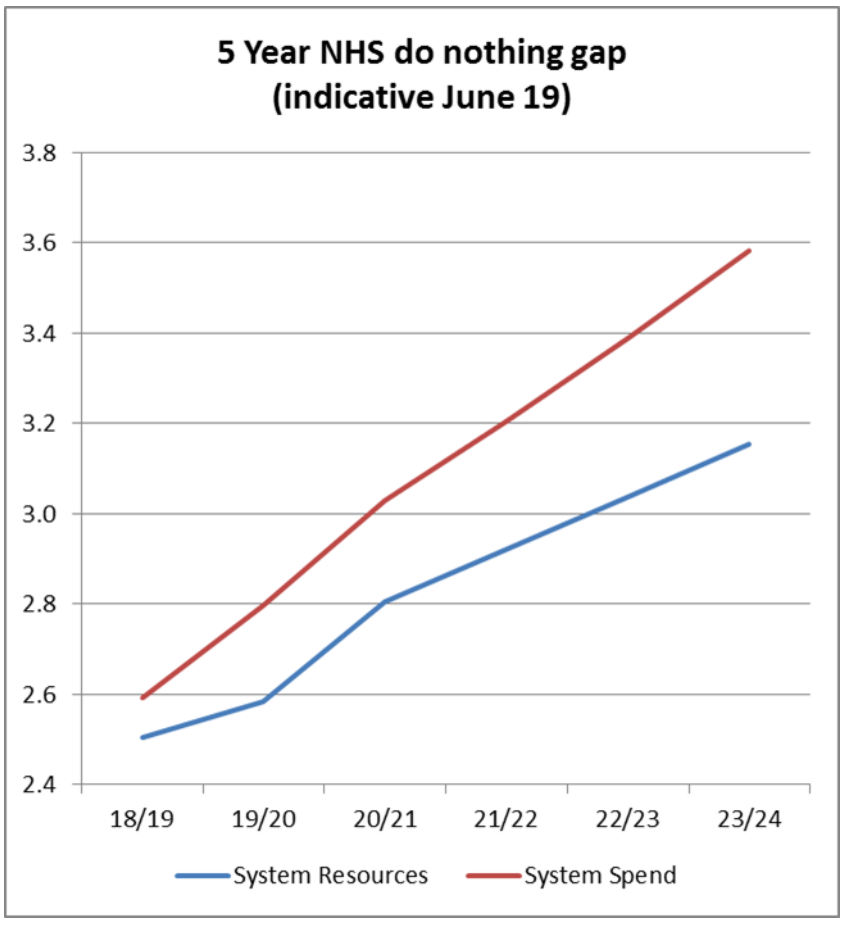
The improved NHS Long Term Plan funding settlement will result in system resources increasing by circa 20% over the next five years but this will not keep pace with cost increases which are projected at 35% for the same period if we don't do anything differently.

To address the financial and operational challenges the system needs to focus on how services are transformed to be delivered within available resources (finance, workforce and capacity).

Five-Year Plan: Finance & Efficiency Gap

- An initial indicative figure (more detailed analysis is ongoing) for the health system's do nothing five year gap has been identified as £428 million (increasing gap)
    - NHS system resources expected to increase by 26% over 5 years to £3.2 billion
    - NHS system costs expected to increase by over 38% over 5 years to £3.6 billion
- ICS has higher levels of fixed costs in comparison to other systems due to PFI costs
- The NHS is implementing a new financial framework for providers and commissioners and it is expected that in future years we will move away from control totals and sustainability funding. However, for 2019/20 control totals remain in place, for individual organisations and ICSs.
- The five-year plan will need to deliver within available resources.

Figure 4-2 - Projected 5 year NHS do nothing gap



4.5 Case for change: Conclusion

The compelling need for change is driven by the views of our citizens, the changing needs of our population, and the need to ensure we are consistently offering timely access to the best evidence based services, set against significant constraints in resources and capacity.

We are faced with a current health and care system that has a number of challenges, ranging from

- **Changing demographics** - a growing and ageing population with challenging health inequalities
- **Workforce -** an inability to recruit and retain the key skills and workforce we require to deliver care,
- **Estates and Infrastructure** - a primary care estate that is ageing and does not have adequate space to support the delivery of new models of care.
- **Financial sustainability** - rising costs that mean our current services are costing more than the income we receive

These issues are very real and we need to address them in a way that will improve outcomes for individuals, our communities as well as all of our staff working across the system.

Experiences locally and nationally from testing alternatives through Vanguards and other developments tell us that primary care has a vital role to play in improving population health and helping to drive the system forward, including relieving pressure on A&E departments and offsetting winter spike demands. However our Primary Care provision also needs to find ways to address its own pressures and challenges in order to be able to fulfil its role effectively.

5 Fulfilling the NHS Long Term Plan

5.1 How we intend to fulfil the ambitions of the NHS Long Term Plan for primary Care

Our overarching aim for PCNs is that;-

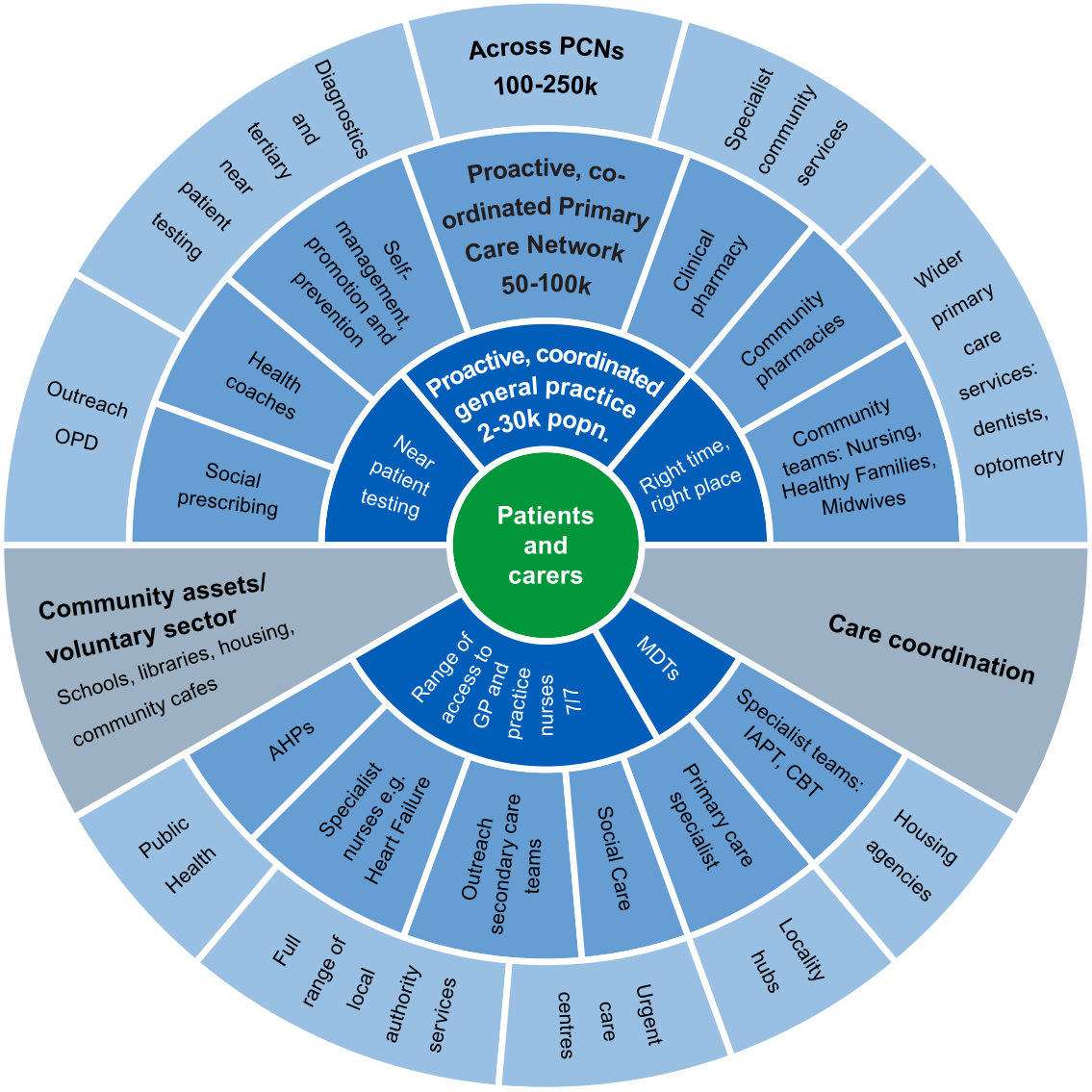
"PCNs will be at the heart of health and care provision; improving the wellbeing of our local populations through proactive, accessible, coordinated, and integrated health and care services."

Integral to delivery against this aim, and in order to fulfil the primary care ambitions of the NHS Long Term Plan, there is a recognised need to ensure the resilience, sustainability and transformation of general practice, including the development and implementation of new business models and models of care.

Our vision therefore is an integrated, place-based care approach developed around natural communities. Key characteristics of each PCN will be:

- An integrated and collaborative primary care workforce, with a strong focus on delivering quality services through partnership – 'primary care' is defined as first line services such as; general practice, community providers, secondary care, mental health, voluntary sector and social care;
- A supported and integrated workforce with a combined focus on prevention and personalisation of care with shared and improved qualitative health and care outcomes utilising population health management data;
- Citizens that are taking personal responsibility for their own well-being and are actively engaged in the development of their local PCN and in strengthening their local community;
- A proactive model of care, utilising risk stratification and targeted interventions to eliminate hospital admissions as a default for people who are not acutely unwell but do need some degree of help and support to prevent further deterioration.

Figure 5-1 - The model of Primary Care Networks across the ICS



In addition to core general practice and associated services, it is anticipated that all PCNs will incorporate the following services within their scope:

- Population health management for risk stratification of the population. Phase 1 will focus on patients with a long term condition but will ultimately cover 100% of the local population
- Proactive and self-care
- Enhanced care to care homes
- Planned care - secondary care consultations, procedures and outpatient appointments
- Urgent and unplanned care - access to GP-led urgent care through GP surgeries, out of hours, integrated urgent care and urgent care centres, including access to diagnostics imaging and x-ray

- Step-up and step down care - to avoid unnecessary hospital admissions and support early discharge, including mental health crisis teams
- Link with other NHS Independent Community Health Providers, including optometrists, dentists and pharmacists. As a priority a working group is being established to consider how the emerging role of the clinical pharmacist will look to integrate to work with community pharmacists, as well as the Medicines Management Team with the CCGs

Over recent years funding received to support delivery of the ambitions set out in the GP Forward View has been used to maximum benefit across a number of areas including GP access, practice resilience, GP recruitment and retention, new models of care and infrastructure. However there is still more work to be done.

The adoption of a new approach to the allocation of GPFV funding for 2019/20 and 2020/21has enabled the identification of priority areas for investment on a system-wide basis (Further details on the GPFV plan for 2019/20 can be found in Appendix 1).

This has included consideration of the development and support needs of the emerging PCNs across the ICS and the expanding role of primary care in order to deliver the ambitions set out in the NHS Long Term Plan. The critical role of primary care in the transformation and delivery of new models of care is described in the following sections.

Timescales for implementation are currently under development and will be incorporated within the fuller response.

5.2 Alignment to ICS Priorities

In addition to the priorities set out in the Long Term Plan, Nottingham and Nottinghamshire ICS has a set of priorities focussed on the particular needs of our population and the challenges in our system. As the table below demonstrates, these complement and support the Long Term Plan whilst helping to direct effort and resource where it is most needed.

Figure 5-2 - ICS Priorities mapped to Long Term Plan priorities

ICS Priorities		
ICS1	**Prevention and wider determinants of health** More action on and improvements in the upstream prevention of avoidable illness and its exacerbations	LTP3 LTP5
ICS2	**Proactive care, self-management and personalisation** Improve support to people at risk of and living with single and multiple long term conditions and disabilities through greater proactive care, self-management and personalisation	LTP3 LTP4
ICS3	**Urgent and Emergency Care** Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting	LTP1 LTP2 LTP5
ICS4	**Mental Health** Re-shape and transform services and other interventions so they better respond to the mental health and care needs of the population	LTP1 LTP5
ICS5	**Value, resilience and sustainability** Deliver increased value, resilience and sustainability across the system (including estates)	LTP4

Long Term Plan Priorities		
LTP1	We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services (section 5)	ICS3 ICS4
LTP2	The NHS will reduce pressure on emergency hospital services (section 6)	ICS3 ICS4
LTP3	People will get more control over their own health and more personalised care when the need it (section 7)	ICS2 ICS1
LTP4	Digitally-enabled primary and outpatient care will go mainstream across the NHS (section 8)	ICS2 ICS5
LTP5	Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere (section 9)	ICS3 ICS4 ICS1

6 Key element 1 - We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services

6.1 Current Situation

A great deal of work has already been undertaken across Nottinghamshire to integrate Primary and Community Services. There are strong examples of good practice already in place, including the award winning Vanguard in Rushcliffe, and a well-established Care Delivery Group model established across Nottingham and Nottinghamshire. Over the last twelve months work has been underway to build on the learning from the four new models of care Vanguard programmes, which have been locally led: urgent care, care home, multi-specialty community provider, and integrated primary and acute care systems.

The four work programmes have provided extensive learning and insights that support the continuation of work to progress and develop care close to home, supported by the integration of general practice, community provision, and social care.

More recently work has focussed on the development of PCNs across Nottingham, South Nottinghamshire and Mid Nottinghamshire. This work has been supported by all key health and care partners across the ICS. The publication of the NHS Long Term Plan and Investment and Evolution: a five-year framework for GP contract reform to implement The NHS Long Term Plan have provided added impetus to progress the work to formally establish PCNs across the ICS area.

6.2 How services will be integrated

PCNs will build on traditional general practice and deliver a model of care that is a place-based Population Health Management (PHM) model, with providers working together in an integrated delivery network to reduce duplication and fragmentation of care delivery.

The PCNs will work with partners across the system to design services which will be provided as close to home as possible. Most services will be delivered at a neighbourhood level, unless they require economies of scale at a specialist local level, and therefore will be delivered across several networks. Where they are delivered at scale, they will be designed and delivered in ways which work with local team arrangements.

The approach will focus on the prevention agenda with the aim of reducing the need for complex care in future years. This will be achieved through:

- robust risk profiling and targeted, outcome based interventions
- 100% coverage of population health management data that links into the wider community to enable people to proactively take control of their health and well-being
- general practice stratifying and proactively targeting at risk people in their locality
- patient choice and self-care, supporting patients to make choices about their care and look after their own health by connecting them with the full range of statutory and voluntary services.

Prevention needs to be seen to have an equal level of importance as treatment modalities and be implemented at scale. It should be accessed at all levels, from an individual GP consultation, right through to accessing the wider community assets. This will be achieved through:

- An expansion of social prescribing and health coaching aligned and navigated through dedicated care co-ordinators.
- Promotion and access to screening programmes will continue to have their profile raised with the aim that national priorities and targets are surpassed.
- A focus on ‘what is important to you’ rather than ‘what is wrong with you’.
- A focus on personalisation and personal health budgets which will also enable a more proactive approach to maintaining well-being.

Care co-ordination needs to take place across all levels of the health and care system from the individual consultation within the GP practice, through to coordinating with wider services across a number of PCN’s. This will be achieved through:

- the development of disease registries and intelligence systems to monitor care processes and outcomes, and identify gaps in provision across the system, as well as for individuals and clinicians making decisions.
- shifting the response of care co-ordination to a more proactive focus so that care co-ordinators are able to actively contact patients and work alongside social prescribers and health coaches to proactively signpost and motivate people to promote their well-being.
- a broader range of services in the community that are more joined up between primary, community, social and acute care services and between physical and mental health to deliver ongoing care needs.

- all the elements of what constitutes best care for each Long Term Condition (LTC) will be agreed across the system, and existing disease pathways will be further developed to provide access to all evidence-based care.
- the identification of people with multiple LTCs and complex needs will be offered individual case management with a named clinician. Each person will have a care plan outlining their priorities, goals and medical details that is accessible by the patient and visible across the whole health and social care system. Each patient will be able to shape their own health care through, for example, personalised care planning, personally-held budgets and use of decision aids.
- hospital specialties will become more community focused, in particular children's services, health care of older people and mental health.
- care for the frail and vulnerable will be around individual preferences, moving away from generic clinical targets towards support to meet personal priorities and goals, including at the end of life. This will reduce unnecessary clinical interventions, and enable people to spend their final days and weeks in the place of their choosing, which in most cases is their own home
- a well-developed JNSA at an ICS level and clear implementation plans developed through the ICPs. Local authority and voluntary sector organisations – housing, education, fire and police services, leisure, and environmental health services, along with engagement with local businesses and voluntary organisations will be key to the system.

Addressing the wider determinants of health through engagement with the wider social network is vital. Issues such as debt, poor housing and social isolation can have a negative impact on a person's health and wellbeing. This will be addressed through:

- giving children and young people a good start in life by engaging with education providers in local communities and focusing on healthy families
- working with patients, families and carers, the voluntary sector, community partners, and other primary care providers such as pharmacy, optometry and dentistry as vital parts of creating a place based way of delivering care.
- development of local strategies that will provide training and job opportunities, good quality housing and keep people connected to their local community by enabling people to create and engage with local community assets
- ensuring that parity of esteem is delivered between physical and mental health problems, and that a holistic approach is delivered to support patients and their families.

6.3 Workforce configuration to deliver integration

Building on the local learning from the New Models of Care and pathway redesign, workforce will evolve to meet growing demands and pressures, and deliver a proactive and integrated model of care.

Workforce will:

- move away from service specific care to a more generalist role and will be trained to treat the patient, not the disease, recognising that most patients may have one or more health or social care needs
- bring staffing resources together to operate in neighbourhoods and/or across localities
- alignment and co-location of a range of professionals and teams including community physical health teams; community mental health teams; social care
- investment in relationships and networks between colleagues working in mental and physical health, and social care
- alignment of GP practices and community teams to the care homes in each PCN.

The PCNs will continue to build on creating the infrastructure for joint working, enhancing existing service delivery in localities and neighbourhoods. The emerging roles such as the Social Prescribing Link Worker and Health Coach roles, Clinical Pharmacists, First Contact Physiotherapists, Physician Associates and Community Paramedics will be developed across the PCNs to optimise community asset resources, utilise appropriate skill sets of workforce, enable stronger connections across service providers, and present an ability to offer an improved, resilient and a more coordinated service offer to patients.

6.4 Service delivery and technology

The use of technology and effective information sharing will be critical. Utilising technology and information, patients will have the ability to book their appointments online, re-order prescriptions, access their GP medical records and access online consultation services. Patients will be empowered by giving them the tools to support their own self-care as well as offering more telephone advice/video consultation appointments.

6.5 Governance and Operational Arrangements

A Primary Care Programme Board has been established. Its core purpose is to provide a structure through which the ICS and CCGs can support the successful delivery of the local primary care strategy.

As the PCNs are established they will work with system partners to develop appropriate local governance arrangements to support the integration and operational delivery of local health and care services.

A Memorandum of Understanding is currently being drafted to support the Schedules of the PCN DES Contract agreement.

6.6 Resourcing and costs

Over the next five years, we will ensure that investment in primary care and community services will grow faster than our allocation. There will be a financial benefit from this investment as demand for emergency care will be reduced – a planned return on investment of approximately 3:1. We will ensure these investments represent value-for money, and that these services are productive and outcomes-focussed.

Years 1-3 will see a focus on Urgent and Proactive Care, with investment in in primary and community care, both as part of Primary Care Networks and more widely, to improve capacity and to ensure that a greater proportion of people with long term conditions stay well and have access to out-of-hospital services when they need them. The will include targeted support for elderly people living in care homes and those within in the last 12 months of life.

Over the five year period we will continue to develop and refine the ICS Population Health Management approach, with proactive identification of “at risk” patient groups and individuals to ensure an earlier targeted intervention can be put in place in order to prevent ill health and reduce demand for medical emergency activity at the acute hospitals.

In years 4 and 5 we also expect to start seeing the benefits of the emerging strategies for primary prevention and personalisation – with people adopting healthier lifestyles, leading to reduced prevalence of long term conditions and reduced demand for emergency acute activity associated with these conditions. We will ensure investment is available to help our patients stop smoking, to reduce obesity, and to lower alcohol consumption.

7 Key element 2 - The NHS will reduce pressure on emergency hospital services

7.1 Current Situation

Our emergency care services are under huge pressure and it is recognised that any sustainable solutions require whole system transformation, including greater leverage of primary and community services. Sustainable, resilient and expanded general practice and community services are pivotal to success in this area and therefore in order to achieve this, PCNs are seen as a key enabler in supporting the transformation.

General practice is already meeting the core national requirements in respect of GP extended access which includes:

- 100% population coverage
- Monday to Friday 8am to 8pm
- Saturday and Sunday/Bank Holiday pre bookable appointments

There are also a number of other initiatives being delivered which are targeted at reducing pressure on emergency services. These include:

- Acute Home Visiting Service – proactively completes 'on the day' requests for a home visit. Leading to reductions in hospital attendance; increase utilisation of single point of access and earlier arrival times at hospital, allowing secondary care to turn patients around on the same day.
- Enhanced Care Home Service which manages patients in a community setting
- Community monthly Multi-Disciplinary Team (MDT) risk stratification meetings by practices identifying those at risk of admission or deterioration.
- High intensity user MDT meeting focussing on proactive care planning for people deemed high intensity service users
- Non clinical navigators using e-Healthscope to identify patients who have triggered demand on secondary care services such as ED.
- Practice level information used to performance manage and support the individual GP practices in their secondary care utilisation
- Local public engagement through Patient Participation Groups, including education

7.2 Role of primary care in reducing pressure on emergency hospital services

A key priority for the ICS is to transform the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting.

This is being addressed through four strategic areas, each supported by a series of initiatives, with Primary Care playing a key role in many of these:

i. Out of hospital urgent care
ii. Pre hospital urgent care
iii. Hospital care - Flow and right place
iv. Effective Integrated Discharge

Further detail for each of these strategic areas is provided overleaf.

i) Out of hospital urgent care

Primary care is core in the delivery of this strategic area and all four initiatives:

Initiative	Description
Same Day Access to Primary Care	Each PCN will provide same day access to an appropriate health or social care professional via a GP led multi-disciplinary service model, including to those who are house bound. Delivery will be through a network of practices and/or hubs within PCNs with services available from early morning into the evening and at weekends. Out of Hours services will be either aligned or integrated with the daytime same day access service. The Strategic Commissioner will agree with the PCNs the model to be deployed.
Single Point of Access (Call for Care)	In circumstances where patients do deteriorate community based urgent response and recovery support will be readily available with the aim of preventing unnecessary admission to hospital. Access to these services will be via a single point of access (Call for Care). Health and social care referrers will hand over the patient, and often complex family, care needs to the service who will assess the patients' needs and mobilise appropriate services and equipment, including a two hour response and support (both social and health care support). The service will be accessible to all health professionals and provide other services, like EMAS, with support so patients can remain at home where clinically appropriate, and will also be able to access step up bedded capacity should a patient require a period of rehabilitation. The Strategic Commissioner will agree with each of the ICPs the optimal hours the service will operate, the pathways, and how it will integrate with its PCNs.
Community Crisis Response	Out of hospital crisis response will centre around an integrated rapid response service that will: Respond within two hours (accessed by the single point of access) of referral in line with NICE guidelines, where clinically judged to be appropriate, thereby preventing A&E attendances and unnecessary admissions to hospitals and residential care; Provide a 'pull approach' by supporting the active management of patients at the front door to prevent A&E attendance and

	admissions by ensuring urgent response pathways are utilised appropriately to prevent decision to admit; and Support and accelerate complex discharges into the community from hospital. This urgent response and recovery support will be delivered by flexible joint health and social care teams that include GPs, allied health professionals, district nurses, mental health nurses, therapists and reablement, and will be fully integrated with PCNs and local hospitals. The integrated rapid response service will deliver holistic assessments and short term interventions based on an acute medical health conditions within the patient's usual place of residence wherever possible, or refer into a 'step-up' bed. The integrated rapid response service will make appropriate referrals and have direct access to other community providers. The Strategic Commissioner will agree with each ICP the hours the service operates, duration of care packages provided, how the service supports the active management of patients at the hospital front door.
Community 'step-up' beds	Step-up beds will be used when it is not safe to support people in their usual place of residence, an assessment is needed and patients are likely to benefit from a short term bed based in patient stay. They will be accessed through the single point of access. The Strategic Commissioner will determine with the three ICPs the location and number of step-up beds on an ongoing basis including in community hospitals, a ward on an acute site and / or in the independent sector to ensure they meet local need. Local PCNs will be looked to for medical cover to the beds.

ii) Pre Hospital Urgent Care

Primary care has a key role in the delivery of two of the four initiatives within this area.

Initiative	Description
Integrated Urgent Care Service	The Strategic Commissioner will commission an Integrated Urgent Care Service that operates across all three ICPs that is comprised of two elements; an integrated Clinical Assessment Service (CAS) and Urgent Treatment Centres. The CAS will move from a 'hear and refer' to a 'consult and complete' model, with the aim to close the majority of calls within its services or make a direct booking into another service for example a GP surgery within a PCN or Urgent Treatment Centre. This consult and complete model would move towards reducing reliance on A&E referral and ambulance conveyance unless clinical presentation indicates this is the only appropriate course of action. A single entry point via NHS 111 either by phone or internet based NHS 111 online applications. These calls (or online referrals) will be received and triaged by 111 call handling staff with appropriate calls be passed to the Clinical Assessment Service for further clinical assessment. Patients who then require treatment face to face (rather than telephone) will be directed to an appropriate service which may be accessed via a booked appointment. One of these options for patients with a minor injury or illnesses will be an Urgent Treatment Centre. The Strategic Commissioner will agree the pathways and conditions that are managed by the CAS and how it integrates with PCNs with the three ICPs to ensure they meet the needs of the population. In addition the Strategic Commissioner will procure an out of hours service across Nottingham and Nottinghamshire to a single specification that provides face to face treatment and home visits
Ambulance Conveyance and Arrivals	The Strategic Commissioner will work with the regional ambulance provider, East Midlands Ambulance Services, to ensure timely responses so patients can be treated by skilled

	paramedics at home or in a more appropriate setting outside of hospital. This will be done by increasing 'hear and treat' and 'see and treat' services and ensuring access to a range of services including Call for Care and Community Pathfinder, thereby reducing the number of conveyances to A&E departments. The emerging role of the community paramedic will further support the PCNs to manage patients in their own homes
Front Door Triage and Divert	When patients present at A&E there are still opportunities to provide alternative care rather than assessment within A&E and potential onward admission. Primary Care Streaming will be provided together with triage and divert supported by a multi-disciplinary front door team who are experts in signposting and finding alternative care, where needed, in the community. Professionals will work to the same thresholds, providing an appropriate response across the spectrum of urgent care. This team and service will be part of or integrated with the Community Crisis Service depending on the model agreed between the Strategic Commissioner and the ICPs. Senior decision makers are key to the success of the A&E. When patients enter the A&E a decision making clinician will see new patients on or as close to arrival as possible. The A&E team will not admit a patient likely to be able to go home just to avoid breaches of emergency care standards.
Mental Health Liaison Service	All age mental health liaison services will be available in all acute trusts 24/7 providing direct support into A&E as well as wards to support admission avoidance and early discharge. These services will meet the 'core 24' service standard.

iii) Hospital Care – Flow and Right Place

The initiatives within this strategic area are predominantly around operational practices within the acute hospitals, although improved management and utilisation of community bed capacity, as well as supporting the timely discharge of a patient to their own home, is needed to support this.

iv) Effective Integrated Discharge

Initiative	Description
Integrated Discharge Function	Within 14 hours of patients being admitted to a hospital an expected date of discharge will be identified. Hospitals will continue to build on the Red/Green day approach with regular audit of practice and internal challenge to ensure treatment time is maximised and waiting time is minimised; at every stage of the patient's journey. Regular ward rounds will take place (twice daily) to identify all patients who are medically optimised for transfer/discharge and discharge processes will operate 7 days/week. To support people to leave hospital at the earliest opportunity, the Strategic Commissioner will agree a model of integrated discharge with each ICP that will be delivered through a dedicated system wide integration function with integrated accountable leadership and management. Interdependencies between organisations and teams will be defined to increase transparency and minimise duplication. Where patients have been admitted from care homes or nursing homes a trusted assessor process will be put into place.
Discharge to Assess and Manage	The vast majority of patients (~85%) will leave hospital with no ongoing care needs, these patients will be discharged in a timely manner. The remaining patients will need to leave hospital with ongoing support when declared to be medically optimised. When an intensive level of care (daily and/or 24 hour care) is agreed the patient will be admitted to either i) Urgent response/intensive rehabilitation at home for home based daily rehabilitation; ii) Intensive rehabilitation within a bedded facility; iii) ongoing assessment and care to assess future needs. When a less intensive level of care is agreed, the patient will be supported either i) Within their usual place of residence with health and/or social care support; or ii) Within a bedded facility to receive rehabilitation, if they are non-weight bearing and their needs cannot be met in an alternative setting or if they are requiring a DST CHC assessment. The Strategic Commissioner will determine with the three ICPs the location, type, duration of care package and number of step-

	down rehabilitation beds on an ongoing basis, supported by bed utilisation reviews, and the required capacity for intensive rehabilitation and less intensive rehabilitation, and the duration of care packages to be provided within patients' homes on an ongoing basis.

7.3 Workforce configuration

There will continue to be innovative approaches to the operational integration of services to support patients presenting the highest risk of attendance at emergency departments or admission, for example:

- Housing officers will be members of the integrated care teams supporting those patients identified under the risk stratification
- Establishment of High Intensity Service User Nurse Coordinators, supporting the interface between the community and the emergency department, connecting patients to a range of local community services around substance misuse, mental health delivered by district councils and the voluntary sector.
- Care coordinator roles around complex individuals that present across a number of partners and agencies
- Community technicians and paramedics to reduce inappropriate conveyance to the hospitals.

In particular the Nursing and AHP workforce will look to work across organisational boundaries to support the reduction on pressures on the emergency pathways. This will include:

- Working to support care home staff to have increased skills and competencies, to support the most frail and vulnerable, and therefore reduce unnecessary hospital attendances and admissions.
- Supporting the interface between the hospital and the community to enable timely repatriation of patients from hospital. The Integrated Discharge Function will require community staff to work closely with hospital ward staff to ‘pull’ patients through the hospital system to support their return home.

Providers will need to work collectively to address where there are recognised shortages in workforce and address how these can collectively be addressed. For example:

- Availability of homecare provision is known to impact on discharge form hospital. Providers need to innovatively address how they can acquire additional skills which will assist in supporting comprehensive integration which will support the urgent care system flow.

7.4 How services will be delivered

Each ICP will undertake work to understand demand and capacity in secondary care.

GPs will continue to offer extended access and will focus on improving the utilisation of pre bookable appointments.

PCNs will continue to work with community provider partners in identifying those most at risk of hospital admission and will proactively put in place plans to manage the particular issues identified; this will be far and wide reaching to include ill health, social care needs and determinants wider than health such as housing and debt.

The ICS expects that a common set of outcomes is adopted across PCNs within the ICPs in Nottingham and Nottinghamshire. Where appropriate, a consistent model for delivery will be adopted by all geographies. Primary care, community services and local authorities will be key partners in providing proactive case management.

Each practice population will be reviewed using a common risk stratification tool that will identify the patients who are most at risk of attendance at or admission to hospital. Once identified some patients may only require a simple intervention that reduces their risk and will not require a full care plan and regular review. For practical reasons only those most complex patients who remain high risk will have regular reviews of their care plans. Other patients will be reviewed as the data iteratively escalates them back into the risk thresholds.

Interventions and care plans agreed should concentrate on managing the patient's needs in the community. If patients do attend A&E or require admission to hospital the care plan will be available to hospital staff and will detail jointly agreed "ceilings" of treatment (as well as care), including a comprehensive social history to allow for effective discharge planning at the point of admission.

The NHSE new care model - Enhanced Health in Care homes framework is being rolled out and the framework aims to enhance 7 core elements and 18 sub elements to maximise benefits of existing works to improve the quality and safety of care for residents living in care homes. Many of these elements will support hospital avoidance.

7.5 Governance and Operational Arrangements

The assurance and monitoring of this will be carried out through the ICS Primary Care Programme Board and the ICP A&E Delivery Board

The Joint Primary Care Commissioning Committee (JPCCC) will provide oversight.

7.6 Resourcing and Costs

The ICS will receive £5 million transformational funding in 2019/20 which has been allocated across the three ICP footprints. In line with the criteria for its investment, schemes are being prioritised which will support system flow, reduce demand on emergency services and provide return on investment.

Areas in include:

- The development of an Intensive At Home Care Service which will include short term overnight care. This will enable patients to be discharged directly home from hospital, to enable their ongoing care needs to be appropriately assessed in the familiarity of their own home, rather than being transferred to a community bed.
- Further investment in the case management of High Intensity Service Users regularly attending the Emergency Department. This will ensure that there is a comprehensive anticipatory care plan for individual patients that has been developed and therefore owned across the system.
- Liaison Psychiatry in the community to support the integration and interface between physical and mental health management. This will ensure patients have an overarching assessment and treatment plan that brings together their whole presentation, from a mental and physical health perspective and ensure appropriate utilisation of acute care only when clinically indicated.
- Development of an integrated end of life care service that is co-ordinated and personalised through anticipatory care plan discussions allowing patients to be cared for in the their own home and avoiding unnecessary attends at the hospital.

8 Key element 3 - People will get more control over their own health and more personalised care when they need it

8.1 Current Situation

NHS England named the Nottingham and Nottinghamshire ICS as a demonstrator site for the comprehensive model of personalised care. The vision of personalised care in the ICS is to maximise independence, good health, and wellbeing throughout people's lives, shifting the focus from 'what is the matter to you' to 'what matters to you'.

The ICS is working to give people access to a range of services that enables them to make choices that will focus on self-care without unnecessary intervention, developing access to an array of appropriate choices to support this. For those who need more assistance, people are offered personal budgets, personal health budgets or integrated budgets in order to ensure meaningful choice and control, resulting in both health and social care that meets the person's needs. A person-centred approach is used to empower all people using health and social care services in order for them to build their own knowledge, skills and confidence to self-care.

In 2018/19, after signing a memorandum of understanding in 2018/19 with NHS England, the ICS and partner organisations have delivered:

- A clear vision for implementing personalised care in line with the NHS Long Term Plan and Universal Personalised Care: Implementing the Comprehensive Model
- System ownership, especially at senior level within ICS organisations, with many starting to see personalised care as a solution
- Shared leadership across health and social care, working as a team
- 2,321 PHBs/integrated budgets, 18,519 personalised care and support plans, and 14,662 self-management and community support plans in 2018/19
- 199 looked-after children and young people with a PHB, with 100% reporting that they feel better about their quality of life
- Patient Activation Measures implemented within pulmonary rehab (resulting in learning to guide further roll-out in 19/20)
- Programmes of workshops including personalised care and support planning, health coaching, and expansion of social prescribing

- A common quality framework and guidance for personalised care and support planning
- Strategic co-production involved in all stages of project planning, delivery, and service development via the My Life Choices group of people with lived experience

Primary care has been a key part of delivering these achievements in 2018/19 and will continue to play a strong role as we move forward in 2019/20 and beyond toward the ambitions of personalised care.

8.2 Role of Primary Care in Personalising Healthcare Services

The focus will be on 'what is important to you' rather than 'what is wrong with you' and will be achieved through patient engagement and activation being fully embedded within each PCN. There will be a focus on personalisation and personal health budgets which will also enable a more proactive approach to maintaining well-being.

8.3 Workforce Configuration

To successfully deliver personalised care, the ICS is working to train and equip staff involved in the delivery of all people's care to identify self-care needs and take a flexible, holistic approach to people's needs with a strong prevention focus, encompassing person-centred approaches. This will develop a workforce which is trained, equipped, and supported to deliver preventative and person-centred approaches and includes:

- Production of a toolkit to provide the ICS workforce with the knowledge and skills to understand and deliver personalised care
- Embedding personalised care in induction, training, supervision and appraisals
- Developing professional skills and behaviours to deliver PCSP as fundamental ways of working across health and social care staff
- Establishing support networks for link workers, navigators, health coaches or community connectors
- Carrying out a train-the-trainer programme to empower members of the workforce to help spread the personalised care approach with their teams and colleagues

In 2018/19, 53 colleagues across the ICS, including those from primary care, received training in health coaching conversations. By 2020, the ICS personalised care team will increase this to 250.

The ICS will embed at least one link worker in every PCN in 2019/20; these link workers will support primary care by signposting people and connecting them with groups and organisations within their community alongside work toward developing local organisations and groups within the community

8.4 Service delivery and implementation

A multi-disciplinary approach to care coordination, reflecting the outputs of segmentation/stratification, will be embedded that breaks down the traditional silos between primary and community services and supports greater integration between health and social care. Each ICP and its PCNs will agree a standard operating model (including capacity requirements) and shared accountability structure for care coordination with the commissioner, with clearly defined responsibilities for each person involved, including the individual receiving the care, the GP and other members of the integrated health and care teams. This will include the frequency and focus of care coordination reviews, the presence of coordinators in practices outside of review meetings, the use of real time information outside of coordination reviews and referrals to disease/condition management programmes. This responsibility and accountability structure will be transparent across organisations and the performance and results (KPIs) of the approach within each PCN defined, monitored and shared. .

Building on the successes of 2018/19, the ICS is discussing a subsequent MOU with NHS England for 2019/20 with further targets toward the embedding of personalised care:

- 1,615 people completing the Patient Activation Measure (PAM)
- 15,000 people referred for self-management support, health coaching and similar interventions
- 15,000 people referred for social prescribing community groups, peer support and similar activities
- 19,580 personalised care and support plans or reviews
- 2,900 personal health budgets or integrated budgets across a range of cohorts

Primary care plays an important role in working toward these targets and developing a culture where a different, person-centred conversation is the norm and people are recognised as equal partners.

i. Personalised Care and Support Planning and Personal Health Budgets

The ICS will build on the successes in 2018/19 to continue the expansion of personalised care and support planning and budgets. This includes expanding both within existing cohorts (such as continuing healthcare, looked-after children, NHS and direct payment carers' breaks, joint-funded budgets, Section 117 aftercare, and personal wheelchair budgets) and expanding to additional cohorts, such as neuro-rehabilitation in Mid-Nottinghamshire, further areas of mental health (including the personality disorder cohort), fast track, and cancer (in partnership with Macmillan).

In 2019/20, the personalised care team will continue working toward a digital solution for sharing the information in the personalised care and support plans between teams across the ICS, building on current work to increase interoperability between primary care systems (such as SystmOne) and other systems across the other health and social care organisations in the ICS.

Alongside this, the 'All About Me' one page profile document is an important element in the shift to personalised care. It forms the first page of a personalised care and support plan and is the starting point to summarise what matters to a person and how they would like to be supported. In 2019/20, the personalised care team will continue to expand the use of the 'All About Me', including with primary care colleagues.

ii. Health Coaching

The ICS will train 250 staff in health coaching by 2020, including those from primary care. This will be evidence-based and include primary and secondary prevention approaches which have an initial focus on delivering outcomes over a short-term timescale. This training will support staff in all interactions with people to have brief conversations on how they might make positive improvements to their health or wellbeing, seeking to have a significant impact on population health through supporting people and their families to live healthier lifestyles.

iii. Patient Activation Measure (PAM)

The ICS personalised care team will continue to drive rollout of the Patient Activation Measure (PAM) tool across the ICS through an action

plan identifying specific cohorts to roll out to each quarter, building on learning from the initial cohort of pulmonary rehabilitation in 2018/19 and working with Sheffield, who have implemented PAM on a wide scale, as a mentor site. The ICS aims to complete 1,615 PAM assessments in primary care in 2019/20.

Through PAM, primary care staff can support people to manage their health in a way that empowers them and suits them best, tailored to their activation level (a person's knowledge, skills, and confidence). This includes those with long-term conditions. Using the results of PAM, primary care colleagues can then support people to build their knowledge, skills, and confidence, leading to improved self-management.

iv. Shared Decision Making (SDM)

Shared decision making (SDM) involves working with clinicians and practitioners to ensure they involve people more fully in designing support around individual needs, meaning equipping people with the knowledge that they need to then be an equal partner in care and treatment decisions. The ICS personalised care team aims to extend SDM to at least two further clinical situations in primary and secondary care and at the primary/secondary care interface, targeting areas where it will have the greatest impact.

v. Community Connectivity and Community Development

Community connectivity programmes are already in place in some areas of Nottingham and Nottinghamshire; in 2019/20, the ICS will extend this capability ICS-wide through establishing at least one link worker per PCN while creating and embedding a social prescribing and community connecting model within ICP and PCN areas. This approach will aim for people to be easily referred to these link workers from a wide range of local agencies, including primary care, local authorities, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations.

Alongside the advent of these link workers, the ICS will work to strengthen and increase capacity to support this community connecting, encouraging a vibrant and active community and self-care sector. This will allow primary care professionals to have confidence when

connecting people to neighbourhood and community groups and local organisations.

The ICS will work in partnership with Community and Voluntary Service (CVS) organisations to establish clear KPIs for community development in the VCSE sector to work to ensure a safe referral system is in place, meaning that primary care colleagues can feel assured when referring people to link workers for community connectivity.

This work will support community groups with all relevant aspects to ensure both people and link workers are safe. This includes, but is not limited to, insurance, safeguarding, lone working, first aid, data protection, DBS checks, food safety, and working with vulnerable citizens. Through this work, referral agencies and statutory bodies have an honest and transparent relationship with VCSE organisations, allowing innovative community initiatives to establish themselves without being prevented by barriers around risk aversion in statutory agencies. The ICS personalised care team will work with VCSE organisations to create reasonable and safe referrals, based on what matters to people while minimising bureaucratic controls and working to overcome an overly risk-averse approach to local community development.

The ICS will also work to further develop digital resources that primary care colleagues can point people toward such as Nottinghamshire Help Yourself and Ask LION for signposting and community support.

8.5 Governance and Operational arrangements

The ICS personalised care team is working toward ensuring personalised care is a golden thread throughout all work at the ICS, ICP, and PCN level and is included as a strategic priority throughout ICS key system and planning processes, working to embed system-wide leadership through a shared understanding of the relationships between the social determinants of health, lifestyles, and health behaviours.

Wording around key elements of personalised care will be included for all new or revised service specifications. The ICS will work in 2019/20 to build a personalised care approach into all commissioning, contracting, and payments, joining up commissioning across primary care and other organisations and providers to maximise funding and reduce duplication. This will maximise funding, reduce duplication, and provide greater flexibility within contracts to provide choice and control.

8.6 Resourcing and costs

The majority of resourcing and cost in 18/19 and 19/20 have been managed through the use of NHSE Memorandum of Understanding (MoU) monies.

In 19/20, the programme has received £225,000 NHSE MoU funding. Much of this, combined with funding from 18/19, has resourced the programme team, comprising:

- 1 Programme Manager
- 1 PMO
- 5 Project Managers
- 1 Administrative Support

The Project Managers have been aligned to key work areas, this includes one focusing on workforce training and culture change and one focusing on our Integrated Accelerator Pilot, developing integrated health and social care working arrangements. The three remaining Project Managers have been aligned to the three ICP's to allow for close working and development of the personalised care agenda at an ICP level. All Project Managers report into a Programme Manager who ensures a consistent approach across the whole ICS footprint.

This is a different structure to the one used in 18/19, shaped by our learning from that year and a response to the development of the ICP's and PCN's.

The remaining funding has been used to fund workforce training sessions, the strategic coproduction group called My Life Choices, evaluation activity and digital development.

Moving into 2019/20 CCGs and provider organisations will need to look at more sustainable plans for releasing resource to manage personalised care. The CCGs have already demonstrated their long term commitment to personalised care by developing a small personalised care team that sits within the newly created CCG structure for Nottinghamshire, predominantly focused on Personal Health Budgets. This team is separate to and compliments the programme team. In order to make the personalised care model sustainable, and to build upon the work of the programme, alignment with ICP's will be important in order to embed personalised care within the wider system. Long term, oversight will be required at an ICS level to ensure a level of consistency of approach across the whole ICS footprint.

9 Key element 4 - Digitally-enabled primary and outpatient care will go mainstream across the NHS

9.1 Current Situation

Primary Care in Nottinghamshire has made significant progress in the delivery of overall the strategic digital plans to support the 19/20 contract requirements and foundations for the Long Term Plan.

The deployment of numerous technological solutions supports improved information sharing, infrastructure and digital maturity. These key enablers deliver the ambitions set out in Nottinghamshire's Local Digital Roadmap[1] (LDR), which has now largely been delivered, and the emerging ICS digital strategies.

Clinical Information Sharing

The CCGs, in agreement with other organisations has successfully rolled out the Medical Interoperability Gateway (MIG) which is used to deliver information to the Nottinghamshire Health and Care Portal. This allows data from GP practices operating to be viewed in other agencies such as emergency departments, community and social care enabling them to make better, informed decisions about care.

The Medical Interoperability Gateway (MIG) also supports information sharing across Out of Hours, Community Services, GP Federation(s) and Mental Health Services. In addition, an End of Life care dataset bought on line through the Electronic Palliative Care Co-ordination System (EPaCCS) is available to all primary and community care providers as well a number of third party care providers across Nottinghamshire.

Use of Information to support care

The GP Repository for Clinical Care (GPRCC) has been developed to support clinical workflows across the community. Data is received nightly from GP, community, mental health, acute provider and social care systems. Over 100 workflows aimed at clinical coordinators, pharmacists, GPs, community teams and mental health are derived in keeping without our clinically led strategy. Risk

[1] The full LDR can be found at *https://www.connectednottinghamshire.nhs.uk/media/1441/connected-nottinghamshire-health-and-care-local-digital-roadmap-v41-public-release.pdf*

stratification and the Electronic Frailty Index are used to prioritise our response to acute workflows. A dashboard informs practices, PCNs and CCGs about how it is performing over hundreds of indicators monitoring key outcomes.

Data standardisation and digital library

F12 is a locally built solution for standardising the collection of data across Long Term Conditions and referrals. All local guidelines and forms are accessible from a central library that is referenced by our other projects along with references to key National guidelines. Information from standard templates is extracted into a database, hosted by e-Healthscope. These can be used to populate other data collection templates used elsewhere in the community.

Information governance

The CCGs have achieved an acceptable level of IG toolkit compliance (including partners) and several pieces of additional assurance work have taken place, relating to shared information tools, in the last 12 months. Nottinghamshire is also engaged with accredited independent third party suppliers to conduct exercises such as PEN/Vulnerability testing when delivering or changing technical infrastructure and Privacy and Security Impact Assessments are undertaken on new technology implementations. Cyber security remains an important consideration in all technology enabled projects. Nottinghamshire adopt robust processes in data security and IT security.

NHS App

Nottinghamshire is a pilot area for the national NHS App which has now been deployed across the whole GP estate in Nottinghamshire and Nottingham. This is a significant step in modernising GP services, and should make life easier for patients and for practices, with the ability to book and manage appointments online, order repeat prescriptions, view your medical history and access 111 Online, among other services.

UEC

As part of the UEC services redesign Nottinghamshire Practices have already completed the technical enablement to allow appointment booking into GP appointments. Following this work is underway to release appointment slots in line with the redesign planning and capacity requirements.

GP IT Futures

The end of the GPSoC contract represents both a challenge and an opportunity to General Practice and the PCNs. The move to a GP IT Futures compliant system will enable new models of digital exploitation and ensure data sharing can be achieved in line with the aspirations of the wider health and care system for the Nottinghamshire ICS. In order to achieve this Nottinghamshire Health Informatics Service will be a key partner and will be commissioned to support practices.

Assistive Technology

Several pieces of work are underway that use technology to support care delivered outside of traditional care settings and that support self-care by patient/citizens. Nottinghamshire has a number of projects underway utilising TeleCare devices in patients' homes in the Greater Nottingham area which include self-care applications and a Tele-dermatology service. Alongside this another initiative using 'Flo' (which is a text messaging 'Telehealth' service to patients) is used widely in the Mid Nottinghamshire area is supporting key cohorts of patient such as those with early heart failure and COPD diagnosis.

9.2 Role of Primary Care in delivering digitally enabled healthcare

The vision is to transform the way people experience access General Practice and Primary Care services across Nottinghamshire. By providing digital health tools and services that connect them to the information and services they need, when they need them it enable people to access care in a convenient and coordinated way, promoting independence through the digital tools they are familiar with in other aspects of daily life.

General Practice across Nottinghamshire will support the NHS England commitment to become much better at involving patients and their carers by:

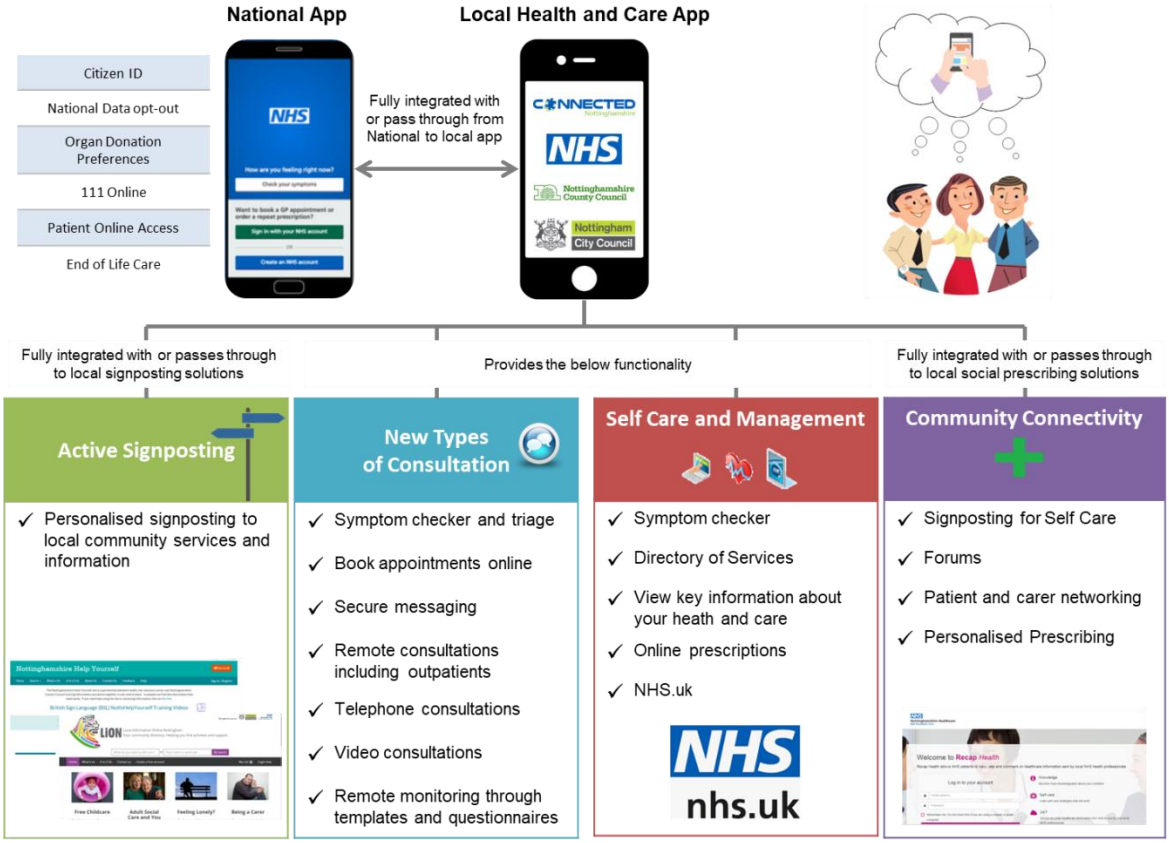
- empowering people to manage their long term conditions and make informed decisions about their care and treatment
- supporting people to improve their health, giving the best opportunity to lead the life that they want

Public Facing Digital Services

In order to support this transformation in the way GP services are delivered practices will need to give people the tools they need to assist them in managing their own health condition, improve their wellbeing and provide

information to enable them to live healthier lifestyles and prevent the development of ill health. This includes the deployment of digital tools to support Self Care and Management, Active Signposting, Community Connectivity and New Types of Consultations (including online and video consultation).

Figure 9-1 - Integration of local capabilities with NHS App



We shall procure a local Application to deliver this functionality. This App will be linked to the NHS App, to provide identity management via a single sign on, and in time it will enable patients to manage their interaction with some secondary care services as well as general practice. This will be rolled out across Nottinghamshire by April 2020, with further development beyond that.

This will enable patients to:

- adopt preventative approaches within their lifestyles
- have easier and more convenient access to key information to enable them to better support themselves at home
- manage and control long term conditions better
- access more convenient methods of consultation (and thereby reduce the number of missed or avoidable appointments)

The intention is that by promoting self-care and signposting to appropriate

services this initiative will reduce demand on general practice as well as supporting more flexible working patterns. This in turn will link to GP retention plans and attracting clinicians back to general practice.

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Population Health Management (PHM)

The development of PCNs will require service transformation based on this neighbourhood unit of delivery. This work is interwoven with other plans to support the PCN digital requirements and will require clinical and managerial input at all practices.

Building on the leading PHM work across GP Practices in Nottinghamshire identification of proactive care interventions has already surpassed 7,700 per month in 2019. Linking into the ICS led work to segment and identify cohorts of patients in the priority multi-morbidity groups primary care teams will further develop and refine the technology that is used in the GPRCC and eHealthscope tools described above. In plain terms, this analytical approach will enable care to be delivered to those patients that need it most.

To implement PHM we will refine and codify standardised data elements as well as work with technical systems leadership on the overall collection process with a focus around mental health, community and social care. Through the work identified in the collection of minimum data sets as well as future state IG and system alignment we will provide a PHM approach that is comprehensive picture of each person's needs, which will better inform the PCN and ICP of the need within their system. To do this we will implement a consistent and well-defined segmentation and stratification approach. By effectively segmenting the population into cohorts and then stratifying the risk levels, the PCNs/ICPS can understand and account for variations in population wide measures for each cohort.

Within Nottinghamshire we have a history of gathering and integrating this 'intelligence' via our local data warehouse. Through this process we have worked and developed the necessary trust to share information to enable PHM to become a reality. Our General Practice Repository for Clinical Care (GPRCC) pulls data from GP systems (SystmOne and EMISWeb), community providers (CityCare, Local Partnerships (LPs), Primary Integrated Community Services (PICS)) and acute hospitals (both Nottingham University Hospital NHS Trust (NUH) and Sherwood Forest Health Trust (SFHT)).

9.3 Workforce configuration

Implementing the Public Facing Digital Services described above will require significant change management. An implementation plan has been produced with a timeframe from mid-2019 for 18 months. The plan identifies the requirement for GP Fellows, GP digital leads, practice nurse digital champions and practice managers to work with general practices. Funding has been identified from the GP Forward View programme.

It is anticipated that this will lead to some changes in clinical work patterns within each general practice as they adapt to digital working but this will be within existing resources. It is hoped that, as described above, this may help alleviate some of the current level of demand in primary care.

Effective organisations are underpinned by successful, resilient and well-supported IT systems. For the ICS to continue our success we must be supported by high quality, resilient, responsive and cost-effective IT services. The increased reliance on IT and the probable extension to the hours within which primary care services are accessible to patients means that the IT service providers must respond to cover the broader scope and time required and meet the rising customer expectations. The ICS will review the arrangements for IT support and ensure fit for purpose, appropriate and cost effective user support is in place to underpin the ambitions of this strategy.

The ICS recognise the importance of training and its vital contribution towards best and efficient use of clinical systems and IT. Through the revised GP IT Futures contracts, the Primary Care Development Centre and local provider arrangements, the ICS will ensure appropriate training is provided to all Nottinghamshire practices.

In addition, PCNs will require additional capabilities to support their new functions and allow greater sharing between individual GP practices. Much of the technology to deliver this is already in place. A review of the analytic support function is currently underway to determine the resources, including workforce, required for this.

9.4 Service delivery

The ICS hold a Service Level Agreement (SLA) between their informatics service provider and the GP practices. This SLA identifies and details all the elements necessary to maintain IT services. It provides a framework for the provision of specified services including operational support, desktop support, network support, application support, programme management and business change, training and telecommunications, where locally agreed and funded. The Strategic Commissioner will continue to review this service against national guidance within the GP IT operating model to ensure value for money in GP IT investment.

Arrangements for GP IT funding are changing as the current GPSoC arrangements are due to end in December 2019. Funding for GP systems will be allocated directly to CCGs on a per capita basis. Guidance is still awaited on future procurement arrangements.

The other elements of the primary care digital landscape are at varying stages of development and implementation:

- Data sharing via the Medical Interoperability Gateway (MIG) is already live
- GPRCC is already working, and the functionality is constantly reviewed and upgraded - Phase 4 implementation will occur during 2019/20
- The Public Facing Digital Services (PFDS) App will be procured in 2019, with implementation across Notts phased through 2019/20 with the aim of every practice being able to offer online consultation by April 2020
- Additional functionality, including video consultation, intelligent management of long term conditions, and links to secondary care and mental health services should be in place by October 2020.

9.5 Governance and operational arrangements

Delivery of the strategic aims will be overseen by the IT Management Board, which reports to the ICS Board. A number of working subgroups report to the IT Management Board, covering records and information governance, technical issues, and project delivery, such as PFDS and GPRCC.

Operational oversight will be provided by the Primary Care IT team, within the Finance directorate of the CGGs, who will manage the SLA with the informatics service provider. Currently, work across the health community is facilitated by a team called Connected Nottinghamshire, but his will be succeeded by different substantive arrangements in 2020.

Across Nottinghamshire we have a diverse population including individuals with specific language or communication requirements. Quality Impact Assessment

(QIA) and Equality Impact Assessment (EIA) are undertaken for all projects and are a key consideration at every stage of the project lifecycle.

9.6 Resource requirements

Future funding for primary care IT clinical systems will be allocated on a per capita basis, currently projected to be £1.26 per patient per annum. However, this funding stream alone is insufficient to deliver our vision for digital transformation in primary care.

To support delivery of this strategy and drive efficiencies there is a requirement for new funding and innovative use of existing funding for both capital and revenue investment. Where possible joint procurements will be utilised through the use of the Midlands Accord, procuring systems and solutions exploiting scales of economy in order to reduce the financial burden on individual organisations and maximise cost savings.

It is anticipated that applications for funding will be submitted against a number of national, regional and local finance schemes. These include but are not limited to; GP Forward View funding, Health Service Led Investment fund, Local Digital Roadmap/National Technology fund, Developing Digital Maturity Fund, Academic Health Science Network funding and other opportunities as they arise.

As part of the controls for each project, identification of finance and controls on expenditure will be managed by the project lead and reported to the appropriate programme board or IGM&T meeting. In addition to this each project will have a benefits evaluation, including return on investment and value for money calculation (where appropriate). These controls will provide assurance to each project board attributed to the individual CCG area.

With national policy changing to move more responsibility for IGM&T to the ICS it is recognised that additional financial pressure will need to be considered. The Health and Social Care Network (HSCN) and GP Public Wi-Fi projects are examples of projects that have to be implemented but that only have limited financial support (two years). This approach must be balanced against limited revenue locally. In order to ensure IM&T projects are affordable and linked to transformation and improvement locally projects will be prioritised annually with the ICS.

10 Key element 5 - Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere

10.1 Current Situation

Nottingham and Nottinghamshire have a fully operational ICS that includes all statutory NHS organisations, Local Authorities in Nottingham and Nottinghamshire and includes: Clinical Commissioning Groups (CCGs) and a unitary and two-tier local government structure with a City Council, and a County Council with seven District Councils as well as the two major hospital trusts, a large mental health, learning disabilities provider and number of community providers that serve the Nottingham and Nottinghamshire population.

The ICS Board meets monthly and is chaired by a Non Exec Director and provides system leadership, oversight and assurance of successful delivery of the whole systems objectives and outcomes. It brings together all Chief Executives and Non-Executive Chairs along with Clinical Leads from statutory health and social care organisations across Nottingham/Nottinghamshire. The Board is committed to strengthening its approach to providing greater transparency to key stakeholders and will continue to embed a unified leadership and governance approach with partners, clinicians, Public Health expert's patients and citizens that affiliates and meets national targets within each organisations strategic objectives.

As an ICS we are currently working with a wider group of representatives from other organisations that deliver local services such as the voluntary and community sector, giving them a forum to contribute to the development of an integrated health and care system where local people will receive better, more joined-up care, closer to home. Local organisations will be better able to keep pace with the growing and ageing population and address some of the current problems in the NHS, while making it sustainable for the future. Benefits will include:

- Those who are largely well today will be helped to stay well.
- Those with complex or advanced long-term conditions will be supported to manage their own care, with a system to escalate care quickly in the event of exacerbations.
- People will remain independent due to prevention programmes and proactive rather than reactive care.
- People will receive care at home and in the community as much as

possible.
- Multi-disciplinary teams will work across organisational boundaries to deliver integrated care as simply and effectively as possible.
- The social value that health and social care can add to communities will be maximised.

10.2 Primary Care's role in the ICS and Mental Health agendas

Mental Health

The ICS has recently published an integrated Mental Health and Social Care Strategy, aiming to transform mental health and wellbeing across the footprint. This strategy is to be factored into all relevant aspects of other ICS work if true integration is to be enabled. This includes the parallel clinical services strategy work around acute, community and primary care services. This strategy represents our system's commitment to the re-shaping of services and other interventions so that they better respond to the needs of our population. We now need to plan together how to achieve this, including where to focus our combined efforts in the short, medium and longer term. We are seeking a seamless service and a step change in people's mental health and wellbeing. Our strategy seeks to recognise that everyone is different and care and support needs to be personalised accordingly, yet everyone deserves equality (with parity of esteem in all situations and scenarios).

Population Health Management

In order to meet the strategic vision of the ICS, The PHM programme will be at the heart of driving this transformational approach forward. The programme will bring key partners together in primary, secondary, social care and voluntary sector providers to fully integrate not just a medical model but an all-encompassing integrated whole system, all-age, person-centred approach, driven by access to physical and mental health and social care in the same place at the same time, with no wrong door, where prevention is at the heart of all we do.

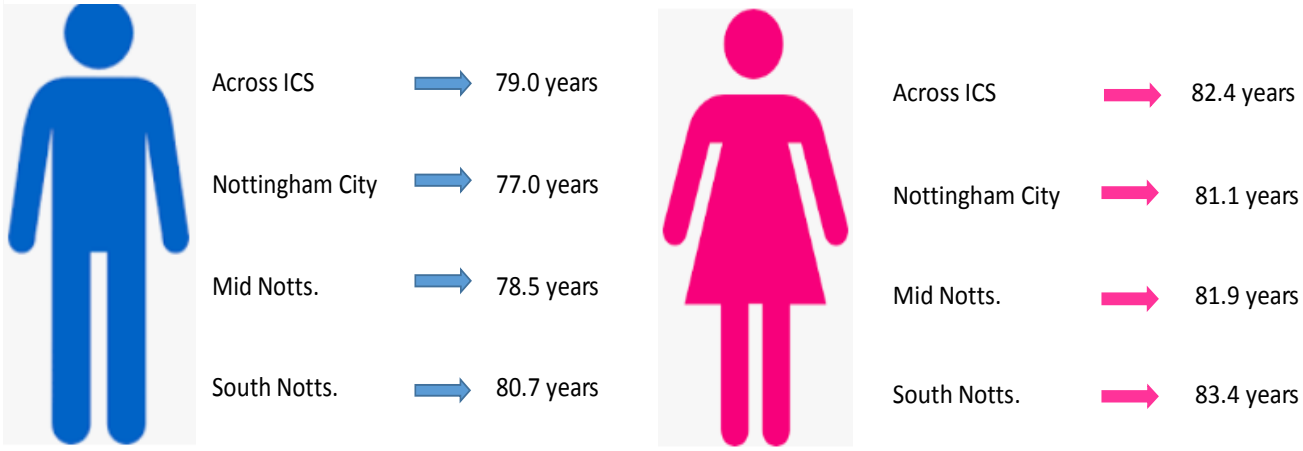
The ICS has identified a significant level of unwarranted variation across our region due to a lack of joined-up services, and a lack of real insight and actionable intelligence about both the needs of our population and standardised interventions to address these. This has led to gaps in health and care outcomes for our population and is a key driver for our system's financial deficit.

We have already undertaken significant work to identify, articulate and quantify the specific gaps and unwarranted variation in health and wellbeing; care and quality; and our baseline financial position. Our aim is to help people to be, stay

or regain good health and wellbeing. To do this we must take a preventative approach and build strong and joined-up community services. Working together in this way will allow us to look across the system at how services are provided and identify opportunities to add value, improve outcomes and eliminate duplication and reduce costs.

We have in the past seen improvements in health outcomes due, in part, to, scientific and technological advances and a better understanding of how our behaviours affect our life expectancy. However, today, for many people a longer life means living longer with multiple chronic conditions. Furthermore, while life expectancy continues to improve for the most affluent ten per cent of the population, Within Nottinghamshire we see this figure stalled or fallen for the most deprived ten per cent (see Figure 10.1). At the same time, the costs of providing care are escalating with many provider organisations facing serious financial challenges, and social care in crisis.

Figure 10-1- Life expectancy by gender and ICP



An average baby boy born in Nottingham City can expect to die 3.7 years younger than one born in South Nottingham. For females, the difference is 2.3 years

Our current approach is underpinned by a rigorous PHM programme structure, utilising a wide range of experts: internal and external, both clinical and non-clinical, in order to understand our population's current needs, activity, cost and outcomes. Our initial focus will be on our population living with Long Term Conditions. Through further sub-segmentation and risk stratification the programme will lead the delivery of standardised, evidence-based pathway/journey redesign approach, with appropriate interventions to achieve the aims of the ICS outcomes framework, and in turn to meet the needs of our population at a PCN level.

The transition towards a PHM approach

The NHS has for many years tried to implement a number of policies that attempt to deliver an integrated approach to health and social care. In 2016, NHS England mandated that all health and social care organisations should form 44 (now 42) geographically-based Sustainability and Transformation Partnerships (STPs), providing a new impetus for integration and collaboration. In 2018, a new form of partnership emerged - an Integrated Care System (ICS) – to take collective responsibility for managing resources, delivering NHS standards, and improving the health of their population. For an STP to become an ICS it has to agree to take on a budget for the health provision of a defined population and demonstrate, system leadership, a shared culture, and that it is capable of implementing an integrated PHM strategy.

The NHS Long Term Plan (LTP), published in January 2019, cements the policy shift towards integrated care and gives a strong boost to the PHM model, reconfirming the need for the NHS to move from reactive care towards a model that embodies proactive PHM.

ICSs are seen as the main mechanism for achieving this. Indeed, the LTP requires every NHS organisation and their local partners to become part of a geographically-based ICS by April 2021. Reforms to the payment system will move funding away from activity-based payments and ensure that a majority of funding is population-based.

There will be a clear process for monitoring and evaluating change within the programme framework. We will quantify the financial impact of the interventions proposed by the programme as part of the evaluation criteria for agreeing these. The approach taken will identify opportunities to address gaps in care, reduce acute emergency activity which is avoidable and which does represents the optimal value-for-money, and shift resource into proactive, targeted out-of-hospital interventions to keep our population well. Ultimately this will underpin our system strategy to achieve financial sustainability and reduce pressure within the hospitals acute sector.

10.3 Workforce Configuration

Redesigning health and care delivery around the needs of our population will require our teams to work in new ways and have new skills as well as offering exciting career and development opportunities to people working in Nottinghamshire. Our People and Culture Strategy sets out our vision for future capacity, capability and behaviours and how we will work with our colleagues to embed our planning into wider system plans to ensure care is delivered in the appropriate setting by people with the right skills. We have set a 10 year strategic horizon to align with the national Long Term Plan and the Nottinghamshire Clinical Services Strategy. However, we will focus on the development of a five year delivery plan (in line with national planning guidance) with the opportunity to review and refresh at regular intervals.

Through the PHM programme we will be able to develop a population health-led approach to shape the skills and future skills that we will need to deliver future models of care using system dynamics modelling. This approach engages clinicians and managers across the system in developing a range of scenarios to bridge the gap between supply and future demand for skills and provides the opportunity to test the impact of new ways of working and new and innovative roles.

Our approach will continue to take a system wide and population health based view of role and team design and cultural aspects of change and includes improvements to our workforce information and intelligence, integrated workforce planning, recruitment and retention, role redesign, attracting the right people with the right skills, career development, training, development and leadership at all levels.

By working together as a system and with our population we will strengthen current teams by supporting them to develop new skills and work in new ways, enable smooth introduction of new roles, developing solutions to support areas where there are shortages, improving integration across sectors and organisations, embedding approaches to prevention, promoting independence, self-care, community resilience and personalisation and enabling change through system wide organisational development and sharing of resources.

Delivering good health and care outcomes will require citizens and communities to understand and take responsibility for their own health and wellbeing. As an ICS we have a role in supporting people, families, carers, communities and voluntary organisations to have the skills and capacity to build that resilience in our communities. The ICS People and Culture Strategy will support development of both our paid workers, volunteers, families and carers.

Further detail on workforce configuration is provided in Section 11.

10.4 Service delivery and implementation

A multi-disciplinary approach to care coordination, reflecting the outputs of segmentation/stratification, will be embedded that breaks down the traditional silos between primary and community services and supports greater integration between health and social care. Each ICP and its PCNs will agree a standard operating model (including capacity requirements) and shared accountability structure for care coordination with the commissioner, with clearly defined responsibilities for each person involved, including the individual receiving the care, the GP and other members of the integrated health and care teams. This will include the frequency and focus of care coordination reviews, the presence of coordinators in practices outside of review meetings, the use of real time information outside of coordination reviews and referrals to disease/condition management programmes. This responsibility and accountability structure will be transparent across organisations and the performance and results (KPIs) of the approach within each PCN defined, monitored and shared.

10.5 Governance and Operational arrangements

The ICS Board meets monthly and provides system leadership and oversight to assure successful delivery of the objectives and outcomes agreed in the STP through the two transformation programmes and supporting workstreams. It brings together all Chief Executives and Non-Executive Chairs along with Clinical Leads from statutory health and social care organisations across Nottingham/Nottinghamshire. The ICS Board is committed to strengthening its approach to providing greater transparency to key stakeholders.

10.6 Resourcing and costs

In order to deliver a sustainable future healthcare model, it is recognised that we will need to shift more spending upstream towards proactive population health and prevention in order to manage the levels of demand for reactive services.

In developing long-term financial plans, the Nottingham and Nottinghamshire ICS has designed an approach to developing a high level financial sustainability model. This starts with understanding current system costs across organisations broken down into a number of cost elements. These elements are based on long-term plan and local priorities and include for example urgent care, community care, primary care.

We know that the current model of care is unsustainable and there is a significant projected financial gap over the next 5 years should we not radically change the overarching clinical model in Nottinghamshire. The financial sustainability model proposes a number of high level levers of change where we will need to implement significant transformation to alter the shape of spend across the ICS. This will inevitably require investment in proactive services in primary and community settings to reduce the need for acute services.

11 Workforce

11.1 Context

National

The NHS Long Term Plan sets out the objective to develop and deliver a national workforce implementation plan in which there are requirements to:

- ensure we have enough people, with the right skills and experience, so that staff have the time they need to care for patients well
- ensure our people have rewarding jobs, work in a positive culture, with opportunities to develop their skills and use state of the art equipment, and have support to manage the complex and often stressful nature of delivering healthcare
- strengthen and support good, compassionate and diverse leadership at all levels – managerial and clinical – to meet the complex practical, financial and cultural challenges a successful workforce plan and Long Term Plan will demand.

The Interim People Plan published June 2019 has provided a focus for immediate action in 2019-20 as well as actions to develop the final workforce implementation plan. These actions are being reviewed and will inform existing delivery plans set in our People and Culture Strategy and delivery plans.

Local

A Nottinghamshire Clinical Services Strategy is currently in development across the ICS, based on a place based model of care. The aim of the overarching strategy is to shift the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate. This will require further workforce planning and modelling to develop delivery plans that will address the workforce implications of this strategy.

The six design principles for the clinical services strategy include the following:

- Care will provided as close to home as is both clinically effective and most appropriate for the patient, promoting equality of access
- Prevention and early intervention will be supported through a system commitment to 'make every contact count'
- Mental health and wellbeing will be considered alongside physical health

and wellbeing
- The model will require a high level of engagement and collaboration both across the ICS and neighbouring ICSs
- The models of care to be developed will be based on evidence and best practice, will ensure that pathways are aligned and will avoid un-necessary duplication
- They will be designed in partnership with patients and the public and will operate across the whole healthcare system to deliver consistent outcomes for patients through standardised models of care except where the variation is clinically justified

In addition to this, the ICS has also set priority objectives for primary care which include:

- a systematic approach to primary care delivery across the ICS to develop local PCNs
- a more integrated and collaborative primary care workforce
- a supported and integrated workforce with a combined focus on prevention and personalisation of care with shared and improved qualitative health and care outcomes utilising population health management data

These national and local priorities both set an ambition and direction that will have a significant impact upon workforce configuration; existing workforce working differently, working in different locations, requiring skills development as well as potential new roles.

The implications for primary care development in supporting this shift in focus on care delivery are two-fold: The first is to ensure that there is sufficient capacity and a sustainability of general practice as a core element to this system change. The second implication is the recognition that the primary care workforce development is a mix of utilising existing roles working differently with development of potential new roles.

Our primary care workforce strategy for the next five years will therefore respond to the challenges identified, and addresses five key areas:

- Planning, attracting and recruiting our future workforce
- Retaining staff and trainees, promoting career paths and talent management
- Role redesign and development of new roles
- Preparing and supporting people to work in new ways, including digital skills development

- Enabling cultural change and leadership development to maximise system effectiveness

Our work programme plan has been developed based on the following principles:

- Securing supply
- Enabling flexibility
- Providing broad pathways for careers
- Widening participation

11.2 Capacity and sustainability of General Practice

Workforce and workload are key issues facing general practice and the pressures experienced both nationally and locally have been detailed earlier in this strategy. These pressures are acknowledged in both the GPFV and *'Investment and Evolution: a five-year framework for GP contract reform to implement The NHS Long Term Plan'*.

System Infrastructure

During 2017-18 and 2018-19 system level workforce development sought to prioritise the capacity and sustainability of primary care, recognising that along with increasing the number of GPs the wider workforce needed to be developed. In partnership with Health Education England (HEE) the establishment of training hubs to deliver training and education and new role development was supported. However, this support has been achieved through non-recurrent funding to supplement the service level agreements in place with HEE. The national announcement of funding to create sustainable hubs was welcomed but has not been realised with HEE withdrawing this funding for 2019-20. We continue to work with HEE and have completed a self-assessment around our system readiness. We will work locally with HEE through 2019-20 in maintaining current support to practices whilst developing the Nottinghamshire Training Hub offer of how we can make the stepped changes needed to support PCNs.

General Practice Forward View

The General Practice Forward View (GPFV) provided both indirect and direct focus on workforce: Indirectly through the resilience approaches support to the training of reception and clerical staff and development of practice managers and directly in seeking to increase the number of General Practitioners, 5,000 additional GPs nationally by 2020. Additional approaches around national programmes to increase clinical pharmacists within practice and recognition of general practice nursing in the development of a 10 point plan also formed part of the GPFV delivery.

General Practitioners

Across Nottinghamshire, great progress has been made in developing and implementing a range of initiatives to support the recruitment and retention of GPs. In establishing our approach and reported trajectory for delivery to meet the Nottinghamshire gap of 77 wte required by 2020 specific aspects of our

workforce were identified. These were gaps in VTS placements, particularly for the Mansfield school, increased attrition of our newly qualified and a higher than national average of GPs over the age of 55 years. We therefore have focused on supply, retention across first, mid and senior years as well as international recruitment.

Supply: Targeted Education Recruitment Scheme (TERS)

TERS is a joint venture between NHS England, Health Education England (HEE), the British Medical Association (BMA) and the Royal College of General Practitioners (RCGP) to support recruitment in areas to which it has traditionally been hard to recruit. NHS England has funded a £20,000 salary supplement to attract GP trainees to work in areas of the country where GP training places have been unfilled. TERS funding of £240k has been utilised in Mansfield and Ashfield CCG to support full take up of GP trainee placements in 2017/18 and 2018/19. All placements have been filled for 2019-20 with interest over and above the original placements with more being supported as a result.

Supply: International GP recruitment

This is a national programme to recruit international GPs, currently from six European Union countries. Initially mid-Notts submitted a bid for 26 international GP recruits. Greater Nottingham submitted a bid to a later tranche for a similar number. However the scheme was heavily oversubscribed and therefore the total Nottinghamshire bid has been limited to 36. Nottinghamshire contributed through our workforce leads in supporting international GP recruitment ahead of implementation of the regional programme team, working with the recruitment partners and regional NHSE leads to maximise the opportunity. Progress has been slow and to date there is only one GP working in Nottinghamshire as a result of the international recruitment scheme. However it is hoped that numbers will increase over the coming months/years as the initiative gains momentum. As a result of the reduced number of international recruits supported for Nottinghamshire and the slow progress our workforce plans have had to move to focusing on better retention strategies and schemes.

Capacity - Additionality of roles

Through a new Additional Roles Reimbursement Scheme, PCNs will be guaranteed funding for an up to estimated 20,000+ additional staff by 2023/24. This funds new roles for which there is both credible supply and demand. The scheme will meet a recurrent 70% of the costs of additional Clinical

Pharmacists, Physician Associates, First Contact Physiotherapists, and First Contact Community Paramedics; and 100% of the costs of additional social prescribing link workers. The funding for these roles will be phased in the reimbursement scheme as follows:

- Clinical pharmacists (from 2019/20)
- Social prescribing link workers (from 2019/20)
- Physiotherapist (from 2020/21)
- Physician associates (from 2020/21)
- Paramedics (from 2021/22)

The PCN approaches to recruitment and introduction in the system of these new roles will (in some, but not all cases) have oversight by the workforce group and ICS Primary Care Programme Board.

There is further support informed by the growth in the core practice contract that will support further expansion of available nurse, GP and other staff numbers.

11.3 GP Retention

Our workforce leads have contributed to the regional team and helped shape the GP retention approaches. Nottinghamshire as a result has received recognition of its GP retention plans and received funding that reflects our being a test bed system.

As the funding has increased to support retention the workforce plan has been developed from separate, lower impact schemes into a coordinated programme, the Phoenix Programme.

The ICS is in the privileged position of having an excellent relationship with the Local Medical Committee who have taken a key role in the development and implementation of the primary care workforce strategy and in particular GP retention. The Nottinghamshire General Practice Phoenix Programme was created in January 2019 to provide a single point of access for workforce schemes in Nottinghamshire. This is hosted by the Nottinghamshire LMC and includes nine workforce schemes:

i. GP Trainee Transition Scheme (Final year registrar and First Fives)
ii. Tier 2 (part of Trainee Transition)
iii. Preceptorship (First Fives)
iv. GP Special Interests
v. Nottinghamshire Post CCT Fellowships (First Five)
vi. Fellowship Lite (First Fives/Mid Years)
vii. GP Portfolio Plus
viii. GP-S Mentoring Service
ix. Clinical Network Leadership Development

A brief description of these schemes is provided below.

i. GP Trainee Transition Scheme

The GP Trainee Transition scheme was set up to support newly qualified GPs as they enter the local workforce by:

- supporting locally trained GP Trainees to gain confidence for independent practice
- encouraging trainees to stay locally
- supporting them to develop a sustainable and enjoyable career path which makes the maximum use of their skills and potential
- developing a workforce able to respond to the NHS 10-year plan

ii. Tier 2 Scheme

This scheme supports the retention of overseas doctors or international medical graduates (IMG) that have completed their GP training in the UK and are looking for a practice to sponsor them for the remaining two years (after five years doctors get indefinite approval to remain in the UK).

There has been some interest in this scheme from practices across Nottingham and Nottinghamshire and practices that express an interest in applying are receiving visits from NHS England staff to support them with the process including accessing funding.

iii. GP Preceptorship

The scheme will offer direct support to trainees as they complete GP training and become available to work as independent practitioners.

GP trainees will be offered a range of support according to their needs which will include:

- access to hosted employment with support, coaching and mentoring through GP-S
- portfolio careers advice through GP Portfolio Plus
- brokering of discussions with potential employers (mainly GP practices but ultimately emerging federations/PCNs once guidance released) through Nottinghamshire LMC
- managed transition into general practice for those requiring sponsorship for Tier 2 visas.
- hands on support during the first 12 months of their employment as independent practitioners (clinical supervision to be provided as part of the employer's offer or through PCNs)
- opportunities for development of enhanced skills through entry onto Fellowship Lite scheme
- access to educational sessions and events 'Life after GP Training'

The GP Preceptorship scheme will build on the existing Trainee Transition retention scheme in providing support to newly trained GPs.

iv. GP Specialist Interests

The monies will be used to fund/part fund diploma places to expand the number of GPwSI in areas aligned to the ICS priorities:

- Dermatology
- Frailty
- Urgent and Emergency care
- ENT
- Gynaecology
- Cardiology
- Respiratory
- General surgery
- Urology
- Endocrinology/Diabetes
- Gastroenterology

There will be an 18-month commitment to remain in the system/pay back. Entry to this scheme will be through GP Portfolio Plus.

v. Nottinghamshire post-CCT fellowships

This involves the development of a Nottinghamshire-specific post-CCT Fellowship scheme, building on the successes of the scheme currently managed by Health Education England (HEE) which has been scaled back in 2018/19.

As per the established approach newly/recently qualified GPs would spend approximately 40% of their time in clinical practice and the remainder on project work, supported by the Nottinghamshire Training Hub Alliance.

This scheme enables participants to develop portfolio careers which may be of more interest than working as a GP on a full-time basis. A Fellowship helps trainees to access a more flexible career, improve networks, and increase project management skills.

Under the existing HEE Post CCT Fellowship Scheme six Fellows were funded and appointed in September 2018. All chose practices in Greater Nottingham for their clinical sessions. Applications have been submitted for 7 in the 2019-20 tranche: 2 x digital technologies, 3 x education, 1 x dermatology and 1 x substance misuse. We are awaiting confirmation of HEE approval.

vi. Fellowship-Lite

This scheme offers the opportunity for newly qualified GPs during their first two years in General Practice to learn additional specialist skills e.g. community Gynaecology or support for urgent and emergency healthcare. It will involve undertaking sessions within different clinical settings for which the trainee will be paid. Fellowship Lite is modelled on HEE fellowships but does not offer a post graduate certificate. Fellowship Lite will offer the first step for new GPs to develop their portfolio career.

vii. Nottinghamshire Portfolio Plus Scheme

The GP Portfolio Plus scheme is available for all GPs in Nottinghamshire and aims to help GPs to enjoy a better working life thus enhancing GP recruitment and retention. The service will link GPs to relevant opportunities after having a personalised one to one with a GP Colleague. GP Portfolio Plus also have a specially created peer support network to provide suggestions to explore interests and direction.

This scheme originated from a survey of GPs approaching retirement. 30 GPs responded to the LMC stating an intent to leave the profession within two years, in the main because of workload, workforce problems and finance. The average age of those known was 52 with the youngest at 35 and oldest at 67. The Scheme launched in May 2018 and had supported 18 GPs by 1 November 2018.

viii. GP-S Mentoring Service

GP-S is a free peer mentoring service for GPs. They offer free mentoring, coaching and signposting. The scheme is now being expanded to include GP trainees in ST3 as well as newly qualified GPs who have been issued their CCT.

Trainees will be entitled to two free sessions (qualified GPs are entitled to four). GP-S can be used by anyone who would like to explore ways to develop themselves. This could be personally, professionally or within their career. They aim to build resilience in the General Practice workforce by allowing time and space to develop personal goals.

ix. Clinical Network Leadership

This scheme is for the aspiring clinical network leaders of the future to include training in how to be a good chair, governance, conflicts of interest, future commissioning and provision.

It is expected that the full benefits of these schemes will be realised as they become more firmly embedded. However, as a system, we recognise that there remains much more to be done.

The workforce plan also supports and promotes the GP Retention (Retainers) Scheme. This long-standing scheme is aimed at doctors who are seriously considering leaving or have left general practice due to personal reasons, approaching retirement, or requiring greater flexibility. The scheme supports both the retained GP and the practice employing them by offering financial support in recognition of the fact that this role is different to a 'regular' part-time, salaried GP post, offering greater flexibility and educational support. Retained GPs may be on the scheme for a maximum of five years with an annual review each year to ensure that the doctor remains in need of the scheme and that the practice is meeting its obligations.

11.4 General Practice Nursing

The challenges within general practice apply to the wider clinical teams. General Practice Nursing specifically, have the following challenges:

- 33 % of the nursing workforce is due to retire within 5 years with little or no succession planning. Currently practices are reliant on poaching recycling experienced nurses already in the primary care system. In addition to this is the impact of workload pressures.
- Nurses reported a significant increase in the workload that was both unmanaged and undifferentiated in terms of clinical focus and administrative responsibilities.
- Are struggling to recruit experienced practice nurses who would ordinarily deliver care to patients with long term conditions, which is set to increase with the population living longer

Practice Nurse 10 Point Plan

In August 2017 NHS England launched a General Practice Nursing 10-point action plan (GPN 10 PP) to increase recruitment into general practice nursing and to develop roles for nurses working in primary care. The plan forms the nursing element of the General Practice Forward View.

The Nottinghamshire GPN 10 PP, which identifies specific actions in relation to each point of the National GPN 10 PP, has been developed to strengthen the workforce plan following slow progress in getting any traction via regional workshops. Delivery is in progress and actions to raise the profile of general practice nursing and promote general practice as a first destination career across Nottinghamshire are being undertaken as a priority.

The focus of the plan is to

- to increase the number of preregistration placements in general practice
- establish induction and preceptorship programmes.
- development of advanced practice skills in the wider team
- the continued development of a highly successful and well-regarded programme of study, delivered by De Montfort University (DMU) that has been helping to attract new nurses to general practice nursing since 2012. It offers a work based learning approach to reaching competence and supports practices to recruit nurses with no previous GPN experience. The course fees are heavily subsidised by Health Education England, East Midlands office (HEE, EM) and some 170 nurses have completed the programme to date. It provides a route for nurses with acute and community experience to develop general practice knowledge and competences.
- an increase in student nurse placements across Nottinghamshire's general

practices, resulting in more newly qualified nurses considering a career in general practice. Experienced nurses are being equipped to fulfil a mentoring role, adding supervision, teaching and assessment to their already diverse and complex clinical skills.

- look at the learning from an Integrated Nursing Pilot, funded via Rushcliffe's Multispecialty Community Provider (MCP), designed to develop closer working between GPNs and community nurses. The 12 month pilot addressed areas where the 2 groups of nurses may overlap or indeed could identify gaps. The aspiration is that the education of primary care nurses will be better aligned and working in primary care will be offered as an innovative, exciting place to work.
- general practice involvement with the first cohort of Trainee Nursing Associates, as part of the East Midlands test bed site is significant during the evolution of this new nursing role. 4 GP practices across Nottinghamshire are currently supporting a health care assistant who is now engaged on a Nursing Associate (NA) programme. Whilst remaining employed in practice each trainee is released for 1 day per week for face to face learning at Derby University and released for clinical placements. Successful completion of the 2-year programme will result in NMC regulation and registration and the new NAs will contribute to their nursing teams adding to the nursing skill mix, being accountable for delivery of holistic care within their team whilst also having a realistic opportunity to continue learning and become a registered nurse.
- in addition to this the local offer of a GP-S Mentoring Service, (referenced earlier under GP retention) has also been rolled out to practice nurses working in Nottingham City since 2015 with a possibility to expand to all nurses working in general practice within Nottinghamshire

Alongside the GP and GPN approaches, the primary care workforce plan includes:

- embedding clinical pharmacists in general practice (national schemes transition to PCN)
- roll-out of the medical team administrator/GP assistant role and extended
- skills for other administrative/support staff
- a greater role for the Training Hub working alongside PCNs to support the expansion of clinical placements, improve quality of education and training, establish shared learning opportunities, roll out bespoke education programmes and support new role development
- robust training needs analysis across primary care
- joint training across health and social care to understand different conditions and the impact on wellbeing and promote better outcomes, particular focus

on long term conditions and mental health
- the use of general practice simulation tools to consider the workforce transformation possibilities

The workforce plan remains a dynamic delivery vehicle that will maximise the opportunities presented to the system as well as locally determine and develop workforce planning and development approaches.

Our workforce team will assist PCNs in workforce planning/Workforce modelling using population health data, ideally supported by the Nottinghamshire Training Hub. As PCNs establish and determine partnership working across all the sectors included within primary care i.e. social care, community services and the voluntary sector, with increasing integration of care the workforce team will support PCNs around wider future workforce requirements.

12 Governance

A Primary Care Programme Board has recently been established. This has been evolved from an established ICS Primary Care Workstream and in response to the NHSE requesting that a system-wide approach to oversight and governance to oversee the investment GPFV transformational monies. The Programme Board will provide the structure through which the ICS and CCGs will support the delivery of the local primary care strategy (see governance chart, fig 12.1 overleaf).

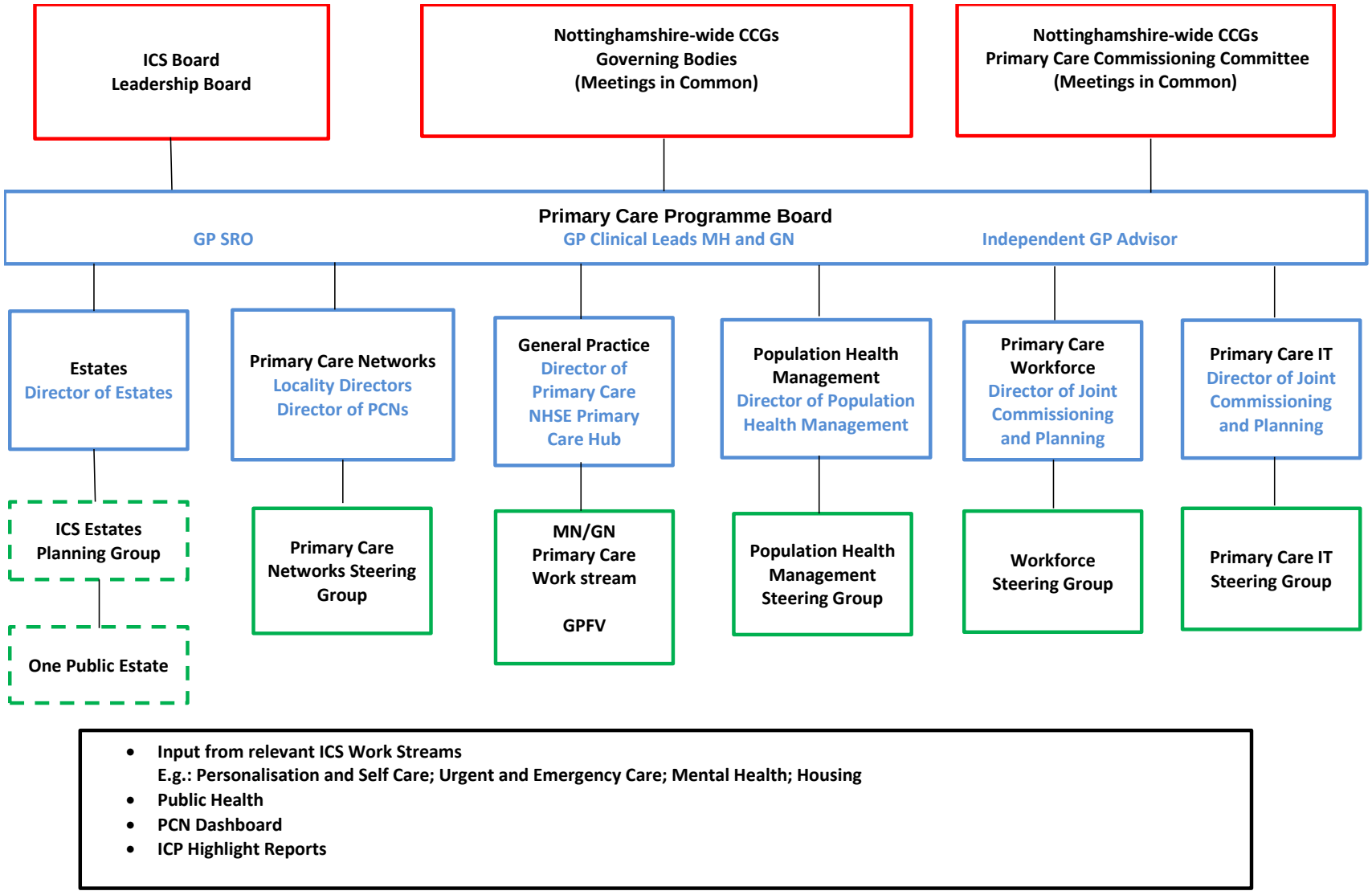
The Primary Care Programme Board will:

- promote primary care within the ICS system, as well as regionally and nationally;
- provide mutual support to the CCGs to implement the agreed primary care strategy and each CCGs' local implementation plan
- oversee a number of shared workstreams, initially identified as: General Practice; Workforce; PCNs; PHM; Estates, Digital Technologies
- agree ICS wide work programmes, bids or returns on behalf of the CCGs and where relevant and necessary secure formal sign off from each CCG
- on behalf of the CCGs, liaise directly with the regional and national teams of NHSE on matters that are ICS wide, including:
    - Primary care estate;
    - Implementation of the GP Forward View; and
    - Developing initiatives that will benefit primary care, the CCGs and the wider system

As the PCNs 'go live' on 1st July 2019 and become established over the coming months, the newly appointed PCN Clinical Directors will be working with system partners to design and develop local governance structure to support service integration for the local population at a neighbourhood level. Learning from the New Models of Care vanguard for Multi-specialist Community Providers will be progressed, and the Memorandum of Understanding which will underpin and support the Schedules of the PCN Contract agreements, will be reviewed and further developed to support the evolving PCNs.

The three ICPs are all currently being developed and work is underway to discuss and consider how PCNs will be represented and support the ICPs. It is recognised that the PCNs will collaborate across an ICP area and with other providers to play their part in delivery of the ICP transformation plan, and ultimately the single ICS strategy and outcomes framework, as well as their part in delivery of the overall ICP contract value and financial balance.

Figure 12-1 - Proposed Governance for Primary Care Programme Board



13 Estates

13.1 Background

With the development of Integrated Care Systems, a significant change to the way planning and resourcing estates is required. Rather than the organisation based approach to planning and managing assets there has to be a collective direction of travel across a wider area involving several partner organisations, including local authorities.

The Nottinghamshire ICS Estates Strategy represents a combined system-wide approach to estates including key priorities and a pipeline of emerging developments. For primary care it incorporates all of the outstanding priorities identified from the previous individual CCG estates strategies approved by Governing Bodies in 2016.

13.2 ICS Estates Strategy

The first Nottinghamshire ICS estates strategy has been assessed as **Improving**. Detailed feedback has been received to improve the assessment to **Good** or **Strong** which is currently being reviewed by system partners ahead of re-submission in June 2019.

An estates group with key individuals from the ICS team and partner organisations has been established reporting into the ICS Planning Group and ultimately the ICS Board. This group will work on the recommendations and refine the estates strategy accordingly.

In relation to primary care, two key areas were identified:

- the link between capital and estates plans and the system's overarching clinical and service strategies was not always clear. This needs to become clearer as the plans evolve and in particular they need to facilitate the system plans for moderating demand and preventing avoidable hospitalisation
- although all strategies set out their approach to primary care estate in general this was less well developed and this will be a key priority for future development.

The final estates strategy will be received by the ICS Board as part of the five-year plan 2019-24.

13.3 Clinical Services and Estates Strategy Alignment

The ICS Clinical Services Strategy is progressing well and will effectively influence the Estates Strategy development, and in particular primary care estate, against a background where there is:

- a system- wide need to have a smaller acute estate footprint but also address very high levels of infrastructure risk
- a requirement to have a more developed community service offer, particularly in relation to providing services closer to home; and the requirements of the emerging PCNs for local network hubs
- a need to utilise PFI estate capacity which is tied to long term commitments in the ICS; recognising fixed points – some service locations will not change in the future clinical model and recognising these allows them to be determined as fixed points around which future care models can be built. It is also important to recognise the need to effectively use PFI and LIFT estate. Fixed points have been agreed by the ICS Clinical Services Strategy Programme Board to reflect these issues and support planning

Clinical pathway reviews are being considered against the twenty service areas of highest activity volume in the system. Six initial areas of priority have been identified:

1. Cardiovascular Disease – Stroke
2. Maternity and Neonatal
3. Respiratory (COPD and Asthma)
4. Frailty
5. Children and Young People
6. Colorectal

The Clinical Service Strategy service review work aims to develop improved models of care with strong emphasis on prevention and education and system sustainability. Service reviews will also be evidence based. Evidence shows that many of the services can have an increased offer of care closer to home, if not in the home setting itself through advances in assistive technology, self-care and monitoring.

Collectively this work should deliver the opportunity to consolidate the care needed in the acute hospital setting by transforming pathways to provide many of these services locally within primary and community hubs.

The Clinical Services Strategy work has a clear connection to the estate requirements in the ICS and as the service models develop will look to the Estate work to help inform the available options that will enable these new care models.

13.4 Approach to Primary Care Estates and Emerging Plans

An estates strategy that focuses entirely on the technical aspects of the location, size and funding of buildings, which seeks to fit an off-the-shelf solution to a complex local problem, is doomed to failure. A strategy with a much greater chance of success will be one developed by system leaders who truly connect with the needs and potential of the population they serve and the staff they employ, who have a deep understanding of the benefits that can be realised through partnerships with local authorities and industry, and who are able to work with advisors that bring creative solutions to well understood challenges.

Strategic estates plans should be developed in an integrated and inclusive way at a more local level with a bottom up approach. It is at local community levels where there is the right level of detailed understanding of population needs, and the most productive opportunities to align the political, civic, institutional, professional and personal interests involved.

To this end the immediate priorities are:

i. To understand the emerging requirements of Primary Care Network hubs:

- For each PCN configuration, map out the current primary and community facilities and provide a reference document for each PCN; meeting with Locality Directors and Clinical Directors to identify key risks and vulnerabilities
- Recognising and identifying requirements for PHM and working with a range of stakeholders in a place based manner
- Linking the development of digitally enabled initiatives with the future requirements for face to face contacts and the impact on estates assets.
- Obtain funding for and commission 6 facet surveys in Greater Nottingham and re-visit surveys done more recently in Mid-Notts
- Identify gaps and further priorities for ICS capital, ETTF and business as usual capital with particular emphasis on:
    - Quality of estate
    - Housing growth
    - Opportunities for consolidating and disposing of estate including co-locating with partner organisations
    - Opportunities for integrating health and social care staff

ii. To link in with the Clinical Services Strategy service reviews at a service level to quantify the impact on primary and community facilities of shifting activity from acute hospital facilities:

- Immediate connection with the existing Outline Business Cases being developed in anticipation of Wave 5 ICS capital bids in 19/20:
  - Eastwood
  - Hucknall
  - Strelley
  - East Leake
  - Newark
- Scope the **fixed points** and identify 'true' vacant space and options for better utilisation
- Continue to support the feasibility of revenue funded schemes through 3PD or GP led funding.

iii. To maximise the potential of working with partners:

- Develop a joint strategy with Nottinghamshire Healthcare Trust for primary and community hubs
- Continue to actively engage with the N2D2 One Public Estate work, including multi-agency locality reviews and linking this work with PCNs; explore opportunities for local government borrowing as a potential funding option.
- Develop a consistent operating model with council planners to be actively consulted/informed of major housing developments, building on successful work with Rushcliffe, Ashfield, Gedling and Newark and Sherwood Borough Councils; maximising the potential for Section 106 contributions

iv. To 'get our house in order':

- Ensure that data is accurate and up to date across the 200+ primary care properties and tenancy agreements
- Simplify or remove complex historical arrangements which are often costly and incur unnecessary management fees
- Explore the opportunities highlighted through the ICS Estates Rationalisation work, including where there are opportunities to dispose of properties whilst not making short term decisions where there may be a longer term need.
- Rationalise the CCGs' Headquarters requirements following the merger and restructure, being mindful of the need to preserve a locality presence for PCN facing teams.

14 Measurement

14.1 GP Patient Survey

The baseline data will be taken from the GPPS 2018 Practice results data file. This gives a practice level breakdown for each question at response level as well as the calculated % question result.

It is proposed that the CCG will use the baseline data from the 2018 GP Practice Survey to provide the PCNs with the ability to monitor their performance against agreed priorities. This will provide the CCG with a robust tool for measuring patient satisfaction to be reported to the Primary Care Programme Board.

The CCG will undertake an analysis of the baseline results to identify areas for improvement or focus. This will include benchmarking results against organisations with a similar demographic profile, against the National results; and presenting results over an historical timeline.

As well as the GP Patient Survey, we have access to a rich mine of information from areas such as Patient Participation Groups; Friends and Family test results; CQC inspections. Additionally, we have the capacity to overlay the GP Patient survey results with the GP Workforce plan. This will indicate whether there is a correlation between staffing levels and rates of patient satisfaction. The aim will be to build a comprehensive picture of overall satisfaction levels at GP practice level which can be aggregated up to PCN level.

The intention is that the CCG will commission GP practices to undertake a patient survey that focusses on the priorities that have been agreed. This will be carried out on a quarterly basis. The results will then be made available to PCNs.

The CCG will deliver the GP Practice survey results aggregated to a PCN level via interactive dashboards and infographics, which will allow users to drill through to row level data. The dashboard tools will allow PCNs to benchmark performance against local and national results; provide a timeline series that can help identify changes in performance.

Wider PCN Reporting

Each PCN will be provided with a “point of contact” so that ongoing needs for analytics and performance data are addressed. We will establish routine reporting of all the relevant, identified metrics. There will be a range of aggregations including drill-down to PCN and neighbourhood level. We are currently planning how these dashboards will be developed and they will include in-depth demographic, epidemiological and other data sets that will

enable population and health care needs to be proactively identified at each neighbourhood level. The data sets will be comprehensive and will draw on data expertise across the full range including local authority and public health analytics expertise.

14.2 GP Workforce plan

The workforce delivery plan for increasing GP numbers particularly but also the wider general practice workforce informed a workforce trajectory. The latest of the trajectory submissions was made in April 2019 as part of the operational planning process with NHSE (see Appendix 2).

This trajectory and assumptions used around delivery have been informed by the practice level data that has been supplied plus information from HEE on the registrar supply. NHS Digital has recently undertaken a refresh of the methodology applied to the data received and backdated that methodology to the September 2015 baseline year the GP wte targets were based upon.

The targets themselves have not yet been adjusted to reflect this methodology.

Appendix 3 provides the latest GPFV Workforce Report which details the position as at March 2019.

NHS Digital has transitioned to NWSR requiring practices to register and data collection is expected 30 June 2019. The CCG and workforce team will ensure that 100% of practices have transferred and submitted.

As we progress and deliver we will utilise of the Workforce reporting tools and planning toolkits made available from NHSE and HEE to inform PCNs It is anticipated we will look at this at practice and PCN level as well as Nottinghamshire wide.

It is proposed that the CCG will use the baseline data from March 2019 GP Workforce datasets to provide the PCNs with the ability to monitor their staffing levels on a quarterly basis. To support the baseline position for the additional roles to be introduced as part of the reimbursement fund the CCG will create its own baseline to inform.

All this helps to provide, alongside organisational Strategic Business and Workforce Plans, indicators on what the workforce will look like in the future. The better the information and its quality the more sound the judgements will be on commissioning the workforce for the future

The CCG will undertake an analysis of the baseline results to identify areas for improvement or focus, such as clinical staff / patient ratio.

The data will help PCNs by building and understanding the:

- Age profile of the workforce which can then be related to understanding turnover, retention (stability) and retirement data;
- Effect of gender on working patterns – for example the increasing numbers of GP's who are female and the impact that this may have on training numbers.
- Staff movements - understanding the workforce data within this area provides essential information on how the shape of the historical and current workforce has ebbed and flowed.

As part of the GPFV delivery we submit routine reports into the NHSE regional team and provide information as per NHSE requirements. The GP retention element of the GPFV funding for 2019-20 will be managed as a workforce deliverable but included in the overall monitoring and quarterly reporting.

At an ICS level a Workforce Information Group exists under the governance of the Strategic Workforce Group which will produce a regular dashboard to the SWG and ICS leadership Board on key workforce metrics. This will include general practice data as well as wider service/provider workforce data.

14.3 GPFV monitoring survey

Primary Care Leads are responsible for managing the monthly completion and submission to NHSE of the GPFV and are well positioned to escalate issues that are identified from the process.

14.4 Primary Care annual assurance statements

Detailed and thorough Primary Care Annual Assurance Statements are submitted to NHSE by the ICS to accompany the Operational Plan. The recently formed Primary Care Programme Board are responsible for maintaining oversight of the assurance statements and ensuring that progress is made against them.

14.5 Learning from GPFV MoU Reviews

The ICS has completed a process to determine how to utilise GPFV funding in order to achieve maximum impact and benefit. A number of schemes have been prioritised which focus on the four key programme areas – GP retention, practice resilience, reception and clerical staff training and online consultation.

Although GPFV funding allocations have been confirmed for 2019/20 and 2020/21 a decision has been made locally that the initial focus will be on 2019/20 only. This is in the context of the emerging PCNs and recognises that the workforce, training and organisational development needs of PCNs are likely to become clearer during 2019/20.

The schemes for 2019/20 will be supported by clear measurable outcomes/outputs. Achievement against these will be assessed via mid and end of year reviews. These reviews will be used to inform investment priorities for 2020/21 and future years. Progress and delivery will be monitored via the ICS Primary Care Programme Board.

14.6 Patient Participation Groups

A new communications and engagement strategy is under development with the objective of demonstrating that the newly merged CCG will have effective engagement of its population in place.

The strategy is being developed as part of the merger process. Its content will be informed by the following:

- Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England (https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf)
- The Patient and Community Engagement Indicator in NHS England's Improvement and Assessment Framework (https://www.england.nhs.uk/wp-content/uploads/2019/01/ccg-iaf-patient-community-engagement-indicator-guidance-v1.pdf).

To provide assurance around PPI the strategy will set out how the merged CCG will manage engagement in relation to the following:

- Governance
  - Involving the public in the CCG's decision making bodies
  - Providing a patient committee structure that assures the CCG that the voice of its population is informing its commissioning decisions on a continuous basis

  - How providers will be held to account for their own public involvement activities
- Engagement in commissioning
  - How engagement will be embedded in commissioning activity
  - How the CCG will determine the appropriate level and approach for engagement e.g. formal consultation
- Equalities and health inequalities
  - Ensuring engagement takes account of equalities and health inequalities
  - Providing assurance that the CCG has mechanisms in place to engage across its populations, including those that are seldom heard and those protected by a characteristic under the Equalities Act 2010.

The above focus is aligned to the guidance for CCGs on meeting their statutory duties for PPI.

A single patient group for Greater Nottingham will be established by the end of June 2019. This group will replace the Greater Nottingham CCGs' existing patient committees. It will sit alongside the Mid Notts Patient and Public Engagement Committee (PPEC) as one of two patient groups providing assurance around PPI for the Nottinghamshire-wide Governing Bodies.

14.7 Governance

The Nottingham and Nottinghamshire CCG PCCCs have recently merged to create a committee in common. A review of the assurance and reporting requirements of the newly formed committee is underway with a focus on quality, finance and GP contracts. Going forward these new arrangements will ensure a consistent, equitable and robust approach to the commissioning and contracting of general practice services across the ICS. The committee will also be responsible for assuring the quality and safety of general practice.

In addition the ICS Primary Care Programme Board will be the overarching forum that will monitor and ensure delivery of the ICS Primary Care Strategy. This will be supported by a number of work streams leading on core areas including general practice, PCNs, estates, workforce and population health. The steering group will also provide the governance around GPFV funding and work to support PCN development.

14.8 Public information

PCNs will be provided with data/information in relation to their local population through different means which will allow them to target programmes as required. The main source will be through the two Joint Strategic Needs Assessments (JSNAs), which are jointly produced with Nottingham City Council and Nottinghamshire County Council.

The structure of the JSNAs is being redefined to fit with the new system architecture including strategic commissioning at ICS level, partnership working and consideration of 'place' at ICP level and supporting neighbourhoods and PCNs. Therefore, the JSNA at the ICS level will cover the following:

- What does our population and place look like?
- What does our population need, now and in the future and what assets do we have?
- What are the priorities for collective action, what outcomes do we want to achieve and how will we achieve them together?
- What is the evidence of what works for these system level issues which are joint and strategic?
- What are our outcomes?

At the ICP level the JSNA will provide information on:

- What is the health and care profile of my place?
- What is the profile/performance of this Place against the outcomes set at system level?
- What is the evidence of what works for these place-based issues which are joint and strategic?
- Local assets, what is currently delivered and what opportunity exists for improvement (opportunity analysis)?

PCN level will include health and care profiles at 'neighbourhood' level which will provide information on the baseline health of the population and inequalities and forecast progress against overarching factors feeding up in the ICS Outcomes Framework.

Alongside the JSNA and in order to target specific programmes, the PCNs will be provided with information on performance against screening and immunisation programmes through the Quality Dashboard.

15 Finance

15.1 Current expenditure

The CCGs in Nottingham and Nottinghamshire ICS currently spend a combined £310 m on Primary Care Services. This is inclusive of spend relating to General Practice (Delegated Co Commissioning), Prescribing, GP Forward View, Out of Hours, GPIT and other initiatives and schemes.

Table 15-1 - 2018/19 Primary Care Expenditure

£m's	City	NNE	NW	Rush-cliffe	M&A	N&S	Total
Primary Care Services Spend in 2018/19	£99,300	£43,500	£27,200	£35,200	£62,100	£43,100	£310,400

The CCGs in Nottingham and Nottinghamshire ICS are facing significant financial pressures. The financial challenge for 2019/20 is £53 million in Greater Nottingham and £25 million in Mid Nottinghamshire. CCG programme budgets are therefore under significant pressure and the level of investment in to Primary Care should be seen in this context. Discretionary areas, funded from core/programme allocations will need to be reviewed to ensure that they are aligned with the PC investment strategy.

15.2 Forecast Levels of Expenditure Using New Models of Care

In addition to the recurrent elements of the baseline expenditure highlighted in 15.1 above, investments in new services to support the new GP Contract include the below:

The table below shows the indicative amounts forecast to be invested by each CCG. The actual values paid to each PCN will be confirmed using the final guidance published by NHS England with the latest populations numbers.

Table 15-2 - Primary Care developments funded via delegated budgets

£'000s	City	NNE	NW	Rush-cliffe	M&A	N&S	Total
£1.761 Participation Payment	£646	£252	£187	£222	£370	£257	**£1,934**
New workforce re-imbursement scheme	£581	£270	£148	£157	£391	£272	**£1,819**
DES changes: ▪ Extended hours DES finishes	-£544	-£219	-£135	-£182	-£167	-£98	**-£1,345**
▪ Network contract DES access	£427	£155	£116	£141	£215	£149	**£1,203**
£1.50 Core PCN Funding	£572	£230	£142	£192	£293	£204	**£1,633**

The CCGs have received non recurrent funding for GP Forward View investments in previous years, the current investment plan for 2019/20 GP Forward View is set out in the table below.

Table 15-3 - GPFV anticipated non recurrent allocation 2019/20

Anticipated Allocation (NB. Covers all 6 CCGs)	**£'000s**
Current Plan	
Practice Resilience	£232
GP Retention Programme	£200
Reception & Clerical Staff Training	£125
Online Consultation	£297
Total Plan	£854

The CCGs will continue to invest in the Extended Access provision as per the values detailed in the table below:

Table 15-4 - GPFV Extended Access

Extended Access £000's	City	NNE	NW	Rush-cliffe	M&A	N&S	Total
From Programme Allocation – baseline and anticipated allocations	£2,250	£920	£568	£676	£1,169	£767	£6,350

On top of mandated areas of expenditure, the CCG also invest in various additional services and engagement models to support General Practice as detailed in the table below. The nature of the model of support has been developed to be tailored to the specific needs of the particular local CCG population.

Table 15-5 - Practice investment, Engagement & Support

Practice Engagement, Investment and Support £000's	City	NNE	NW	Rush-cliffe	M&A	N&S	Total
From programme allocation – baseline and anticipated allocations	£2,133	£1,124	£793	£826	£1,148	£742	£6,766

15.3 2019/20 Planned Expenditure for the CCGs in Nottingham and Nottinghamshire ICS

The forecast expenditure is in line with the below anticipated 2019/20 financial plan values. These values are inclusive of spend relating to General Practice (Delegated Co Commissioning), Prescribing, GP Forward View (where allocations are in the baseline), Out of Hours, GPIT and other initiatives and schemes. They do not include any allocations not yet received by the CCGs, such as for the GPFV investments.

Table 15-6 - 2019/20 Primary Care Opening Plans

£'000s	City	NNE	NW	Rush-cliffe	M&A	N&S	Total
Primary Care Services opening plans for 2019/20	£103,400	£45,700	£28,800	£35,800	£65,500	£44,400	£323,600

15.4 Overall ICS Position, broken down by CCG

Table 15-7 - ICS Financial Position 18/19 and 19/20 by CCG

	Greater Nottingham				Mid Notts		TOTAL Nottingham and Nottinghamshire CCGs
	City CCG	Nottm North & East CCG	Nottm West CCG	Rushcliffe CCG	Mansfield & Ashfield CCG	Newark & Sherwood CCG	
18/19	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Financial Position 18/19 - in year outturn variance surplus/(deficit)	2	1	2	2	39	32	78
Financial Position 18/19 - cumulative outturn surplus/(deficit)	9,528	4,070	2,659	3,099	(8,416)	(1,368)	9,572
QIPP Target 18/19	24,690	13,311	5,062	9,467	19,370	11,669	83,569
QIPP Delivery 18/19	22,303	12,000	5,168	8,780	17,509	10,998	76,758
Exit Underlying Position surplus/(defict)	(1,000)	(4,000)	0	(4,000)	(7,680)	(5,820)	(22,500)
19/20							
Financial Position 19/20 - Planned surplus/(deficit)	1,173	0	0	0	870	300	2,343
QIPP Target 19/20	22,245	13,790	5,567	11,403	14,991	10,159	78,155
QIPP Delivery 19/20 - Risk Adjusted	19,900	9,056	3,656	7,488	12,053	8,199	60,352
Opening Underlying Position	521	106	67	79	(3,395)	(1,516)	(4,138)
QIPP gap 20/21 - savings required on 'do nothing' spend	21,100	9,579	5,969	7,376	14,019	9,126	67,169
QIPP gap 21/22 - savings required on 'do nothing' spend	15,441	7,004	4,372	5,375	10,428	6,781	49,401
QIPP gap 22/23 - savings required on 'do nothing' spend	8,151	3,828	2,317	2,897	5,825	3,781	26,799
QIPP gap 23/24 - savings required on 'do nothing' spend	9,619	4,434	2,789	3,327	6,828	4,327	31,324

NB All numbers are taken from CCGs' draft financial strategy at June 2019 and are subject to change

15.5 Risks and mitigations

The expenditure of the CCGs is limited to the anticipated financial plan values noted above. The CCGs have funded the £1.50 per head requirement from core allocations as per planning guidance. This has been done and provided for within the 2019/20 financial plans.

The CCGs will wish to satisfy themselves that the host PCN organisations to which funding is passed through to have robust arrangements in place to safeguard the funds and to ensure the funds are expended in line with agreed plans and the Directed Enhanced Service that they form part of.

Any emerging risks will need to be added to the CCGs risk register and managed in accordance with the CCGs normal policies and procedures.

Appendix 1 – ICS GPFV Finance Plans 19/20

NHS ENGLAND MIDLANDS REGION

GPFV 2019/20

19/20 plan information													**Anticipated in year monitoring**			
STP :	***Nottingham & Nottinghamshire***															
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)		(m)	(n)	(o)	
Scheme	**Detail of Scheme**	**No. of GP Practices Covered**	**wte (if applicable)**	**Key Measurable**	**Cost £'s**	**Phasing of Expenditure Q1**	**Q2**	**Q3**	**Q4**	**Capital Costs £'s (if applicable)**	**Supporting information**		**Actions completed this Quarter**	**Actions to be completed next Quarter**	**Risks / Issues**	
Practice Resilience	PCN Organisational Development - Low priority scheme for funding dependent on national funding available to support PCN OD	23 PCNs		Support sustainable models of care in general practice to build resilience	28,100		10,537	10,538	7,025	0	Overarching aims 1. to facilitate the organisational development of sustainable PCNs 2. to build capacity and resilience across GP practices 3. to support the development of sustainable models of care in general practice					
	Group Consultations	23 PCNs		Group consultations to support practices to become more sustainable and resilient - ICS pilot	30,000		11,250	11,250	7,500	0						
	HCA Workforce Training	23 PCNs		Cover gaps in Workforce Training to support improved utilisation of appointments in GP Practices	20,000		7,500	7,500	5,000	0						
	Practice Manager Roving Support - ICS Wide	23 PCNs	2	Recruitment of 'roving' practice management supporters to work on an in-hours on call basis with practices requiring operational assistance	120,000		45,000	45,000	30,000	0						
	Practice Manager Training and Development	23 PCNs		Development and implementation of training for aspiring and existing Practice Managers to support GP practice business resilience. To be aligned with the Practice Manager Roving Support Scheme	33,900		12,712	12,713	8,475	0						
Sub Total Practice Resilience					232,000	0	86,999	87,001	58,000	0						
GP Retention Programme	Senior Fellowship Programme (ICS Wide)	23 PCNs		Allowing GPs to work more flexibly, by granting an allowance to support placement / project work. Growth of extra GP support for others in the system as mentor hub forms.	90,000		33,750	33,750	22,500	0	Overarching aims to 1. Increase retention of GPs considering retirement 2. Support retention of younger/less esperienced GPs 3. Support succession planning for GP practices 4. Increase the range of clinical skills and expertise in general practice		*Not to be populated at this stage. To be used for in year monitoring*	*Not to be populated at this stage. To be used for in year monitoring*	*Not to be populated at this stage. To be used for in year monitoring*	
	Fellowship Lite (ICS Wide initiative)	23 PCNs		Opportunity for mid-career GPs to learn additional specialist skills - the overall aim is for more mid-career GP's to be retained in Nottinghamshire with a greater pool of GPs able to offer additional skills / services to the ICS.	60,000		22,500	22,500	15,000	0						
	GP Fundamentals Programme - Practice Nursing (ICS Wide)	23 PCNs		This scheme involves delivery of a co-ordinated and centrally delivered training programme to improve delivery of services and capacity in general practice,	50,000		18,750	18,750	12,500	0						
Sub Total GP Retention Programme					200,000	0	75,000	75,000	50,000	0						
Reception & Clerical Staff Training	Training Programme - ICS Wide)	8 PCNs		Development and implementation of an ICS-wide training programme for reception and clerical staff based on local needs such as workflow optimisation, care navigation and signposting health, and correspondance management.	125,000		46,875	46,875	31,250	0	Overarching aims to: 1. Release clinical time by up-skilling administrative staff 2.Improve practice efficiency and resilience 3. Increase the skills of Reception and Clerical staff 4. Improve the patient experience		*Not to be populated at this stage. To be used for in year monitoring*	*Not to be populated at this stage. To be used for in year monitoring*	*Not to be populated at this stage. To be used for in year monitoring*	
Sub Total Reception & Clerical Staff Training					125,000	0	46,875	46,875	31,250	0						
Online Consultation	Online Consultation (ICS Wide)	23 PCNs		This forms part of the wider strategic public facing digital services, that is being deployed across Nottinghamshire and progressed across the ICS footprint. Significant change management requirements is fundamental to achieve wole system benefits.	297,000		111,375	111,375	74,250	0	Overarching aims to: 1.Support delivery of the wider public facing digital services strategy 2. Increase GP practice engagement in the development and implementation of online consultation 3. Support roll-out of online consultation across the ICS		*Not to be populated at this stage. To be used for in year monitoring*	*Not to be populated at this stage. To be used for in year monitoring*	*Not to be populated at this stage. To be used for in year monitoring*	
Sub Total On Line Consultation					297,000	0	111,375	111,375	74,250	0						
Total STP					854,000	0	320,249	320,251	213,500	0						

Notes : Please insert or delete rows as required

Please provide a link to the key deliverable (column e) in the GPFV programme and how success will be measured - use supporting informaiton column (l) if easier

If you have no detail plan at this stage (eg resilience due to bids having to be made and approved by practices) please provide an estimate of the envelope you have ear marked

Appendix 2 – GPFV Workforce Final Planning Trajectory 2019/20

Primary Care Workforce STP: Nottinghamshire

				Headcount							FTE					
				2018/19 Inflows Oct-Mar	2019/20 Inflow Q1	Q2	Q3	Q4	2019/20 Planned inflow	Participation rate	2018/19 Inflows	2019/20 Inflow Q1	Q2	Q3	Q4	2019/20 Planned inflow
33	Inflow	GP	New Fully Qualified GPs	1	0	38	0	1	39	0.67	0.67	0.00	25.46	0.00	0.67	26.13
			Induction & Refresher scheme	0	0	0	0	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00
			International recruitment	2	2	2	2	2	8	0.67	1.34	1.34	1.34	1.34	1.34	5.36
			GP Retention Scheme	2	1	1	1	1	4	0.4	0.80	0.40	0.40	0.40	0.40	1.60
			Other GP retention initiatives	10	8	13	9	11	41	0.67	6.70	5.36	8.71	6.03	7.37	27.47
			Other	0	0	0	0	0	0	0.67	0.00	0.00	0.00	0.00	0.00	0.00
		Clinical	Nurses	4	2	1	1	1	5	0.64	2.56	1.28	0.64	0.64	0.64	3.20
			Direct Patient Care staff (excluding physician associates	8	5	5	5	4	19	0.62	4.96	3.10	3.10	3.10	2.48	11.78
			Physician Associates	0	0	0	0	0	0	1	0.00	0.00	0.00	0.00	0.00	0.00
			Pharmacists	4	14	1	1	0	16	1	4.00	14.00	1.00	1.00	0.00	16.00
		Non Clini	Admin Staff	26	13	35	13	13	74	0.65	16.90	8.45	22.75	8.45	8.45	48.10

				Headcount							FTE					
				2018/19 Outflow Oct-Mar	2019/20 Outflow Q1	Q2	Q3	Q4	2019/20 Planned	Participation rate	2018/19 Outflow	2019/20 Outflow Q1	Q2	Q3	Q4	2019/20 Planned
	Outflow	GP	Retirement	13	6	6	6	7	25	0.8	10.40	4.80	4.80	4.80	5.60	20.00
13			Other	5	6	7	6	7	26	0.8	4.00	4.80	5.60	4.80	5.60	20.80
			Nurses	4	1	1	1	0	3	0.64	2.56	0.64	0.64	0.64	0.00	1.92
			Direct Patient Care staff (excluding physician associates and pharmacists	8	5	5	5	4	19	0.62	4.96	3.10	3.10	3.10	2.48	11.78
			Physician Associates	0	0	0	0	0	0	1	0.00	0.00	0.00	0.00	0.00	0.00
		Clinical	Pharmacists	0	0	0	1	1	2	1	0.00	0.00	0.00	1.00	1.00	2.00
		Non Clini	Admin Staff	26	13	35	13	13	74	0.65	16.90	8.45	22.75	8.45	8.45	48.10

				Historic Trend									Forecast Plan					
				17-18 Q1	17-18 Q2	17-18 Q3	17-18 Q4	18-19 Q1	18-19 Q2	18-19 Q3	2018/19 Net Flow	2018/19 Forecast	Q1	Q2	Q3	Q4	2019/20 Plan	Growth
****Please do not u	Rolling Total	GP	Excluding Registrars	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	-4.89	0.00	-2.50	23.01	21.18	19.76	19.76	0.0%
			Nurses	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	0.00	0.00	0.64	0.64	0.64	1.28	1.28	0.0%
			Direct Patient Care staff (excluding physician associates and pharmacists	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
			Physician Associates	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%
		Clinical	Pharmacists	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	4.00	0.00	14.00	15.00	15.00	14.00	14.00	0.0%
		Non Clini	Admin Staff	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.0%

Appendix 3 – Plan v Actual Workforce Data (as at March 2019)

GP Workforce – Nottingham & Nottinghamshire STP

NHS England and NHS Improvement

Purpose

The purpose of this presentation is to provide Nottingham & Nottinghamshire STP with a more detailed interpretation of the primary care workforce statistics shared previously for the Midlands Region, to support local discussions and the delivery of key priority areas in 2019/20 including:

- The Four Pillars Retention Programme, which builds on the progress achieved using Local GP Retention funds in 2018/19.
- GP Retention funds, as part of the GPFV Funding Programme (which includes Online Consultation, Practice Resilience and Reception & Clerical Staff Training)
- Continuation of workforce data quality improvement
- HEE/NHSE/I collaborative workforce programmes including: Physicians Associates, GP Trainees
- Supporting the foundation for implementation of the NHS Long Term Plan and General Practice DES contract
- To transition workforce in to core NHSE/I functions

Nottingham & Nottinghamshire STP – GP Workforce numbers

Nottingham and Nottinghamshire Health and Care STP summary, by staff group and for specific job roles, to compare the actual figures published by NHS Digital with the STP plan trajectories for 19/20 submitted as part of the Operational Planning. As at March 2019.

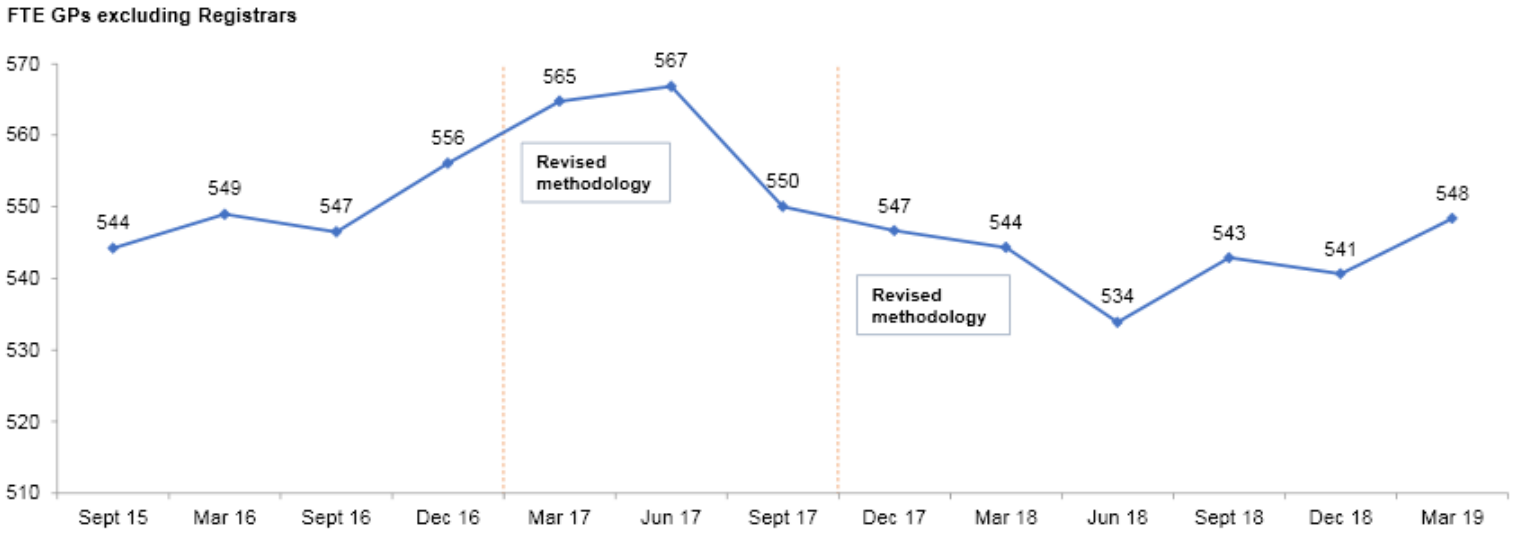
Actual vs Plan by Staff Group and STP

		Month of Census Date																
Staff Group	Data Type	September 2015	March 2016	September 2016	December 2016	March 2017	June 2017	September 2017	December 2017	March 2018	June 2018	September 2018	December 2018	March 2019	June 2019	September 2019	March 2020	Year on Year change (Mar '19 vs Mar '18)
GP excluding Registrars	Actual	544	549	547	556	565	567	550	547	544	534	543	541	548				0.7%
	Variance from Plan													2.6%				
	Plan													534.4	531.9	557.4	554.2	
Nurse	Actual	276	289	295		296		300	299	303	305	304	308	314				3.5%
	Variance from Plan													1.7%				
	Plan													308	309	309	309	
Direct Patient Care	Actual	182	186	189		190		193	192	193	196	199	205	209				8.4%
	Variance from Plan													0.3%				
	Plan													209	223	224	223	
Admin/Non-Clinical	Actual	1,175	1,212	1,222		1,218		1,216	1,217	1,224	1,244	1,251	1,259	1,289				5.3%
	Variance from Plan													2.4%				
	Plan													1,259	1,259	1,273	1,273	

Actual vs Plan by Job Role and STP

		Month of Census Date																
Job Role	Data Type	September 2015	March 2016	September 2016	March 2017	September 2017	December 2017	March 2018	June 2018	September 2018	December 2018	March 2019	June 2019	September 2019	December 2019	March 2020	Year on Year change (Mar '19 vs Mar '18)
Pharmacists	Actual	2.21	2.20	4.75	6.95	8.30	8.34	7.43	9.38	10.64	12.63	13.28					78.6%
	Variance from plan											-20.16%					
	Plan											16.63	30.63	31.63	31.63	30.63	
Physician Associates	Actual					1.07	1.07	1.07				0.64					-40.0%
	Plan											0.00	0.00	0.00	0.00	0.00	
Physiotherapists	Actual																

FTE General Practitioners (excluding Registrars)



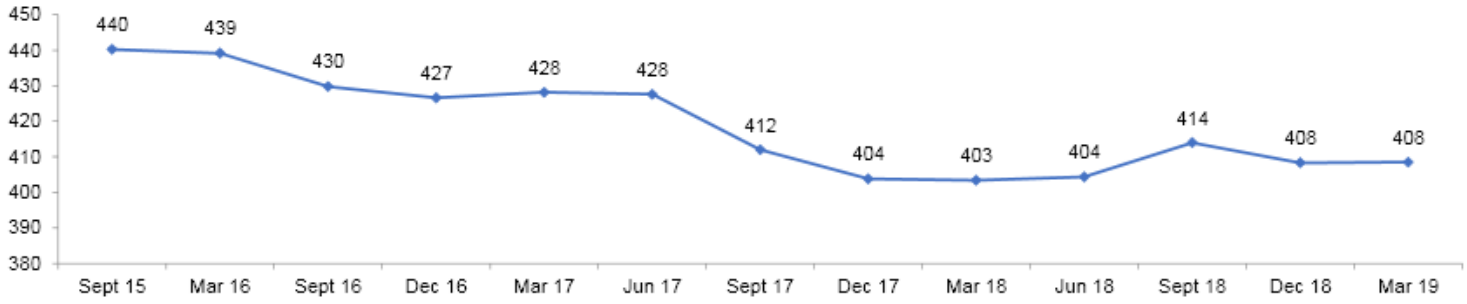
- As at the end of March 2019, there were 548 FTE GPs (excluding registrars) in post across Nottingham & Nottinghamshire STP.
- This represents an increase in GPs FTE of 4 (0.7%) between Mar 2018 & Mar 2019. This is 3.1% more than the Midlands Region's decrease of 2.4%.

NOTE: Previously published FTE data has been revised due to methodological changes and improvements in recording and estimation. However NHS Digital have not been able to fully back update GP locum data so these still have breaks in the data series. The data shown in this pack includes estimates calculated by NHS Digital for the proportions of practices that did not submit valid data.

Source: NHS Digital, GP Workforce

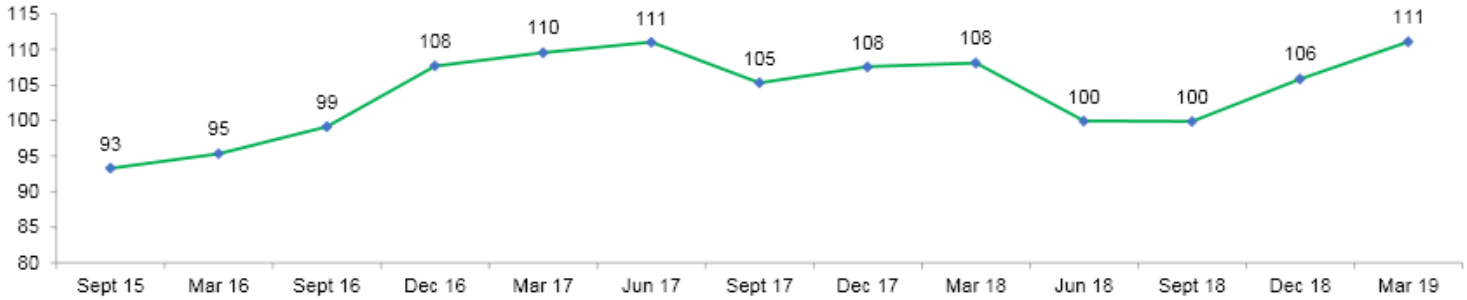
FTE General Practitioners (Partners & Salaried)

FTE GP Partners



- As at the end of March 2019, there were 408 FTE GP Partners in post across Nottingham & Nottinghamshire STP.
- This represents an increase of 5 (1.2%) between Mar 2018 & Mar 2019. This is 2.9% less than the Midlands Region's decrease of 4.1%.

FTE Salaried GPs



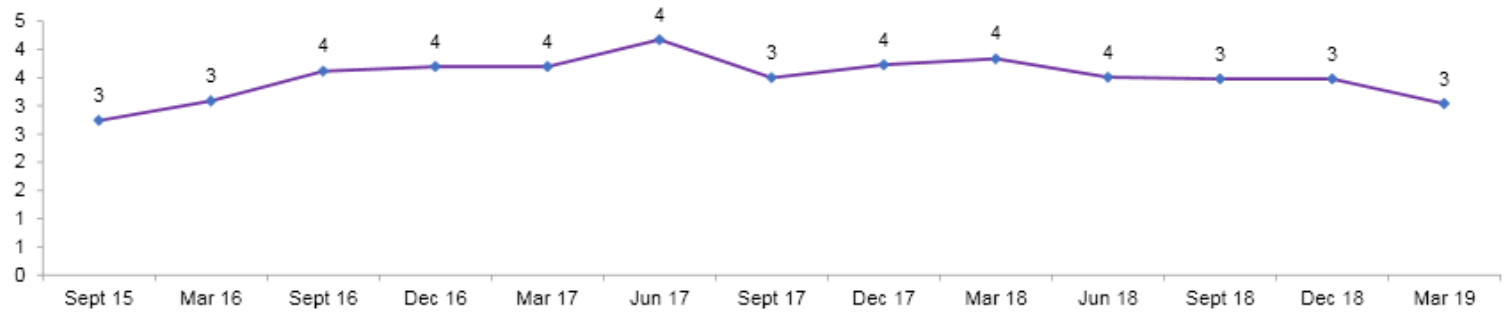
- As at the end of March 2019, there were 111 FTE Salaried GPs in post across Nottingham & Nottinghamshire STP.
- This represents an increase of 2 (1.9%) between Mar 2018 & Mar 2019. This is 0.1% less than the Midlands Region's increase of 2.0%

NOTE: Previously published FTE data has been revised due to methodological changes and improvements in recording and estimation. However NHS Digital have not been able to fully back update GP locum data so these still have breaks in the data series. The data shown in this pack includes estimates calculated by NHS Digital for the proportions of practices that did not submit valid data.

Source: NHS Digital, GP Workforce

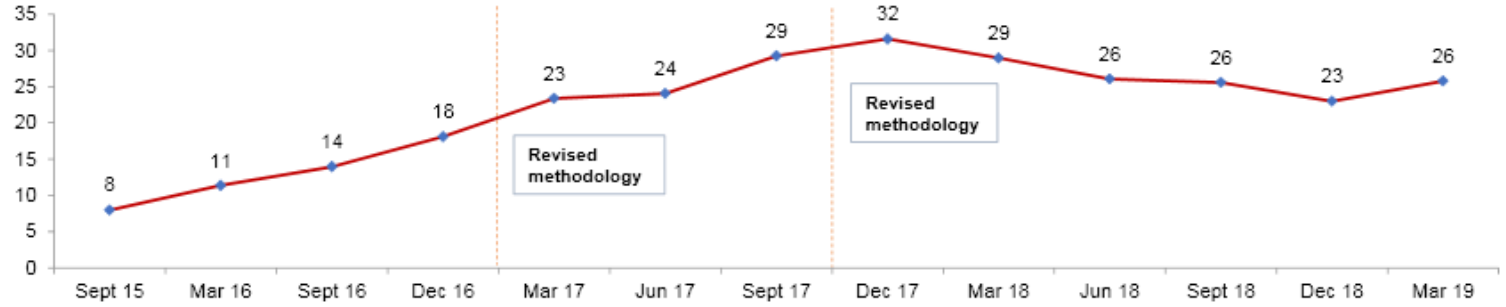
FTE General Practitioners (Retainers & Locums)

FTE GP Retainers



- As at the end of March 2019, there were 3 FTE GP Retainers in post across Nottingham & Nottinghamshire STP.
- This represents a decrease of 1 (33%) between Mar 2018 & Mar 2019. This is 51% less than the Midlands Region's increase of 17.6%.

FTE GP Locums

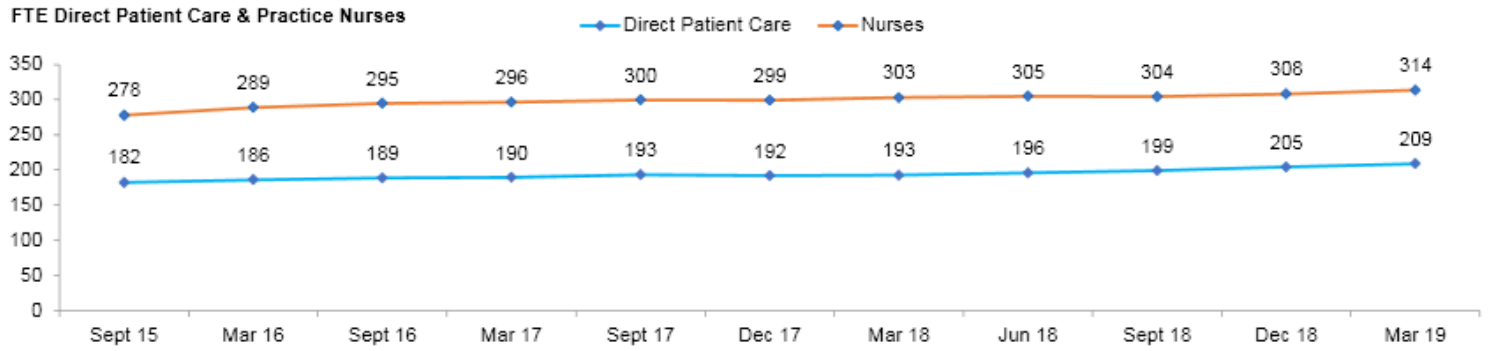


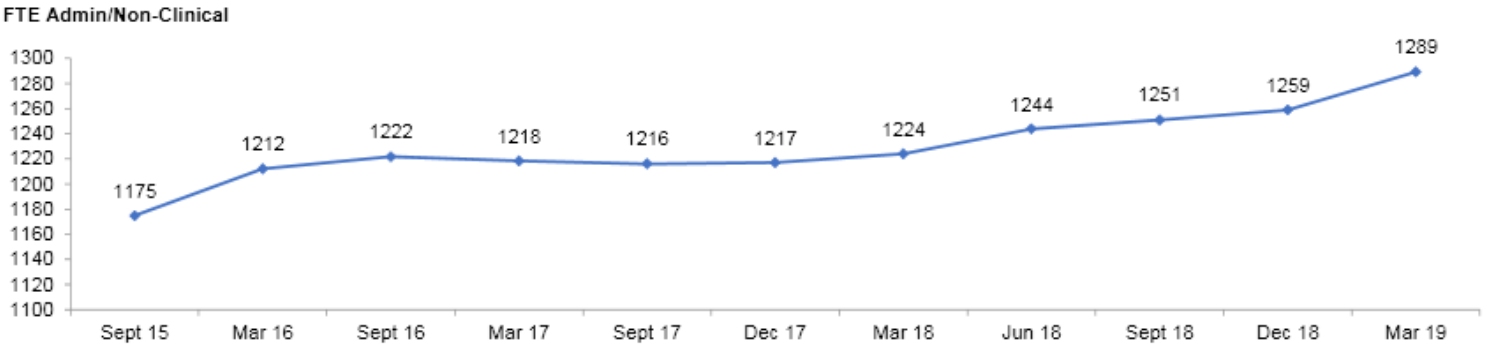
- As at the end of March 2019, there were 26 FTE GP Locums in post across Nottingham & Nottinghamshire STP.
- This represents a decrease of 3 (10.3%) between Mar 2018 & Mar 2019. This is 9.1% more than the Midlands Region's decrease of 1.2%.

NOTE: Previously published FTE data has been revised due to methodological changes and improvements in recording and estimation. However NHS Digital have not been able to fully back update GP locum data so these still have breaks in the data series. The data shown in this pack includes estimates calculated by NHS Digital for the proportions of practices that did not submit valid data.

Source: NHS Digital, GP Workforce

FTE Wider Workforce





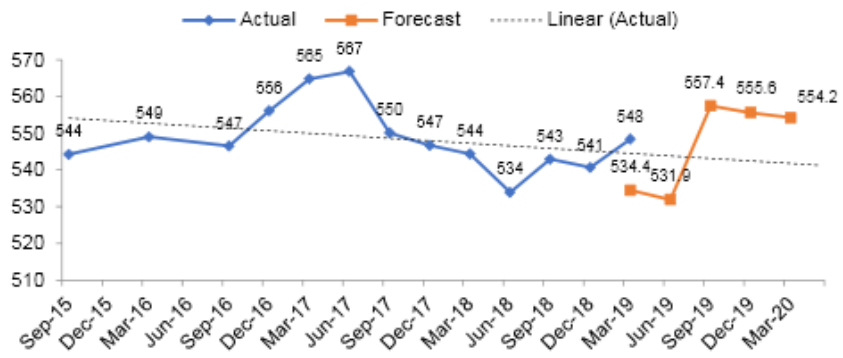
- As at the end of March 2019, there was 314 FTE Practice Nurses in post across Nottingham & Nottinghamshire STP.
- This represents a increase of 11 (3.6%) between Mar 2018 & Mar 2019. This is 3.1% more than the Midlands Region's increase of 0.5%.
- As at the end of March 2019, there was 209 FTE Direct Patient Care staff in post across Nottingham & Nottinghamshire STP.
- This represents a increase of 16 (8.3%) between Mar 2018 & Mar 2019. This is 5.6% more than the Midlands Region's increase of 2.7%.
- As at the end of March 2019, there was 1289 FTE Admin/Non Clinical staff in post across Nottingham & Nottinghamshire STP.
- This represents a increase of 65 (5.3%) between Mar 2018 & Mar 2019. This is 4.2% more than the Midlands Region's increase of 1.1%.

NOTE: Previously published FTE data has been revised due to methodological changes and improvements in recording and estimation. However NHS Digital have not been able to fully back update GP locum data so these still have breaks in the data series. The data shown in this pack includes estimates calculated by NHS Digital for the proportions of practices that did not submit valid data.

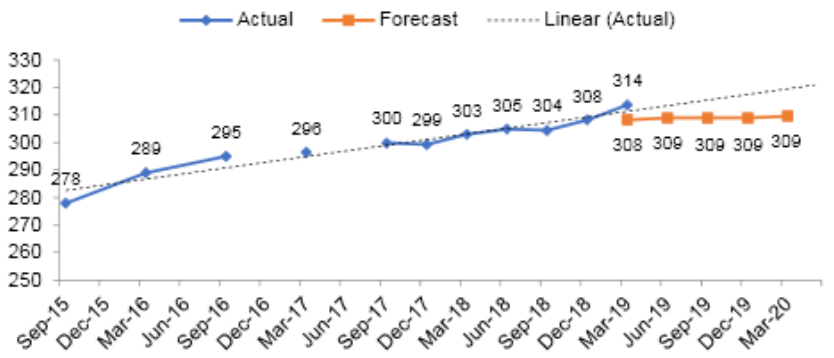
Source: NHS Digital, GP Workforce

Actual vs Plan by Staff Group

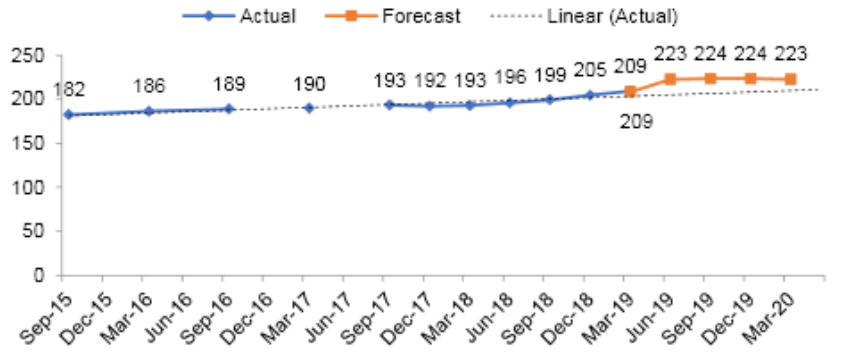
FTE General Practitioners (excluding Registrars)



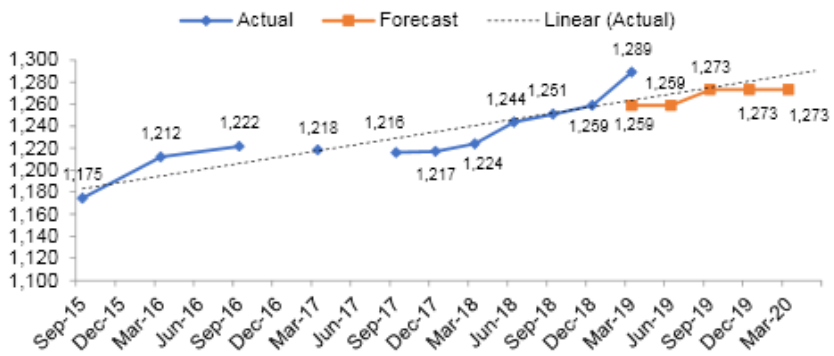
FTE Practice Nurses



FTE Direct Patient Care



FTE Admin/Non Clinical



8 | Source: Actuals - NHS Digital, GP Workforce, Plan – Operational Planning 19/20 data