Derbyshire GP Forward View Implementation Plan

ONGOING WORK IN PROGRESS

CONFIDENTIAL

24th February 2017

Chapter One

Introduction

- Our Vision

- ***The Case for Change***
- ***Planning alignment & Delivering the '9 must dos'***
- ***Baseline position***
  - ***Workforce***
  - ***Estates***
  - ***IT***
  - ***At Scale Provision***

1. Introduction: *The plan, direction of travel and details of how we will deliver the GPFV. This is the starting point for further discussions and work with General Practice, other providers and the public.*

Contained within this submission

This is Derbyshire's plan for General Practice from 2017/18 to 2020/21. It covers the Joined Up Care Derbyshire STP footprint incorporating the four Derbyshire CCGs (North Derbyshire, South Derbyshire, Erewash and Hardwick).

Our plan sets out:

- Our vision of what General Practice in Derbyshire will look like in 2021
- How we will deliver the targets set out in the GPFV
- How we will invest local and national funding in General Practice
- How we will support transformation in General Practice

The plan is a 'work in progress'. It is not intended as a definitive final statement but is the summary of discussion to date and the starting point for further discussion with General Practice, other providers in Place and the public .

We aim to set out a clear direction of travel, and outline the key characteristics of successful, high quality, General Practice. As these characteristics include the requirement that change happens in a devolved way within Place and that General Practice are empowered to own and drive the changes needed, we expect that the plan itself will be adapted and become more detailed with local ownership as we progress towards implementation.

The unify planning template links to this plan and is submitted separately

Our overall vision : *Derbyshire's STP sets out a vision which sees patients cared for in their own communities (Place) by integrated primary and community care services. Building on that vision for General Practice in Place, working together and within that local network of health and social care providers to provide integrated, accessible, high quality and seamless care*

Our Vision for Primary Care in Derbyshire

Primary care in Derbyshire will be supported to fulfill five key functions

- Improving population health, particularly amongst those at greatest risk of illness or injury
- Managing short-term, non-urgent episodes of minor illness or injury
- Managing and co-ordinating the health and care of those with long-term conditions
- Managing urgent episodes of illness or injury
- Managing and coordinating care for those who are at the end of their lives

(Ref: Securing the future of general practice: new models of primary care)

To achieve this to a high standard primary care has to be: comprehensive; person centred; population orientated; coordinated; accessible, and; offer safe and high quality care.

The vision, therefore, is to have integrated, accessible, high quality care provided by GP practices that work together and work within a network of health and social providers in local communities (Place).

A combination of additional investment, service redesign and increased capacity allow places to deliver improved in hours and extended access with the appropriate balance of pre-bookable, same day and urgent appointments to meet local needs.

An expanded multidisciplinary primary and community health and social care team, including primary care, community, mental health, voluntary sector and hospital teams care for patients at a Place level

Care is provided holistically with staff equipped with the skills and knowledge to access the support to meet the causes of ill health as well as the health need (physical or mental) itself. Families and carers will be supported, and the primary and community care teams including voluntary sector and others will provide ongoing support to enable people's lives to become as healthy as possible.

GP roles and workload evolve increasing the time available for:

- Consultation and treatment time focussed on the most complex patients with sufficient time to meet their care needs
- Increased professional development

To do this we need to invest in and support General Practice to:

- Work smarter: Invest in and support change to transform how practices work to allow them to manage workload, improve access, and provide high quality and patient centred services
- Work together: Support practices to share resources 'at scale', develop a more resilient organisation, extend access, offer a wider range of services for patients and a more attractive place to work for staff
- Integrate: Within a network of integrated community and health care service providers in local communities (places) wrapping services around the most vulnerable people in the community.

The case for change: *General Practice is at the heart of our system and our plan. Effective access to General Practice and primary care is critical to gate-keep demand across the system, and primary care is central to caring for people at home. Rising demand, a decreasing GP workforce and an aging population are all drivers for change.*

Closing the care and quality gap

- Demand for general practice and wider primary care is putting pressure on the quality of the service
- Some patients are reporting difficulty in accessing General Practice care when they need it (GP Survey 2015)
- Other providers of primary care (ED and OOH) are also seeing increased demand & issues with access
- 15% increase in consultations since 2010 has outstripped growth in GP and nurse workforce (4.75% & 2.85%) and funding
- Changes in other services such as community nursing, mental health and care homes are increasing pressure on General Practice

Closing the health and wellbeing gap

- Insufficient capacity, time and expertise in General Practice/primary care and the community to care for the rising number of complex frail elderly patients and patients with complex health and social care needs
- Provision of Minor Injury Unit, walk in and other non GP primary care services are not equitably provided across the county
- 'Joins' between services and between 'in' and 'out of hours' care are not always seamless with urgent care often provided without access to the complete medical record
- Pressure on A&E would be exacerbated by worsening access to General Practice (a 1% shift from primary care causes a 15% shift in A&E activity)

Closing the finance and efficiency gap

- The share of funding for General Practice has fallen since 2006 and is underfunded compared to secondary care (GPFYFV)
- The spend on non-elective admissions which might have been avoided with improved General Practice, primary and community care is rising
- MIU, walk in centres and other services are not as cost effective as General Practice and primary care
- 40% of Emergency Department and 70% of Minor Injury Unit attendances could be seen in General Practice/primary care
- General Practice is not supported to be as efficient as it could be; demand is not measured; and clinical triage and streaming is not always systematic. Capacity is not pooled between practices or with the wider system sufficiently

Interdependency with other plans; supporting delivery of the 9 'must dos':

This section sets out how the plan relates to other local plans and supports delivery of the 9 'must dos' and related national programmes

Key interdependencies with other plans:

In developing local plans in response to the GPFV, our planning assumptions and outcomes have been aligned to and are interdependent with those described within the following :

- Derbyshire Sustainability and Transformation Plan
- The Operating Plan
- The Five Year Forward View
- Mental Health Forward View

The primary interdependency is with the **Joined Up Care Derbyshire STP** (2016), and this plan should be considered as an adjunct to that strategy which aims to:

- Keep people: **safe & healthy** –free from crisis and exacerbation; **at home** –out of social and health care beds; **and independent** –managing with minimum support and **improve access** to urgent and routine care.
- Achieve **a financially balanced health system in 2020/21**.
- **Develop place-based care:** 'join-up' care to operate as a single team to wrap care around a person and their family, tailoring services to different community requirements across our 21 places.
- **Deliver £247m more care through Place** (growing from 30% to 39% of all care delivered) and a reduction in care delivered in specialist settings
- Have **2500 more staff delivering place based care** (c.10% of our current workforce),
- Reduce bed based care –**535 fewer beds** (400 acute NEL; 300 within Derbyshire system)

This plan builds on the STP Business Case 'Redesign Access to Primary Care' and sets out a strategy for General Practice in line with the GPFV in Place and within the STP over the next five years.

Supporting delivery of the 9 'must dos'

Must do	Supporting delivery by
Develop a high quality and agreed STP	This Derbyshire GPFV plan is an essential adjunct to the STP
Return the system to aggregate financial balance	Effective General Practice/ primary care will be central to managing complex patients in the community and gatekeeping demand
Address the sustainability and quality of general practice	This plan aims to address GP sustainability and quality directly
Access standards for A&E and ambulance waits	Effective access to GPs/ primary care should support A&E/ ambulance access
Achieve referral to treatment targets	Establishing the infrastructure to promote appropriate referrals
Deliver the cancer standard and improve the survival rate	Giving practices time to support cancer survivors and ensure early detection
Achieve the mental health access standard and dementia diagnosis rate	Support practices to identify and refer appropriately and deliver dementia diagnosis target rates
Transform care for people with learning disabilities	Supporting practices to close the health inequity gap for people with LD
Improvements in quality for organisations in special measures	Supporting vulnerable practices & those rated as inadequate by CQC; promoting at scale peer support

Where are we now *: The baseline for local General Practice /primary care .*

Demographic and health needs

- Total population over 1 million people.
- By 2033, 27.5% of population will be over 65, number of over 75s will be more than 40% higher than today
- Life expectancy in Derbyshire County (M 78.9, F 82.7) is similar to England average (78.9 M, 82.8 F) while life expectancy in Derby City (M 78, F82.2) is lower than the England average
- Life expectancy increases have slowed in recent years
- Obesity is higher than the national average in all four of our CCG areas
- The proportion of mothers that smoke at the time of delivery (14.6%) is in the highest quartile of STP areas nationally
- The number of diabetes patients achieving all NICE-recommended treatment targets is in the lowest quartile of STP areas nationally

Our plan must be both realistic about the challenges we face and ambitious in tackling them – particularly in addressing the determinants of health to slow future increases in healthcare demand

A wide range of health and care commissioners and providers

- Four CCGs (Erewash, Hardwick, North Derbyshire, Sothern Derbyshire), two local authorities (Derby City and Derbyshire County)
- Two acute Foundation Trusts in Derby (Royal Derby Hospitals) and Chesterfield (Chesterfield Royal Hospital)
- One community Foundation Trust (Derbyshire Community Health Service)
- One Mental Health Foundation Trust (Derbyshire Healthcare)
- 117 GP practices (reg. pop. ranges (2-25k), plus Out of Hours provider
- Residential and care home providers
- Ambulance Trust – East Midlands wide
- Vanguard MCP in Erewash

Our plan must provide a common framework and importantly aligned incentives for us to work together

Diversity, affluence and deprivation

- High deprivation in Derby and the North East contrasts with affluence in the Dales and South West
- Dense urban communities in Derby and North East; rural comparatively isolated communities in the North and West
- Similar urban centres a mix of more affluent market towns and more deprived ex-mining areas
- Rich cultural mix across Derby City, compared with 97.5% white British in the County

Our plan must be flexible to meet diverse needs – in relation to both geography and population. To achieve consistent quality we must not take a 'one size fits all' approach

Current primary care provision

- The majority of primary care is provided by 117 practices across Derbyshire from 8am – 6.30pm Monday to Friday.
- Some practices deliver extended hours for routine non-urgent appointments before 8am and after 6.30pm Monday to Friday and some Saturday & Sunday mornings
- Outside of this, additional primary care is provided in a variety of ways; at the ED departments of acute hospitals, an MIU, an OOH primary Care Centre, a walk In centre and a weekday acute home visiting service

Workforce

National picture

A recent Health Education England report , 'By choice – not by chance' (November 2016) identifies that recruitment into general practice has become a major issue nationally. The report looks at students experiences at medical school and shines the spotlight on the need to tackle long held views about general practice.

- The report identifies low morale in general practice, professional denigration of a career in General Practice and the inequity in the financing of undergraduate education are all having a negative impact.
- The GP Directorate, at Health Education England is responsible for the Postgraduate Medical Education of General Practitioners across the East Midlands.

The report identifies that although several interventions are under way to improve GP recruitment including, the GP Retention Scheme launched in 2015 which gives an opportunity for GPs to return to practice, it also supports the safe introduction of overseas GPs who have qualified outside the UK and have no previous NHS experience, minimal attention has been paid to the role medical schools have to play in promoting general practice as a career to medical students. However, the report makes a number of recommendations to work towards improving the current situation.

Local picture

Within Derbyshire, across the four CCGs we have 117 practices. Currently there are over 650 GPs which equates to 541 full time equivalents (fte). This is different to the number stated in the STP submission as at the time of submission estimated data was used. We have a significant number of male GPs who work full time and are close to retirement, more positively Derbyshire are attracting and retaining female workforce which is a problem in other areas of Country. A number of practices across Derbyshire have had difficulties in recruiting and retaining GPs and this has led to a number of long standing vacancies.

Over recent years, through our collaborative approach to workforce planning and development , a range of activities has taken place to support skill mix and enable delivery of the future models of care. Some examples include;

- Derbyshire wide framework for the training and education of Advanced Clinical Practitioners
- Establishment of Talent Academy led by Derbyshire County Council Adult Care
- Through the Erewash Multispecialty Community Provider Vanguard we have been able to understand the requirements through testing new ways of working and new workforce models within our GP and primary care provision
- Employment of pharmacists and mental health staff to provide different models of primary care intervention (Erewash MCP/ Hardwick CCG & North Derbyshire)
- ACPs running on-day services , out of hours and home visiting services, (Erewash MCP/ Swadlincote)

Our future plans include;

- Increase in numbers of GPs by 20wte whilst sustaining GP numbers across all CCG's and growth in three out of four CCG's
- Ability to attract, recruit and retain workforce providing attractive and innovative careers and noting the ageing workforce and new GP's different requirements
- Engaging, communicating and delivering different workforce solutions with GPs and their practices whilst they continue to provide day to day services
- Ensuring increase in trainee placements and recruitment to these roles to enable the required workforce supply

Estates

There are 179 GP premises in Derbyshire with several practices having branches and a wide mix of city, town and rural premises of varying type, age, size and quality. Some large purpose built new premises exist as well as, at the other end of the spectrum small premises in old adapted houses. Due to the historic development of General Practice as individual businesses, it is evident that there has been an inconsistent approach to the placing and spacing of practices, which means that some geographic communities are better served than others.

Other premises in Derbyshire include;

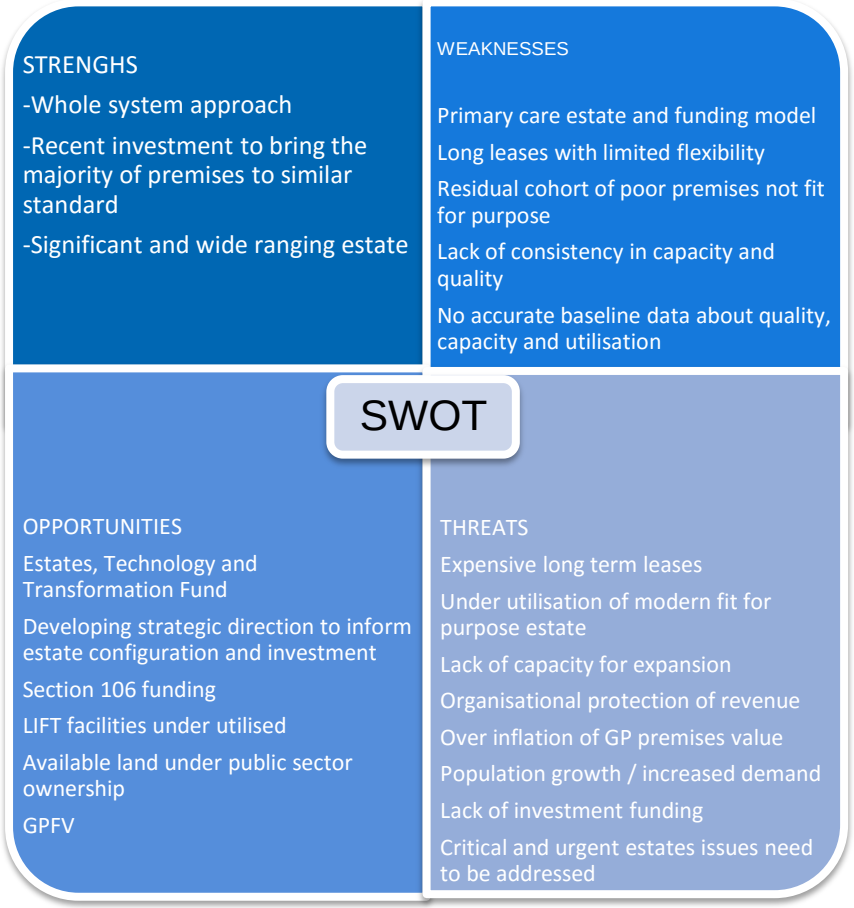
- 13 community hospitals
- 5 health centres
- 1 residential building
- 5 LD buildings
- 22 ambulance premises
- 2 acute hospitals
- 3 CCG HQs

There is no consistent, accurate baseline data about the current quality, capacity and utilisation of GP premises. Work has begun to provide improved data on premises and SHAPE tool will assist the process and functionality. This will be completed by end of 2017/18.

For many year the GP Estate has received limited investment resulting in poor quality premises with little scope for extension or expansion for new models of care. Many premises are now fully utilised which is preventing expansion of clinical services into existing primary / community care buildings. Estates, Technology and Transformation Funding has been prioritised at CCG level for estates improvements and from 2017 this will begin to improve capacity and access across Derbyshire (refer to Infrastructure section for further details)

There are currently two interim local estates strategies, one for Southern Derbyshire and Erewash and one for North Derbyshire and Hardwick. The plan is to combine these strategies with the STP estates plan to create a single STP estates strategy which will be managed through the Derbyshire Local Estates Forum.

SWOT Analysis:



IT

Baseline

Primary care IT in Derbyshire is starting from a relatively strong baseline, with all practices meeting minimum standards for GP IT, patient on-line access (POLAR) enablement, and a high degree of wi-fi deployment. However, infrastructure has a history of under-investment, and the mixed economy of TPP systmOne and EMIS systems generates interoperability issues, which are expected to become more acute over time.

LDR Status and Relationship to STP

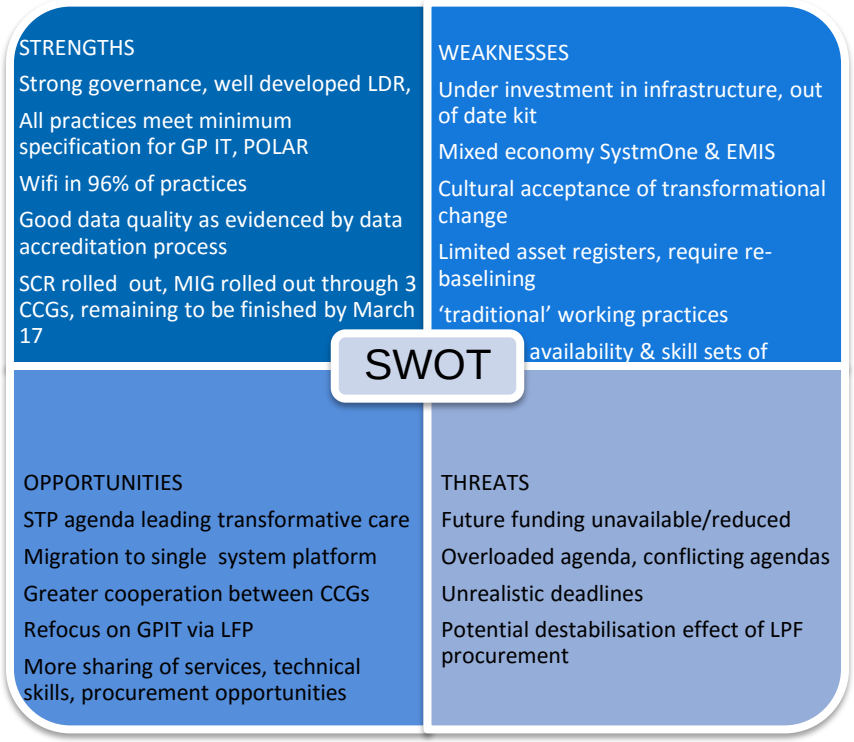
The LDR was approved by all Derbyshire partner organisations in June 2016. The roadmap was updated and resubmitted in October 2016, in line with NHSE requirements.

The LDR is an integral component of the STP. A comprehensive exercise has been undertaken to ensure that the roadmap is fully aligned with all STP workstreams, and projects have been mapped to STP priorities. Funding proposals have been incorporated into the overall STP financial plan.

The Joined Up Care Derbyshire (STP) is crucially dependent on information technology, particularly in the delivery of place-based care. Without a comprehensive, digital care record, available at point of need, delivery of high quality care will be severely compromised.

Summary of key gaps and issues:

- **Delivering new models of care through new and emerging technology:** Enabling well equipped health and care professionals to work together within the community, in and around primary care. Enabling the delivery of care and treatments options close to the homes of their patients.
- **Changing the face of GP Access:** Continue to provide and expand upon a modern , efficient and efficient digital infrastructure that will ensure patients are cared for in the most appropriate setting by connecting primary care with the wider health and care footprint reducing the administrative burden and creating addition capacity.
- **Shared and integrated health and care record:** Authorised access to all relevant patient information to plan and undertake care to achieve the best possible clinical and social outcomes. Wider use of information to underpin reactive and urgent care services and to reduce hospital admissions and length of stay.
- **Decision making through insight and intelligence:** Continue to expand health and care datasets to build better insights in to population health using risk stratification to refine and present pertinent patient data to health and care professionals for action.
- **Empowering patients and those that care for them:** Patient information gathered from many sources will be collated and supported by many other functions to enable patient to be more informed and take a greater degree of responsibility for their own health and care



At Scale Providers

There are a number of 'At Scale' Providers operating within Derbyshire, below is a description of the current baseline per CCG area;

Erewash CCG has two 'At Scale' Providers which together cover a population of 97,000 within the towns of Ilkeston and Long Eaton, consisting of Sandiacre, Risley, Kirk Hallam, Awsworth, Cossall, Stanton Village, Stanley Common and Dale Abbey. There are currently two At Scale' providers operating within Erewash;

- **Erewash Health Limited (GP Provider Organisation and Federation) –** Erewash Health became a formal GP Provider Organisation and Federation. The Federation supports the practices in providing high quality patient centred care whether this is through service provision, sharing resources or administrative functions. Key area of work currently is the On Day Service pilot, .
- **Wellbeing Erewash (Multi-Speciality Community Provider) -** Wellbeing Erewash is a new approach to health and social care. Erewash has been chosen as one of a number of places across the country looking at new ways of improving people's health and wellbeing. Wellbeing means feeling as well as you can be, physically and mentally, with the confidence and support you need to choose a healthy lifestyle and to get help when you need it. Currently focussing on three main areas; personal resilience, community resilience and integrated primary and community services.

Hardwick CCG covers the town of Bolsover, North East Derbyshire and the border with Amber Valley and has a patient population of 102,000. Currently they have one 'At Scale' Provider covering 12 of the 15 practices in Hardwick.;

- **North East Derbyshire Healthcare** is a Federation of practices and is a limited not for profit company. Key areas of work include supporting and developing practices and delivery of an MSK triage service.

North Derbyshire CCG has 35 GP practices within the towns of Buxton, Bakewell, Dronfield, Chesterfield and Matlock with a practice population of 290,198. It currently has two 'At Scale' providers;

- Chesterfield practices are members of **Chesterfield Health Provider Ltd** which is the emerging federation for Chesterfield Place. Chesterfield Health Provider Ltd is delivering the notes summarisation and workflow redirection project, through an agreed training programme as part of the GPRP funding for Chesterfield practices. Chesterfield Health Provider Ltd also operate the Chesterfield Community Eye Care Service and Angina Management programme.

- The North Derbyshire Federation holds the local authority enhanced services contracts on behalf of all practices.

Southern Derbyshire CCG has 55 practices covering a population of 548,000 patients within Southern Derbyshire which includes, Amber Valley, South Derbyshire Dales and Derby City. It currently has one 'At Scale' provider which includes 52/55 practices;

- **Alexin Healthcare Limited** officially launch in July 2013 and has Company Interest Status. It offers its practices the opportunity to collaborate on the further development of primary care as a federation. As well as providing commissioned services for the NHS and in Private Medical Services and to develop frameworks and relationships which take advantage of economies of scale and improved ways of working.

Where are we now: *How does the health of our population compare? (Nationally)*

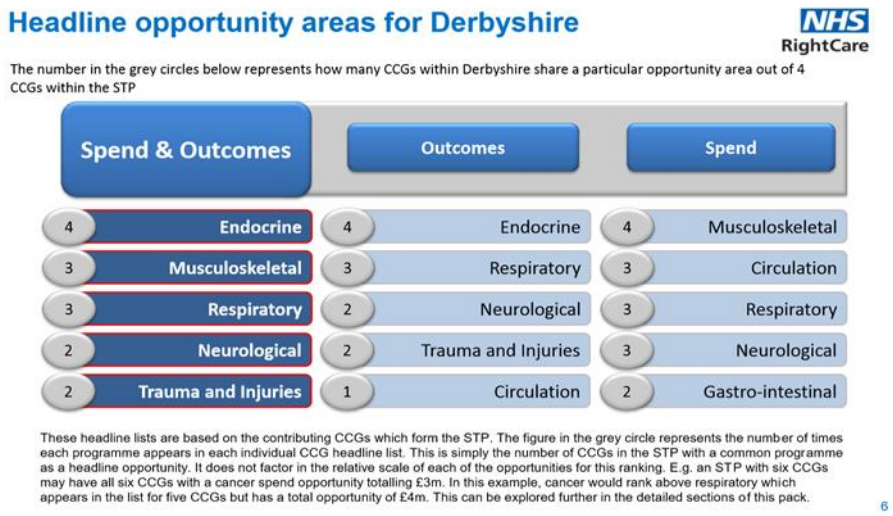
More people in Derbyshire are living longer in poor health due to a combination of increasing life expectancy and decreasing healthy life expectancy. We are in the worst quartile of STP areas for key indicators of preventing disease e.g. the number of mothers smoking at the time of delivery and reducing the impact of established disease e.g. the number of diabetes patients to achieve all three NICE recommended treatment targets.

We also know there are marked inequalities in healthy life expectancy. People who live in the more deprived communities in the footprint or are part of certain groups such as those with severe and enduring mental health or learning disabilities spend most of their lives in ill health.

Deprived communities have greatest exposure to a range of factors that impact adversely on the health of individuals, families and communities, including fuel poverty, poor housing, higher unemployment and low paid jobs, lower educational attainment and poorer access to services. These wider determinants of health underpin lifestyle risk factors such as smoking, physical inactivity and poor diet, which are most prevalent in these communities.

The table below shows the variation in lifestyle and behaviour between our most and least deprived areas

Healthy behaviour (% of population)	Most deprived 10%	Derbyshire	Least deprived 10%	National
Healthy eating adults	22.1	28.8	34.9	28.7
Binge drinking adults	19.5	21.3	20.5	20.1
Under 18 conceptions	2.9	2	0.2	1.5
Regular smokers (aged 15)	12.4	9.8	7.9	8.7
Obese adults	27.4	24.9	21.2	24.2
Obese children in reception	10	8.8	7	9.4
Obese children in year 6	22.7	18	13.6	19.1



The numbers in the grey circles ,in the above table, represent how many CCGs within Derbyshire share a particular opportunity area out of the four CCGs within the STP.

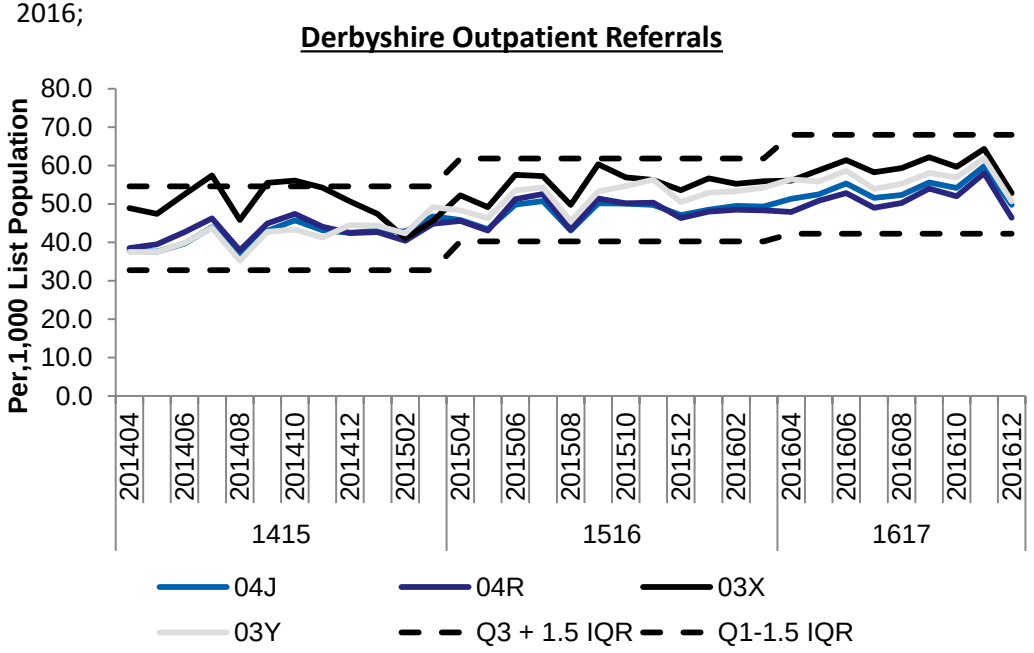
The table highlights where Derbyshire is an outlier in comparison to other CCGs in terms of spend and outcome. It highlights five areas in which Derbyshire spend more but have lower outcomes compared to our peers.

Full details of how Derbyshire compares to other CCGs can be found in the 'Commissioning for Value, Where to Look' pack. We will use this information and other data to address and improve inequalities within Derbyshire.

Where are we now: *How does the health of our population compare? (Locally)*

As well as national indicators, local indicators will also be used to address the inequalities between the four CCGs in Derbyshire. Some examples of the type of data available are given below . We will work to combine the four CCGs quality and performance dashboards into one generic quality assurance dashboard for Derbyshire. This will enable us to target areas of good practice and address areas where there is significant variation affecting care and outcomes.

Some of this work has already started as indicated in the Derbyshire Outpatient Referrals graph below where Erewash CCG was an outlier at the beginning of April 2014 but indicates the gap has been significantly reduced by December 2016;



Other examples of local data we will use includes ;

Primary Care Web Tool Outliers;

Data from Primary Care Web Tool (Jan 17)	Erewash	Hardwick	North Derbyhire	South Derbyshire
% of GP Practices with at least one outlier within CCG	25%	75%	54%	49%
Number of GP Practices with at least one outlier within CCG	3	12	19	27

Care Quality Commission Ratings;

CQC Inspection Ratings	**Oustanding**	**Good**	**Requires Improvement**	**Inadequate**	**No. of practices awaiting inspection**
Erewash	1	11	0	0	0
Hardwick	1	11	2	1	0
Southern Derbyshire	9	39	1	0	6
North Derbyshire	9	25	0	0	1

Chapter Two

New Model of Care – 'local care delivered by local teams'

- ***Where do we want to be***
- ***From now to then***
- ***What is different***
- ***How will the GPFV support the Place***

1. Where do we want to be; 'local care delivered by local teams' *For practices this would be structured within four key design principles*

Access and continuity

A balance of access and continuity is offered.

Greater use of self care and signposting, triage and streaming means that demand is filtered, managed and shaped to ensure its dealt with 'in the right place, by the right person, at the right time'. This is underpinned by systematic use of the latest technology. Care is consistent both in and out of hours.

Care is tailored and co-ordinated for those who most require it, with continuity of care. Care is provided by a multi-disciplinary team centred on the patient and linked by care plans and common information systems.

Patients and population

Care is pro-active and population based, focused on the key long term conditions that most affect health. Where required, care is focused on special groups who are offered more support and greater specialist input.

Patients are supported to identify their own goals and manage their own condition and care. More focus is placed on what the patient values rather than a narrow focus on bio-medical indicators and process measures.

Patients are linked into wider social networks, using health trainers and the voluntary sector to build and connect existing community assets.

Information and outcomes

There is an electronic patient record, accessible to all members of the health and social care teams delivering care to the patient

Clinicians are able to access diagnostics when they need them, and are supported by the latest evidence on best practice for care and referrals.

Clinicians have access to timely information on all aspects of their patients health and social care.

The CCG also makes information on quality and outcomes publically available as close to real time as possible.

Management & accountability

General Practice/Primary care continues to be based on autonomous practices, and these are supported to thrive as individual organisations.

Autonomous practices work closely together to share resources and set common aims, providing a resilient network and improved economy of scale. This network of practices develops and monitors high standards of care across all constituent practices. Practices and the network of practices are supported by expert management.

2. Future model of care: 'from' now 'to' then

By 2021 three elements ((i) sustaining, investing and transforming General Practice through the GPFV; (ii) offering appropriate access and (iii) investment in services in 'Place' will have come together to transform services. Practices will be working together to provide some services at scale and be integrated with an expanded multi-disciplinary team (including MIUs and WiCs) in local communities ('Place'). Places will expand access to match demand, regardless of 'in/out of hours' time bands.

From	To	(i) GPFV	(ii) Access	(iii) Place
1. General Practice underfunded compared to other NHS sectors (Ref: 5YFV/ GPFV)	1. General Practice better funded; receiving a real terms funding increase, including £500m national 'turnaround' funding	✓		
2. Not enough staff in practice & limited capacity and range of staff in the wider community	2. Additional GPs and other staff including clinical pharmacists and mental health workers in practice. Better integrated community teams (including GPs) working in an efficient and collaborative way to deliver rapid, responsive integrated care		✓	
3. Heavy workload on General Practice	3. Skilled staff supporting GPs and practices to ensure patients see the most suitably qualified professional with GPs allowed time to focus on more complex long term conditions patients	✓		
4. Poor primary care estate and limited available technology	4. General Practice capital investment. Technology used to manage and stream demand and offer increased self care. Ability to 'read and write' across IT systems	✓		
5. Practices, and other providers of primary care, working separately and struggling to meet demand and deliver extended access for patients	5. General practice empowered to work as part of a larger primary and community multi-disciplinary team. An integrated team in a geographical community (Place) pooling capacity to match demand across the week, including an extended offer on weekday evenings and weekends. Patients access this service through a single point and are triaged and then streamed according to need. Capacity is pooled in a multi-disciplinary team including GPs and associated health, social care and community providers		✓	✓

3. How this model of care is different: *this section sets out how this new model of care differs from historical and current models and from old ways of working. It describes a different way of working and new rules for sustaining and transforming General Practice*

What it's not

- More of the same: continuing to rely on investment in the old business model of small organisations and traditional partnerships
- A prescribed final organisation form
- GPs and frontline staff working harder and longer hours
- More face to face GP appointments
- Assuming significant cash investment uplifting overall funding to General Practice
- Assuming lots more staff will be available to be recruited into General Practice
- Multiplying access points without considering the capacity of staff to deal with the increased demand
- Significant variation between practices

What it is

- A new model of practices working together and pooling capacity and resources with other practices and with other providers
- Staff time freed up to give time to reflect, learn and lead
- Better access overall and better access to GPs for those who need it, with fewer face to face GP appointments
- Investment to groups of practices and to Place as the default for focused pieces of work
- Growing our own staff, and retaining them with attractive packages of support and working environments
- A greater range of existing staff working in General Practice, all working to the 'top of their licenses'
- Clarified and simplified access points , with effective signposting and triage streaming to a wider group of staff; and more self-care
- Consistent quality and service offer across Place

4. How does it fit: General Practice's Place in the Derbyshire vision: *General Practice is at the heart of Place, with Place at the heart of the Joined Up Care Derbyshire STP and our plans to deliver high quality integrated care*

Joined Up Care Derbyshire (STP)

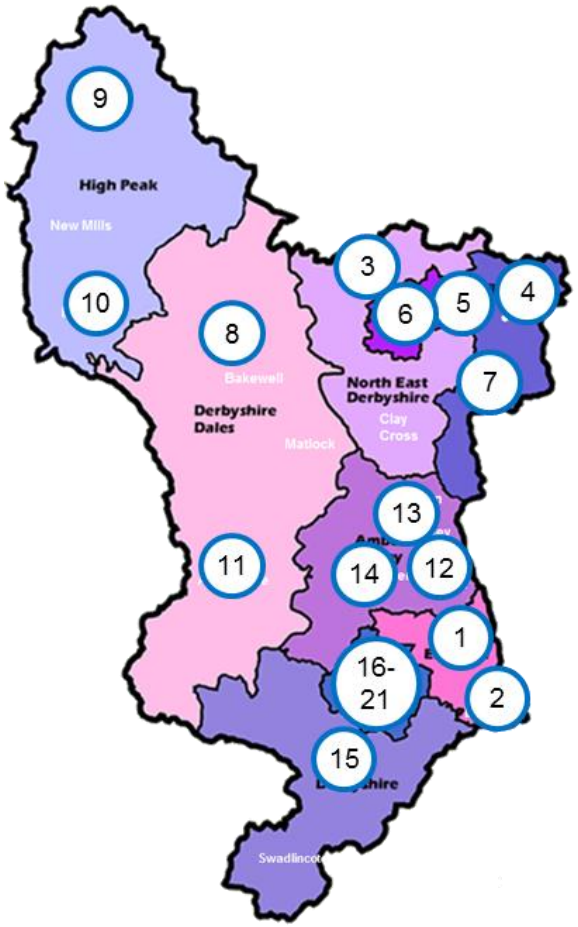
Sets out a model of care which aims to:

- Keep people: **safe & healthy** –free from crisis and exacerbation;
- **at home** –out of social and health care beds; **and independent** –managing with minimum support and **improve access** to urgent and routine care.
- Achieve **a financially balanced health system in 2020/21**.
- **Develop place-based care:** 'join-up' care to operate as a single team to wrap care around a person and their family, tailoring services to different community requirements across our 21 places.
- **Deliver £247m more care through Place** (growing from 30% to 39% of all care delivered) and a reduction in care delivered in specialist settings
- Have **2500 more staff delivering place-based care** (c.10% of our current workforce),
- Reduce bed based care –**535 fewer beds** (400 acute NEL; 300 within Derbyshire system)

This model is developed and delivered in 'places' across Derbyshire

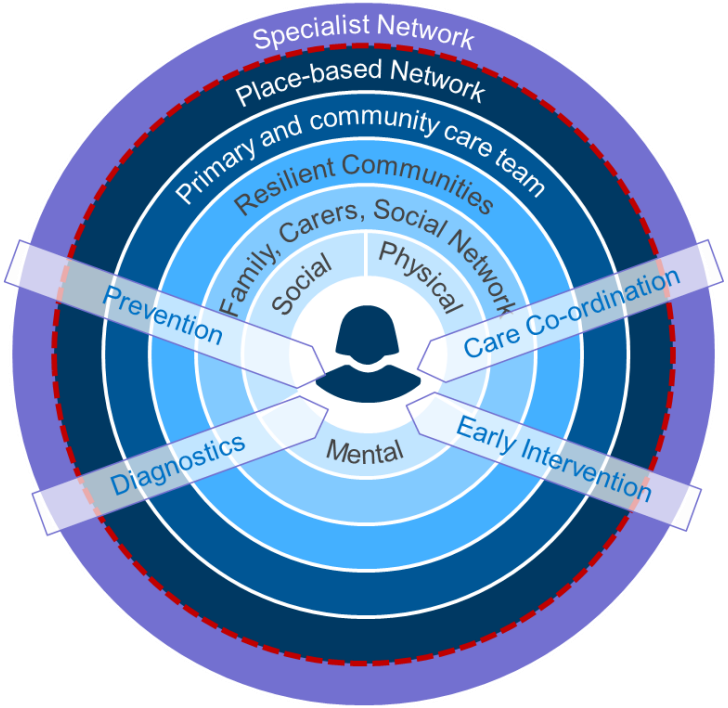
Derbyshire places

- Networks of providers joining up services in local communities



General Practice in Place

- General Practice is at the heart of the Place 'concentric rings' model of care
- Working together at scale on a Place footprint &;
- In an integrated way with a health and social care primary and community teams
- Pooling resources to increase capacity and offer a wider range of services in a more seamless way



5. What are our big ideas: *we know that there are a number of key initiatives and design principles that will support our primary and community teams to work together to integrate and deliver care for patients*

The model of care: 'local care delivered by local teams'

- 'Practices in Place' providing clinical leadership within a wider multi-disciplinary team, offering integrated care for patients and increased pooled capacity
- Practices working together at scale
- Potential for an eventual natural progression to a hybrid 'MCP' style model of working (multi-disciplinary teams working together to provide local population based care at scale

Access: 'advice when you want it; care when you need it'

- Patients are assessed, triaged and streamed in a consistent way to ensure they get appropriate help and advice
- System is simplified, with fewer and more accessible points of access
- More triage; more self care; more skill mix; more use of IT; increased telemedicine; more non-medical support, allowing capacity for;
- Patients needing face to face episodic / urgent care to be seen in pooled 'on day 'hot' clinics & GPs to focus on the needs of the most complex and lead an integrated primary and community team
- Care extended out of hours to match need (weekday and weekend)

Workforce: 'grow and diversify'

- 'Grow and keep our own': support our training practices and retain ex trainees by using the potential of at scale working
- Offer attractive packages for a portfolio career within at scale working; CPD; mentoring; safe and supportive places to work
- Diversity skill mix: pharmacists; MH therapists; physicians associates
- Support practices individually and at scale to improve their workload management through implementing the ten high impact actions
- Manage and shape demand and increase and pool capacity to give time back to GPs for personal development and clinical leadership
- Establish opportunities for new roles; coaching, mentoring and development of multi disciplinary teams
- Clinically high quality and safe – supportive and easy to use systems across all practices minimize personal risk

Infrastructure: 'connected space'

- An integrated care record available at the point of contact
- Moving the information not the patient; a step change in the use of digital technology: self care IT; skype
- Give patients the tools and information and raise our expectations that they can manage their own health - Rights and responsibilities charter
- A 'one estate' approach: combining existing estate to provide space for multi-disciplinary provision
- Improved GP estates

Investment: 'new investment at scale'

- CCG funding to match the core allocation and support transformation
- Effective use of ring-fenced investment from national funding streams
- A clear plan for investment in cash and people over the next five years
- A clear line of sight showing delivery of GPFV requirements (KPIs) from investment made

6. What will it look like and how will it benefit patients: *as resources are pooled within Place; services traditionally commissioned and provided by individual practices , or within a hospital setting will be delivered at scale, alongside a wider range of health and social services and acute outreach.*

Where	What: services that could be provided
Individual existing General Practice sites	Core GMS/PMS with increased focus on: • Day to day care for more complex patients e.g. frail elderly and end of life patients • Integrated care provided by multi-disciplinary teams • Services benefiting from very local physical access such as near patient testing
At scale General Practice (e.g. a common physical space within a Place footprint, or a virtual space)	• Triage and treatment of 'urgent' episodic care (e.g. on the day, less medically complex problems) • Extended hours • Care Home Services • Dermatology; ENT; ophthalmology • ECG analysis; Phlebotomy; Spirometry • Family planning; teenage Health • Home visits • Admin and back office functions Wider Integrated Care Team (ICT): • Admissions avoidance & supported discharge • Carers support; night sitting services • Frail elderly assessment; falls services • Specialist nursing support; COPD; diabetes; CVD etc • Consultant out-reach (e.g. Consultant Geriatrician support ICT) and access to advice and support • Elective O/Ps (e.g. MSK triage; ophthalmology)

Benefits: For all patients	• Greater opportunity and support to self care, with better access to own record • More consistent care between practices with less distinction between in/out hours • Signposting, triage and single record mean quick access to 'right person, right place, right time'
For patients with less complexity/ predominantly needing episodic care	• Rapid assessment and triage and signposting to right person and place • More opportunity to self care with greater use of technology • Access to routine elective procedures in the community at a Place level • Better triage and access to specialist advice reduces unnecessary interventions
For patients with greater complexity / predominantly needing continuous care	• Wrap around care from an integrated, multi-disciplinary team • More time with, and easier access to a GP • A greater range of services delivered through place-based care • Pro-active support, empowering people to plan their own care

7. Key benefits and implementation: *this section describes how the health model will support the delivery of key health needs and priorities, improved access to services; out of hospital services and outlines implementation issues*

Delivery of health needs/ priorities	Access including reducing inequalities	Improving out of hospital services and supporting care closer to home
• Better outcomes for patients who are complex and resource intensive • Services delivered at Place , providing access to the most appropriate clinician • Efficiency through integration and at scale working reduces duplication and increases value	• Improved monitoring of demand; triage, streaming, and pooling of capacity improves access • Improved responsiveness for people needing routine 'on day' care • Greater continuity of care for more complex patients	• Place provides a platform on which to build extended out of hospital services • Integrated teams supports improved discharge from Acute Hospitals (Step down) and proactively manage patients through proactive step up care models • Increased elective care is provided by Place-based teams, patients will have increased access to specialist medical teams in the community (Geriatricians)

Major service changes & consultation

- Plan sets out framework for integrating and expanding services in the primary and community, as such;
- No substantial service changes are set out in this document that would require public consultation now, however;
- Local plans will be developed which may require consultation, such as the bringing together of services onto a single site;
- If so these will be consulted on, in the same way as NDCCG and HCCG are currently consulting on their 'Better Care Closer to Home' proposals

Implications for workforce

- The section on workforce sets out the implications, which will include:
- Diversification of the primary care workforce through recruitment & skill mix
- Changing role for GPs
- Organisational Development and behaviour change to create new multi-disciplinary teams
- Development of new organisational and governance structures to form safe and effective frameworks for those teams

Engagement

- CCGs will engage with General Practices on the GPFV through CCG and the development of Place
- CCGs will continue to engage with GP and LMC colleagues
- GPs working in Place, will be supported to develop local plans within the framework of the national and local plans
- A high level approach to communications and engagement will be developed

8. Longer term vision for practices in Place : *this section sets out the vision for how 'practices in Place' would operate within an integrated model with the focus on population outcomes*

From	To
• Focus on organisations	• Focus on specified populations
• Individual organisational incentives	• Aligned incentives (e.g. population budgets)
• Process targets to support day to day activity	• Use of outcomes that matter to those populations
• Monitoring performance	• Measuring outcomes
• Risk transfer	• Risk share
• Separate episodes of care – reactively provided	• Knowing the population and providing care proactively to those most at risk
• Fragmented care with multiple handoffs	• Integrated care – co-ordinating delivery across providers
• Individual records	• Information sharing and a common record
• Maximising cost reduction	• Maximising value

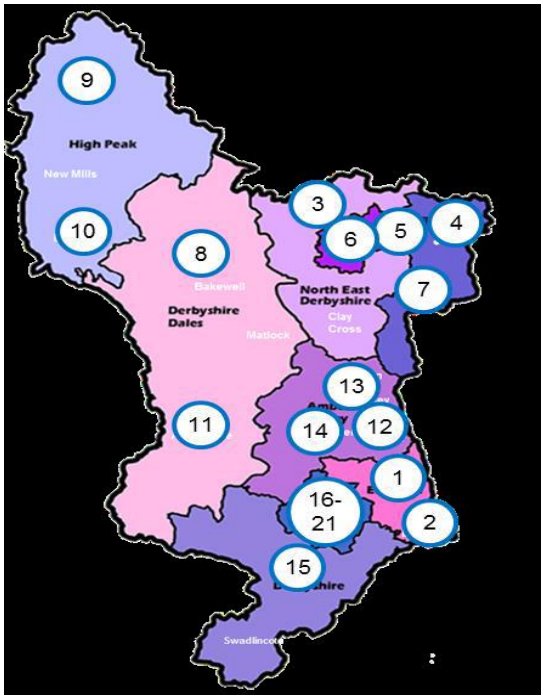
Chapter Three

Improving Access across Derbyshire

The Derbyshire vision for extended access in primary care:

Our vision for the future model of care is for practices to work together to provide some services at scale and integrate with an expanded primary and community team (including urgent care services) in local communities (Places).

A new model of care described within chapter two provides the strategic direction for the development of Place-based care and the delivery of the GP Forward View whilst enabling each Place to address their local issues through a combination of additional investment, service redesign and extended access will enable us to develop the appropriate balance of pre-bookable, same day and urgent appointments to meet local needs.



Care will be provided holistically with staff equipped with the skills and knowledge to provide support to meet causes of ill health as well as the health need itself (physical or mental). Families and carers will be better supported. Multidisciplinary integrated primary and community care teams including voluntary and other sectors to provide ongoing support to enable people's lives to become as healthy as possible.

Both the clinical pathways, the role of the GP and other healthcare professionals roles and workloads will be redesigned enabling consultation and treatment time to focus on the needs of the complex patients. Skills and capabilities will change and develop to deliver the new model across healthcare. This should ensure there is sufficient time to meet their care needs and for greater supervision, clinical leadership and professional development. Existing Minor Injury and walk in services will be incorporated into an extended primary care offer, equitably distributed by geography and need.

Derbyshire are committed to maintaining , strengthening and developing our clear vision for improvement of primary care access.

Our approach to implementation and what we aim to achieve

The Approach

- Understand the specific challenges and issues at Place level through the workforce evaluation and workload development
- Support service re-design in general practice
- Continue to support practices to work together
- Expand and connect integrated primary and community care teams
- Integrate general practice and Place-based working teams
- Build on the process for triage, streaming and shaping demand across services
- Develop consultation types
- Develop patient awareness and behaviours towards self-care
- Deliver evening and weekend access

Outcomes

- Patients accessing the appropriate level of intervention appropriate to their needs
- Increased patient confidence and satisfaction in primary care services
- Reduced inappropriate attendance at A&E and OOH services
- An additional 1.5 hours per day pre-bookable and same day appointments after 6.30pm
- Weekend provision of additional access based on population need
- Provision of a minimum additional 30 minutes consultation capacity per 1000 population per week rising to a minimum additional 45 minutes consultation capacity per 1000 population per week
- Ensure usage of a nationally commissioned GPAT tool to automatically measure appointment activity both in-hours and extended hours provision
- Ensure services are advertised and easily accessible to patients
- Develop the use of digital approaches to support new models of care in general practice
- Ensure any inequalities in patients experience of accessing general

Current primary care service provision across Derbyshire

Service	Hours	Activity per annum	Description
GP	8am – 6.30pm	5,8,10,310 Est 15/16	117 practices (Reg. pop. Ranges 2-25k)
A&E	24/7	208,453	2 acute FTs Derby & Chesterfield plus cross border flows to into neighbouring counties
GP OOH	6.30pm – 8am M-F + 24hrs on weekends & Bank Hols	148, 896	1 Derbyshire wide provider
MIU	8am – 10pm	51,778	MIUs at Whitworth, Buxton, Ilkeston & Ripley
UCC	8am – 8pm	50,034	Derby
Walk in Centres	6.30pm – 10.30pm M-F day times, 9am – 10.30pm weekends & Bank Holidays	TBC	Ashbourne (more limited opening hours), High Peak, Swadlincote
Extended Access Hubs	5.15 - 8pm weekdays & weekend mornings		Ilkeston & Long Eaton
Acute Home Visiting Service	9.30 – 6.30pm weekdays		Erewash
Care Homes Support Service	9-5pm weekdays		Erewash

Derbyshire extended access baseline

CCG	Extended Hours DES Provision	Extended Hours DES Population Coverage of (April 2016 data)	Extended Hours DES Saturday Coverage (April 2016 data)	Current Access Wave One Pilot Sites	Areas With Less or No Provision
Derbyshire County	All four CCGs practices participate in the extended hours DES 90/117 practices provide extended hours (please see appendix X for full details by practice).	78.4%- 812,310 patients from a total population of 1,036,589 being able to access services outside of core hours.	24.7% - 23 practices offer Saturday access through this service and this covers 255,662 patients.	2/4 CCGs in Derbyshire are wave one pilot participants to initiate improved access schemes	78.4% patients have access to extended hours. 11.3% patients have access to Wave one pilot sites.
Erewash CCG	8/12 practices	76.8%	31.6% - 30,787 patients (31.6%) are able to access Saturday services.	Two hub sites in Long Eaton and Ilkeston offering evening appointments Mon-Fri 17:15-20:00 and Saturday 09:00-12:00 and Sunday 10:00-13:00 to 100% of the population	3/6 Ilkeston practices and 1/6 Long Eaton practices not providing 100% coverage through extended hours hubs to evening and weekends
Southern Derbyshire CCG	39/55 practices	71%	26.4% - 143,988 patients are able to access Saturday services		8/26 County practices and 8/29 City practices not providing
North Derbyshire CCG	32/35 practices	93.9%	22.2% - 64,835 patients are able to access Saturday services		3/35 practices not providing are in Dronfield S18, Killamarsh S21 & High Peak SK22 areas
Hardwick CCG	11/15 practices	74.6%	15.6% - 16,052 patients are able to access Saturday services.	Three practices currently providing weekend access to an approximate population of 20,000 patients.	4/15 practices not providing are in the Alfreton/South Normanton area (Village/Limes/Blackwell) and Chesterfield

How and where is extended access going to be provided

The Joined Up Care Derbyshire STP describes a fundamental shift in care into Place within the community. Places will provide integrated care for their population and will be the co-ordinating units for more specialist services provided in specialist networks across the County or more widely.

As it currently stands, we have a significant amount of work to do to get us from the baseline to our vision. Our CCGs are starting with different core baselines and variation with extended hour provision via the Directed Enhanced Service. We have two established but different pilots and one in its infancy.

The proposed Place model for Derbyshire is for primary care, mental health, community services, social care and third sector to operate as a single team to wrap care around a person and their family in Place. General Practice is therefore key to delivery of Place and access to services.

Whilst recognising the agreed model, how this is delivered and where will be unique to the 21 Places in Derbyshire. Each CCG is at a difference stage in the journey of developing and implementing their plans;

Erewash CCG has two natural geographic Places, Long Eaton and Ilkeston. As a result of the Prime Ministers Challenge Fund (PMCF) and being a Vanguard site they have already made progress towards the proposed Derbyshire model. Extended access hub sites have been developed in their two Places which gives evening (6.30-8.00) and weekend (Saturday and Sunday mornings) access the intention is to build on this model. A dedicated acute home visiting service and care home support service have also been established and are run by Advanced Nurse Practitioner (ANPs) which has released time and capacity within GP practices. Erewash are also piloting an 'On Day' service based on a multi-disciplinary team model which is 'GP light' which provides additional urgent and same day appointments.

Hardwick CCG has also utilised the PMCF and have three practices currently providing extended access from one site at weekends (Saturdays and Sundays). They will be asking all practices to confirm by the end of June 2017 whether they wish to provide for their population in Places. Following this any gaps in provision will be subject to a Derbyshire wide procurement exercise which will build on learning from the Erewash model of extended access hubs.

North Derbyshire CCG, held a membership event with all practices in September 2016 to start the discussions with practices regarding the options for delivery of 6.30-8pm provision Monday to Friday from April 2018. All practices will be meeting with their Place colleagues in March 2017 to have a focussed session to explore the options in detail. All practices will be asked to confirm by the end of June 2017 if they wish to provide for their own population in Place, if they do wish to provide they will need to submit a detailed plan to include location and plans for stakeholder engagement. If there are any gaps in provision then a single Derbyshire procurement exercise will commence to deliver the mandate.

Southern Derbyshire CCG are also a wave one pilot through the Access Fund (previously PMCF) and they are planning a Place based pilot which will cover an approximate population of 130,000. Places are currently developing plans for how this could be implemented starting April 2017.

Delivery of the extended access capacity in Places who are not currently involved with the wave one pilot will develop along similar lines to Hardwick and North Derbyshire as outlined as above.

How our model for Derbyshire will alter pathways and support optimal out of hospital services

Within the Derbyshire model, prevention, early intervention, diagnosis and care co-ordination will be integrated across pathways, from the individual patient level (including self-monitoring, management and care) to specialist provision.

It is anticipated that the delivery of an integrated model will have a significant impact on care pathways. The extended access model further supports the work by optimising time management within practices to focus on:

- Opportunities to improve long term disease management
- Introduction of new ways of providing consultations
- Opportunity for improvement in referral management
- Improvement of admission avoidance
- Increased opportunity to improve care of frail and elderly
- Improving quality of service for specific vulnerable groups
- Reducing inappropriate time in secondary care
- Decreasing minor attendances in A&E that could be dealt with in primary care
- Specific disease management clinics e.g. asthma and stop smoking
- Earlier detection of cancers
- Improving practice responsiveness, communication and engagement with patients and their carers

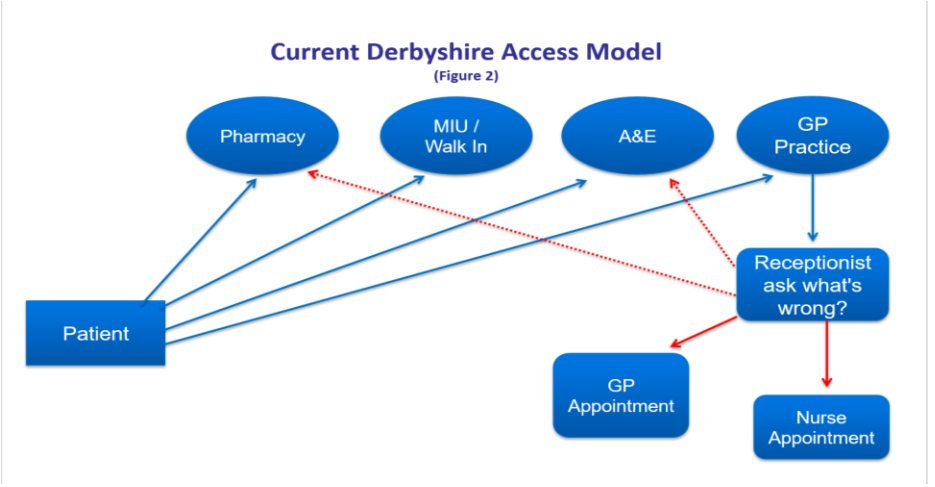
By focussing on distinct patient cohorts and their needs we believe this will contribute to a reduction in A&E attendances and hospital admissions.

Within the current GPAF pilots and other pilots taking Place across Derbyshire we are already seeing a move away from traditional GP led pathways, for example within Erewash CCG, the extended access hubs are lead by Advanced Nurse Practitioners (ANPs) supported by Health Care Assistants.

Erewash are also trialling a new at scale 'On Day' pilot providing same day access to primary care in a 'one stop shop' approach and Southern Derbyshire have a small number of practices offering additional hours functioning as 8-8 practices.

The ambition is to deliver care in a seamless way reducing the number of visits and number of professionals working with a person and their family there by reducing time wasted by the person repeating their story. The service is 'GP light' with a multi-disciplinary approach consisting of ANP's, Pharmacist, Health Care Assistants / Receptionist, Physiotherapy, Mental Health Worker, Well-Being Worker and Voluntary sector. The pilot is based in Place and is intended to relieve pressure in practice to free up capacity to focus on long term condition patients.

Within Southern Derbyshire and Erewash following a successful pilot a 'Minor Ailments Scheme' has been rolled out. The scheme is available for patients who are exempt from prescription charges and are registered with a Southern Derbyshire or Erewash GP practice. The scheme aims to provide self-care advice and possible treatment , if deemed necessary, by encouraging patients with certain minor or common ailments to use their local pharmacy rather than making an appointment at their GP practice. This will relieve the pressure on current appointment schedules and allow those patients with more urgent or serious needs to see their GP sooner.



How we will assess patient demand

Anecdotal evidence and patient feedback is that people are finding it increasingly difficult to get GP appointments. Currently there is no systematic national data collection that can tell us about the number of consultations, who undertakes them or the nature of those consultations. We anticipate and will specify that the new national appointment tool software which is being rolled out to the Wave One pilot sites will start to give us some detailed information locally on this in the near future.

Local patient feedback shows low anxiety regarding access and does not reflect national data. The National Patient Satisfaction survey shows high levels of satisfaction with practice opening hours for Derbyshire CCGs. Patient survey measures and CQC results appear to be in direct contrast where it is deemed that patients are unable to get a timely appointment more often than not.

The most recent (July 2016) National Patient Satisfaction Survey showed peoples satisfaction with opening hours in Derbyshire was:

Satisfaction with opening hours				
	Very & fairly satisfied	Neither satisfied nor dissatisfied	Fairly or very dissatisfied	Not sure when GP surgery is open
ECCG	78%	11%	9%	6%
HCCG	78%	10%	8%	4%
NCCG	79%	9%	7%	5%
SCCG	77%	9%	9%	5%

Local evidence suggests that patients want access to Saturday and Sunday morning appointments and not necessarily all day appointments. When Erewash CCG established its extended access hub pilot in 2014/15 the opening hours included 9am – 5pm on weekends however, following evaluation it was agreed to change the opening hours at weekends to mornings only (Sat 9-12, Sun 10-1), this decision was taken based on utilisation rates and staffing considerations and concurs with information DHU collected regarding Hardwick patients use of out of hours services.

Within the proposed model for extended access we will need to review and monitor usage and have the flexibility to react to demand. We want to ensure that the model fits with local needs and each Place will need to design their model to ensure it reflects the local needs in Place. How each Place develops its model will be dependent on the needs of the local population within Place and we will need to retain judgement on how this is done until we have a better understanding of the local population in Places.

Places are using Public Health data and Place level epidemiology to understand where there is increasing demand for practice time and management of patients long term conditions. Developments of these pathways will be underpinned by Right Care approaches.

How we will address and reduce inequalities

Our overall aim is to provide an equal footing for accessing quality primary care for all Derbyshire patients.

The plan to drive continuous improvement in quality of access across Derbyshire is at the focal point of General Practice/Primary care planning at Place level. By improving access in General Practice/Primary Care we aim to reduce health inequalities, improve access to practices, improving pathways, improve overall health, and support reduction of inappropriate attendance at A&E.

A full equality impact assessment will be undertaken with any new service design to ensure the needs of specific groups are addressed.

Derbyshire CCGs will continue to promote equality and set out how we plan to meet the 'general' and specific duties'.

We recognise there is no one size fits all solution and different solutions will need to be developed/implemented for different groups - for example for patients whose first language is not English, access to translation and interpreting services will be required. The specific solutions will be addressed by CCG, Place and practice level to ensure consistent implementation of a quality improved access service.

Premises will need to be carefully considered and continually monitored to ensure accessibility for all patients with differing types of disability are addressed and accounted for. This will be reflected in our estates plan with Quality Diversity Assessments undertaken in line with CCG policy.

Development of the systems in Place for specific groups of patients e.g. those with hearing loops, blind or partially sighted will be particularly important when developing online consultation models. By improving access through employing different consultation types, capacity to address individual patient needs will be increased i.e. longer appointment times appropriate to health conditions and the needs of the patient. Consideration of the specific technology required for inclusion in the infrastructure will be assessed at Place level as they develop their Place plan supported by GPFV transformation funding. Patient engagement of major developments will be addressed through both Derbyshire-wide and individual CCG engagement plans.

The development of access as CCGs we need to know which practices premises provides the ability to cater to different patients and to what degree. We also need to have a clear idea of space needs for a growing population and what we may need over the next five years with regards to additional and improvement of premises.

Online consultations form a part of Derbyshire's plan for the development of consultation options for patients to reduce access inequalities, provide diversity of accessing GP assistance and easier management of workload in practices. Enabling the use of remote consultations between GP practice and patients provides:

- Improvement of the patient experience by giving choice
- increased access to clinicians time
- efficiency gains for GP practice service delivery
- remote and smarter working capabilities for patients and staff
- innovative delivery of care in a timely, safe and secure manner

Making use of best practice and local pilots

Both Local and National pilots provide us with best practice examples and an evidence base for the development of our services. Key elements to effective improvement in access are consistent approaches to identifying and sharing best practice at Place, CCG, Derbyshire and North Midlands levels.

Local and National Pilots

Erewash CCG provide us with a local pilot of a hub based increased access model. The hubs will provide us with a locally developed evidence base for access improvement in Derbyshire using ANPs, provision of an acute home visiting service and a care home support service.

We can use best practice from national pilots offering varied hub models e.g. Open Doors pilot in Lancashire and Integrated South Kent Coast in Kent & Medway for the continued development of our local hub in Erewash.

Closer to home in Manchester, who were also successful in securing Prime Ministers Challenge funding, have developed primary care access through a Hub model which we can learn from. 91 Manchester practices covering a registered population of 589,942 have been involved in the pilot. The scheme increased access by providing pre-bookable appointments from 12 Community Primary Care Hubs strategically placed to increase access and equity for patients.

Manchester have also developed three further Hubs which are co-located adjacent to A&E departments.

Derbyshire CCGs will use the learning from the local and national pilots to inform our plans for the provision of remote access via video consultations, routinely offering telephone consultations and clinical call back for same day appointments through an integrated multi-disciplinary team maximising availability for patients to book appointments through a variety of digital and technological solutions. For example;

- Health United Birmingham (Birmingham, Solihull and Black Country) - 70% of appointments handled via a phone or skype consultation
- Bury Easy GP Project (Greater Manchester) – GP patient App to enable patients to choose and book an appointment at any participating site
- Better Access, Better Care, Better Standards (NE London) – GP triage in A&E
- Caring for Darlington Beyond Tomorrow (Darlington, Durham & Tees) – wrapping services around the older person
- Improving Access, Supporting Primary Care Integrated Whole System Change (Taurus Healthcare Ltd (Arden, Herefordshire and Worcestershire) – access to primary care records via 'Tough Pads' in the community
- Better Local Care (South Hampshire) – joined up care, closer to home

Funding that will be used to improve extended access

The NHS Operational Planning and Contracting Guidance 2017-19 identified the funding for improved access and is split between;

(1) those CCGs which have successful pilot sites in 2015/16, known originally as the 'Prime Ministers Challenge Fund ' sites and now known as the '**General Practice Access Fund (GPAF)' sites.**

In Derbyshire, this is relevant to Erewash CCG, who are a full population GPAF site, Hardwick who have a GPAF scheme totalling 20,000 population and Southern Derbyshire are due to launch a pilot in April 2017 covering 130,000 population.

For GPAF sites CCG's will receive ;

- £6 per weighted patient for each of these sites in 2017/18 and £6 per weighted patient in 2018/19

During 2017/18 CCGs will need to ensure 100% coverage of extended access (evening and weekend appointments) is achieved in GPAF sites, this will include commissioning a minimum additional 30 minutes consultation capacity rising to 45 minutes per 1000 population by 31 March 2018.

(2) For **remaining CCGS** there will be further funding coming on stream in 2018/19, totalling £258 million. This additional funding will be allocated across all remaining CCGs to support improvements in access.

In Derbyshire this is relevant to 100% population of North Derbyshire and the remaining populations in Hardwick and Southern Derbyshire not already part of a GPAF pilot;

- £3.34 per head of population 2018/19 rising to £6 per head of population in 19/20 for 100% coverage

The three CCGs will be using part of the £3 per head non-recurrent transformational support for 2017/19 (either £1.50 over two years are one-off £3) to support discussions with its membership practices on how to implement improved access to primary care. Practices will be given a choice of whether they wish to provide the evening and weekend access individually, collaboratively in a hub arrangement or via sub-contracting arrangements. The CCGs will review the plans and commission any gaps in provision for the population to ensure 100% coverage is provided by March 2019.

Chapter Four

Workforce Development & Optimisation

Approach to workforce planning

- The GPFV makes a number of commitments on workforce, including an additional 5,000 extra doctors in primary care by 2020, and a minimum additional 5,000 other clinicians working in primary care. There are specific commitments to invest in an extra 3000 mental health therapists and 1500 clinical pharmacists, and in the training of 1000 general practice physicians' associates.
- The workforce commitments set out in the GPFV will be delivered jointly by NHS England, Health Education England, CCGs and practices; therefore this section of the plan has been reviewed with the local NHS England Medical Director Ken Deacon.
- We are working with Health Education England in East Midlands to develop and refine the modelling of our workforce. Early indication from our Sustainability and Transformation plan workforce return suggested a growth of circa 90 GPs.
- STP workforce data return used estimated data for Sept 2015
- Derbyshire's approach to workforce planning within the STP footprint will be supported by the creation of the Local Workforce Action Board (LWAB.) This approach is currently in development.

LWAB

- This Board will support the development and delivery of our local workforce strategy to enable transformational change to be planned and delivered more effectively across the system.
- Supported by NHSE and Health Education England , LWAB will bring together stakeholders across the system including health and education providers and the Local Medical Committee . Our workforce priorities will consider the work that is required to shape the workforce for primary care and associated services.
- LWAB will access resources from Health Education England and national transformation funds with local support from stakeholders and will be responsible for:
- Delivering a comprehensive baseline of the health and social care workforce within the Derbyshire Sustainability and Transformation Plan footprint
- Developing a high level workforce strategy to set out the workforce implications of the ambitions of the STP
- Writing a Workforce Transformation Plan which focuses on the support required to deliver these ambitions
- Creating and monitoring an action plan proposing the necessary investment to support the delivery of the STP plans including Place and support the implementation of the GPFV work programme
- Oversight of the delivery of the STP workforce work-stream and the Chair of the LWAB will be the Chief Executive of Derby Teaching Hospitals Foundation Trust and supported by a co-chair from HEE, the Postgraduate Dean, HEE East Midlands, and Chair of Health Education England's Deans. The LWAB will provide regular updates on progress through the governance structure to the STP partners, who will monitor its progress against its Workforce Transformation Plan.
- The Joined Up Care Derbyshire STP plan describes a number of key interventions which will enable the system to optimise the system workforce including;

  - Attendance management/ reducing absenteesism
  - Vacancy management
  - Rostering management
  - Utilise Training and Development
  - Optimisation of Teams

Workforce Profile (1): *Current workforce, including key risks and issues across Derbyshire*

Workforce Profile

- Across Derbyshire we have 117 practices spanning our four CCGs in which there are over 650 GPs equating to circa 541fte
- It is recognised that in reviewing the data advised in our STP workforce plan the information submitted used data which included estimated workforce number due to the low return from Derbyshire practices in 2015. Subsequently our return of information has increased and thus in September 2016 there is significant difference in the information retrieved. The current information supplied (table 1) is advising a decreasing number of GPs across Derbyshire with the estimated view now suggesting circa 541wte.

Table 1 : Summary of GP numbers

Including estimates

	September 2015		March 2016		September 2016	
	Headcount	FTE	Headcount	FTE	Headcount	FTE
GP	756	636	705	595	722	594
GP (excluding Registrars, Retainers & Locums)	684	570	647	550	655	541
Nurses	497	343	479	335		
Direct Patient Care	275	170	261	165		
Admin/Non Clinical Staff	1,863	1,277	1,863	1,293		

Excluding estimates

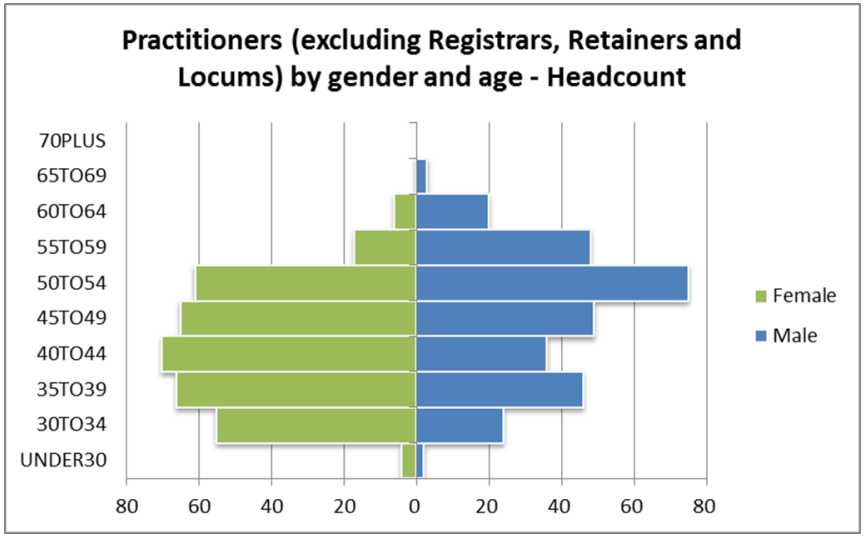
	September 2015		March 2016		September 2016	
	Headcount	FTE	Headcount	FTE	Headcount	FTE
GP	677	568	704	588	682	557
GP (excluding Registrars, Retainers & Locums)	608	507	647	543	618	506
Nurses	448	309	483	331		
Direct Patient Care	246	151	264	163		
Admin/Non Clinical Staff	1,666	1,142	1,837	1,269		

Total number of Practices	122	120	121
Number of Practices excluding estimates	106	118	115

Key Challenges

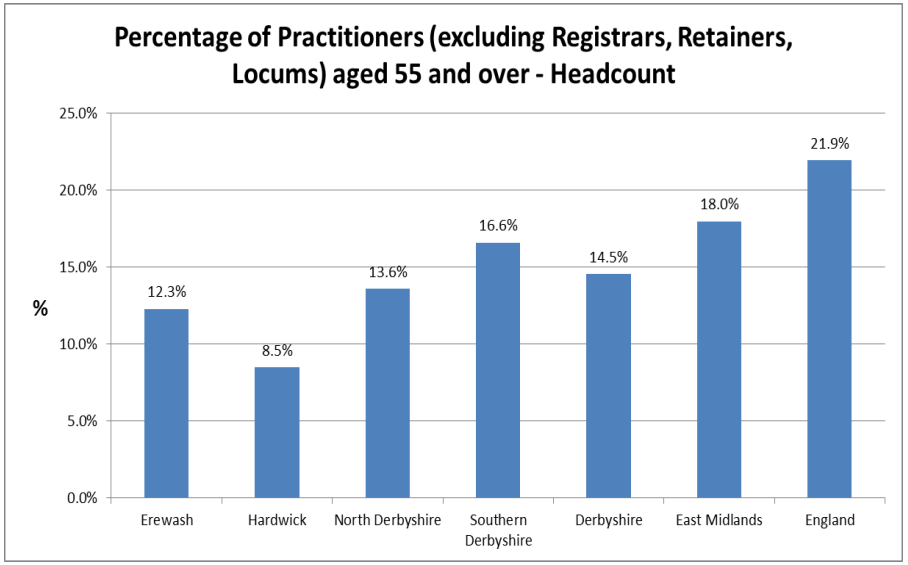
- Our key risks and issues relate to the profile of our current GP workforce; where we have a significant number of male GPs who work full time and are close to retirement (table 2 & 3). Furthermore due to the increasing volume and complexity of work, with limited recognition or remuneration many feel under siege with a number of GPs retiring early and/or an inability to continue working due to stress/health/burnout issues.
- Positively in Derbyshire we are attracting and retaining a female workforce (table 2) as those completing training are predominantly female; however many wish to work part time either now or in the future and there is less appetite to enter into the GP partnership approach.

Table 2 GP's by gender, age and headcount



Workforce Profile (2)

Table 3 Percentage of GP's aged 55 and over by Headcount



Tabl **-2016)**

	Chesterfield	Derby
ST1	29	32
ST2	17	26
ST3	19	31
Total	65	89

- In relation to training places for GPs, the East Midlands has a unique 20 month trainee programme. Across Derbyshire there are a variety of urban and rural experiences with choice of programmes and rotations. However there has not been consistency in filling all our GP training places for a number of years but in 2016 the position was improved with:
  - Chesterfield – 29 (96%)
  - Derby – 32 (100%)
- The previous years position is advised in table 4 which shows the variance in previous years especially in Chesterfield against the number of available posts.
- As the inconsistency to attract trainees is replicated regionally and nationally we have to consider innovative options and solutions as well as working with the Deanery. Finally it is deemed that the future GP workforce is also generally being trained to be more risk averse and so takes longer to complete the same tasks and at a greater cost to the system overall.

Workforce Implications of the New Models of Care

- The New Model of Care approach will lead to expanded multidisciplinary health and social care (integrated care) teams, comprised of GPs & practice staff, clinical pharmacists, mental health therapists , physicians associates, nurses and AHPs in line with the vision of the GPFV.
- GPs will be pivotal to delivering the integrated model of care.
- Over recent years through our collaborative approach to workforce planning and development we have commenced on a range of activity to support skill mix and enable delivery of the future models of care;
- We have developed a Derbyshire wide framework for training and education of our recruited Advanced Clinical Practitioner workforce and this approach aims to support our GP workforce as well as offering opportunity to other staff in the Practice or to work in this setting from other healthcare partners
- We have increased understanding of future workforce requirements based on population cohort workforce modelling , initially looking at our Frail Elderly population requirements inclusive of GP workforce
- We have strengthened our approach to the wider health and care workforce through the establishment of a Talent Academy led by Adult Care DCC
- We have already started to introduce new roles and new ways of working through the Vanguard and across practices .
- Our experience of introducing new roles will be used to inform the future workforce model
- Across Derbyshire we are working with HEE and the Postgraduate Deanery to deliver a sustainable programme of Advanced Clinical Practitioners (ACPs) whom can therefore compliment and support our existing GP partners; this workforce offers a range of capacity. In Erewash MCP the ACP roles have been used to address on day appointments, out of hours appointments (evenings and weekends) and home visiting services in daytime hours. Our model is to have ACPs drawn from a range of workforce groups such as Nursing, Pharmacy, Therapists and Paramedics and working across a range of areas.
- Through our collaborative approach (having an academy/school of ACPs run through the HEE Post Graduate Deanery and utilising HEE funding) further education and training has been offered across all partners inclusive of GP practices to develop trainee roles , this in turn provides due opportunity for the wider team to upskill as well as an ability to attract new team members into what may have been a vacant GP post.

How well do we understand our workforce position and recruitment needs?

Understanding the workforce gap

- In reviewing our workforce position and assessing the gap between current and projected workforce there are a number it is evident that:
  - A significant increase in the data return from Practices has provided a more credible local data source, resulting in an adjustment in the actual numbers of GPs from previous estimates
  - The recent trend in securing female General Practitioners has been positive for the GP workforce across Derbyshire and we will take steps to explore this trend in more detail and develop opportunities for job share
  - based on current data, taking into account the forecast number of retirees and throughput of trainees , it is apparent Derbyshire is expected to achieve the necessary number of GPs; however
  - When the workforce numbers are adjusted to take account of the increasing demographic and attrition rate it becomes evident that there will be insufficient numbers of GP and that it will be necessary to develop new roles as substitution as a way to deliver the new models of care
- in reviewing role substitution we are developing increased capacity through Advanced Clinical Practitioner roles, Physicians Associates, Pharmacists roles and mental health practitioners, thus work as described above has been underway in Derbyshire since 2016/17 and continues in 2017
- Across Derbyshire in 2015 we commenced population workforce modelling using a methodology known as SWiPE, this considered the total workforce inclusive of General practitioners, looking at our Frail Elderly population. Further work is now planned to refresh our understanding (through workforce modelling building on our existing knowledge and refreshing this data) across each Place inclusive of GP workforce will aid increased understanding of areas requiring innovative solutions or increased focus in terms of attracting and recruiting GPs.
- In addition Derbyshire CCGs have been working with HEE to develop a Derbyshire workforce modelling tool that will support the ongoing assessment of the workforce gap (Appendix 2)
- This tool is being shared with NHSE as an example of best practice

Recruitment, training and developing our workforce

- Our aim will be to establish Derbyshire as an attractive proposition for clinicians to train and remain. The development of place-based care with GP practices networked under principles of the new alliance models will give greater stability and individual support to practitioners.
- Having greater standardisation of working practices will make it easier for people to move within the area and to offer services to wider populations than their own list. Building the collaboration between providers groups will support the sustainability of the workforce.
- A Derbyshire workforce plan will be developed to support the ongoing recruitment, retention and development of a sustainable workforce.
- CCG will continue to promote the support the available through the national GP retainer scheme and share learning from participating practices.
- As a part of our workforce strategy international recruitment opportunities will be explored

How will we develop clinical leadership and maximise operational efficiency ?

Development of back office functions

- There is a strong culture of working together in some areas across Derbyshire; practices are working more collaboratively and finding ways to share back office functions. Sharing of practice managers, a common approach to note summarisation and clinical coding and sharing of learning and peer support between practice managers are just some of the initiatives that we have seen
- The learning will be more widely shared and the opportunities presented by the National GP Development Programme supporting practices to think more creatively.

Developing clinical leadership, at scale provision and MDT development

- Clinical leadership is seen as key to the development of the new models of care to support at scale provision within Derbyshire . We have many GPs who have taken leadership roles in the CCGs and in the multiple transformational work streams established to develop and deliver 'Joined Up Care' for Derbyshire.
- It is anticipated that as development of Place evolves a coordinated approach to supporting and developing General Practice which builds on existing clinical leadership will be implemented.
- GPs have also been encouraged to access the GP improvement leaders programme and the GP Development Programme
- East Midlands Leadership Academy offers for leadership development and coaching support and similar development opportunities will continue to be made available.
- The development of Place relies on greater multi-disciplinary development and models where teams work more closely together, it is evident that providing the opportunity to access training and development together (as a team), regardless of profession, employing organisation has significant benefits; it is proposed that this approach will be adopted more widely across Derbyshire.

Chapter Five

Workload :

- General Practice Resilience Programme
- 10 High Impact Actions
- General Practice Development Programme

Workload: *Understanding and improving workload issues though new initiatives and transformation*

Derbyshire CCGs (Erewash CCG, Hardwick CCG, North Derbyshire CCG and Southern Derbyshire CCG) have compiled the following response in respect of the requirements detailed within the 2017-2019 NHS Operational Planning and Contracting Guidance, identifying and linking the national requirements to local actions and plans. This section demonstrates how workload issues in General Practice will be improved through a variety of initiatives, resources, and transformational developments across the 21 Places in the Joined Up Care Derbyshire STP.

This programme dovetails with the Derbyshire Sustainability and Transformation Plan and associated programmes of work and development, specifically the 'Redesign Access to Primary Care' outline business case (v.9), and the individual Derbyshire CCGs Operational Plan 2017/18-19. (23/12/16).

General Practice Forward View represents a step change in the level of investment and support for general practice. It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to accelerate transformation of services. NHS England is committing to an increase in investment to support general practice over the next five years.

In addition, Joined Up Care Derbyshire STP outlines the transformation to the new model of care which is built around patients, around the wider workforce, around the redesign of our workload and organisation of care, and creating a satisfying and rewarding career for everyone working in general practice.

Derbyshire CCGs recognise that some patients want to be partners in their own care. They want the knowledge, skills and confidence to take more responsibility for their health and feel more in control of their outcomes. Channelling this growing patient appetite for services that help patients to help themselves unlocks both a better patient experience and a way to alleviate practice workload. No amount of reform of the existing system will work unless we also partner with our patients to manage demand more efficiently

Derbyshire has a diverse population with a mixture of City, urban and rural geographies, affluent and deprived ethnic diverse populations. In 2011, across Derbyshire County (excluding Derby City) a locally agreed 'fairer funding' initiative was implemented as a method of establishing equitable access for primary care services and consistent funding for practices.

Practices in Derbyshire are experiencing differing levels of workforce challenges and recruitment issues, coupled with a rising patient demand and expectations, morale is challenged which is more evident in some practices. Practices are struggling to balance rising workload within tighter financial controls and constraints. Clinicians increasingly feel unable to provide the care they want to give, and understandable resentment of working under this pressure is growing at both a national and local level.

Workload: *Understanding and improving workload issues though new initiatives and transformation*

Background

A number of changes are being pursued by NHS England and through CCGs, CQC, LMC, Health Education England and other key stakeholders to reduce the workload in general practice. This includes changes to streamline the Care Quality Commission inspection regime, support for GPs suffering from burnout and stress, reduction in red-tape, legal limits on administrative burdens at the hospital/GP interface and action to reduce inappropriate demand on general practice.

It also includes a new GP Resilience Programme to support vulnerable practices, and a GP development programme focused on developing more productive general practice, through the implementation of 10 High Impact Actions.

This programme dovetails with the Derbyshire Sustainability and Transformation Plan and associated programmes of work and development, specifically the 'Redesign Access to Primary Care' outline business case (v.9), and the individual Derbyshire CCGs Operational Plan 2017/18-19. (23/12/16).

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Workload

Derbyshire CCGs fully recognise that a strengthened version of general practice is essential to the wider system sustainability and the enabler for the transformational change to take place across Derbyshire. The aim for Derbyshire is that there is a clear understanding of GP workload issues which is supported through a range of national and local programmes. Derbyshire practices will be able to access best practice, areas of innovation through a mixture of nationally and locally available programmes and resources to support the sustainability of general practice.

Our aim is that by April 2020 all patients continue to have access to high quality primary care services across Derbyshire and Places are sustainable.

Derbyshire practices are more proactive and open to new ways of working with 25 practices participating in the first wave of Productive General Practice. Derbyshire CCGs are supporting practices with investment in a range of technological initiatives (see Infrastructure section) including investing in diagnostic equipment that is interfaced with the clinical record which supports making time in general practice.

Derbyshire CCGs recognise the importance of providing investment to practices to enable every practice to have the opportunity to have a meaningful conversation with staff through planned QUEST (clinical education and training sessions), to enable clinical leaders to support the delivery of the CCG priorities and workstreams and be champions of new ways of working and testing audit methodology.

General Practice Resilience Programme: *Plans for use and monitoring of GP resilience funding*

Background

All Derbyshire CCGs accessed the Vulnerable Practice Programme in 2015/16 to provide targeted support to identified practices. This has formed the basis of the plans submitted in 2016/17 for the General Practice Resilience Programme.

Summary of the Derbyshire Approach

Derbyshire CCGs contacted practices asking them to identify the support they would need to develop and sustain provision of good quality healthcare for their patients and to help towards maintaining this provision long-term. The practices responded with their individual prioritised areas for improvement, support and training need on an individual or group basis.

Practices will be assisted with training support and funding for these initiatives individually and at scale to maximise the outcomes and use of the funding. In 2016/17 there was an individual CCG approach adopted as the funding was allocated directly to each CCG. Some CCGs targeted individual practices and other CCGs provided funding to all practices in recognition of the pressures and challenges that all practices are experiencing.

Summary of Vulnerable Practice funding 2015/16

CCG	Number of practices	Planned outcomes of support
Erewash CCG	3	Backfill for senior GP partners, summarising notes, e-learning training package
Hardwick CCG	1	Managerial, Administrative, Clinical peer review and actions identified
North Derbyshire CCG	4	Initial project for standardising notes summarisation and clinical coding
Southern Derbyshire CCG	18	Range of support deemed necessary by the individual practices eg. Backfill for senior GP partners, practice projects
Total funding for Derbyshire CCGs agreed in 15/16	£150,000	

General Practice Resilience Programme 2.5.1

Derbyshire CCGs assessed and analysed the prioritised areas, grouping them to form the menu of support outlined below.

Area	Support proposed
Administration Training	Summarising Notes training
	Reception Staff Training
	Receptionist signposting training
	Repeat prescription receptionist training
	Medical terminology training
	Processing and coding letters protocol and training
Nurse Training	Minor Ailments Training
	Nurse Prescribing
	Respiratory Training
	Diabetes Training
	Asthmas Training
PM Development	Practice Manager training
	Practice Manager Mentorship / support
Human Resources	Recruitment issues
	General HR Guidance
	Contract Reviews
	Reducing turnover support
	Succession Planning
	Leadership Training

Area	Support proposed
Business Management	Whole Practice Development / Working as a team
	Improvement and Redesign of Operational Efficiency / practice workflow
	Cross Practice Working / Working as a "place"
	Creation of work protocols
	Vision Development & Planning
	Skill Mix Development / Change Management
	Triaging approaches workshop
	Reducing DNAs
	Utilising data and insight to find efficiencies
	Managing inappropriate workload
	Time management training
	Right patient to Right Clinician Training
Staff Wellbeing	Mental Health Support for Practice Staff
Finance	Financial Review/ maximising income training
	Maximising QoF/ prevalence income
IT Support	Clinical Note Sharing
	IT Innovation / Skype, etc.
	IT Support / Use of IT training

General Practice Resilience Programme

- Derbyshire CCGs are encouraging all remaining practices to continue to access support under the General Practice Resilience Programme and plans for 2017/18 are being developed in collaboration with practices in Places.
- Derbyshire CCGs are continuing to work closely with NHS England North Midlands GPFV lead to jointly agree the Memorandum of Understanding, action plans and monitoring to demonstrate the delivery of the agreed outcomes.
- The following table provides a summary of the investment to practices by CCG in 2016/17.

CCG	Number of practices	Funding 2016/17
Erewash CCG	12	£27,000
Hardwick CCG	15	£28,000
North Derbyshire CCG	35	£81,000
Southern Derbyshire CCG	37	£151,000
Total funding	99	£287,000

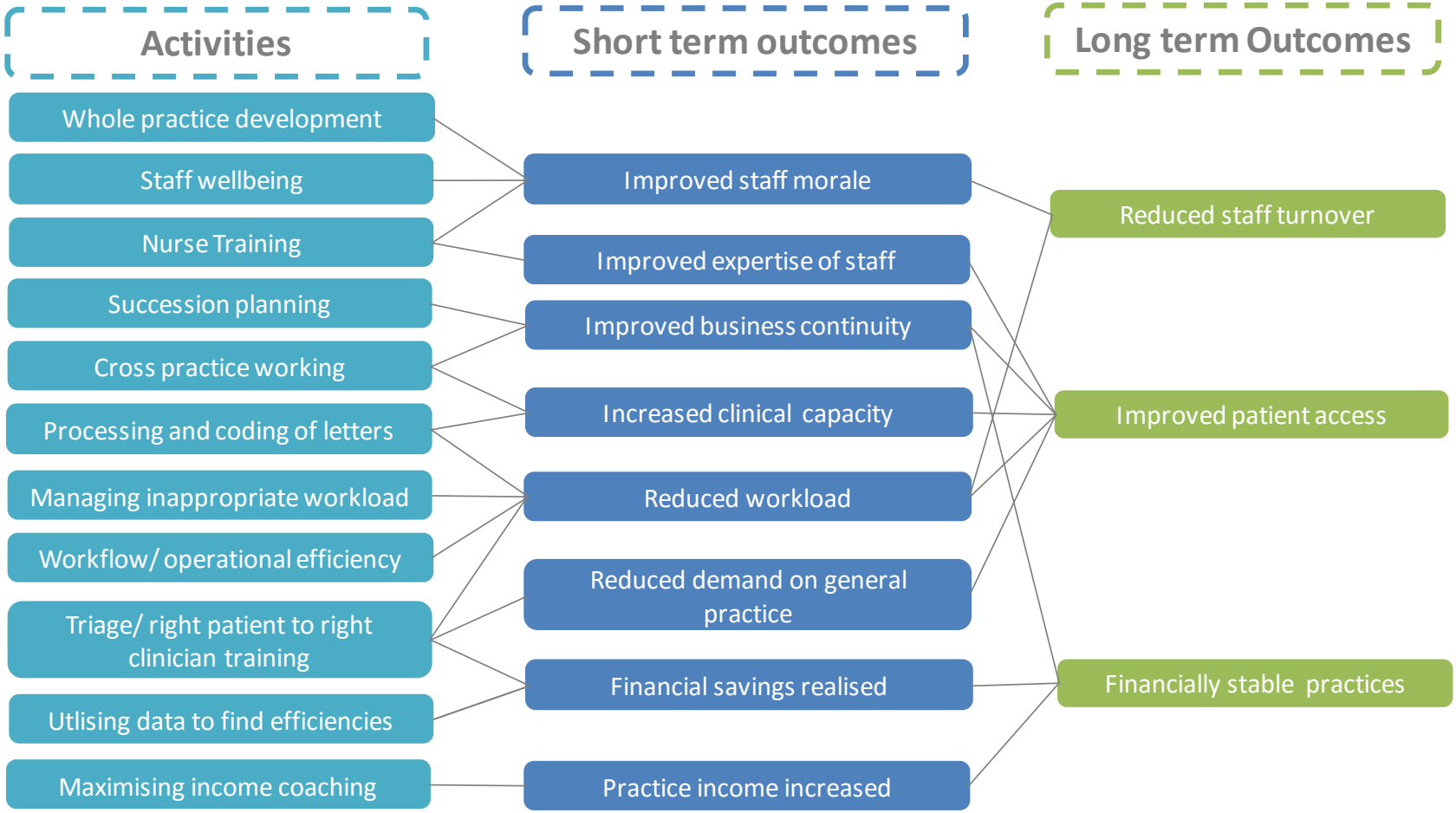
Monitoring

- In utilising the 2016/17 GP resilience funding the Derbyshire CCGs have established a mechanism by which practices are requested to provide project update reports at the stages: at pre-project identifying individual need against proposed outcomes, at mid-way project highlight report detailing planning and how the use of initiatives to that point has started to benefit the practice against the outcomes and an end of project report which builds on the detail of the previous reports and giving an overview of the effectiveness of the initiatives undertaken as a part of the programme.
- This will enable all the CCGs to evaluate the impact of the initiatives and training and the services from providers used (where relevant) to determine how the funding has helped improvement against the issues identified. Where training or support is accessed for practices under the scheme which could be useful for a wider number of practices we will make this available at scale.
- The focus is the provision of various targeted initiatives over the short term for practice support and development for sustainability of resilience in the long term. Examples include exploring the options to share resources at scale or potential practice mergers.

General Practice Resilience Programme

The logical framework below sets out how the proposed activities contribute to the overall aim of the scheme and the anticipated outcomes. The logical framework will inform the evaluation of the projects effectiveness against the identified need and the development and progression towards sustainable resilience as reported by our practices.

In addition, to inform the planning for 2017/18 funding, Derbyshire CCGs will analyse the outcomes from 2016/17 initiatives which will inform the future investment plans across Derbyshire.



General Practice Resilience Programme

This section sets out the approach by the Derbyshire CCGs to how practices will be identified to participate in the resilience programme and planned outcomes of support.

In accordance with NHS England requirements the Derbyshire CCGs have agreed that an individual CCG approach to the identification and allocation of funding will continue in 2017/18. However, all Derbyshire CCGs will be working towards a fully integrated approach across Joined Up Care Derbyshire STP from 2018/19. This will ensure that the practices that are most at risk across the Joined Up Care Derbyshire STP maximise from the national funding available in 2018/19 and 2019/20.

In 2017/18 Derbyshire CCGs will continue with the same approach to contact practices on an annual basis to identify the support they would need to develop and sustain provision of good quality healthcare for their patients and to help towards maintaining this provision long-term. We will continue to deliver this programme in collaboration with our practices, local providers and working closely with our Local Medical Committee to provide the most suited, timely and effective package of support.

Funding will be prioritised and allocated to those groups of practices that identify proposals to work at scale, share resources, develop new ways of working to support sustainability in the Place.

Practices will be assisted with training support and funding for these initiatives individually and at scale to maximise the outcomes and use of the funding.

In 2017/18 Derbyshire CCGs will revisit the prioritised areas to inform any changes to the groupings or themes to the menu of support outlined above.

Allocation of funding by CCG in 2017/18

CCG	Number of practices	Funding in 2017/18
Erewash CCG	12	£14,000pa recurrently until 2020
Hardwick CCG	15	£14,000pa recurrently until 2020
North Derbyshire CCG	35	£40,000pa recurrently until 2020
Southern Derbyshire CCG	55	£76000pa recurrently until 2020
Total funding	117	£144,000

For detailed summary of the financial allocations please refer to the Investment section

10 High Impact Actions and Self Care: *Our approach to implementation of the 10 High Impact Actions, productive workflows, promotion of self care and providing access to new consultation types are key vehicles for delivering improved efficiency and increased access to Primary Care across Derbyshire*

Approach

Implementation of the 10 High Impact Actions is in its planning stage, identifying actions / delivery that can be undertaken as a place-based initiative and those that can be adopted individually by practices. Opportunities to identify common areas to be provided at scale across Derbyshire are being explored during 2017.

Derbyshire CCGs recognise that it takes time and planning to create the conditions for successful change and transformation. Implementation of the 10 High Impact Actions should promote collaborative working between providers whilst providing more opportunity for practices to engage in innovative development of healthcare. At the same time the implementation of the 10 High Impact Actions will free up GP/Practice time and offer measures to secure the sustainability of general practice.

Practices will be supported to access the modules that will make the most difference to their sustainability and the CCGs will facilitate the sharing of the outcomes of the modules with other practices across Derbyshire.

Derbyshire CCGs are developing a service level agreement with practices from April 2017 to ensure that the overall CCG transformation funding of £3.00 per head over 2 years supports discussions in Places for the delivery of Improved Access (April – June 2017) but also supports practices in accessing the Releasing Time for Care Programme and 10 High Impact Action modules. This funding will support and release GPs and practice managers to attend workshops, redesigning systems and processes and sharing learning with their peers across Derbyshire. To inform the selection of the High Impact Actions to release time to care, all practices will be requested to complete the 'readiness assessment' in Places with the CCGs by September 2017.

Derbyshire LMC has promoted the General Practice Improvement Leaders Programme to practices. Derbyshire CCGs are encouraging practices to sign up for the National programme taking part in 2017-18.

Derbyshire CCGs will work with the GP federations, local practices outside the federations and the LMC to shape the development of a Derbyshire local plan, tailored to the needs of our local practices and populations and delivered by practices supported by other providers in 'place'.

Within the Joined Up Care Derbyshire STP plans it was acknowledged that a medical model of care may not always be the most appropriate response to a persons needs and that there should be a greater focus on improving the health and wellbeing of our citizens and encouraging greater opportunities for self-care.

Through the development of place-based care we plan to strengthen the links between healthcare, social care and the voluntary sector to support people to proactively manage their needs .

Derbyshire CCGs are working together to develop a more coordinated approach to encouraging self-care across a variety of NHS England work streams, with a particular focus on empowering patients and reducing the demand on the workload in general practices. Developments to NHS Choices, self-care for long term condition patients through patient activation, 111 Online and social prescribing pilots are all underway.

Local communication plans across Derbyshire are supporting the national NHS England communications to emphasise the need for patients to use general practice responsibly, as well as A&E and other providers

10 High Impact Actions and Self Care

In addition to the national offer under the Releasing Time to Care programme from NHS England, Derbyshire CCGs have reviewed the 10 High Impact Actions to release time for care and mapped the local initiatives in Derbyshire that practices are accessing across the CCGs. The following table demonstrates how local CCG or Derbyshire wide initiatives link to the national 10 High Impact Action modules to release time for care.

10 High Impact Actions	**Supporting initiatives / programmes (by specific CCG where appropriate)**
1. Active Signposting	Blue Stream Academy – e-learning module for practice receptionists and clerical staff with a local directory to support consistent signposting to local services in Derbyshire. Face to face training to be available in Places for all practices.
2. New Consultation Types	Online consultations –Equipment provided to practices in 2017 to enable Skype/Vidyo to be rolled out for all practices. Consultant Connect, ASK my GP pilot (Erewash CCG), Clinical Pharmacist in general practices across all CCGs, ANP led services, integrated Multi disciplinary teams
3. Reduce DNAs	During 2015/16 all Practices within Erewash participated in a LEAN project supported by an external provider to introduce the Practices to LEAN methodology. The result has already seen a number of Practices reducing their DNA rates, thereby increasing access for patients to their GP. Learning from Productive General Practice
4. Develop the Team	Derbyshire QUEST / Education / Learning Events, clinical networks, practice manager networks
5. Productive Work Flows	Learning from Productive General Practice Derbyshire CCGs have supported practices in reviewing workload and initiatives to reduce administrative time by GPs. Examples include, managing clinical correspondence, use of technology Voice Connect, and automated telephone appointment booking service, digital dictation.
6. Personal Productivity	Learning from Productive General Practice and LEAN programme.
7. Partnership working	Learning from Vanguard and MCP model and other local collaborative working pilots across the Derbyshire CCGs for Integrated Primary and Community Services pilot to bring health and social care professionals together to focus on the needs of individual patients without being hampered by organisational boundaries.
8. Social Prescribing	Learning from Vanguard and MCP model (Erewash CCG). Personal and community resilience pilot to work with and support communities to look after each other, working closely with the voluntary sector and other stakeholders.
9. Support Self Care	Learning from Vanguard and MCP model (Erewash CCG). Personal resilience – 'how I keep myself well pilot' to help people gain confidence and skills in managing their own health and well being.
10. Develop Expertise	Joint work with LMC through Derbyshire GP Taskforce to provide change management

10 High Impact Actions and Self Care: *The following examples provide further detail on the pilots that will inform the future approach across Derbyshire CCGs.*

Consultant Connect

North Derbyshire CCG has invested in Consultant Connect, in accordance with the General Practice Forward View and learning from Vanguard sites. This provides GPs with direct access to consultants in Secondary Care, to improve the quality of patient care and also reduce workload in Secondary Care and Primary Care. The CCG has worked closely with the Medical Director in the Acute Trust and Derbyshire LMC to support the rollout of this initiative.

Community Pharmacy Based Minor Ailments Service

The GP Forward View planning guidance suggests that CCGs consider implementation of a minor ailments scheme. The CCG piloted a Pharmacy First (Minor Ailments) Scheme in one of its localities and has now (December 2016) rolled this out across Southern Derbyshire CCG and in Erewash CCG. The scheme is available to eligible patients across the CCGs area in participating community pharmacies to link in with other winter pressures initiatives, and the new NHS 111 pilot whereby patients will be signposted to community pharmacies for support for minor ailments.

The Pharmacy First Scheme is available for patients who are registered with one of our GP practices and who are exempt from prescription charges. The scheme aims to provide self-care advice and possible treatment, if deemed necessary, by encouraging patients with certain minor or common ailments to use their local pharmacy rather than making an appointment at their GP practice. This will relieve the pressure on current appointment schedules and allow those patients with more urgent or serious needs to see their GP sooner. A longer term Community Pharmacy strategy is under review with the aim to support Joined Up Care Derbyshire STP and the wider contribution this workforce can make to place base populations. This includes Community Pharmacy based non-medical prescribers and Healthy Living Pharmacies.

Ask my GP pilot

Erewash CCG funded one of their larger Practices to trial 'ask my GP', an online consultation system (from April 16). Accessed through the practice website, a patient can seek help on a medical or other matter. Answering a series of questions about their symptoms leads to the creation of an automated patient history and triages their specific clinical complaint/issue. This allows the patient and GP time to enable shared decision making due to the level of detailed history. The GP is then able to propose to the patient the best course of action i.e. deal with remotely, by phone, see a clinically appropriate physician. The learning from the evaluation of the pilot will be shared across Derbyshire in 2017 and will also inform the Derbyshire CCGs approach for Online Consultations from April 2017. Derbyshire CCGs will also be reviewing the learning from other national pilots to procure the most appropriate system

On Day pilot

In Erewash CCG, currently there are 6 practices piloting an 'on day' service for patients to access booked and urgent care, this will be increased to 8 practices by the end of March. The pilot includes a multi-disciplinary team including the facility to book appointments for patients directly for physiotherapy, mental health services, pharmacist, ANP and healthcare assistant instead of seeing a GP. The learning from the pilot will be shared across Derbyshire CCGs.

10 High Impact Actions and Self Care

Clinical Pharmacists in General Practice

Derbyshire CCGs have supported practices to access the Clinical Pharmacists in General Practice wave 1 and the learning is being shared across practices to encourage applications to Phase 2 of the national Clinical Pharmacist in General Practice programme.

CCG	Number of practices employing a Clinical Pharmacist (Phase 1) or employed by individual practice
Erewash CCG	2 practice employed pharmacists
Hardwick CCG	4 practices
North Derbyshire CCG	4 – 1 practice in NHS England North Midlands local pilot and 2 practices for first wave of national clinical pharmacist programme. 1 practice employed pharmacist
Southern Derbyshire CCG	17 - 2 practices in NHS England North Midlands pilot. 6 pharmacists for first wave of national clinical pharmacist programme. 9 practice employed pharmacists/technicians.

Local initiatives to reduce practice workload

Derbyshire CCGs are working closely with the Derbyshire LMC in supporting general practice with the implementation of NHS England guidance issued to hospitals to regarding secondary care responsibilities following the Standard Contract changes to ensure the reduction of unnecessary use of GP appointments relating to hospital episodes of care. Derbyshire CCGs are working closely with secondary care Medical Directors to support and reinforce the NHS England guidance to ensure that this is adhered to locally.

Derbyshire CCGs are committed to supporting all practices in Derbyshire to release time for care through the adoption of new ways of working

The implementation of the national and local initiatives will support the development of further work in 2017/18 to support practices to undertake the assessment for participation in the GP Development Programme and 10 High Impact Actions. All Places to undertake the readiness assessment by end of September 2017 to inform selection of the module from the 10 High Impact Actions

Reducing pressure in general practice

Derbyshire CCGs fully recognise that general practices are under considerable pressure and have reviewed the recommendations of the Making Time in General Practice study by the Primary Care Foundation with the NHS Alliance which was published in October 2015.

Derbyshire CCGs are supporting practices to reduce the pressure in general practice by:

- improve information and communication flows from hospitals including challenging the processing of information on behalf of other organisations
- keeping up to date with changes in the health and care system, including regular updates on the General Practice Forward View and funding opportunities.
- Working with CQC and NHS England to co-ordinate and reduce duplication of information requests.
- Supporting practices to help patients navigate the health and care system.

General Practice Development Programme: *The following section outlines the Derbyshire CCGs approach to practice engagement with the general practice development programme.*

Derbyshire CCGs and the Derbyshire LMC have had an initial introductory meeting with the local Sustainable Improvement Team lead for Derbyshire to inform the CCGs approach for supporting practices in accessing the national development programmes.

Time for Care Programme - Approach and support

Derbyshire CCGs have taken advantage of the opportunity to engage its member practices in the NHS England's funded initiative as part of the Releasing Time to Care programme.

NHS England has directly funded a provider (KM&T) to offer a 9-12 month programme of collaborative service redesign to release time for care in 2016/17. Erewash CCG, North Derbyshire CCG and Southern Derbyshire CCG all have practices participating in Wave 1 of the Productive General Practice Programme across Derbyshire.

Derbyshire CCGs contacted all practices to seek expressions of interest to participate in the first wave of the Productive General Practice programme for completion by March 2017.

- Derbyshire CCGs will share the experience and learning from Wave 1 across all practices in 2017/18.
- Derbyshire CCGs already have a number of practices who have expressed an interest in joining Wave two in 2017/18 as outlined in the table below.
- Derbyshire CCGs will continue with the existing approach in ensuring that all remaining practices are contacted once further details are available for Wave 2 to encourage and promote participation in Wave 2 and Wave 3.

CCG	Productive General Practice Wave 1- Completion by March 17 Number of practices undertaking the programme	Productive General Practive Wave 2 - Completion by March 18 Number of practices who have expressed an interest in 2016/17
Erewash CCG	7 practices	To be confirmed in April 17
Hardwick CCG	Nil practices	To be confirmed in April 17
North Derbyshire CCG	5 practices	2 practices initially identified from wave 1 with additional practices to be confirmed in April 17
Southern Derbyshire CCG	11 practices	7 practices initially identified from wave 1 with additional practices to be confirmed in April 17
Total	25 practices	To be confirmed April 17

General Practice Development Programme- 2.5.3

Practice Manager Development Programme

Practice managers are a vital resource in the NHS, playing a key role in maintaining a quality service and in redesigning care for the future. Yet they are also one of the most neglected parts of the workforce, receiving relatively little formal training or ongoing development. Many practice managers' report feeling overburdened and isolated in their role, and it is often noted that the most efficient ways of working are slow to spread between practices.

To address these challenges, Derbyshire CCGs have supported the development of local networks of practice managers. These forums provide an avenue to share good ideas, learning and peer support.

Derbyshire CCGs will actively encourage and support Practice Managers to access the national development programme or provide tailored local programmes once the funding and further details of the national offer become available.

Southern Derbyshire CCG are funding 2 sessions per week of Practice Manager time to support implementation of the GPFV e.g. practice engagement and communication and identified specific initiatives.

Derbyshire Local Medical Committee

To support the delivery of the primary care vision and strategy, Derbyshire CCGs are working with the Derbyshire LMC to support practices who wish to work together clinically to spread good practice and reduce unwarranted clinical variation. This same methodology is also being applied to back office functions and administration staff.

Derbyshire practices are working together in Places and are being encouraged to work towards a 'place based' model of care. Practices are jointly discussing operational as well as clinical matters and agreed plans for the use of the GP Resilience funding and funding for non-clinical training. This will also include the additional GP Forward View workstreams when further information becomes available, e.g. Practice Manager Development programme and ongoing delivery of training in Places to support the Active signposting / Clinical assistant role in practices.

Chapter Six

Primary Care Infrastructure:

- *Vision*
- *Strategy*
- *Governance*
- *Workplans*

Primary Care Infrastructure: Vision

The Derbyshire vision for GP Infrastructure is to provide a comprehensive range of services to GP practices, supporting professionals delivering care. *This section outlines the primary care estates and technology vision, how both are inextricably linked, sharing a single finite funding stream to provide the foundation of sustainable and transformation change.*

Estates and technology will, together, not only meet the needs of health and care professionals but will also make the necessary investments will support delivery of the model of care and extended GP access, including shared and integrated care records, insight and intelligence to support decision making and patient empowerment. Effective County-wide management of primary care estates is a key enabler in delivering transformed services in primary care in Derbyshire

Estates:

- **Primary care has capacity to meet demand:** premises in each place can meet demand and have capacity to be flexible with changing requirements in service delivery and meet the needs of its population
- **Care closer to home:** improved place based facilities provide services that are patient focused and community based with more agile mobile working
- **Premises are of a consistently high standard:** patients and the workforce have premises that provide a safe and effective environment for service delivery. Minimum standards are set and achieved everywhere, being exceeded in most places.
- **Premises provide the best facilities in each Place:** primary care hubs and realignment of existing premises will provide enhanced facilities in each Place such as improved diagnostics
- **Whole system approach to estates:** with a shift from acute settings to community a change in use of existing premises is required across the system, shared approaches to premises, integrated work with One Public Estate Forum that will provide maximum value for Derbyshire
- **Address Inequalities:** Investment in areas of high deprivation to address health inequalities

Information Technology:

- **Delivering new models of care through new and emerging technology:** Enabling well equipped health and care professionals to work together within the primary/community setting. Enabling the delivery of care and treatments options close to the homes of their patients
- **Changing the face of GP Access:** Continue to provide and expand upon a modern , efficient and efficient digital infrastructure that will ensure patients are cared for in the most appropriate setting by connecting primary care with the wider health and care footprint reducing the administrative burden and creating additional capacity
- **Shared and integrated health and care record:** Authorised access to all relevant patient information at any point of need anywhere to plan and undertake care to achieve the best possible clinical and social outcomes. Wider use of information to underpin reactive and urgent care services and to reduce hospital admissions and length of stay
- **Decision making through insight and intelligence:** Continue to expand health and care datasets to build better insights in to population health using risk stratification to refine and present pertinent patient data to health and care professionals for action on improving health, reducing ill health for the future
- **Empowering patients and those that care for them:** Patient information gathered from many sources will be collated and supported by many other functions to enable patients to be more informed and take a greater degree of responsibility for their own health and self-care

2. Primary Care Infrastructure: Strategy

The Derbyshire GP FV infrastructure strategy is fully aligned with the overall Sustainability and Transformation Plan (STP*).* *This section outlines the primary care estates and technology strategy, showing how both elements have been considered across the whole system making effective use of whole system assets to serve the needs of patients, populations and practices.*

Redesign of primary care and placed-based care, where care will be delivered differently, can only be realised by a coherent, joined up county wide strategic planning process for estate and technology infrastructure which is ambitious, dynamic and responsive to the rapidly evolving requirements of the service.

Estates:

Primary care estates strategy is described in detail in the two Interim Local Estates Strategies (ILES) for the North of the County and the South of the County and in the STP submission.

The key themes that are driving strategic planning are as follows:

- Develop a single STP Primary Care Estates Plan: North and South plans will be combined within the STP estates plan to ensure a single approach across the county supporting wider developments
- Rationalisation and consolidation: The overall estate will be reduced to provide efficiencies in line with the needs of the population and support 'right person , right place ,right time' with fewer beds and acute activity and a shift into primary and community settings
- Funding models developed to support the required changes: consider how the system of providers having responsibility for premises can be spread across the system and support changes in how premises are used and in capital investment, i.e. One Public Estate , Private Public Partnerships, etc.
- Optimise existing Estate: Some existing premises are not fully utilised and could provide additional capacity
- Delivering at scale: Placed based care model will be enabled by a consolidation of primary care estate along with the development of Hubs over time

Information Technology:

Primary care technology infrastructure strategy is described in detail in the Derbyshire Local Digital Roadmap.

- Models of care underpinned by technology : Recognising the requirements of primary care services and the needs of clinicians to easily adapt to the changing landscape, investing in the right tools and training to minimise the impact of change whilst still achieving transformational results
- GP access, IT at the grass roots: The application of smart digital tools and well thought out business processes to manage demand and create additional capacity. Patient online services with sophisticated triage and signposting, coupled with e-consultation will guide and re-educate patients to the most appropriate care and care setting
- Derbyshire Digital Care Record (DCR): Providing a single complete view of all relevant data for an individual patient which authorised users are able to access as the patient travels though the health and care system, and which is easily accessible by the patient themselves. This is available at any point of care anywhere
- Business Intelligence: Objective assessment of patient needs is key to improving outcomes, and therefore a major focus of the current LPF procurement is the provision of an analytics function that allows clinical needs to be clearly identified, and care plans to be developed
- Helping patients to help themselves: Patients need information and support of varying levels as they come to terms with their health and become experts in the management of their various conditions. A comprehensive range of digital tools is needed to ensure staff and patients work effectively together and share the responsibility for improving outcomes.

Primary Care Infrastructure: Governance

Governance of Infrastructure services is firmly embedded in the Joined Up Care Derbyshire STP processes: *This section outlines that the estates and technology have respective governance arrangements which are balanced through an evolving management system.*

Delivery of a whole range of supporting infrastructure components within primary care , and the wider health and care footprint, is key to the effective operation of the primary care service, each component of which plays its part in ensuring that professionals are able to deliver front-line care.

Estates:

A single Derbyshire 'footprint' Local Estates Forum (LEF) is in place and acts as the Programme Board for estates matters. Providers and CCGs are in attendance with links to One Public Estate. The LEF reports to the STP Senior Management Executive.

- **Local Estates Forum(LEF):** is jointly chaired by STP Estates lead, DCHS COO and a CCG CFO with suitable county wide attendance including representation from CHP, LIFT and NHSPS which will be extended to include General Practice
- **STP Strategic Estates Plan (SEP) :** The Local Estates Strategies brought together into a Strategic Estates Plan (SEP) that forms part of the STP
- **Delegated work programmes:** Task and finish groups or ad hoc project teams are established to undertake specific pieces of work and develop the detail and fill in gaps in information that exist
- **Estates and Technology Transformation Fund:** NHSE provides update reports on ETTF progress to this board
- **CCGs Governance:** Local governance arrangements are in place in each CCG to decide on estates matters where there are funding implications

Information Technology:

The overall management and direction of IT within the Derbyshire 'footprint' is the responsibility of the Derbyshire Informatics Delivery Board (DIDB). Primary Care IT is overseen by the IT Steering Group (ISG), which reports to DIDB.

The following key aspects of governance relate to primary care IT:

- **The Derbyshire Informatics Delivery Board (DIDB):** chaired by a CCG AO (reporting to STP SME), the group has full representation from all health and social care bodies in Derbyshire including General Practice, LMC and patient representation. DIDB is responsible for design and delivery of the Local Digital Roadmap (LDR)
- **The Local Digital Roadmap:** describes the system-wide plan for all IT in Derbyshire. Primary care IT is a vital part of the LDR, central to the programme of transformation being undertaken
- **The LDR is aligned to, and articulates the IT Strategy for the STP:** The LDR is a mandatory requirement, and has specific requirements. The Derbyshire LDR has recently (January 2017) reviewed positively by NHSE
- **The ISG has responsibility for primary care IT:** The ISG has representation from all CCGs, and is chaired by the Director of Transformation of a CCG

Primary Care Infrastructure: Development Plan - Estates

The Primary Care infrastructure is at the centre of a Derbyshire footprint wide health and care system. *This section provides a clear narrative on the use of technology in primary care and demonstrate how the estates and technology will deploy the necessary infrastructure.*

The deployment plan continues to enhance this direction of travel and work towards a fully accessible health and care system were primary care is pivotal, information sharing is real-time and population health is improving.

Transforming Primary Care	Estates enablement
New model of care	**A footprint approach ensures the new service models, working at scale, delivering more locally with increasing demand can be better managed.** Developing a more detailed county wide estates strategy and work programme will compliment and enable the new service models. Planning at scale across the 21 places will enable services to be delivered which are based around populations in a cluster of premises offering complimentary services across the area, supporting local primary and community care delivery.
Extended GP access	**Workbook programme:** A programme of work in addition to ETTF projects is underway managed through the LEF. This programme is designed to enable STP initiatives which shift activity towards primary and community care. ETTF schemes will improve capacity in practices by providing additional clinic space which will improve access.
Insight and intelligence to support decision making	**Whole system approach:** through the Local estates Forum (LEF) a stock take of premises across the public sector is underway and any requirements or disposals are considered in the whole with joint projects already underway. **Improving baseline data:** Information is now being gathered and entered onto one system (SHAPE) to enable all LEF members to share and access information on estate, service , population and housing growth. Practice and Place level data is also being developed to support new models of care. Gaps have been identified in primary care information and steps are in place to rectify this.

Primary Care Infrastructure: Development Plan - Technology

The Primary Care infrastructure is at the centre of a Derbyshire footprint wide health and care system. *This section provides a summary initiatives in primary care and demonstrate how the estates and technology will deploy the necessary infrastructure.*

Transforming Primary Care	Technology enablement	Key initiatives
New model of care	**Working flexibly and effectively throughout the primary and community:** by equipping staff with the devices they need, by allowing staff to have visibility of services through a comprehensive directory of services (DOS) that would better meet the needs of their patients and release time back into general practice.	• **Expansion of a fast and reliable broadband connection:** Migration from N3 to community interest network (COIN) through the health and social care network (HSCN) with appropriate links to required infrastructure. • **Agile & mobile working** – Delivering care closer to home, access to real-times Wi-Fi in care homes, collaborative working (MCP) professionals to work seamlessly across the county from any primary care or Place location • **Convergence and interoperability –** system rationalisation, disparate systems communicating using a common language e.g. SNOMED CT
Extended GP access	**The tools to provide consistent levels of care and flexibility:** by ensuring that professionals have access to appropriate clinical systems and all the functionality that is available including the support which is needed to expand their operation with emerging digital capability e.g. e-consultation, patient triage and online services.	• **Wi-Fi available within general practice and care homes:** For visiting clinicians, staff and patients access extending to care homes to improve the delivery of care. • **Patient online services** – the facility to book or cancel an appointment and request repeat medication online. Access to the full clinical or detailed patient record for advanced self care. • **E-consultation:** GP and Nurse consultation enabling patients to remain at home and still receive care wherever possible.
Shared and integrated care records	**The Digital Care Record (DCR):** for improved clincial decision making and to reduce the volume of information and request for information that practices process from the other health and care settings across the Derbyshire footprint and beyond.	• **Digital Care Record (DCR)** enables the sharing of comprehensive patient information to authorised professionals to improve clinical decision making and patient experience. Available across the digital footprint to urgent care, out-off hours and integrated services at any location, at any time.
Insight and intelligence to support decision making	**Derbyshire wide Information Sharing:** Implementing a county wide information sharing agreement between practices, CCGs and providers allowing them to work together to deliver care and transformational change. Bringing data together to inform on population and locality health, risk stratification to focus resources and drive prevention.	• **County-wide Business intelligence service (out to LPF):** Derbyshire wide Information Sharing agreement provided the necessary agreement for practices, CCGs and providers to work together to deliver care and transformational change. E.g. Big Data, House of Care and Risk Stratification .
Patient empowerment	**Assistive and telehealth technology:** tools to support patient self-management and support primary care workload.	• **Assistive and telehealth technology** primarily tools to encourage patient self-management but also a means to extending the reach of primary care and allow workloads to be reassessed and managed differently.

Primary Care Infrastructure: Investment

Funding streams that will enable the Derbyshire Health and Care economy to not only achieve the GP Forward View but the high level 5 Year Forward View paper free at the point of care. *This section outlines the major funding streams available, their proximity to realisation and impact on primary care.*

Funding Stream	Description
Estate and Technology Transformation Fund	Estates Technology and Transformation fund (ETTF) as part of GPFV required a process of gathering information, developing a plan and prioritising primary care estates and technology schemes and has allocated £7,800,000 for Joined Up Care Derbyshire STP footprint split over three years. By March 2017; four estates schemes totalling £1,000,000 will be completed and deliver significant increases in capacity and access. Five technology schemes will be completed totalling £1,000,000 and will deliver significant improvements in capacity and access . By March 2019; 10 estates schemes are planned to be supported in principle and would total in excess of the remaining allocation. A number of IT bids are also being developed in addition to those already approved. In order to prioritise the limited funding available the governance process described earlier will support decision making in this area. ETTF criteria supports access and workforce and ensures value for money through a prioritisation and due diligence process. ETTF criteria requires improved access, increased capacity for training, increased capacity for primary care out of hospital and to reduce unplanned admissions. Estates revenue consequences are limited to any potential increase in rent which is abated (reduced) for 5, 10 or 15 years by the ETTF 66% funding, this is considered affordable and good value. Revenue for GPIT is nil for CCGs. NHSE as the asset owner have revenue depreciation costs.
GP IT Operating Model	Pooled GP IT capital plans were submitted at the end of 2016 for years 2017/18 and 2018/19. Each years plan has two separate bids: • 2017/18 Bid 1 – Refresh £793,000 Bid 2 – Service improvement £131,000 • 2018/19 Bid 1 – Refresh £522,000 Bid 2 – Service improvement £469,000 (refresh requirements are predicted to reduce)
Local Digital Roadmap (LDR)	The LDR final submission was sent to NHS England October 2016. The total bid is £35,242,500 was submitted for the Derbyshire Health and Care footprint.

Primary Care Infrastructure: Challenges and Priority for Action - Estates

A number of challenges and priority actions have been identified: *This section outlines the high level estates and technology challenges, risks and priority actions that could impact the transformation of primary care and the wider Derbyshire health and care footprint*

A t*ight financial environment will make any infrastructure changes both difficult and necessary.* A lack of clinical engagement in plans to develop primary care infrastructure would make implementation of the strategy difficult. The full integration of General Practice with CCGs in terms of planning and delivery is still in an embryonic stage and requires an injection of pace in order to deliver maximum benefits across the system

Challenge and priority for action	Mitigating action
Demand escalates: A growing and aging population means the demands on primary care are increasing	S106 funding offers some capital funding from housing developments. New models of delivery offer opportunities for managing demand. IT developments will reduce demand on face to face contacts.
Existing ownership models: Around two thirds of GP premises in Derbyshire are freehold, owned by one or more partners. This restricts options for changing premises as does premises with long leases.	The whole system approach will work toward creating more flexible and costs effective models for ownership and rental that provides fit for purpose, well maintained premises than can adapt to a changing environment.
Lack of consistency in standards: Some premises are purpose built in the right location and of a high quality whilst others lack capacity and require urgent attention.	A baseline and minimum standards will be developed to ensure all premises are of a reasonable standard and a higher more consistent level is achieved.
Lack of investment: Capital and revenue are limited and reduce the ability to develop new premises as required.	A shift from acute and better use of technology will assist the transition into greater activity in primary care and in the community. Investment from S106, ETTF and opportunities from OPE, PPP models etc. will support new investment.
Short timescales: Planning and building large scale developments requires long term planning and funding opportunities are often time limited.	Plans are being developed to allow quicker responses to opportunities that may arise.

Primary Care Infrastructure: Challenges and Priority for Action - Technology

A number of challenges and priority actions have been identified: *This section outlines the high level estates and technology challenges and priority actions that risk the transformation of primary care and the wider Derbyshire health and care footprint*

A t*ight financial environment will make any infrastructure changes both difficult and necessary.* A lack of clinical engagement in plans to develop primary care infrastructure would make implementation of the strategy difficult. This is overcome via the governance processes previously discussed.

Challenge and priority for action	Mitigating action
Availability of investment to support LDR - Insufficient funding available for LDR will inhibit ability to achieve PF@PC by 2020.	Prioritisation of individual projects within the programme, as well as detailed review of exact scoping of work within projects is being undertaken, to ensure that key deliverables are met.
Cultural change required for professionals and citizens - Understanding the working culture and practice changes required to implement and embed successful change, citizens willingness to engage using digital channels, citizens and professionals underutilisation leading to reduction in level benefits achieved	A clear vision for change, informed and supported by real experience from the public and staff, underpinned by research where available, will be used to develop strong business change and training processes. It is critical that new products and services are aligned with 'industry standard' norms ensuring that all users are comfortable with using them.
Digital tools are inadequately designed for effective use in health and care settings - Technologies, disparate systems and devices are not seamless integrated within the health and social care system.	Digital clinical tools are evolving constantly, but it is recognised that there is a long way still to go to provide uniformly excellent quality products. Local developments will draw upon the best national practices to strive to meet this challenge
Digital literacy of Staff - Ensuring that staff have the necessary skills and capability to take advantage of available technologies and information	Local training programmes, allied with strong business change processes will be developed, including tailored training for complex needs
Level of business change required to delivery LDR - level of business change required is likely to be significant, change required may exceed the capacity of the footprint implement within the required timeframe, impacts on the ability to deliver business as usual and care quality	A key deliverable of all technology projects is to ensure that sufficient business change resources are allocated to meet the requirements of users and the service. Appropriate funding, supported by effective, skilled staff is key to managing this risk which is specified in the LDR
Digital capability of Population - The capacity and opportunity for patients to take advantage of digital technologies available, citizens don't have the connectivity or devices to enable them to engage with the digital offer	Population digital capability is a key requirement for many agencies, and health will work together with partner organisations to build effective engagement strategies in seldom heard groups

Chapter Seven

Investment

Investing in General Practice: *This section describes how investments will be used locally across the Derbyshire CCGs to achieve sustainability and transformation in general practice and deliver the overall vision for Primary Care in line with the national requirements and the Joined Up Care Derbyshire STP.*

Structured investment into General Practice (GPFV)

Core (see next slide)

- Increase general practice funding by at least the % increase in core CCG allocations, to fund core contract changes

Transformation

- £3 per head (option to split over 2017/18 and 2018/19) – non-recurrent transformation support funded from CCG allocations to stimulate development of at scale provision, implementation of 10 high impact actions and secure sustainability;

National 'Ring Fenced'

- £15m devolved to CCGs in 2017/18 and £20m in 2018/19 to fund online GP consultation software in line with national specification;
- £10m devolved to NHS England local teams or delegated CCGs in each 2017/18 and 2018/19 to fund training for care navigators and medical assistants for all practices in line with national specification; and £8m funding in each 2017/18 and 2018/19 to support practice resilience (NHS England)
- Increase access - £6 per weighted patient for GPAF sites and Transformation Area CCGs in both 2017/18 and 2018/19, and £3.34 per head for all remaining CCGs in 2018/19 increasing to £6 for all in 2019/20 for CCGs to commission the required improved access

Planning and Processes in Joined Up Care Derbyshire STP

The Derbyshire CCGs received authorisation for full delegation of co - commissioning from NHS England with effect from April 2015 onwards. Of the four CCGs, Erewash is a vanguard site, with specific funding arrangements and two others (South Derbyshire and Hardwick) have PMCF funding arrangements for specific practices.

Maturity of investment plans

Planning and delivery of agreed investment are at different levels of maturity across the multiple elements of the strategy. There is a mix of individual CCG working and Derbyshire wide approaches . Future focus will be to deliver effective and efficient local population services equitably.

Business case development and approval process

There is a commitment to deliver the requirements of the national schemes in line with guidance and specifications. For local investment the approach is to require proposals or business cases which either respond to set outcomes or include outcomes or metrics as part of the proposal. Wherever possible these will be consistent across the CCGs, allowing innovation and meeting local need.

STP, operational plans and the GPFV The STP includes a high level ambitious investment plan for primary care (Redesigning Access to Primary Care) which exceeds the minimum allocation required and reflects our ambition to invest in general practice and primary care.

Following guidance the operational plan sets out only the funding the CCGs could guarantee. This section follows the operational plan to set out guaranteed funding, which still exceeds the minimum required. Our aspiration, as set out in the STP, is to exceed this. All investments within this section and this document are reflected in STP and operational plans,.

Major investment proposals for estates and IT are co-ordinated through Derbyshire wide existing governance processes and link back to the STP.

Procurement Strategy

Our STP and all our strategic plans focus on the need for providers to collaborate and integrate. Our strategy therefore is to support existing providers, including General Practices, to work together and not to go to market procurement unless absolutely necessary or where poor performance for patient care has not been addressed.

Investment Outline - Core funding & CCG transformation support: *this section sets out the core funding allocation and the funding for transformation (£3/head), affirming our plan to invest more than the direct general practice / primary care medical allocation and the minimum requirement of the GPFV. This additional funding will support Derbyshire practices to sustain and transform, in line with the GPFV.*

Derbyshire Commitment	**17/18**	**18/19**	**Description**
Growth in primary care medical (allocation)	1.69% £2.2m	1.86% £2.5m	The growth in the primary care medical allocation Derbyshire CCGs will receive.
Total Derbyshire Commitment	1.69% £2.2m	1.86% £2.5m	

In addition to the funding outlined above, Derbyshire CCGs will also be investing £3 per head over 17/18 and 18/19 to fund primary care transformation

Derbyshire Commitment	**17/18**	**18/19**	**Description**
Additional investment to primary care medical (allocation)	£1.6m	£1.6m	Non recurrent funding to support transformation of primary care equating to £3 per head. In Derbyshire this will be allocated equally over 2 years.

National Funding and Extended Access Funding

n addition to the funding to be invested by Derbyshire there will be national funding through the GPFV, plus additional funding for extended access. This section outlines those national funding streams and associated targets

GP Forward View	Derbyshire investment			Outcome		
	17/18	18/19	19/20	17/18	18/19	19/10
Online consultation	£0.27m	£0.36m	£0.18m	• Increased self care • Reduced demand		
Training care navigators and medical assistants	£0.18m	£0.18m	£0.18m	• Patients streamed appropriately within practice • Making time in General Practice and providing additional capacity		
General Practice resilience programme	£0.14m	£0.14m		• Vulnerable practices supported to increase resilience		
Other funding:	To be confirmed. GPFV national £508m including £206m (workforce)			Non-recurrent funding held nationally to support: GP workforce increase, premises & national development programme. Increases in investment for: estates and technology; GP trainees; GP IT systems; public health payments; MH therapists		

Extending access	Derbyshire investment			Outcomes		
	17/18	18/19	19/20	17/18	18/19	19/10
Access in current PM Challenge Fund (PMCF)/ Vanguard sites (recurrent)	£1.46m	£1.46m	£1.46m	M-F 6.30-8pm & Sat/Sun	M-F & Sat/Sun	M-F & Sat/Sun
Access in non-PMCF sites (recurrent)		£2.64m	£4.89m		M-F 6.30-8pm	M-F & Sat/Sun

Transformational support: *plans for the use of this funding are to be co-produced with practices working together in places.*

Priorities	Potential Investment areas	Key Actions 2017/18	Key Actions 2018/19	KPIs	Phasing of funding
Practices will be asked to work at scale in their place footprints to develop a plan. The plan will set out how, they propose to: • Develop at scale provision • Implement the 10 high impact changes • Secure sustainability of General Practice	To be developed by practices within their Place at scale practice plans but likely to include funding for: At scale working: • Development of collective working • Planning time for extended access • Access hubs • Pump priming at scale joint work Implement high impact • Backfill for staff • Learning sets • OD and facilitation Sustainability • Peer support for practices • Pooling capacity and extending services at scale	To be agreed, but as a minimum the following outcomes would be expected: Plan for at scale working in Places including: Plan to provide or commission extended access from April 2018 (by July 2017) Participation or plan to participate by all practices in: • High Impact Changes • Releasing Time to Care • Use of technology (e-consultations) Stocktake at a place level of practice sustainability	Minimum outcomes by March 2019 as follows: At scale working in line with local plan e.g.: • Delivery of extended access M-F evenings • Back office staff/ functions/efficiency • Working across practices e.g. joint home visiting or care home services All practices participating in national and local programmes to implement high impact changes Implementing local sustainability plan	To be developed but outcomes could be measured by: • At scale extended access (M-F) • Formalised pan GP working arrangements • Formalised GP collective structures • Completion of at least 2 high impact changes by all practices and; • Measuring of benefits of high impact changes • Reduction in practice crisis • GP/ practice reported outcome measures re sustainability	Over two years with £1.50 / head allocated in each year.

Ring fenced devolved funding; on-line consultation software and training for reception and clerical staff: *summarises our plans for use of this funding, an STP approach, engagement with practices and the public, and anticipated outcomes*

On-line consultation software: strategic aim

Derbyshire sees this as a key element of our overall strategy, central to new ways of working to improve access to advice and support whilst improving capacity. This is discussed in more detail in the sections on access, workload and infrastructure.

Local pilots

There are no Derbyshire e-consultation pilots, though one practice in Erewash is piloting the 'AskmyGP' tool, within the CCG's vanguard work.

An STP approach to roll out and procurement

Once the national guidance and the specification have been received by Derbyshire CCGs an analysis of our current plans and options against the National guidance will be undertaken. A project of work to implement the best combination of initiatives against provided funding will be implemented across Derbyshire once the guidance is published. The procurement strategy will be incorporated within the ETTF process as outlined in the infrastructure section. Both roll out and procurement will be Derbyshire wide, ensuring consistency across CCGs, population and the STP footprint.

Change in practice; consultation with the public

The CCGs will ensure that opportunities for engagement with key stakeholders will form part of the delivery plans to introduce new technology

Training for reception and clerical staff

The initial allocation in 2016/17 for Derbyshire CCGs has been utilised for Receptionist and Clerical signposting training. There is a mixture of access for practices to the online e-learning training available through Bluestream Academy across the Derbyshire CCGs ranging from part to 100% of practices in each CCG area. It is intended that all practices across Derbyshire CCGs will be able to access the Online Receptionist Training via Bluestream Academy (an online training system provider that is used by Derbyshire practices) during 2017. Derbyshire practices have been engaged with the development of the Bluestream Academy module and presentations on the new module will be provided to Practice Managers during 2017.

Other initiatives that are being considered for implementation in 2017 include:

- Two day Receptionist and Clerical Triage and signposting course organised via the Primary Care Development Centre or other providers across Derbyshire.
- Accredited training package by West Wakefield Health and Wellbeing who are an approved NHSE provider. This accredited training package includes guided learning, online sessions plus consultancy to support the development of systems and processes.
- Sharing of best practice from practices that have implemented signposting training in their practice.
- Development of a local directory to support receptionists in signposting patients to alternative providers and organisations.

The next stage of the project will be to further engage with practices by March 2017 regarding the options for delivery and agree the expected outcomes, impact and timelines for all practices . Further detail is included within the delivery plan trajectory.

Other investment: *all Derbyshire CCGs will work with NHS England and Health Education England to allocate ring fenced national funding and deliver programmes. This section outlines how the funding available via co-commissioning will be allocated to primary care; provides assurance that revenue impacts of ETTF are affordable; outlines approach to investment in primary care workforce, and; outlines plans to invest the PMS premium*

Use of co-commissioning funding

The funding available via co-commissioning will be allocated in line with the plans set out in this document, either:

- Directly to practices either individually or at scale (e.g. resilience funding or vulnerable practice funding)
- At a Derbyshire wide level funding CCG allocations will be pooled to procure a Derbyshire solution which all practices will be able to access (e.g. online consultation or reception and clerical training)

Further detail on specific schemes is set out in sections within the plan and delivery trajectories

Impact of ETTF projects

The revenue impacts of ETTF projects have been assessed and are planned, achievable and affordable. The detail of this is available within the Local Digital Roadmap (LDR) and linked ETTF submissions.

Plans for investment in primary care workforce

This section sets out the proposed investment in primary care. Within that it is anticipated that some of this funding will be invested in new workforce initiatives, including new staff, training, skill mix and the development of new roles.

The STP vision is that as a system we increase the workforce in place around General Practice by 2500 staff over a five year period, and that alongside this General Practice is funded and supported to increase capacity and develop new roles. The detail of this is set out in the workforce section.

Investment of the PMS premium

In Derbyshire County PCT 'fairer funding initiative' in 2010/11 invested MPIG and PMS premiums in a range of enhanced services to ensure equitable access across Derbyshire with practices paid at GMS Global sum.

The remainder of the practices mainly in Derby City are included as part of the national approach to remove MPIG by 2021 and the national reinvestment of PMS premiums in Primary Medical Care, incorporated within the Southern Derbyshire CCG 'Locally Commissioned Service Framework' approach.

Additional investment

In addition to core funding CCGs currently invest additionally in a number of different ways including, for example:

- Winter pressures funding to provide additional primary care capacity and appointments
- Engagement schemes to support ongoing conversations in communities relating to General Practice Forward View, Making Time in General Practice, and link to Primary Care Development. (e.g. NDCCG £1/head in 16/17 & 17/18)
- Funding to support federation development and at scale working (e.g. HCCG commissioning of the NEDH federation)
- Funding for clinical leadership programmes and clinical involvement in developing place and in Primary Care Development

Chapter Eight

Leadership, Governance and Programme Arrangements

Governance Arrangements for GPFV

CCG - CURRENT

- The Primary Care Co-Commissioning Committee (PCCC) is a decision making forum and is the main committee where all aspects of primary care are discussed. It is the decision making committee regarding quality, performance finance and contracting. This is the main forum for discussing and planning the GPFV programme, agreeing GPFV expenditure and direction of travel; and potential impacts on core budgets as a result of the GPFV are reported to the Finance committees. Membership of PCCC consists of lay representation, Healthwatch, clinicians, (GPs) NHSE, LMC, Local Authority and CCG members.

  PCCC reports directly to NHSE & for information to Governing Bodies. Current arrangements means there is duplication of systems & processes 4 times & is not aligned to the overall STP for place based care.

Place

As part of the STP it was agreed there would be 21 Places across Derbyshire, 2 each in Erewash and Hardwick CCGs, 6 in North Derbyshire CCG and 11 in Southern Derbyshire CCG. These places are beginning to become established, and their current governance arrangements are:

- Place Co-ordinating group has membership from all of the organisations involved in Place (GPs, community services, CCG, out of hours/111 service, local authority, mental health) and this group oversees the development of Place across Derbyshire.
- The Chair of the Place Co-ordinating Group is also the Chair of the Derbyshire Informatics Delivery Board (DIDB). The membership of DIDB are Heads of IT & representatives from all health & social care organisations from across Derbyshire, including the LMC. The role of this Board is to have oversight & provide direction for digital transformation aligned to the STP.
- The Chair of the Place Co-ordinating Group and DIDB reports the development of this transformation to the 4+4 which is attended by the Accountable Officers, Chairs from the Derbyshire CCGs and the STP System Management Executive.

Primary Care

- There are 4 Primary Care Co-Commissioning Committees
- Each CCG has a form of GP group/led meetings where service developments are discussed
- Each CCG has GP groups to discuss clinical governance/performance
- Practice visits are undertaken to monitor quality, performance and contracting by all CCGs
- There is GP practice representation throughout the current governance arrangements to ensure there is alignment with GPFV to Place/STP, and LDR.

2017/18

The following proposed transitional stage will begin to reduce duplication of systems & processes, releasing resource to focus on the programmes of work associated with the GPFV, STP & LDR programme:

CCG

- From April 2017 there is a plan to have one overarching commissioning officer structure , which will support strategic commissioning. Due to statutory requirements there will be four Governing Bodies and four Primary Care Co- Commissioning Committees.
- The overall membership of these committees will not change but will ensure that there is public/patient representation at these meetings.

Place

- From April 2017, Place Co-ordinating group will have terms of reference and standing agenda items to ensure consistency of how Place is delivered across the STP.
- Place Co-ordinating group will report to Governing Bodies (GB) but will ensure that PCCCs are sighted on the GPFV elements as this is the approval committee for GPFV issues.
- The overall membership of this group will not change but will ensure that there is public/patient representation at these meetings.

Primary Care

- We will be developing a Derbyshire wide GPFV Development and Delivery Group for managing GPFV that will have terms of reference, aims and objectives that will report directly to PCCCs and will link with the Place Co-ordinating group to ensure alignment with transformation and service improvements and developments.
- Throughout 17/18 to benchmark across practices from a quality, performance and service development perspective in order to share best practice to improve quality and ensure equity.
- Identify a GPFV Programme Management Lead for Derbyshire.

Proposed Governance Arrangements for GPFV 18/19

Across Derbyshire CCGs and the wider health and social care system, governance arrangements are undergoing review and development. The following governance proposal , will require further discussions and development with System Management Executive.

The following proposal provides an outline framework which would support the system to reduce duplication of processes, releasing resource to focus on the programmes of work associated with the GPFV, STP and LDR programme to ensure these are aligned.

There will be clear leadership regarding the GPFV programme management that will work closely with the Executive Place Lead to ensure delivery of GPFV and alignment with STP and LDR :

CCGs

- From April 2018 move to a single Strategic Commissioning Body and PCCC as statute allows.
- Strategic commissioner is the responsible commissioner for the system agreeing outcomes with the STP System Management Executives (SME) and will provide assurance to NHSE of delivery of constitution and report on areas of concern.
- There will be a Derbyshire GPFV Commissioning Programme Board that will be the assurance mechanism to PCCC.

Primary Care

- GPFV monies will be received from NHSE by the Strategic Commissioner and then allocated to the GPFV Programme Board.
- Reporting to the Derbyshire GPFV Commissioning Programme Board is the GPFV Development and Delivery Group linking with the STP/SME.
- GP practices within Place will be key to the discussions to how the GPFV money is spent being part of the GPFV Development and Delivery Group, and approval sought from PCCC via the Derbyshire GPFV Commissioning Programme Board.

Place

- Service development and delivery within Place reporting to Place co-ordinating group
- Place co-ordinating group will oversee the development of Place and link with the Derbyshire wide GPFV Development and Delivery group who links into the Derbyshire GPFV Commissioning Programme Board for primary care elements and development as a result of the GPFV monies.
- The Derbyshire System Management Executive (STP Programme Board) are the system leaders and have oversight of delivery of Place.
- Across Derbyshire there are 2 streams to reflect statutory obligations i.e. commissioning GP as a provider and support general practice to develop within Place. The representation at these Boards and Groups will be fluid ensuring the clinical voice is heard and will have patient and public membership.

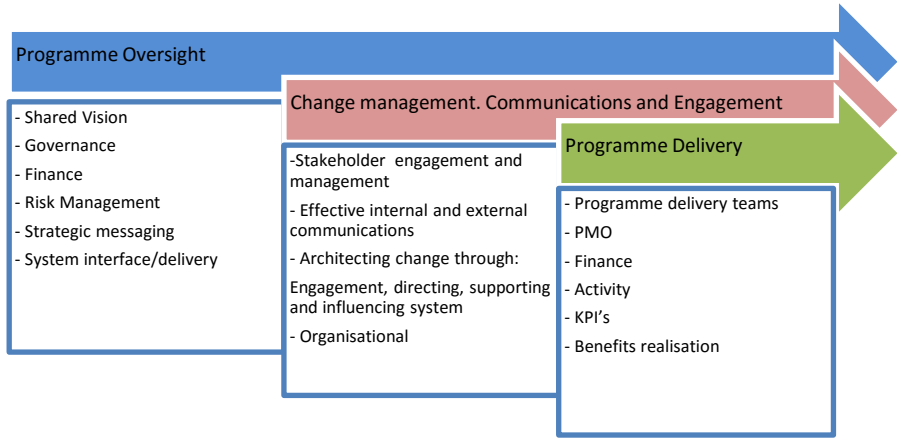
Programme Management Arrangements

Current
There are various programme management arrangements for GPFV & it will be necessary to understand the local management arrangements in greater detail in order to ensure an effective transition to system management arrangements that reflect what is required to ensure Place based development including GPFV implementation.

Looking Forward
From April 2017 there will be development and establishment of a Derbyshire GPFV Programme Board/ Committee that will ensure the delivery of GPFV.

Resources will be provided via alignment in accordance with the STP footprint allowing and enabling reinvestment of resources.
The delivery of the GPFV will be operationalised within practices and there will be groups set up that will report to the GPFV Programme Board. There will be stakeholder involvement within this governance structure including patients, public & practice staff. There will be key clinical leadership and involvement for delivering the GPFV.
The programme management of GPFV will be parallel to the delivery of STP, Place and the local digital roadmap. Attendance at the GPFV programme Board will be lead representatives from the Place co-ordinating group, GPFV Development and Delivery Group and the Derbyshire Informatics Delivery Board so that the STP, GPFV and LDR are clearly aligned.

Programme Management Principles



Leadership Arrangements

To deliver the GPFV programme an executive lead for across Derbyshire will be assigned V. and chair the Derbyshire GPFV Commissioning Programme Board in April 2017. There will be a GPFV Programme Management Lead who will support the Executive Lead for Place .

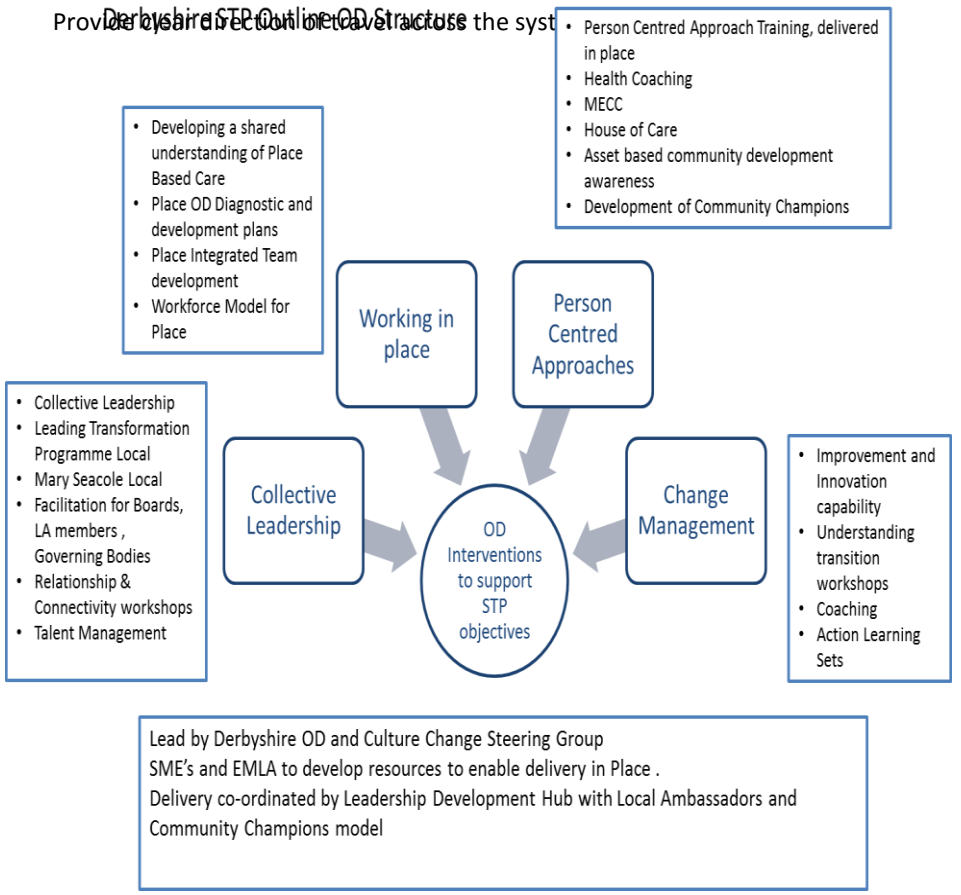
The Derbyshire wide leadership model for delivering the GPFV will have established GP clinical leaders at the GPFV Commissioning Programme Board level which will be continued throughout the governance structure from this Board through to individual practice level. We will ensure that there is public/patient representation at GPFV meetings who will be part of the leadership framework.

Effective leadership is essential for the delivery of the GPFV and to ensure alignment with the STP and LDR. Key leadership required for this are:

- Clinical leaders (GPs) – to advise regarding the initiatives that will enhance quality of care
- Transformational leadership - to ensure the vision for General Practice/primary care is clear, and able to engage with all relevant people including stakeholders and public.
- System leadership – to ensure change occurs across the multiple systems collaboratively.
- Managerial – to manage the GPFV requirements and returns to ensure there is effective monitoring and measuring of service development to ensure it is value for money and delivering what is required.

These leaders are within the membership of the proposed structure above and are already working across the STP and LDR – it will be crucial to ensure the correct people are identified for this work, i.e. have the core skills required:

I. Able to clearly and simply articulate the vision
II. Personable, approachable
III. Ensure the work needed is delivered
IV. Hold people to account across differing systems and organisations



Engagement with patients, primary care professionals and staff

Engagement with patients, public & primary care workforce to deliver the GPFV is essential so that they have the opportunity to be part of the journey of transforming practices within Place. As a system we need to ensure that robust mechanisms are embedded to ensure we receive information and feedback so that the available services within primary care are what the primary care professionals, patients and public feel is truly needed.

We will ensure within our approach to engagement that we abide by the Six Principles for Engaging People and Communities

It is recognised that more work is required to engage with our public, patients and staff regarding the GPFV. Derbyshire has a desire for transparency and this plan has been shared with key clinical leaders throughout its development.

In addition to having stakeholder and engagement events there will be patient, public and primary care professional representation at the core meetings to ensure the Derbyshire journey of implementing STP and delivering the GPFV is truly shared with our population by providing the opportunity for them to be actively part of the journey encouraging direct involvement in proposing developments that will be presented to stakeholder groups.

General Approach

The CCGs' approach to communication and engaging key stakeholders in the development and delivery of our GPFV plans will mirror and align with the overarching communications and engagement approach for the Joined Up Care Derbyshire STP. This approach will be layered to:

- commence universal engagement in the main issues emerging from the STP, as well as national initiatives to support GPFV
- establish Place level engagement programmes, representative of Place demography and services, to help inform more localised planning
- devise engagement and communications plans to support the implementation of Place and service line transformation, including those elements related directly to the local response to GPFV.

STP-wide

- We are developing an engagement plan for April 2017 and launching the engagement process by planning conversations with as many people as possible and introduce the basics of STP, starting May 2017 following the local election purdah period. We need to dedicate time to understanding people who live in Derbyshire and find out what their ideas and thoughts are about health and social care services for the future. The aim of the sessions will be to start to gather details on people who are keen to get involved in the STP and also start to test our key messages with the public and establish if they resonate at this stage.

Place-Based

- We are planning a targeted approach focussing on the 21 Places identified across Derbyshire. Initially we are mapping the local knowledge we have on places with our partners (Healthwatch Derbyshire and Derby city, voluntary sector). The profiles for each place will include demographic information for each place as well and utilise population data which is being used to understand local need and service commissioning/provision.

Practice-Based

- We will develop specific communications and engagement plans, in support of our GPFV implementation programme, which ensures that local practices, patients and other key stakeholders are fully sighted, engaged and consulted on our emerging plans. Where possible this will be aggregated up to place level, as practices begin to work in a more federated manner, and also aggregated up to county and national level where there is benefit in delivering a consistent message across a broader geography. We know that our communications to patients will involve as a minimum the following elements:
- Cultural change as people are encouraged to understand that services will be provided in new ways
- Empowerment, where patients will be encouraged to access services appropriate to their level of need including enabling them to self care.
- Navigation, to support patients who understand the interrelationships between services both with and outside of general practice and assist them in choosing the right service for the needs of them and their families.

Chapter Nine

Delivery Plan Trajectory

- ***Model of Care***
- ***Access***
- ***Workforce***
- ***Workload***
- ***Infrastructure***
- ***Investment***
- ***Leadership, governance and programme arrangements***

Delivery Plan Trajectory

Schemes	Key deliverables	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Model of Care								
Development of GP alliances 'at scale'	Plans to begin 'at scale' working across GP practices in place	Partial Federated approaches across STP	£3/ head 17/18 and 18/19 for 'at scale working'	Development of 'at scale' plans by March 2018	GP collaborations GPFV delivery/ development group	March 2018	GP 'at scale' plans for each place 'At scale approach to extended access from April 2018	Plan (03/18) Extended Access (04/18)
GP Engagement in co-producing approach/ plan	Local GP ownership/ sign off of GPFV plans	Discussion of GPFV – some involvement	Backfill costs for time (£3/head)	Sign off of local GPFV plans	GPFV delivery/ development group GP collaborations	July 2017	Owned and signed off local GPFV plan in Place	Local plan in Place (07/17)
Development of 'place' forums	Places well established across STP Practices actively participating in planning and delivery	All Place boundaries agreed Places established – variation in functionality	Funding for backfill (2016/17) Capacity released to support place (from April 17)	Places established; meeting regularly	Place co-ordination group	June 2017	Sense of place as tangible 'real' thing Places beginning to deliver real change for patients	Extended access (04/18) At scale working (from 04/18)
Establishment of organisational / governance approaches	Governance Infrastructure established across Derbyshire	STP structures / CCG alignment plans set out	Reallocation of funding / capacity to support structures	CCG Strategic Outline Case / Development of single GPFV programme approach	Exec Lead - Place CCG GBs	April 2017 April 2018	Infrastructure established New governance forms developed	Governance formally established by April 18
Clinical leadership of place/	Leadership established for GP collbaorations in place	GP leaders for Places	Backfill costs for individuals OD programme costs	Named individuals with capacity OD programme in place	Place co-ordination group	April 2017 September 2017	Clear leadership with individuals with sufficient time OD programme delivered	Well-led GP Federations with OD April 17 Sept 17

Delivery Plan Trajectory

Schemes	Key deliverables (same for all CCGs)	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Improving Access								
Erewash CCG	Additional 1.5 hours per day pre-bookable and same day appointments Monday to Friday 6.30 – 8pm By providing a minimum of 30 minutes per 1000 populating and rising to 45 minutes per 1000 population	GPAF pilot 2 extended access hubs covers whole patient population. Additional access available from 5.15 – 8pm Monday to Friday	GPAF funding agreed with NHS England for the pilot	Maintain delivery and continue implementation of robust communication and engagement plans to promote improved access. Continued use of national GPAF tool installed in all practices and clinical hubs	Erewash CCG Primary Care / Transformation Lead	Quarterly monitoring to NHS England	Achieved – all population able to access 6.30 – 8pm appointments Monday to Friday Patients accessing appropriate level of intervention to meet their needs	All CCGS to have achieved 100% population coverage by April 2018 (Erewash already achieved as GPAF pilot) 100% population coverage for 45 minutes per 1000 population
Hardwick CCG , North Derbyshire CCG and part of Southern Derbyshire CCG		Population not covered April 2017.	£3 per head over 2 years for planning improving access and delivery of 10 High Impact Actions from April 2018	Practice engagement for a decision by practices in Places by the end of June 2017. Detailed plans for provision to be submitted to CCGs by end of June 2017. Procurement to commence July 2017 across Derbyshire to address any gaps in provision from April 2018. Development of robust patient communication and engagement plans to promote improved access in line with the procurement.	Hardwick, North Derbyshire and part of SDCCG Primary Care / Transformation Lead	30 June 2017 July 2017 for implementation from April 2018.	All population able to access 6.30 - 8 pm appointments Monday to Friday in Places Patients accessing appropriate level of intervention to meet their needs	

Delivery Plan Trajectory

Schemes	Key deliverables (same for all CCGs)	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Improving Access								
Southern Derbyshire CCG	Additional 1.5 hours per day pre-bookable and same day appointments Monday to Friday 6.30 – 8pm By providing a minimum of 30 minutes per 1000 populating and rising to 45 minutes per 1000 population	GPAF pilot 130,000 population	GPAF funding agreed with NHS England for the pilot	Plans being developed for implementation to commence from April 2017.	SDCCG	April 2017	All pilot population able to access 6.30 -8 pm appointments Monday to Friday in pilot Places Patients accessing appropriate level of intervention to meet their needs	100% population coverage of pilot sites from April 2017 100% population coverage for 30 minutes per 1000 population as per existing guidance

Delivery Plan Trajectory

Schemes	Key deliverables (same for all CCGs)	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Improving Access								
Erewash CCG	Weekend provision of additional access based on population need in all Places Implementation of nationally commissioned GPAT tool to measure appointment activity	GPAF pilot 2 extended access hubs covers whole patient population. Additional access available from 9-12 Saturdays and 10-1 on Sundays	See investment section	Maintain delivery and continue implementation of robust communication and engagement plans to promote improved access. Continued use of national GPAF tool installed in all practices and clinical hubs	Erewash CCG Primary Care / Transformation Lead	Quarterly monitoring to NHS England	Achieved – all population able to access weekend appointments on Saturday and Sunday based on population need Patients accessing appropriate level of intervention to meet their needs	100% population coverage achieved
Hardwick CCG (Part)		2 practices offering Saturday and Sunday appointments at one site covering 20,500 patients	See investment section	Maintain delivery	Hardwick CCG	Quarterly monitoring to NHS England	Achieved for part of the population who are able to access weekend appointments on Saturday and Sunday based on population need Patients accessing appropriate level of intervention to meet their needs	100% part population coverage achieved

Delivery Plan Trajectory

Schemes	Key deliverables (same for all CCGs)	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Improving Access								
Part of Hardwick CCG , North Derbyshire CCG and part of Southern Derbyshire CCG North Derbyshire CCG	Weekend provision of additional access based on population need in all Places Implementation of nationally commissioned GPAT tool to measure appointment activity Practice audit across Derbyshire to evaluate inappropriate attendance at A&E and OOH Services. CCG evaluation of practice audits to be shared across Derbyshire	Population not covered as at April 2017	£3 per head over 2 years for planning improving access and delivery of 10 High Impact Actions from April 2018	Practice engagement for a decision by practices in Places by the end of June 2017 . Detailed plans for provision to be submitted to CCGs by end of June 2017. Procurement to commence July 2017 across Derbyshire to address any gaps in provision from April 2018. Development of robust patient communication and engagement plans to promote improved access in line with the procurement. Development of Derbyshire wide practice audit	Hardwick, North Derbyshire and part of SDCCG Primary Care / Transformation Lead	30 June 2017 July 2017 for implementation from April 2018. From April 2019 for implementation Dec – Mar 2020	All population able to access weekend appointments on Saturday and Sunday based on population need Patients accessing appropriate level of intervention to meet their needs Improved patient satisfaction with access to primary care services across Derbyshire	100% population coverage by April 2019 75% practices to complete practice audit by April 2020. % increase in national GP patient survey and annual local patient surveys

Delivery Plan Template

Schemes	Key deliverables	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
Workforce								
Local Workforce Tool	Work with HEE to validate accuracy of Local Workforce Tool information	First draft of local workforce tool	HEE	Meeting with CCGs May 2017	HEE	May 2017	Understanding of gaps in local workforce tool to inform further development	All CCGs understand gaps and agree plan to address
	Use the local workforce tool within Places to model the gaps in existing and future workforce and then develop and action plan	A/A	A/A	To meet with HEE, CCGs, LMC to inform the development of the primary care workforce plan for Derbyshire	HEE / CCG Primary Care Leads	March 2018	Primary Care Workforce Development Plan in place (1st draft)	1st draft to be developed by March 18
NHSE National Initiative; GP Retainer Scheme, GP Induction and Refresher and International Recruitment	Engagement with practices to promote awareness of availability of national schemes	A few (TBC) practices currently participating in the GP Retainer schemes	NHSE	Practice engagement	CCG Primary Care Leads / LMC	On-going	All practices aware of support available	100% of practices aware of national support offers through NHSE
Back office functions and clinical leadership – please refer to Workload delivery plan								

Delivery Plan Trajectory

Schemes	Key deliverables	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Workload								
GP Resilience Programme	Delivery of GPRP 16/17 plans. Practices identified for 2017/18 and plans agreed. Develop plan for transition to single approach in 18/19 onwards	99 practices supported in 16/17.	£287,000 16/17 £144,000 17/18 See Investment section for full details by CCG which has been fully allocated.	GPRP 16/17 monitoring as per MOU agreed reporting dates. Identification of practices for 2017/18 by March 2017 and for 2018/19 by January 2018 Agree for 2017/18 by July 2017 Monitoring of delivery of plans 17/18 in accordance with MOU agreed with NHS England North Midlands. Derbyshire CCGs to develop transition plan for a single approach from April 2018 by October 2017.	Each CCG GPRP Lead	Ongoing during 2017/18 as per MOU. March 2017 and January 2018. July 2017 Ongoing during 2017/18 as per MOU. October 2017	As set out in each practice MOU with NHS England North Midlands. Sustainability of practices, working at scale, consistently and supporting freeing up time in general practice to provide additional capacity.	100% of practices offered to access GPRP In 2017/18 All CCGs agree transition delivery plan for implementation from April 2018.

Delivery Plan Trajectory

Schemes	Key deliverables	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Workload								
Training for reception and clerical staff	Consultation with practices on the proposed investment in 2016/17. Online learning training package being developed with local directory of services for all practices to access from April 2017. Derbyshire wide training to be developed to be delivered in Places	2016/17 funding invested in development of online learning with local directory of services	Funding is ring fenced by all CCGs. Derbyshire Allocation is £180,00 in 2017/18 See investment section for full details by CCG.	Practice engagement Sept 16 onwards for 16/17 investment and ongoing for 2017/18. Blue stream academy e-learning module developed by April 2017. Demonstration to Practice Manager networks rolled out across Derbyshire from March 2017 Development of plan to deliver training to support on-line training and provide face to face training from May 2017 include sharing best practice, procurement if required. Link to 10 High Impact Actions	Each CCG Primary Care /Quality leads	April 2017 Ongoing during 2017/18 From May 2017 ongoing	Freeing up time in practice to provide additional capacity to support delivery of GPFV	100% of practices offered access to on line learning package by end of April 2017. 100% of practice manager networks attended to promote work programme and implementation plan from May 2017 All CCGs to agree delivery plan for implementation from May 2017 across Derbyshire.

Delivery Plan Trajectory

Schemes	Key deliverables	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Workload								
On line practice consultations	Pilot of online practice consultations feedback by May 2017 Practice engagement to inform procurement. Derbyshire wide procurement once national specification received from NHS England. Delivery plan to be developed and rolled out in Places across Derbyshire STP. Delivery to be aligned to readiness assessment for 10 High Impact Actions.	1 practice (Erewash CCG piloting Ask MY GP)	Funding is ring fenced by all CCGs. Derbyshire Allocation in 2017/18 i£270,00 See Investment section for full details by CCG.	Evaluation of local pilot (by June 2017) Development of a plan for a Derbyshire wide procurement once the national specification is received. Development of a delivery plan for roll out of the on line practice consultations in line with the procurement plan Link to GP Development programme 10 High Impact actions and readiness assessment by Sept 17.	Erewash CCG Lead All Derbyshire CCG Primary Care Leads supported by Arden and GEM CSU.	March 2017 To be confirmed once national specificatio n received. To be confirmed once national specificatio n received	Learning shared across Derbyshire to inform discussions for the procurement All practices to have access to on-line consultations in line with roll out plan to support improving access in Places and provide additional capacity	All CCGs to agree delivery plan for implementati on across Derbyshire once national specification received. Erewash CCG to share learning to inform procurement in line with procurement delivery plan timescales once national specification received.

Delivery Plan Trajectory

Schemes	Key deliverables	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Workload								
GP Development Programme **10 High Impact Actions**	Engagement with practices March 2017 – June 2017. Development of plan for Places to identify and agree modules from 10 High Impact Actions for implementation during 2017-2019. State of readiness completed in Places by end of September 2017.	25 practices participating in Productive General Practice in 2016/17 across Derbyshire.	£3 per head funding ring fenced in all CCGs to support the delivery of improving access and access to the national development programmes including 10 High Impact Actions and Productive General Practice Quick Start. See investment section for detail on individual CCG plans.	Practice engagement Sharing of learning from Productive General Practice in 2016/17. Encourage practice participation in PGP Quick Start in 2017/18 as details emerge. Readiness assessment completed in all PLACES and information shared with CCG leads.	All individual CCG Primary Care Leads	By June 2017 Initial plan by June 2017 and then ongoing By 30 September 2017	Derbyshire wide plan for practices to access the GP Development Programme Rollout of 10 High Impact Actions across Places from November 2017 Practices participating in second wave of Productive General Practice Quick Start and learning shared.	100% of practices aware of GPDP, 10 HIA by 30 June 2017. 100% or places to have completed Readiness assessment by 30 September 2017.

Delivery Plan Trajectory

Schemes	Key deliverables	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Infrastructure								
Scheme 1 Estates Hollybrook practice reconfiguration	Additional clinical capacity	Practice considered significantly over capacity	£325,000 ETTF (66%) by 31.3.17	April 2017 in operation	Practice, with SDCCG and NHSE to support and approve	31.3.17	Additional clinic space utilised to increase appointments	Complete by 31.3.17 to meet 4 ETTF criteria
Scheme 2 Estates Arthur Medical Centre Extension	Additional clinical capacity	Practice considered significantly over capacity	£183,000 ETTF (66%) by 31.3.17	April 2017 in operation	Practice, with SDCCG and NHSE to support and approve	31.3.17	Additional space is utilised as a phased approach to build additional clinical capacity	Complete by 31.3.17 to meet 4 ETTF criteria
Scheme 3 Estates Melbourne Practice	Additional clinical capacity	Practice considered significantly over capacity	£92,000 ETTF (66%) by 31.3.17	April 2017 in operation	Practice, with SDCCG and NHSE to support and approve	31.3.17	Additional clinic space utilised to increase appointments	Complete by 31.3.17 to meet 4 ETTF criteria
Scheme 4 Estates Arden House Second floor fit out	Additional clinical capacity	Practice considered significantly over capacity	£62,000 ETTF (66%) by 31.3.17	April 2017 in operation	Practice, with NDCCG and NHSE to support and approve	31.3.17	Additional clinic space utilised to increase appointments	Complete by 31.3.17 to meet 4 ETTF criteria
Scheme 11 Estates Cohort 2 The Limes	Extension	Practice considered significantly over capacity	£782,000 ETTF (66%) by 31.3.19	March 2019 in operation	Practice, with Hardwick CCG and NHSE to support and approve	31.3.19	Additional clinic space utilised to increase appointments	Complete by 31.3.19 to meet 4 ETTF criteria
Scheme 12 Estates Cohort 2 Springs	Extension	Practice considered significantly over capacity	£574,000 ETTF (66%) by 31.3.18	March 2018 in operation	Practice, with NDCCG and NHSE to support and approve	31.3.18	Additional clinic space utilised to increase appointments	Complete by 31.3.18 to meet 4 ETTF criteria
Scheme 13 Estates Cohort 2 Erewash Old Station	Extension	Practice considered significantly over capacity	£67,000 ETTF (66%) by 31.3.19	March 2019 in operation	Practice, with Erewash CCG and NHSE to support and approve	31.3.19	Additional clinic space utilised to increase appointments	Complete by 31.3.19 to meet 4 ETTF criteria
Scheme 14 Estates Cohort 2 Hasland	Extension	Practice considered significantly over capacity	£288,000 ETTF (66%) by 31.3.18	March 2018 in operation	Practice, with NDCCG and NHSE to support and approve	31.3.18	Additional clinic space utilised to increase appointments	Complete by 31.3.18 to meet 4 ETTF criteria

Delivery Plan Trajectory

Schemes	Key deliverables	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Infrastructure								
Scheme 15 Estates Cohort 2 Lime Grove	Extension	Practice considered significantly over capacity	£297,000 ETTF (66%) by 31.3.19	March 2019 in operation	Practice, with NDCCG and NHSE to support and approve	31.3.19	Additional clinic space utilised to increase appointments	Complete by 31.3.19 to meet 4 ETTF criteria
Scheme 16 Estates Cohort 2 Newbold Surgery	Extension	Practice considered significantly over capacity	£363,000 ETTF (66%) by 31.3.19	March 2019 in operation	Practice, with NDCCG and NHSE to support and approve	31.3.19	Additional clinic space utilised to increase appointments	Complete by 31.3.19 to meet 4 ETTF criteria
Scheme 17 Estates Cohort 2 Avenue House Surgery	Extension	Practice considered significantly over capacity	£574,000 ETTF (66%) by 31.3.19	March 2019 in operation	Practice, with NDCCG and NHSE to support and approve	31.3.19	Additional clinic space utilised to increase appointments	Complete by 31.3.19 to meet 4 ETTF criteria
Scheme 18 Estates Cohort 2 Thornbrook	Extension	Practice considered significantly over capacity	£157,000 ETTF (66%) by 31.3.19	March 2019 in operation	Practice, with NDCCG and NHSE to support and approve	31.3.19	Additional clinic space utilised to increase appointments	Complete by 31.3.19 to meet 4 ETTF criteria
Scheme 19 Estates Cohort 2 Mickleover	New Build	Practice considered significantly over capacity	£5,600,000 ETTF (66%) by 31.3.19	March 2019 in operation	Practice, with SDCCG and NHSE to support and approve	31.3.18	Additional clinic space utilised to increase appointments	Complete by 31.3.19 to meet 4 ETTF criteria
Scheme 20 Estates Cohort 2 Heanor	New Build	Practice considered significantly over capacity	£3,400,000 ETTF (66%) by 31.3.19	March 2019 in operation	Practice, with SDCCG and NHSE to support and approve	31.3.19	Additional clinic space utilised to increase appointments	Complete by 31.3.19 to meet 4 ETTF criteria
Scheme 21 Estates Cohort 2 Sinfin	New Build	Practice considered significantly over capacity	£4,800,000 ETTF (66%) by 31.3.19	March 2019 in operation	Practice, with SDCCG and NHSE to support and approve	31.3.19	Additional clinic space utilised to increase appointments	Complete by 31.3.19 to meet 4 ETTF criteria

Delivery Plan Trajectory

Schemes	Key deliverables	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Infrastructure								
Scheme 5 GPIT Derbyshire ICE Pathology (ETTF)	Direct pathology reporting cross border	No cross border system	£300,000	April 2017 in operation	Derbyshire LDR Programme	31.3.17	Cross border system in operation to support new models of care	Complete by 31.3.17 to meet 4 ETTF criteria
Scheme 6 GPIT E-Consultations (ETTF)	Enable use of remote consultations	Systems in place but requires further roll out	£144,000	April 2017 in operation	Derbyshire LDR Programme	31.3.17	Increased functionality and usage of remote consultations	Complete by 31.3.17 to meet 4 ETTF criteria
Scheme 7 GPIT Diagnostic testing Equipment (ETTF)	Provide diagnostic testing equipment	Systems in place but requires further roll out	£300,000	April 2017 in operation	Derbyshire LDR Programme	31.3.17	Increased use, speed and management of diagnosis of long term conditions	Complete by 31.3.17 to meet 4 ETTF criteria
Scheme 8 GPIT Connected Derbyshire (ETTF)	Increase IP addresses and ports in GP practices	Systems in place but requires further roll out in around 60 locations	£163,000	April 2017 in operation	Derbyshire LDR Programme	31.3.17	Expand digital footprint and allow more effective use of hardware	Complete by 31.3.17 to meet 4 ETTF criteria
Scheme 9 GPIT Patient arrival screens (ETTF)	Provide patient arrival screens	Systems in place but requires further roll out	£104,000	April 2017 in operation	Derbyshire LDR Programme	31.3.17	Improve speed of patient arrival process	Complete by 31.3.17 to meet 4 ETTF criteria
Scheme 10 GPIT Patient Arrival Screens (ETTF)	Provide full coverage of patient arrival screens	Some gaps to be filled in this phase.	£208,000	March 2018 in operation	Derbyshire LDR Programme	31.3.18	Improve speed of patient arrival process	Complete by 31.3.18 to meet 4 ETTF criteria
ETTF Cohort 2 – Proposals sent to NHS England, new projects and extension to cohort 1 roll-out	Wi-Fi care homes, clinical portal, patient self-care tools, practice infrastructure performance	Extension of Derbyshire digital capability and primary care infrastructure	£1,904,000	March 2018 in operation	Derbyshire LDR Programme	31.3.19	Various	Complete by 31.3.19 to meet 4 ETTF criteria

Delivery Plan Trajectory

The Derbyshire Local Digital Roadmap (LDR) final iteration was submitted to NHS England in October 2016. In order to deliver the LDR and STP priorities 51 projects have been identified and detailed in the October submission. The overall bid for all settings in Derbyshire is £35,242,500 over a 5 year period. NHS England have accepted the Derbyshire submission but have yet to determine an allocation of funding to Derbyshire. Monitoring of all 51 projects that impact on primary care to one degree or another will be through the LDR Programme Management Office as described in the LDR, reporting to the Derbyshire Informatics Delivery Group (DIDB).

There are a programme of GPIT Developments being managed though the local CSU.

Schemes	Key deliverables	Baseline position	Investment (inc dates)	Action / milestone	Action owner (organisation)	Milestone delivery date	Success measure	KPIs / Plan trajectory
GPFV – Infrastructure								
Wi-Fi in General Practice – Phase 1	For visiting clinicians, staff and patients	96% rolled out to GP Practices	Already fully funded	March 2017	All Derbyshire GP Practices	31.3.17	Percentage of practices with Wi-Fi.	100% rolled out to GP Practices
LDR Universal Capability (2) Access to GP record information in wider urgent care settings	Summary Care Record (SCR) Upload	Phase 1 - complete	National Programme	Phase 1 - March 2014, additional phases included in LDR	All Derbyshire GP Practices	31.03.14	All GP Practices uploaded	100% GP Practice uploaded
LDR Universal Capability (4) NHS e-Referral	Exploit capability , advice & guidance	69% July 2016	£500,000 LDR by TBC	March 2018	Derbyshire LDR Footprint, National Programme	31.3.18	Percentage achievement	80%
LDR Universal Capability (3, 10) Patient online (POLAR Project)	Optimisation	100% practices enabled	£150,000 LDR by TBC	March 2018	All Derbyshire GP Practices	31.03.18	Percentage of patient within practice that have access to online services	10% of patients from each practice 2016/17
LDR Universal Capability (3, 10) Citizen Information Project	Raise awareness and use of online services	100% practices enabled	£370,000 LDR by TBC	March 2018	All Derbyshire GP Practices	31.03.18	Percentage of patient within practice that have access to online services	10% of patients from each practice 2016/17
GPIT Developments	To meet agreed Digital Maturity Assessment (DMA) standards	DMA for Primary Care	£2.1m GPIT Funding	CSU work Programme	CCG Joint IT Steering Group	Annual Plan	Various measured through DMA improvement.	Various measured through DMA improvement.

Chapter Ten

GPFV Risks for Derbyshire

- ***Programme***
- ***Model of Care***
- ***Access***
- ***Workforce***
- ***Workload***
- ***Infrastructure***
- ***Investment***
- ***Leadership, governance and programme arrangements***

Risks

Challenges and priority actions for the GP FV which is at the centre of a Derbyshire footprint wide health and care system. *This section provides a summary of key risks and mitigating action for the GPFV agenda across Derbyshire.*

GP FV Section	Risk Description	Mitigation
Programme Risks	**Timely Access to sufficient funding**: Risks associated with the significant funding shifts required to make the planned changes include: • Planned national funding to be made available in full in a timely manner. This includes the risk that local processes are insufficiently prepared to meet pre-requisite standards for the release of funds; • Planned STP Transformational funding shifts to primary care must be achieved; • Unforeseen costs arise during the course of programme implementation; • No formal contingency fund has been identified;	The STP has prioritised investment in primary care and community in 'Place', and therefore will prioritise a whole system response to any funding shortfall that will re-allocate funding from alternative non-primary care sources, managing risks in these areas. In addition, the programme plan has some flexibility in intermediate delivery targets, while retaining achievement of overall objectives.
Programme Risks	**Widespread engagement of all stakeholders:** Ensuring that all participants in the programme fully understand, and are positively engaged with the necessary changes is a key risk: • Practices and individual GPs and other primary care professionals are willing and able to make the cultural and operational changes necessary to fully embrace the planned changes; • Colleagues in the rest of the Derbyshire-wide system understand and support the need for change, and support the necessary consequential impacts;	The STP is founded upon the need to shift care from secondary care settings to be provided closer to home. A full communications and engagement programme is being undertaken to raise participation in the programme. Delivery of improved outcomes to patients is a key motivator for health care staff, and the programme will focus on raising awareness of the positive results expected from the change. Clinical leadership in Place, together with peer support, will help resolve issues arising from at scale working. Where necessary and appropriate, targeted incentives will be applied. Finally, CCG alignment is expected to release time and resources to support practices through the change process.

Risks

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GP FV Section	Risk Description	Mitigation
Programme Risks	**Availability of sufficient number of appropriately trained staff:** The successful implementation of the programme will depend on a large number of professionals working together in a cohesive and coherent way. Risks associated with this are: • Recruitment and retention of key clinical staff groups; • Supporting managerial and non-clinical staff groups	A major review of workforce requirements will identify any projected shortfalls in specific staff groups. Targeted action will be taken to address these areas. Derbyshire is actively exploring the development of new roles and innovative approaches to solving complex requirements as set out in detail in the workforce section.
Programme Risks	**Full participation by vulnerable Practices:** It is recognised that all practices will be making substantial changes, and these will bear down most heavily on those which are already experiencing challenges. This could have impacts in the following areas: • Lack of equity in patient access to services; • Increased pressures on front-line staff;	Vulnerable practices are already strongly supported by commissioners through a variety of mechanisms. These include: • Establishment of robust recovery plans for all vulnerable practices; • Additional resourcing where appropriate, including additional staffing; • Mentoring and targeted support processes; • Peer support through 'at scale' practice collaborations; • Regular performance management process; Opportunities to provide an increased focus will be available from CCG staff freed up by CCG alignment.
Programme Risks	**Public Engagement** To fully realise the whole vision of transformative change to primary care, it is vital the patients and carers are actively supportive of the planned approach. The risks of the public being disengaged or opposed to changes are: • Confusion over access routes to primary care; • Public opposition to change; • Impact on care outcomes	A strong theme of the Derbyshire STP is a robust PPI engagement process, working with national resources where available. Existing PPI processes will also be fully utilised, emphasising the positive outcomes arising from the planned changes. GP collaborations will be supported to develop strong public engagement plans. Practices will be supported to engage with patients on specific changes via established mechanisms such as Patient Reference groups.

Risks

Challenges and priority actions for the GP FV which is at the centre of a Derbyshire footprint wide health and care system. *This section provides a summary of key risks and mitigating action for the GPFV agenda across Derbyshire.*

GP FV Section	Risk Description	Mitigation
Programme Risks	**National Policy impacts:** It is recognised that learning from other footprints may impact national guidance, which may have 'knock on' effects on the local programme, resulting in the following risks: • Delays to key elements of the delivery plans; • Changes to funding requirements;	The Derbyshire-wide system has defined a programme plan which is flexible to limited changes. Major changes to national policy and guidance may require a future re-planning exercise.

Risks

Challenges and priority actions for the GP FV which is at the centre of a Derbyshire footprint wide health and care system. *This section provides a summary of key risks and mitigating action for the GPFV agenda across Derbyshire.*

GP FV Section	Risk Description	Mitigation
Model of care	Ability of GP practices to organise into at scale organisations / effective collaborations	Support through the £3/head transformational funding, facilitated by CCGs. Support through the LMC, GPTAG and other agencies Good clinical leadership already in situ across Derbyshire Existing models of at scale working already thrive locally and nationally.
Model of care	Increasing demand and workload leaves no time to undertake the changes to model of care	Combination of investment and reform outlined in GPFV will help release time 'Burning platform' urgency will motivate changes to current models of care.
Model of care	Difficulty in changing traditional ways of working, culture and behaviour	Development of OD programmes across STP footprint and locally in place will help change cultures. Success of existing and emerging multi-agency teams will encourage clinicians and staff to work together.
Model of care	Lack of resources particularly in terms of financial investment and staff time	Investment programme will be delivered in line with local and national GPFV Existing investment in GP time may be refocused to support delivery of GPFV Backfill funding will be available to support clinical leaders.

Risks

Challenges and priority actions for the GP FV which is at the centre of a Derbyshire footprint wide health and care system. *This section provides a summary of key risks and mitigating action for the GPFV agenda across Derbyshire.*

GP FV Section	Risk Description	Mitigation
Access	Without an accurate system to identify demand it will be difficult to match capacity effcetively or appropriately	Early planning of stocktaking exercises; Continual measurement of effectiveness of service provision; Evaluation of other access pilots demand and capacity exercises.
Access	Difficulties in Recruiting and retaining staff	Staff recruitment and retention are issues specifically addressed in the workforce plan; innovative approaches to managing workforce will be employed to ensure effective cover at all times.
Access	Ensuring resources sufficient to cover workload	Detailed planning will robustly challenge workload assumptions, with appropriate contingency arrangements where necessary.
Access	Meeting tight timelines with possibly conflicting interdependencies	Strong programme management arrangements have been developed to ensure that all deliverable targets are met.
Access	Ensuring CCG staff and skill mix are appropriate for guiding required change and development against tight timelines	The current plan is sufficiently flexible to be responsive to variances against planned timelines.
Access	Ensuring adequate and appropriate engagement with patients and internal CCG staff members	A robust engagement programme will be undertaken, led by a nominated Executive Lead.
Access	Impact of GP indemnity issues	Changes impacting GPs (and other professional groups) will be monitored through the agreed programme management arrangements, and action taken as necessary.

Risks

Challenges and priority actions for the GP FV which is at the centre of a Derbyshire footprint wide health and care system. *This section provides a summary of key risks and mitigating action for the GPFV agenda across Derbyshire.*

GP FV Section	Risk Description	Mitigation
Workforce	Gaps in baseline position for current GP and primary care workforce	Workforce information has been collated in depth Further detailed stocktake at practice level will be undertaken as part of at scale working at place level.
Workforce	Rapid loss of GPs and failure to train and replace GPs or to diversify and recruit new roles	HEE Workforce planners developed detailed scenario plans identifying plans and contingency plans to recruit and retain staff. Derbyshire models suggest that strategy of retention of trained staff, plus diversification and skill mixing will bridge gap. Strategy will focus on making Derbyshire General Practice attractive place to work to retain and attract staff.
Workforce	Failure of national training programmes to deliver numbers, or inability to attract staff who are trained	
Workforce	Lack of acceptance of new roles by existing clinicians	Roles already generally accepted at national and local level. Development of pilot sites showing success will encourage further roll out. Peer support and challenge led by clinical champions.
Workforce	Lack of clarity about governance arrangements for new style teams leading to failure to implement them	Senior Clinical Professional Groups are already working through governance models (e.g. Clinical Professional Reference Group in ND & HCCGs). Established governance structures exist elsewhere in the country.
Workforce	Lack of leadership and failure to adopt new ways of working	Clinical leaders already exist across Derbyshire, and are leading new ways of working. OD programme will support change.

Risks

Challenges and priority actions for the GP FV which is at the centre of a Derbyshire footprint wide health and care system. *This section provides a summary of key risks and mitigating action for the GPFV agenda across Derbyshire.*

GP FV Section	Risk Description	Mitigation
Workload	Location of national events and workshops - greater attendance and engagement for local Derbyshire events	Developing local resources with Derbyshire LMC to support practice engagement locally including buying in expertise as required.
Workload	Whole practice engagement	CCG funding to support backfill, clinical leadership at place. Opportunities for standardisation of approaches as practices work at scale in Places.
Workload	Practice pressures to release time	CCG to work with practices in Places to understand individual pressures . Support to be provided and rollout plans for the delivery of the GPFV programmes of practice pressures.
Workload	Quality and flexibility of national providers for releasing Time to Care Productive General Practice Quick Start programme	CCG to feedback to NHS England and the preferred provider following each cohort to learn lessons to influence future approaches.

Risks

Challenges and priority actions for the GP FV which is at the centre of a Derbyshire footprint wide health and care system. *This section provides a summary of key risks and mitigating action for the GPFV agenda across Derbyshire.*

GP FV Section	Risk Description	Mitigation
Infrastructure - Estates	Demand escalates: A growing and aging population means the demands on primary care are increasing.	S106 funding offers some capital funding from housing developments. New models of delivery, working at scale and having more efficient well utlised premises all offer opportunities for managing demand. IT developments will reduce demand on face to face contacts.
Infrastructure - Estates	Lack of consistency in standards: Some premises are purpose built in the right location and of a high quality whilst others lack capacity and require urgent attention.	A baseline and minimum standards will be developed to ensure all premises are of a reasonable standard and a higher more consistent level is achieved.
Infrastructure - Estates	Lack of investment: Capital and revenue are limited and reduce the ability to develop new premises as required.	A shift from acute and better use of technology will assist the transition into greater activity in primary and community settings. Investment from S106, ETTF and opportunities from OPE, PPP models etc. will support some new investment. Working at scale and having more efficient well utilised premises will reduce the need for further investment.
Infrastructure - Estates	Existing ownership models: Around two thirds of GP premises in Derbyshire are freehold, owned by one or more partners. This restricts options for changing premises as does premises with long leases.	The whole system approach will work toward creating more flexible and costs effective models for ownership and rental that provides fit for purpose, well maintained premises than can adapt to a changing environment. Explore innovative solutions.
Infrastructure - Estates	Short timescales: Planning and building large scale developments requires long term planning and funding opportunities are often time limited.	Plans are being developed to allow quicker responses to changing needs and opportunities that may arise with a pipeline of projects that could be delivered if funding streams become available.

Risks

Challenges and priority actions for the GP FV which is at the centre of a Derbyshire footprint wide health and care system. *This section provides a summary of key risks and mitigating action for the GPFV agenda across Derbyshire.*

GP FV Section	Risk Description	Mitigation
Infrastructure - IT	Ability of investment to support LDR - Insufficient funding available for LDR will inhibit ability to achieve PF@PC by 2020.	Prioritisation of individual projects within the programme, as well as detailed review of exact scoping of work within projects is being undertaken, to ensure that key deliverables are met.
Infrastructure - IT	High levels of cultural and business change required for professionals and citizens - significant business change implications that will need to take into account strong cultural dynamics and putting patients at the centre of everything we do. Citizens willingness to engage using digital channels and those that are unable or who choose not to have equal access to care.	A clear vision for change, informed and supported by real experience from the public and staff, underpinned by research where available, will be used to develop strong business change and training processes. It is critical that new products and services are aligned with 'industry standard' norms ensuring that all users and citizens are comfortable with using them.
Infrastructure - IT	Digital tools are inadequately designed for effective use in health and care settings - Technologies, disparate systems and devices are not seamless integrated within the health and social care system. Ensuring that staff have the necessary skills and capability to take advantage of available technologies and information.	Digital clinical tools are evolving constantly, but it is recognised that there is a long way still to go to provide uniformly excellent quality products. Local developments will draw upon the best national practices to strive to meet this challenge. Local training programmes, allied with strong business change processes will be developed, including tailored training for users and teams with complex requirements.

Risks

Challenges and priority actions for the GP FV which is at the centre of a Derbyshire footprint wide health and care system. *This section provides a summary of key risks and mitigating action for the GPFV agenda across Derbyshire.*

GP FV Section	Risk Description	Mitigation
Investment	Insufficient funding for core GMS/PMS and enhanced services	CCGs committed to funding core GMS/PMS and existing services. Also in line with STP strategy CCGs looking to protect General Practice/primary care from financial QIPP challenge as far as possible, and to continue to invest additional funding in other enhanced services.
Investment	Failure to deliver funding for transformation	All CCGs have stated commitment to allocate all available funding in line with national requirements. Clear plan to invest £3/head transformation funding over two years.
Investment	Delays in funding for national programme	Work with NHSE to allocate national funding as soon as its available. Derbyshire GPFV plan gives opportunity to plan ahead in readiness for funding when available.
Investment	Multiple, fragmented and 'siloed' funding streams each with separate reporting timetable requiring rapid decision and response	Work with NHSE, seek flexibility to pool and flex funding in line with spirit of GPFV, the Derbyshire GPFV plan. Proactive planning at STP and local level to assure NHSE and 'earn' autonomy and develop a mature and sensible approach to local reporting.
Investment	Failure to deliver STP funding to support community and other linked services	STP strategy sees investment in primary and community care as k priority, so would seek to prioritise this funding.

Risks

Challenges and priority actions for the GP FV which is at the centre of a Derbyshire footprint wide health and care system. *This section provides a summary of key risks and mitigating action for the GPFV agenda across Derbyshire.*

GP FV Section	Risk Description	Mitigation
Leadership, Governance and Programme arrangements	Co-ordination of aligning GPFV to STP/Place	Proposed governance structures / programme management will ensure alignment as there will be cross over of representation at relevant committees to ensure alignment. Key leadership such as an Executive lead across the system.
Leadership, Governance and Programme arrangements	Challenging timescales delivering and implementing the GPFV Commissioning Programme Board	Working across the STP and developing governance and programme structures aligned to the STP will provide increased opportunities for consulting and engaging with patients public and primary care professional to ensure optimum benefits of expenditure.
Leadership, Governance and Programme arrangements	Delayed and uncoordinated approach to patient/public engagement	This will be co-ordinated across Derbyshire and there will be patient/ public engagement throughout the programme/ governance structure. In addition to this there will be forums for engaging with stakeholders across Derbyshire.
Leadership, Governance and Programme arrangements	Capacity and resources to provide leadership and management to the GPFV Programme Board	Rapidly emerging strategic commissioner role will release resource to ensure key leaders remain in the system.

Appendices

GPFV for Derbyshire

- *1 Public Health Data in Derbyshire*
- *2 Workforce*
  - *2a General Practice Workforce*
  - *2b Midlands and East GP Supplier Forecast Model – scenario 1*
  - *2c Midlands and East GP Supplier Forecast Model – scenario 2*
- *3 GPFV Investment*

Health and Wellbeing Gap

Understanding the Health and Wellbeing Gap

This section sets out the scope and scale of the health and wellbeing gap across and within Derby and Derbyshire.

Introduction

"The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness" (*Five Year Forward View*, 2014, p.7).

"In England, inequalities in health exist across a range of social and demographic indicators, including income, social class, occupation and parental occupation, level of education, housing condition, neighbourhood quality, geographic region, gender and ethnicity" (Marmot, 2010, p.45).

The scope and scale of the health and wellbeing gap in Derby and Derbyshire through health inequalities is considered in relation to:

- Life expectancy;
- Healthy life expectancy;
- Premature mortality;
- Disease prevalence;
- Living with limiting long-term illness or disability.

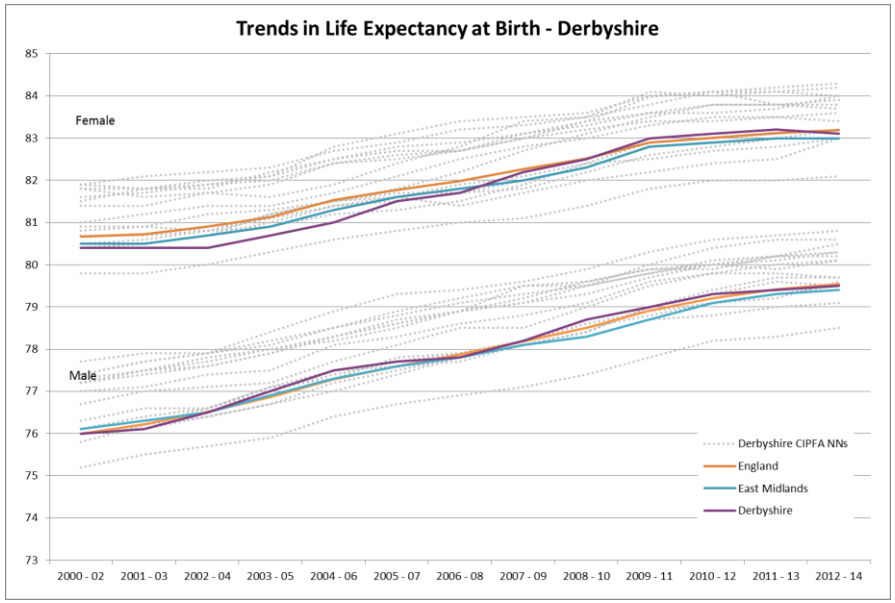
Understanding the Health and Wellbeing Gap

Life expectancy has been increasing albeit at a slower rate in recent years. There are, however, significant variations in life expectancy between those living in the least and most deprived areas and in certain groups such as those with severe and enduring mental health problems.

Life expectancy

Life expectancy has been increasing over time both locally and nationally – although the rate has slowed in recent years in both Derby and Derbyshire.

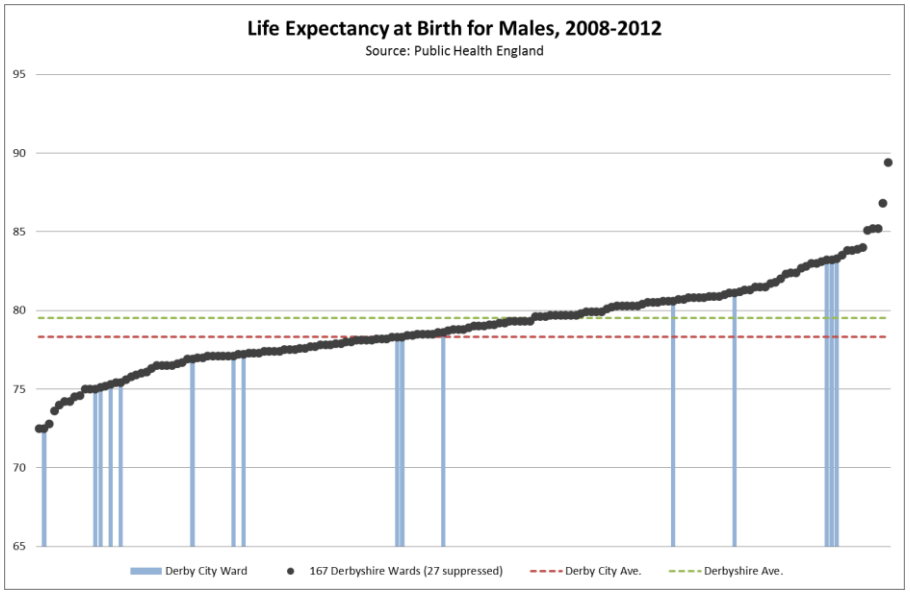
Whilst the graph shows Derbyshire, this trend is replicated in Derby.



The average male life expectancy in Derbyshire is comparable to the England average at 79.5 years (England 79.5 years), whilst in Derby a significantly lower life expectancy of 78.3 years is average.

There is a wide variation in life expectancy between Wards: with a gap of almost **17 years** between St Helen's Ward, Chesterfield at 72.5 years and Doveridge and Sudbury Ward, Derbyshire Dales at 89.4 years.

Among the five (of 167 Wards) with the lowest male life expectancy is Arboretum an inner city deprived area of Derby. Placed 11th, 12th and 13th respectively for highest male life expectancy are the Derby Wards of: Allestree, Mickleover and Littleover.



It should be noted that deprivation is not the only factor associated with reduced life expectancy. Certain groups have shorter life expectancy, including certain ethnic groups; those with severe and enduring mental health problems - with some studies reporting a gap of 14 - 20 yrs for males and 6 - 15 yrs for females, mostly attributable to cardiovascular and respiratory diseases and cancer. Compared to the general population, the biggest gaps are seen in substance abusers; people with learning disabilities who have shorter life expectancy and increased risk of early death when compared to the general population.

All cause mortality rates among people with moderate to severe learning disabilities are three times higher than in the general population, with mortality being particularly high for young adults, women and people with Down's syndrome.

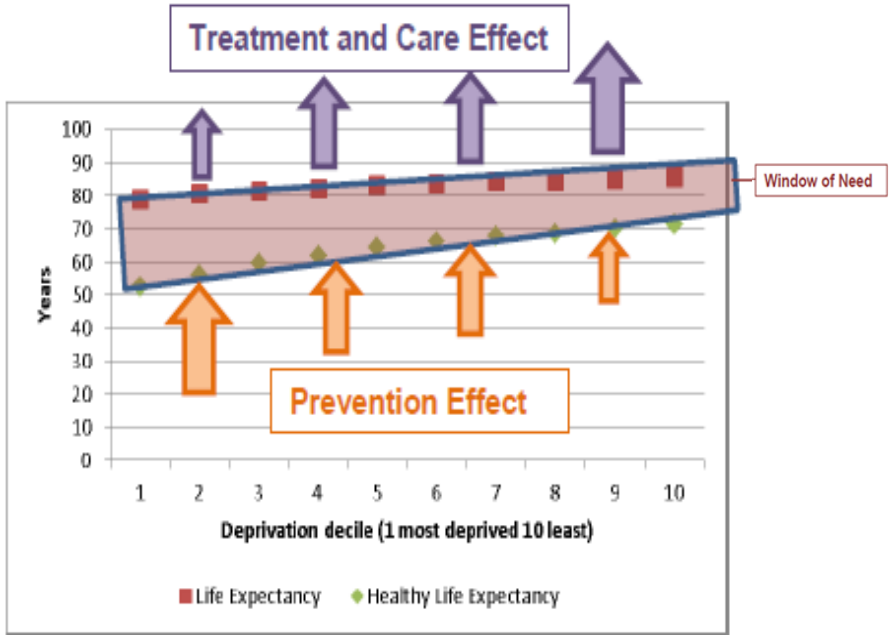
Understanding the Health and Wellbeing Gap

In addition, healthy life expectancy is decreasing with more people living longer in poor health – particularly women.

Healthy life expectancy

The chart below shows that both life expectancy and health life expectancy are affected by deprivation but it has a greater impact upon the length of time spent living with poor health and/or with disability.

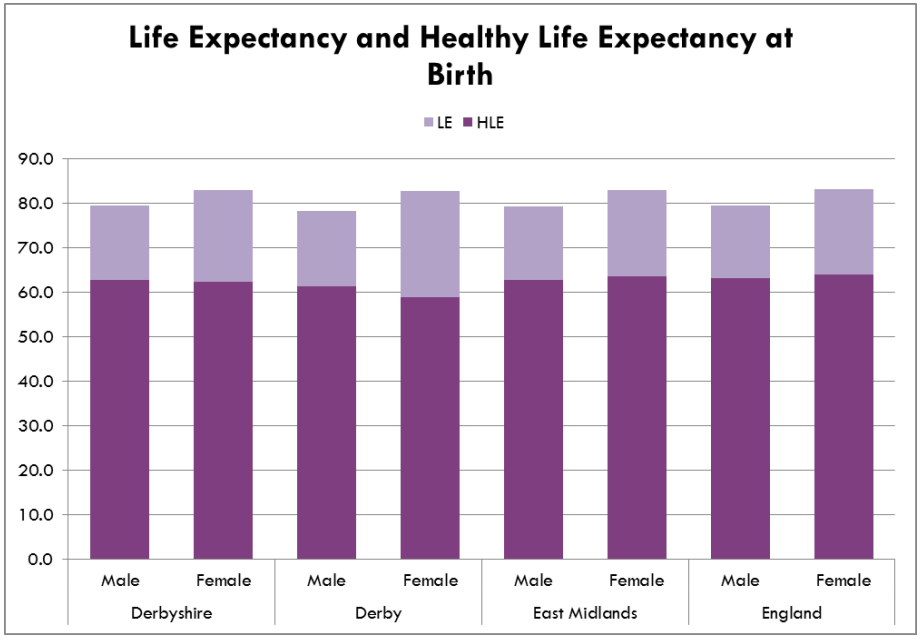
The life expectancy gap between the most and least deprived of the population is between just over 6 yrs (for women) and nearly 9 yrs (for men) in Derbyshire. For healthy life expectancy the gap is much wider at around 14 years for both men and women.



More people maintaining a healthy and independent life for longer reduces the 'window of need' (the period in people's lives when they require treatment and care).

The chart below shows the life expectancy and healthy life expectancy of both males and female in Derby and Derbyshire compared to the East Midlands and England.

Whilst women are living longer, the onset of 'ill health' starts around the same time as men meaning they are spending longer living in poor health – over 20 yrs for women in Derby.



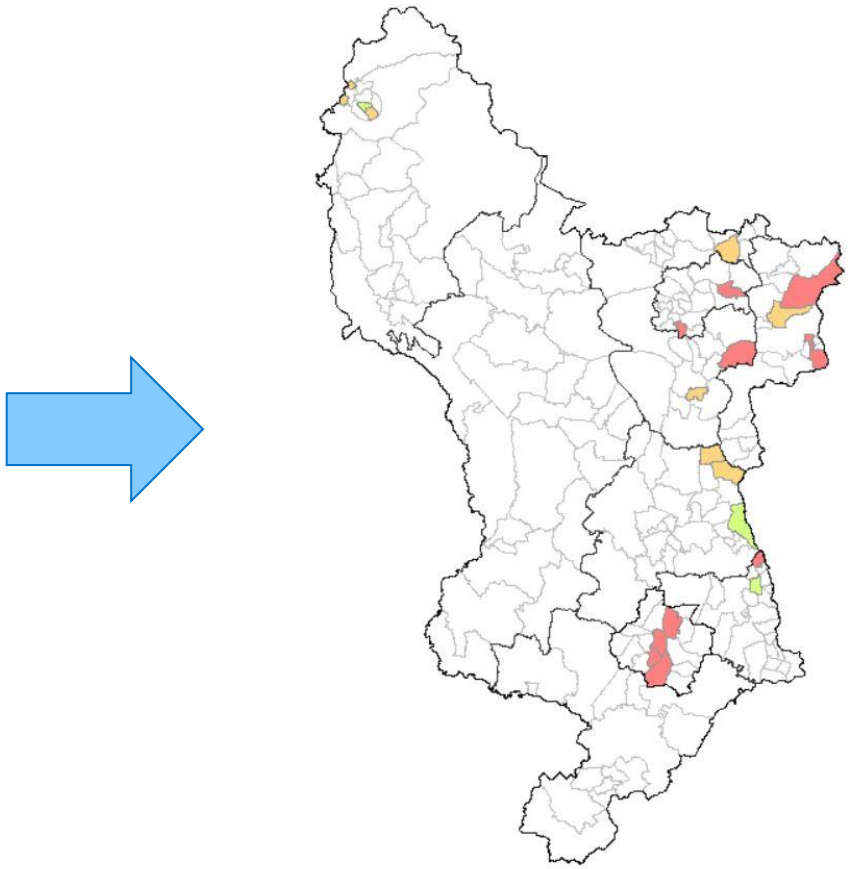
Understanding the Health and Wellbeing Gap

Across Derbyshire there are a number of communities where the health and wellbeing gap is greatest…

Most deprived wards across Derbyshire

Across Derbyshire the most deprived 10% of wards were identified against four indicators i) Male Life Expectancy ii) Female Life Expectancy iii) Limiting Long Term Illness iv) Income Deprivation. Theses wards together with the number of indicators against which they are in the bottom decile is shown below…

Ward	Count of Bottom 10
Elmton-with-Creswell; Bolsover, Derbyshire	3
Middlecroft and Poolsbrook; Chesterfield, Derbyshire	3
Derwent; Derby	3
Ilkeston North; Erewash, Derbyshire	3
Gamesley; High Peak, Derbyshire	2
Alfreton; Amber Valley, Derbyshire	2
Clay Cross South; North East Derbyshire, Derbyshire	2
Newhall and Stanton; South Derbyshire, Derbyshire	
Normanton; Derby	3
Sinfin; Derby	3
Arboretum; Derby	3
Shirebrook North West; Bolsover, Derbyshire	3
Rother; Chesterfield, Derbyshire	3
Shirebrook South East; Bolsover, Derbyshire	3
Holmewood and Heath; North East Derbyshire, Derbys	3
Eckington South; North East Derbyshire, Derbyshire	2
Bolsover South; Bolsover, Derbyshire	2
Hadfield North; High Peak, Derbyshire	2
Somercotes; Amber Valley, Derbyshire	2
Whitfield; High Peak, Derbyshire	2
Little Hallam; Erewash, Derbyshire	1
Howard Town; High Peak, Derbyshire	1
Langley Mill and Aldercar; Amber Valley, Derbyshire	1



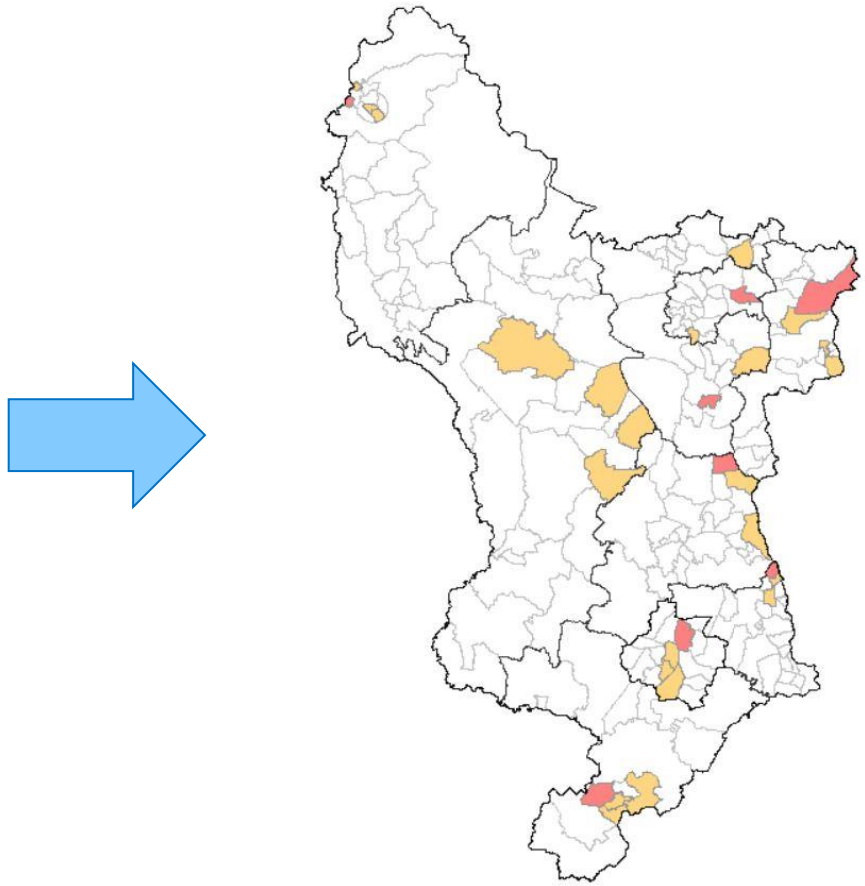
Understanding the Health and Wellbeing Gap

Across Derbyshire there are a number of communities where the health and wellbeing gap is greatest…

Most deprived wards in each district

For each of the nine districts across Derbyshire (Amber Valley, Bolsover, Chesterfield, Derby, Derbyshire Dales, Erewash, High Peak, North East Derbyshire and South Derbyshire) the most deprived 10% of wards were identified against four indicators i) Male Life Expectancy ii) Female Life Expectancy iii) Limiting Long Term Illness iv) Income Deprivation. Those wards that were identified across 3 or all 4 of the indicators are shown below.

Ward	Count of Ward
Elmton-with-Creswell; Bolsover, Derbyshire	4
Middlecroft and Poolsbrook; Chesterfield, Derbyshire	4
Derwent; Derby	4
Ilkeston North; Erewash, Derbyshire	4
Gamesley; High Peak, Derbyshire	4
Alfreton; Amber Valley, Derbyshire	4
Clay Cross South; North East Derbyshire, Derbyshire	4
Newhall and Stanton; South Derbyshire, Derbyshire	4
Normanton; Derby	3
Sinfin; Derby	3
Arboretum; Derby	3
Shirebrook North West; Bolsover, Derbyshire	3
Rother; Chesterfield, Derbyshire	3
Shirebrook South East; Bolsover, Derbyshire	3
Holmewood and Heath; North East Derbyshire, Derbys	3
Eckington South; North East Derbyshire, Derbyshire	3
Bolsover South; Bolsover, Derbyshire	3
Hadfield North; High Peak, Derbyshire	3
Somercotes; Amber Valley, Derbyshire	3
Whitfield; High Peak, Derbyshire	3
Little Hallam; Erewash, Derbyshire	3
Howard Town; High Peak, Derbyshire	3
Langley Mill and Aldercar; Amber Valley, Derbyshire	3
Wirksworth; Derbyshire Dales, Derbyshire	3
Church Gresley; South Derbyshire, Derbyshire	3
Matlock St Giles; Derbyshire Dales, Derbyshire	3
Cotmanhay; Erewash, Derbyshire	3
Swadlincote; South Derbyshire, Derbyshire	3
Darley Dale; Derbyshire Dales, Derbyshire	3
Bakewell; Derbyshire Dales, Derbyshire	3
Woodville; South Derbyshire, Derbyshire	3



Causes of Health and Wellbeing Gap – Healthy Behaviours

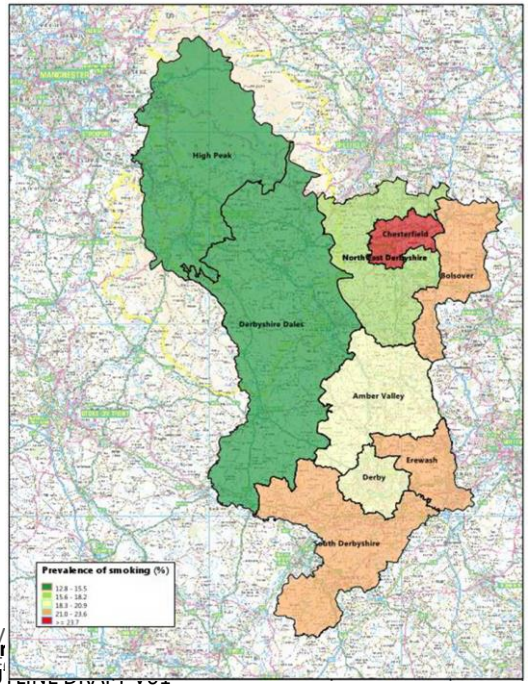
There are a range of factors that significantly contribute to the gap : premature mortality; to living in poor health; and the health and wellbeing gap. These factors include: lifestyle and individual behaviours such as smoking, obesity and alcohol consumption and wider determinants such as poverty, poor housing etc.

Lifestyle and behaviour

The table below shows the variation in lifestyle and behaviour between the most and least deprived areas of Derbyshire. Almost all are notably higher in the deprived communities. An interesting exception is binge drinking which is slightly higher in the least deprived communities.

Healthy behaviour	Most deprived 10%	Average	Least deprived 10%	National	Percentage difference
Healthy eating adults	22.1	28.8	34.9	28.7	57.9
Binge drinking adults	19.5	21.3	20.5	20.1	5.1
Under-18 conceptions	2.9	2.0	0.2	1.5	1349.9
Regular smokers (aged 15)	12.4	9.8	7.9	8.7	57.0
Obese adults	27.4	24.9	21.2	24.2	29.2
Obese children in reception	10.0	8.8	7.0	9.4	42.9
Obese children in Year 6	22.7	18.0	13.6	19.1	66.9

Smoking



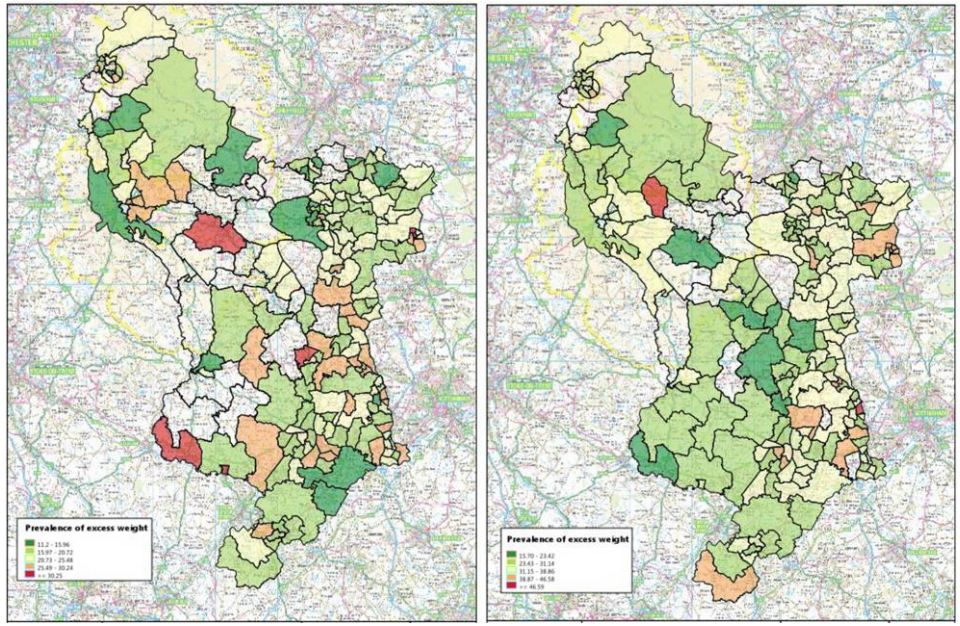
Across the county, there appears to be an almost "left-right" split in the prevalence of current smokers across the districts. Whilst the High Peak and Derbyshire Dales districts have the lowest proportions, Chesterfield (26.4%) and South Derbyshire (23.5%) have the highest.

Although Derby city appears to have a modest proportion in comparison, there are variations between groups – 18.7% of all adults aged 18 or over smoke compared to 33.1% in those with routine and manual occupations.

Obesity

The proportion of adults classified as overweight or obese within Derbyshire districts ranges from 62.2% in High Peak up to 73.4% in Chesterfield. There are also large variations within the city and the Districts. For example, in Derby, the proportion of obese adults ranges from 15.5% in Darley ward up to 28.3% in Sinfin ward.

Excess weight in children - Reception year ***Excess weight in children – Year 6***



Overall levels of excess weight in children in Derby and Derbyshire are comparable to the national average. The maps above ,however, demonstrate variations by area.

The level of excess weight in children in Reception Year – aged just 4/5 years suggests that obesity levels will be a growing problem.

Causes of Health and Wellbeing Gap – Disease Prevalence

Disease Prevalence

The table below shows disease prevalence as recorded in practices through the Quality Outcomes Framework (QOF) aggregated into the most and least deprived 10%.

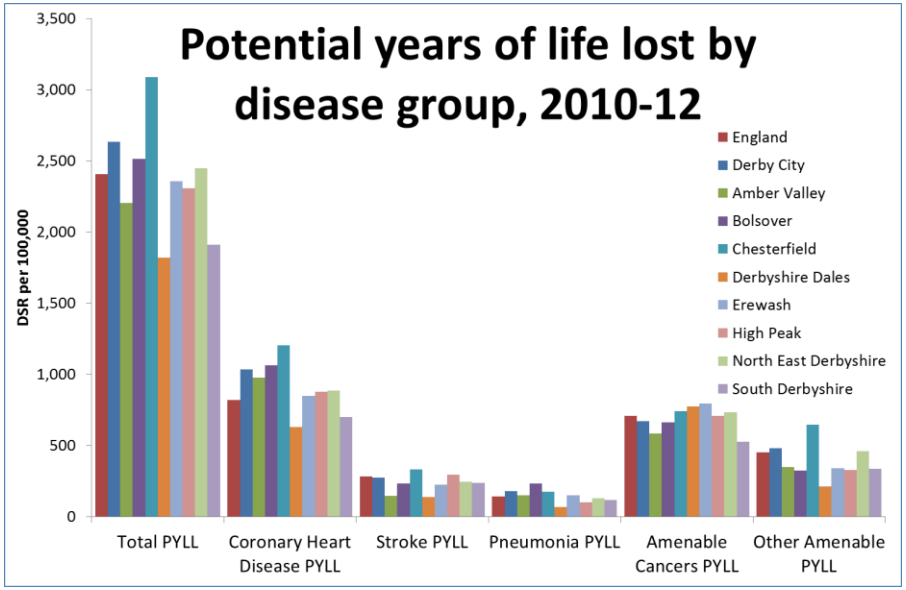
Some of the highest prevalence levels appear in the least deprived areas. It is difficult to know whether this accurately reflects the reality or is a result of the level and quality of reporting.

QOF Group	Disease Area	Most deprived 10%	Derbyshire Ave.	Least deprived 10%	National Ave.	Gap
Cardio-vascular	Cardiovascular Disease	0.5%	0.6%	0.6%	1.1%	-0.5%
	Stroke / TIA	1.5%	2.0%	2.3%	1.7%	0.3%
	Atrial Fibrilation	1.2%	1.9%	2.2%	1.6%	0.3%
	Coronary Heart Disease	3.1%	3.8%	3.8%	3.3%	0.6%
	Heart Failure	0.7%	0.9%	1.1%	0.7%	0.2%
	Hypertension	13.2%	15.3%	15.4%	13.8%	1.5%
	Peripheral Arterial Disease	0.6%	0.7%	0.6%	0.6%	0.1%
Respiratory	Asthma	6.0%	6.4%	6.4%	6.0%	0.4%
	COPD	2.0%	2.1%	1.5%	1.8%	0.3%
Lifestyle	Obesity	9.6%	9.8%	7.5%	9.0%	0.8%
High Dependency	Diabetes	8.3%	7.0%	5.6%	6.4%	0.6%
	Cancer	1.5%	2.4%	3.0%	2.3%	0.1%
	Chronic Kidney Disease	4.1%	5.2%	5.5%	4.1%	1.1%
	Palliative Care	0.2%	0.5%	0.6%	0.3%	0.2%
Mental Health	Dementia	0.7%	0.9%	0.9%	0.7%	0.2%
	Depression	6.8%	8.2%	5.8%	7.3%	0.9%
	Learning Disability	0.9%	0.6%	0.3%	0.4%	0.2%
	Epilepsy	0.9%	0.9%	0.7%	0.8%	0.1%
	Mental Health	1.0%	0.8%	0.6%	0.9%	-0.1%
MSK	Osteoporosis	0.1%	0.2%	0.2%	0.2%	0.0%
	Rheumatoid Arthritis	0.7%	0.8%	0.8%	0.7%	0.1%

Potential years of life lost

This chart shows that across the districts that the greatest number of years of life lost relate to coronary heart disease and amenable cancers. It demonstrates that there is significant opportunity to save years of life by tackling the conditions, and their causes, that are preventable and amenable to health care.

It should be noted that there is, however, variation between areas.



Closing the gap

The health and wellbeing gap is not inevitable and it is preventable. There are a range of factors that significantly contribute to: premature mortality; to living in poor health; and in the health and wellbeing gap. These factors include: lifestyle and individual behaviours such as smoking, obesity and alcohol consumption and wider determinants such as poverty and deprivation, poor housing etc.

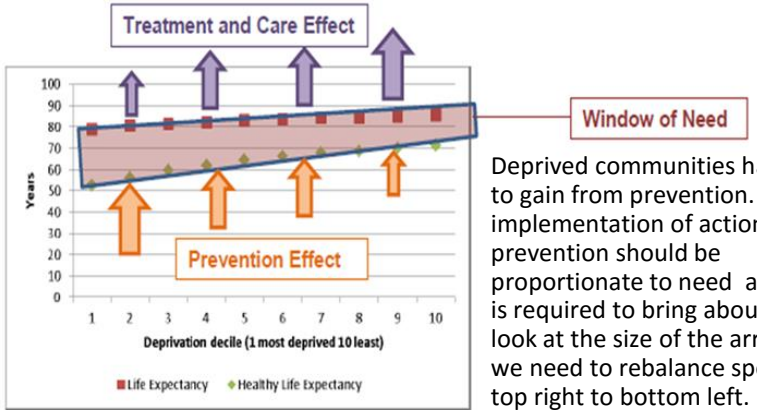
Closing the health and wellbeing gap requires action in the following areas:

- **Prevention** (primary and secondary) – to tackle the fundamental causes of the HWB gap;
- **Early intervention** – early identification of risk and disease onset;
- **Mitigation of variation** – tackling variations in access, quality and delivery of services.

Focusing on prevention

"The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness" (*Five Year Forward View*, 2014, p.7).

Our aim is not just to extend life (the 'treatment and care' effect) but also, through primary and secondary prevention, to reduce the time spent in poor health - the 'prevention effect'.



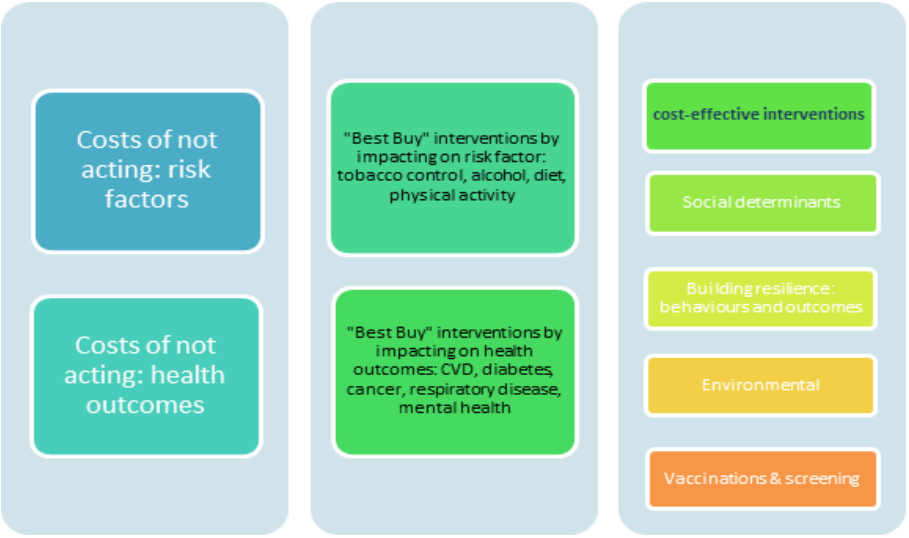
Deprived communities have most to gain from prevention. The implementation of action on prevention should be proportionate to need and to what is required to bring about change – look at the size of the arrows - i.e. we need to rebalance spend from top right to bottom left.

Evidence demonstrates wellbeing services and prevention can be the most cost-effective way to maintain the health of a population in a sustainable manner and some interventions produce returns on investment in the short term.

Focusing on prevention

Prevention will save the NHS money over time by reducing use of services; conversely costs of not acting to address the challenges will cost money, e.g., smoking related conditions cost the NHS more than £5 billion/year (2009).

Benefits of prevention/wellbeing measures are not restricted to the NHS, as gains are seen in other sectors such as the economy.



Opportunities in health and social care

- Early diagnosis and intervention (e.g. screening & immunisation uptake);
- Effective disease management;
- Tackling unwarranted variation;
- Promoting lifestyle and behaviour change;
- Supporting the 'promoters of wellbeing' e.g. resilience, community networks, community capital etc.

General Practice Workforce

Andrew See
Strategic Workforce Development Manager

Introduction

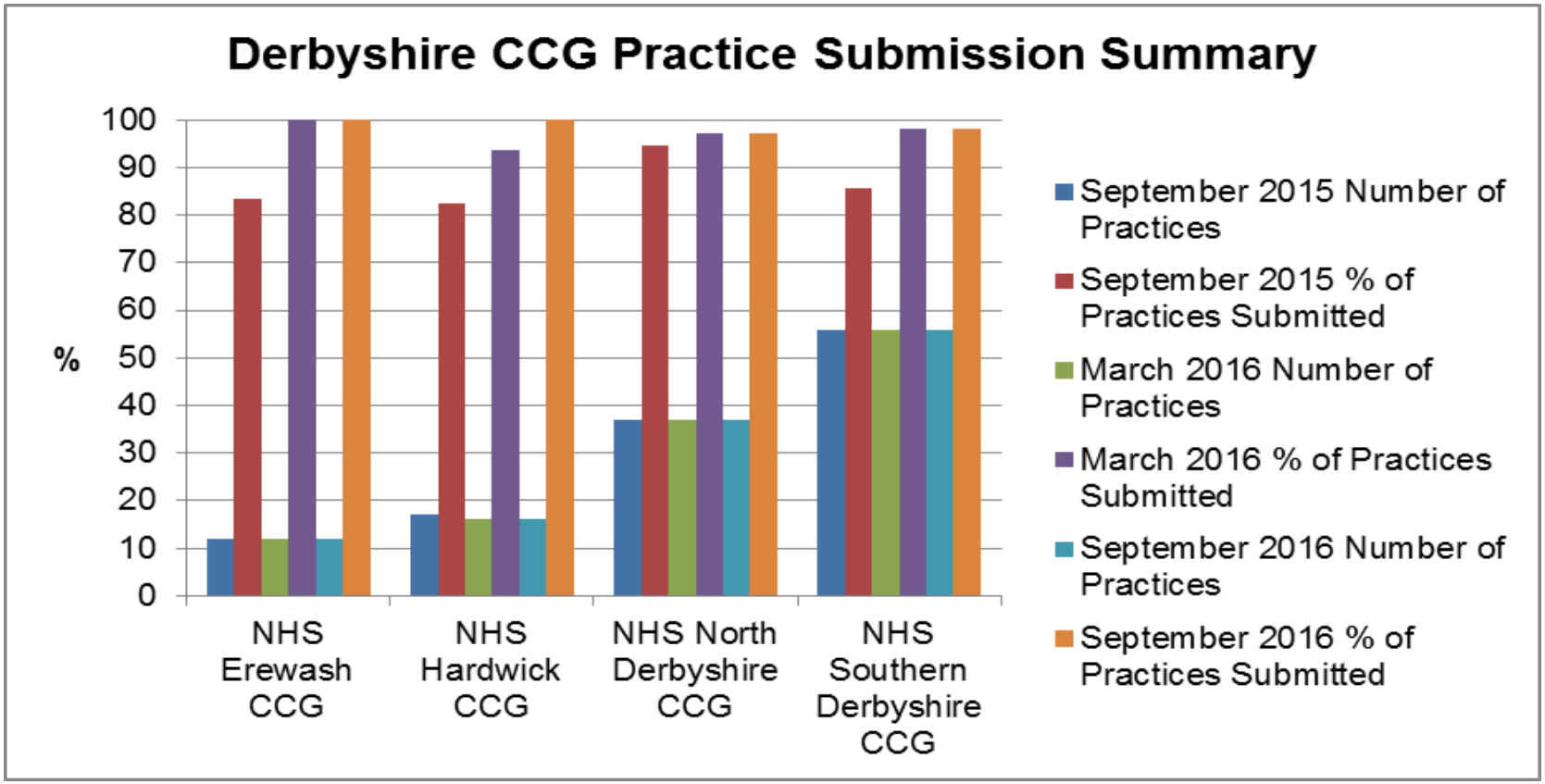
- General Practice workforce data is collected quarterly via a mandated submission process managed by NHS Digital, formerly the Health and Social Care Information Centre (HSCIC).

- This report combines the results of the March 2016 collection published on 27 September 2016 (all job roles) and September 2016 collection published on 25 January 2017 (solely GP).

- Across Derbyshire, NHS Digital identified that 98.3% of eligible general practices submitted a return in September 2016, with a further 3.3% of practices having estimates applied as a result of data quality issues.

- The main body of this report details analysis solely from data provided by submitting practices, rather than the estimated data published by NHS Digital. This ensures consistency with the workforce that has been described by Derbyshire general practices.

Practice Submission Summary



Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – September 2015, March 2016 and September 2016

Summary

Across Derbyshire:-

Including estimates

	September 2015		March 2016		September 2016	
	Headcount	FTE	Headcount	FTE	Headcount	FTE
GP	756	636	705	595	722	594
GP (excluding Registrars, Retainers & Locums)	684	570	647	550	655	541
Nurses	497	343	479	335		
Direct Patient Care	275	170	261	165		
Admin/Non Clinical Staff	1,863	1,277	1,863	1,293		

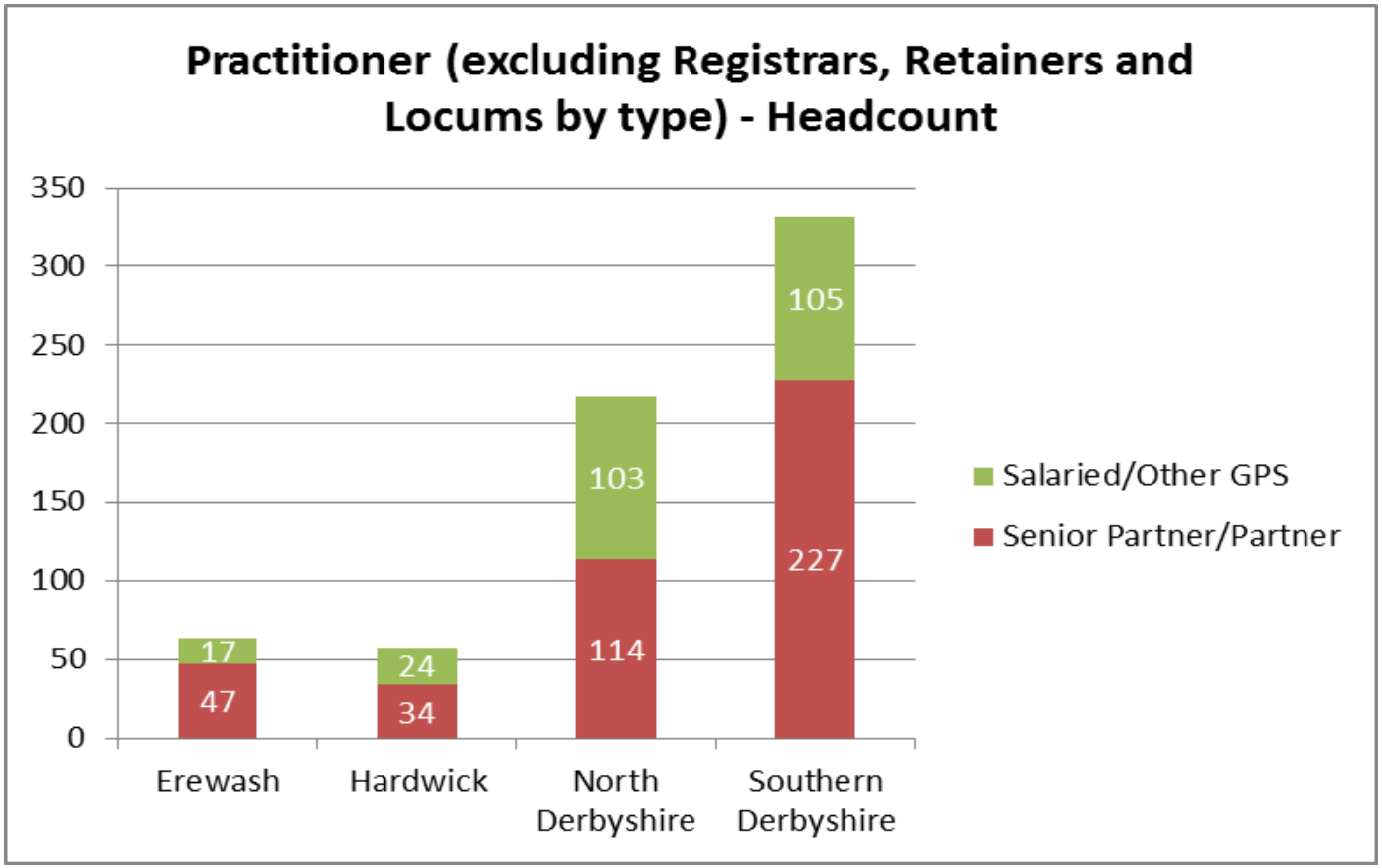
Excluding estimates

	September 2015		March 2016		September 2016	
	Headcount	FTE	Headcount	FTE	Headcount	FTE
GP	677	568	704	588	682	557
GP (excluding Registrars, Retainers & Locums)	608	507	647	543	618	506
Nurses	448	309	483	331		
Direct Patient Care	246	151	264	163		
Admin/Non Clinical Staff	1,666	1,142	1,837	1,269		

Total number of Practices	122	120	121
Number of Practices excluding estimates	106	118	115

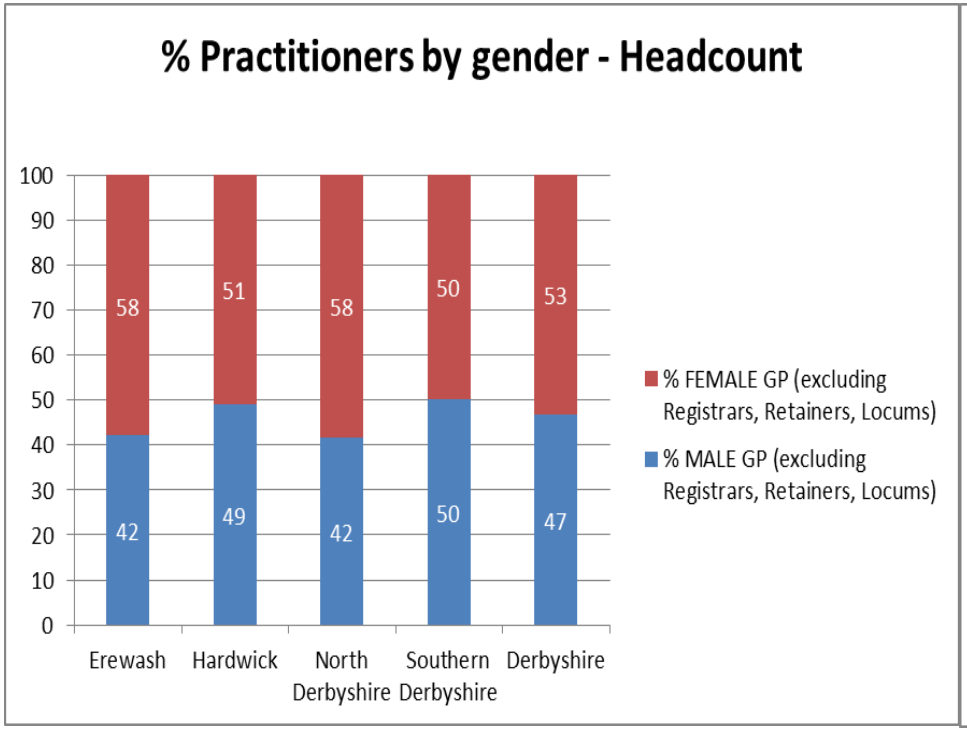
Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – September 2015, March 2016 & September 2016

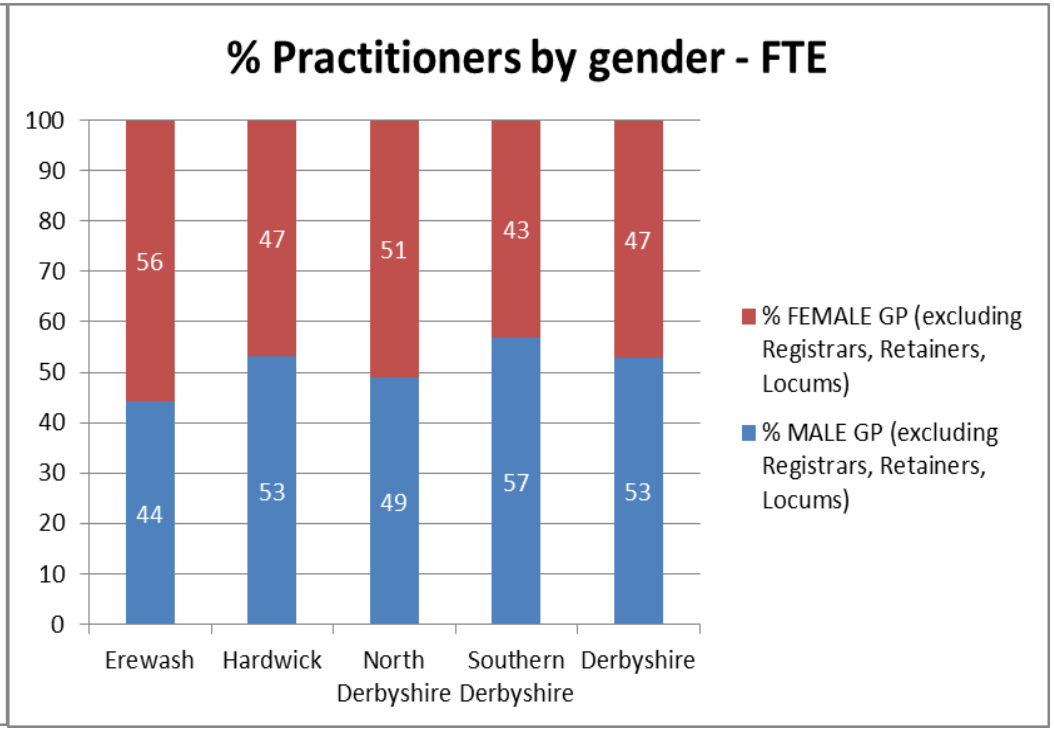
Practitioners by type



Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – September 2016

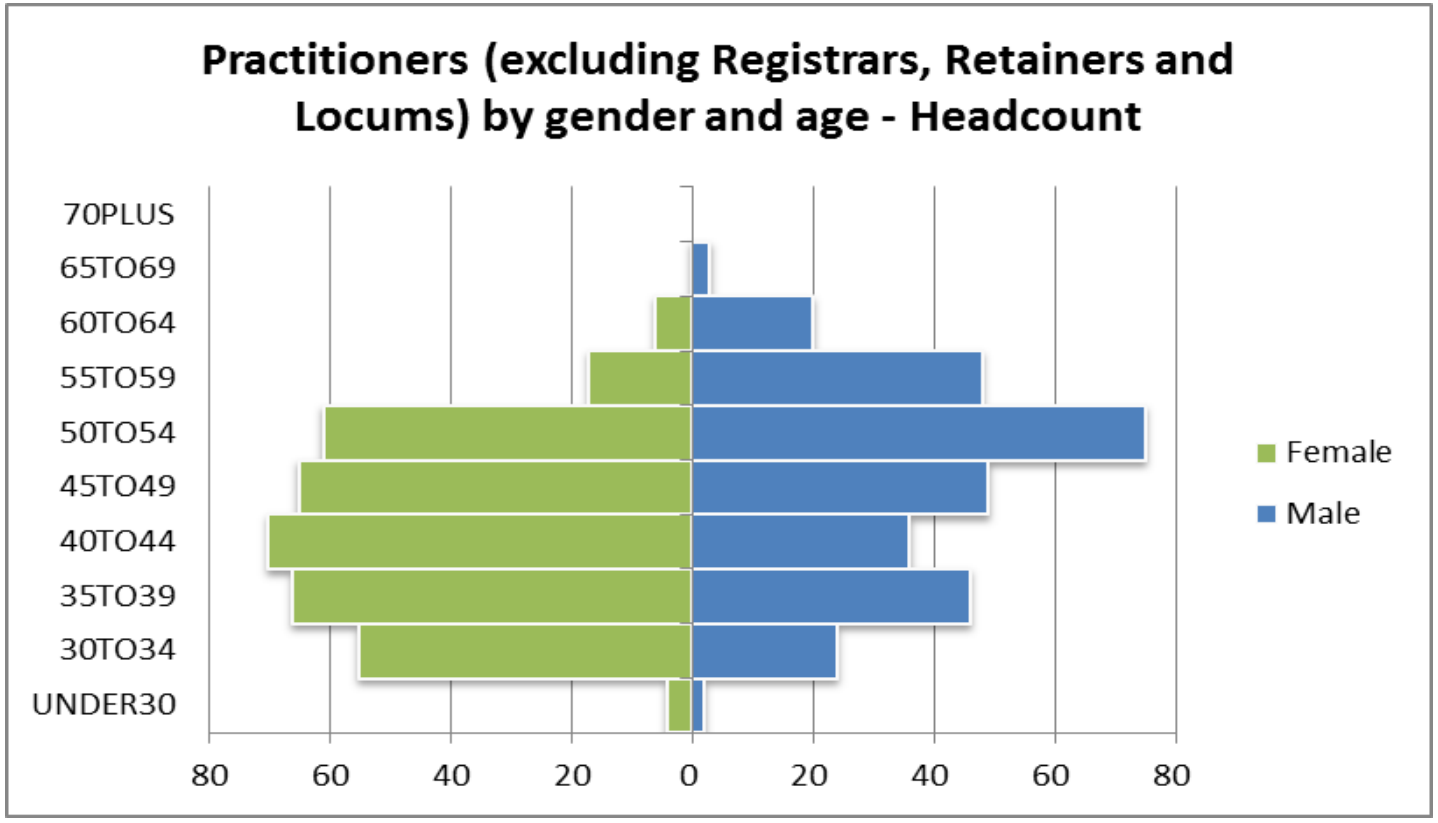
Practitioners by gender





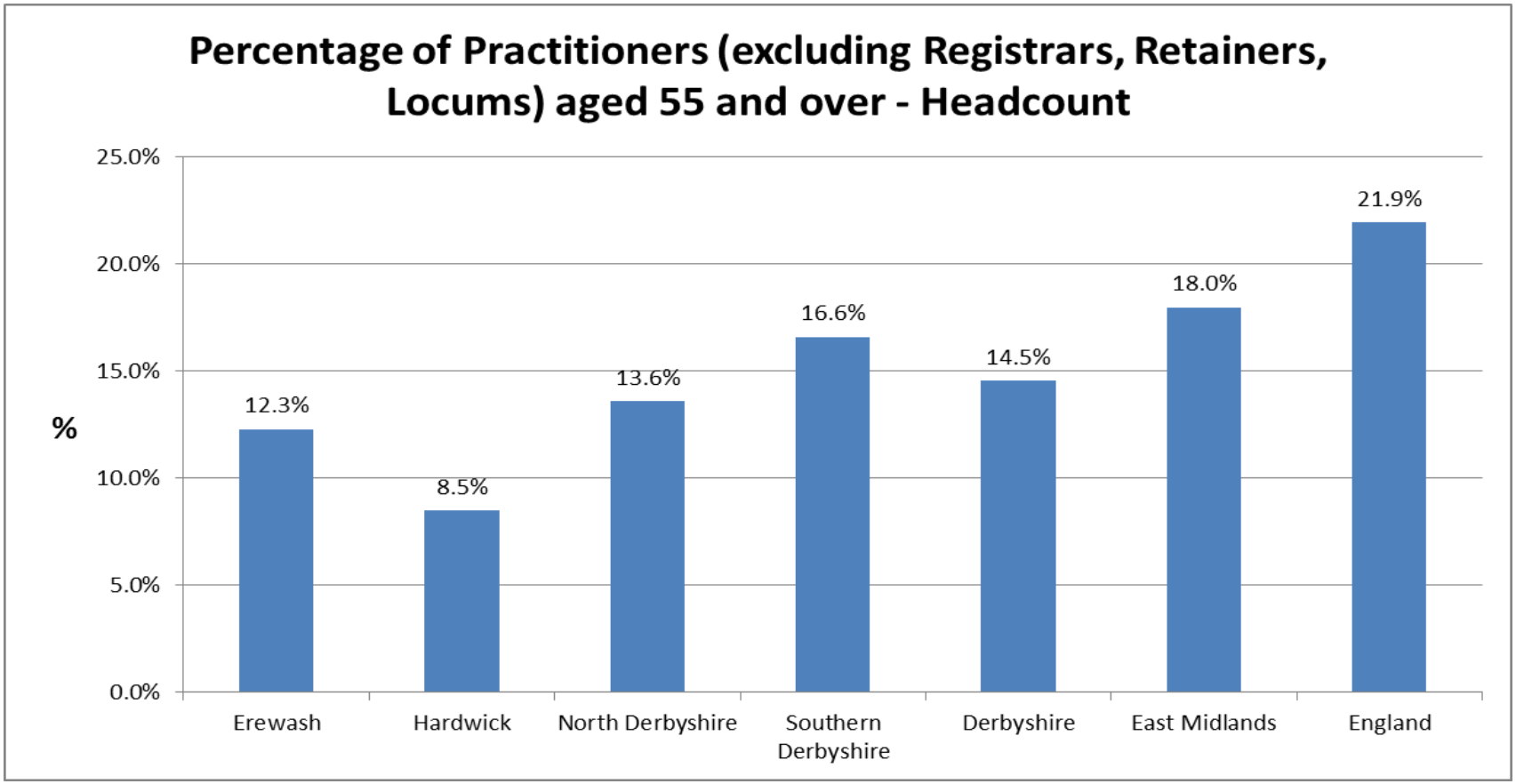
Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – March 2016

Practitioners (excluding Registrars, Retainers, Locums) by Gender and Age



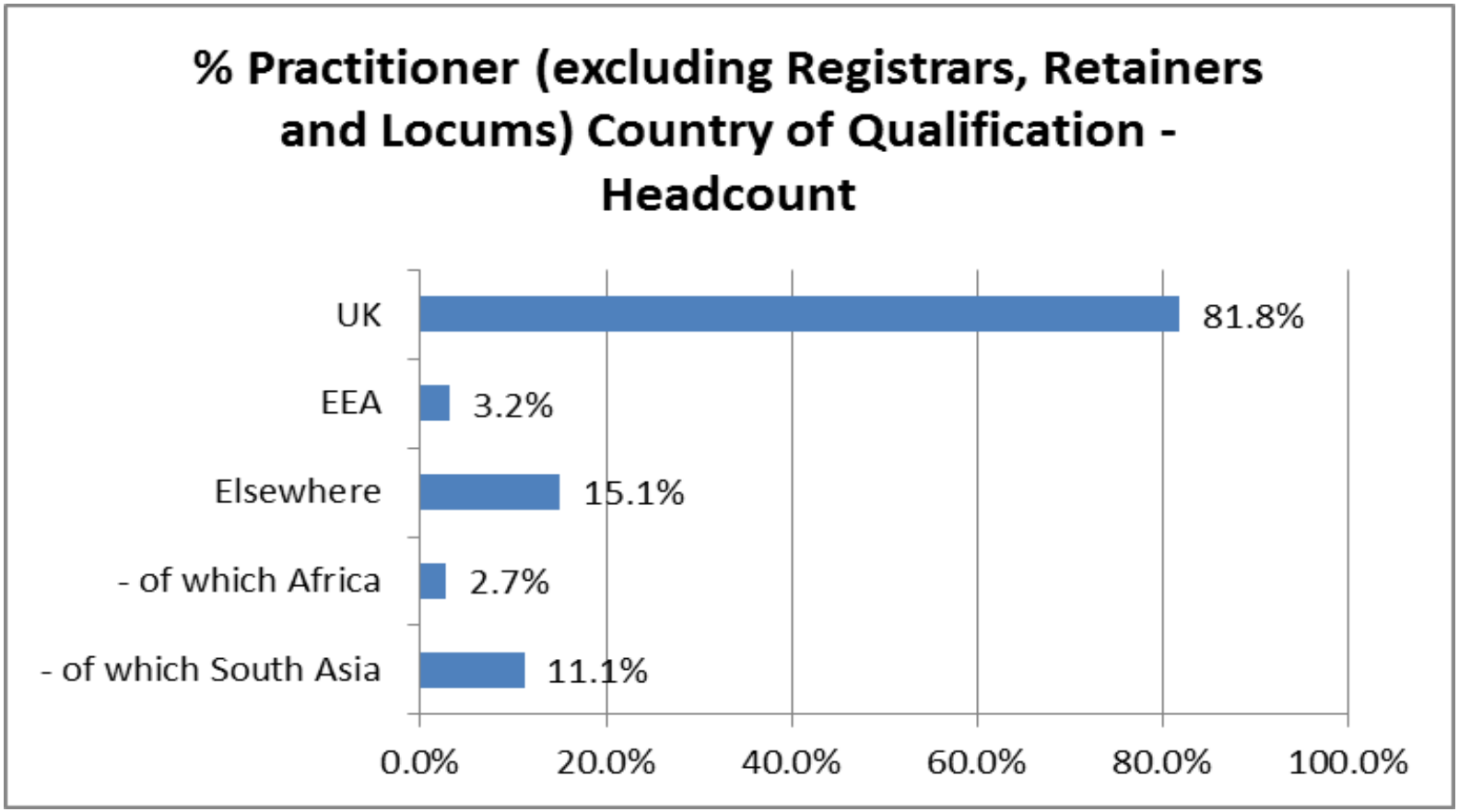
Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – March 2016

Percentage of Practitioners (excluding Registrars, Retainers, Locums) aged 55 and over



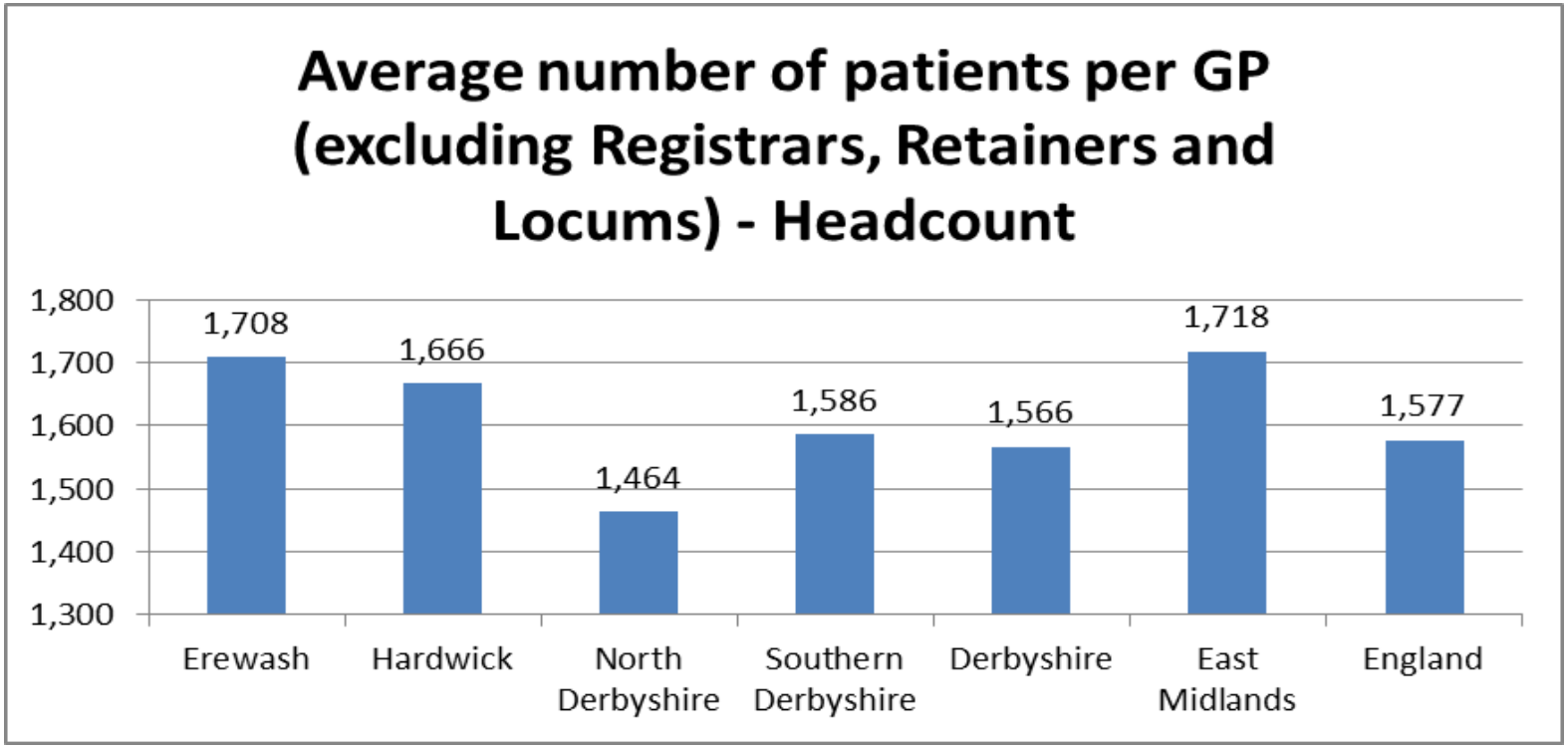
Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – March 2016

Country of Primary Medical Qualification (PMQ)



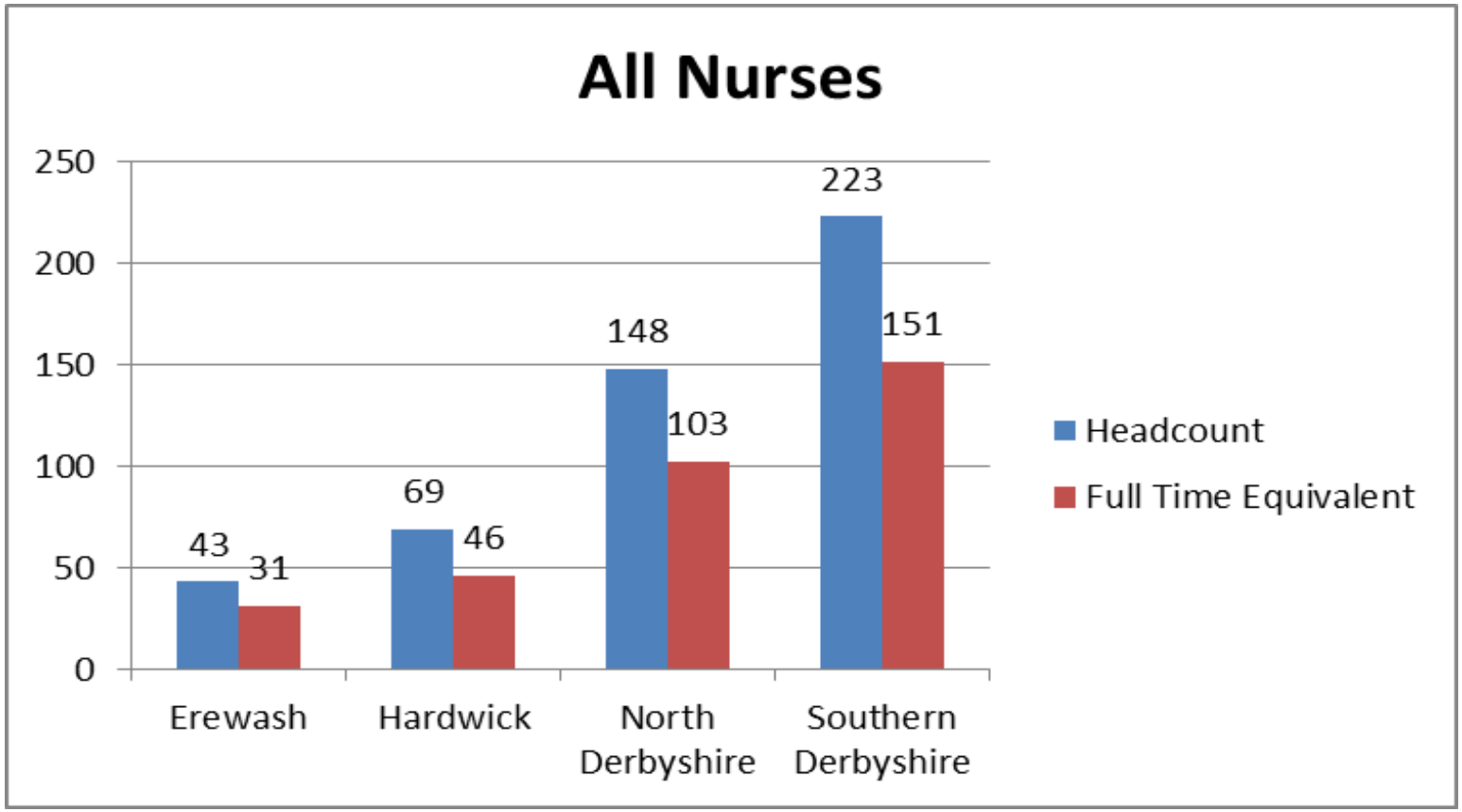
Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – March 2016

Average number of patients per practice (excluding Registrars, Retainers and Locums) - Headcount



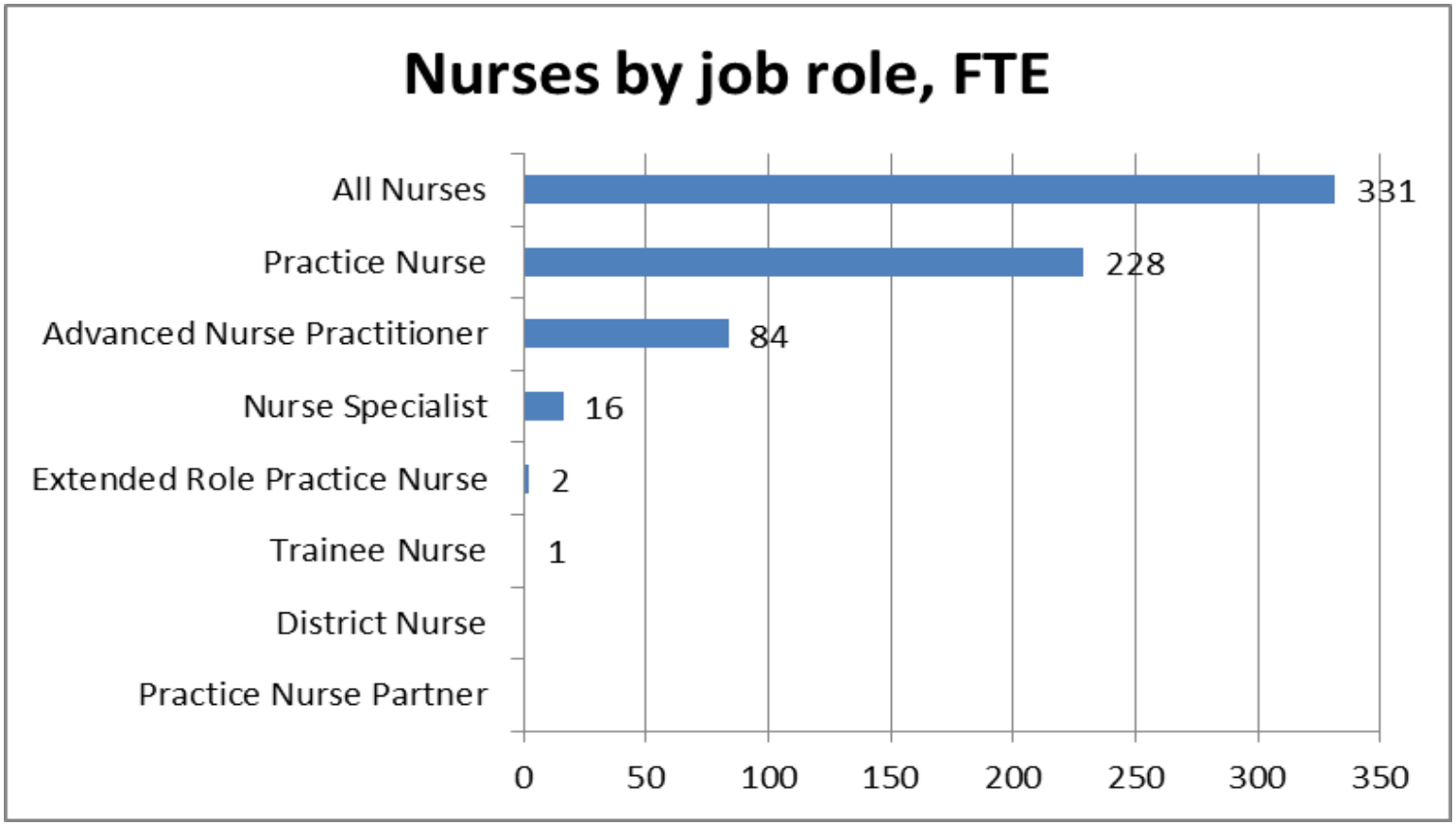
Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – March 2016

All Nurses



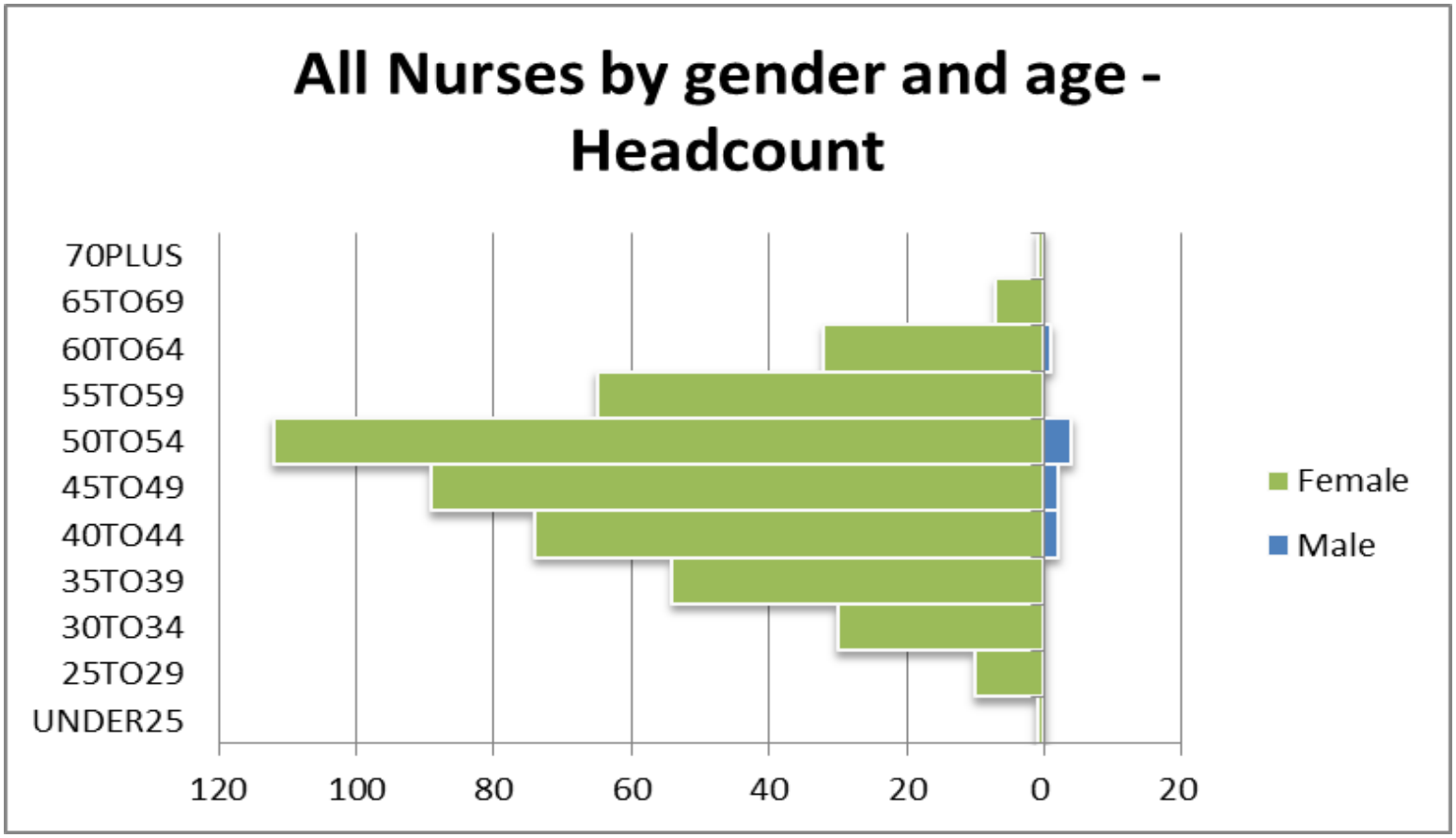
Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – March 2016

Nurses by job role



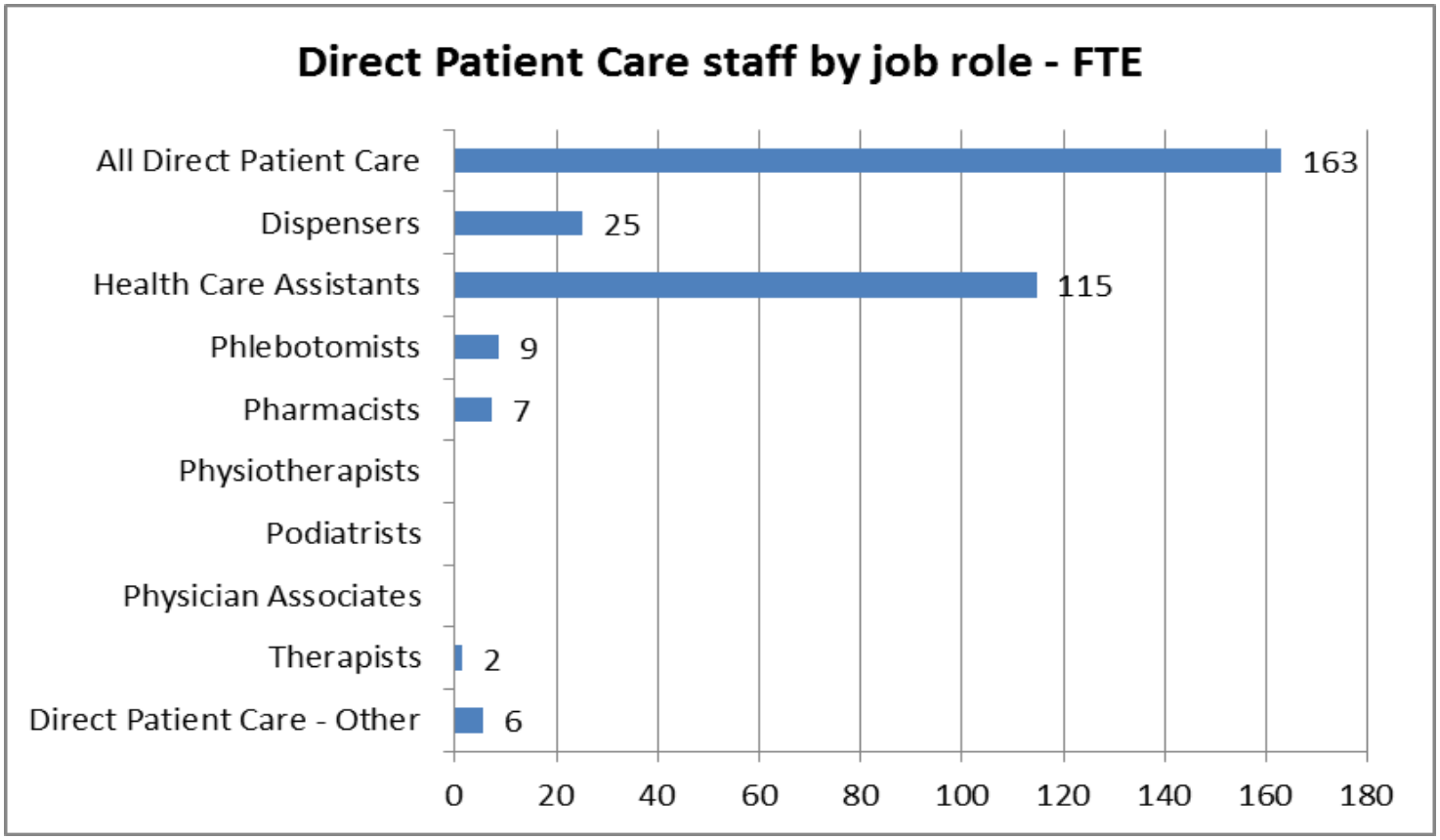
Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – March 2016

All Nurses by gender and age



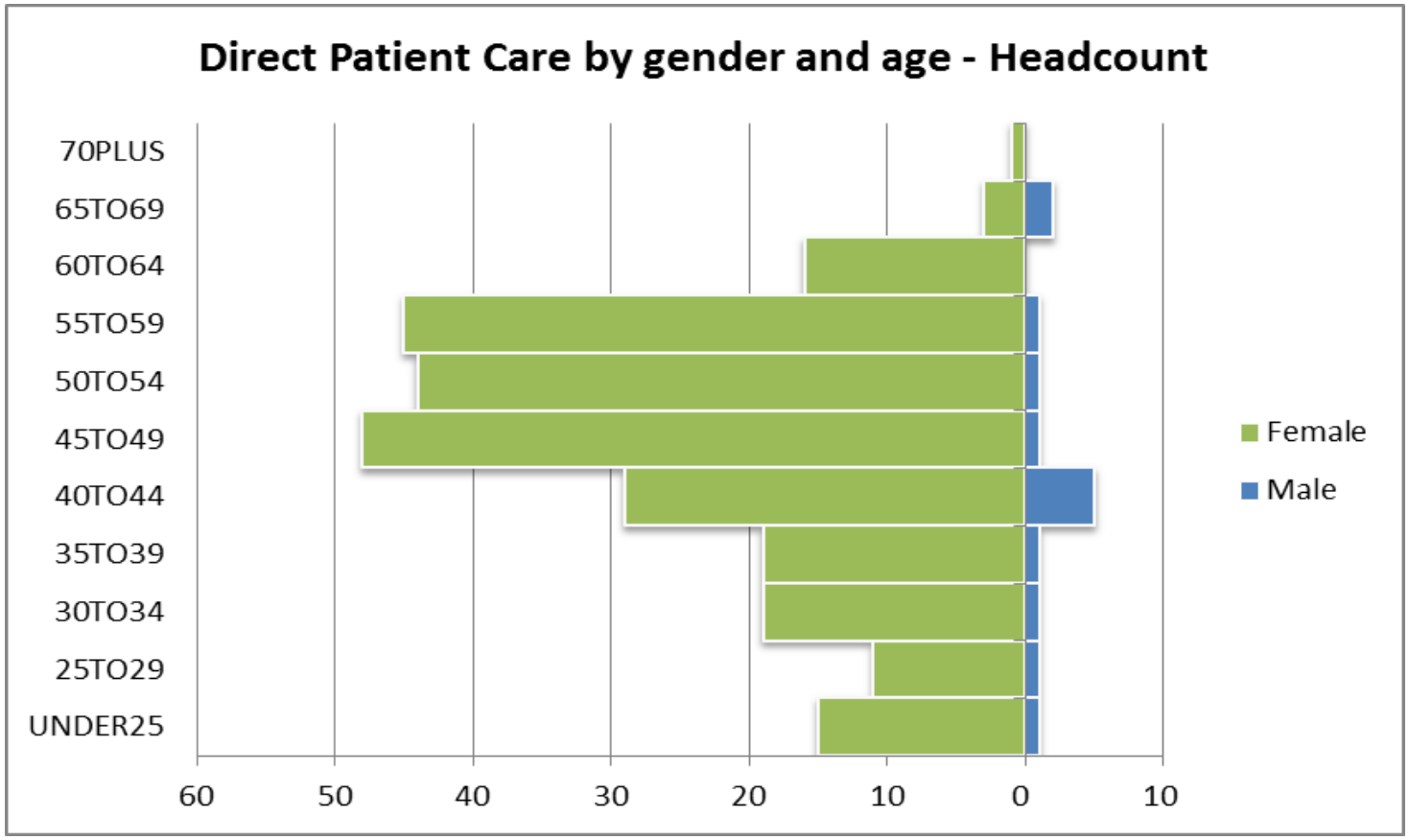
Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – March 2016

Direct Patient Care Staff by Job Role



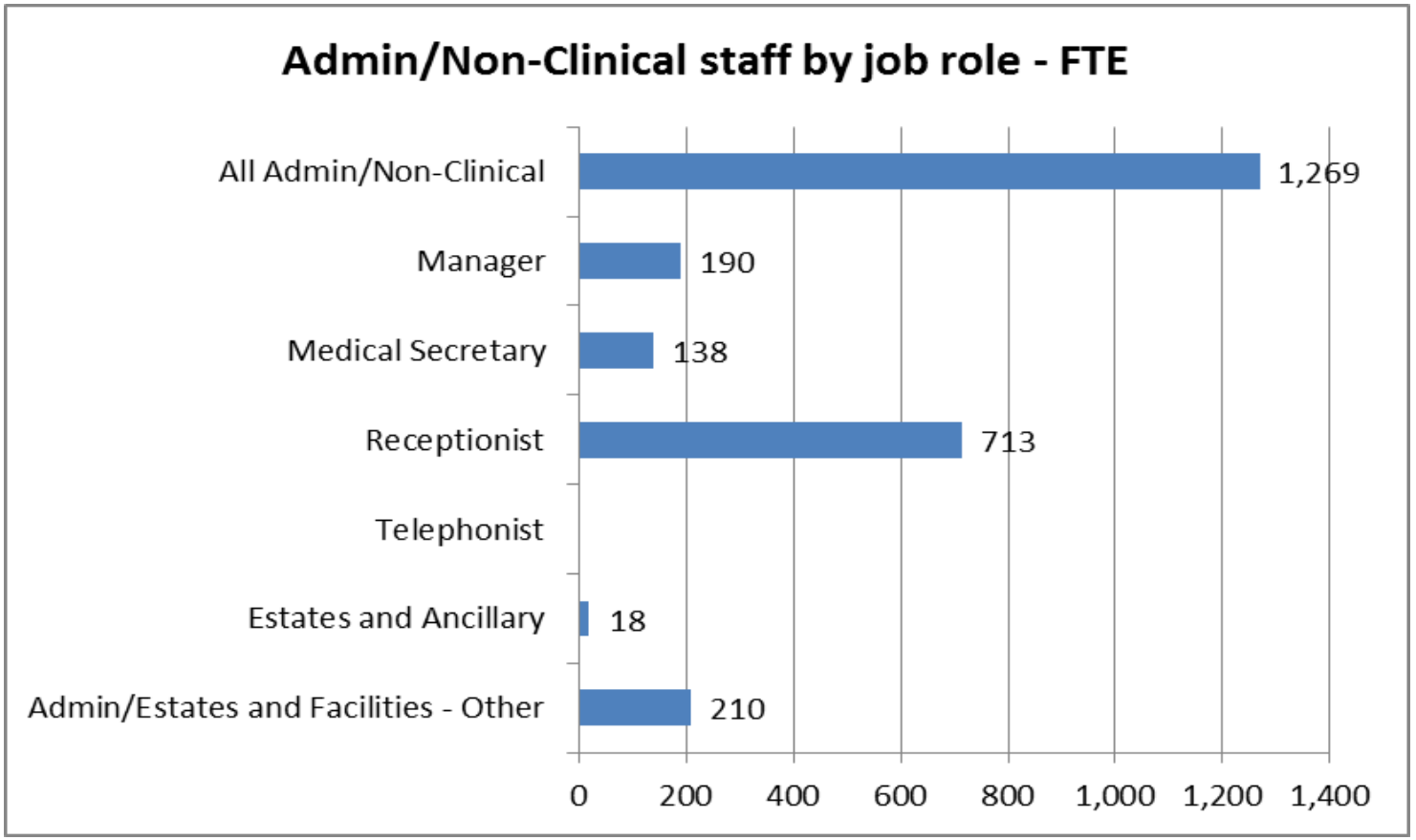
Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – March 2016

Direct Patient Care staff by gender and age



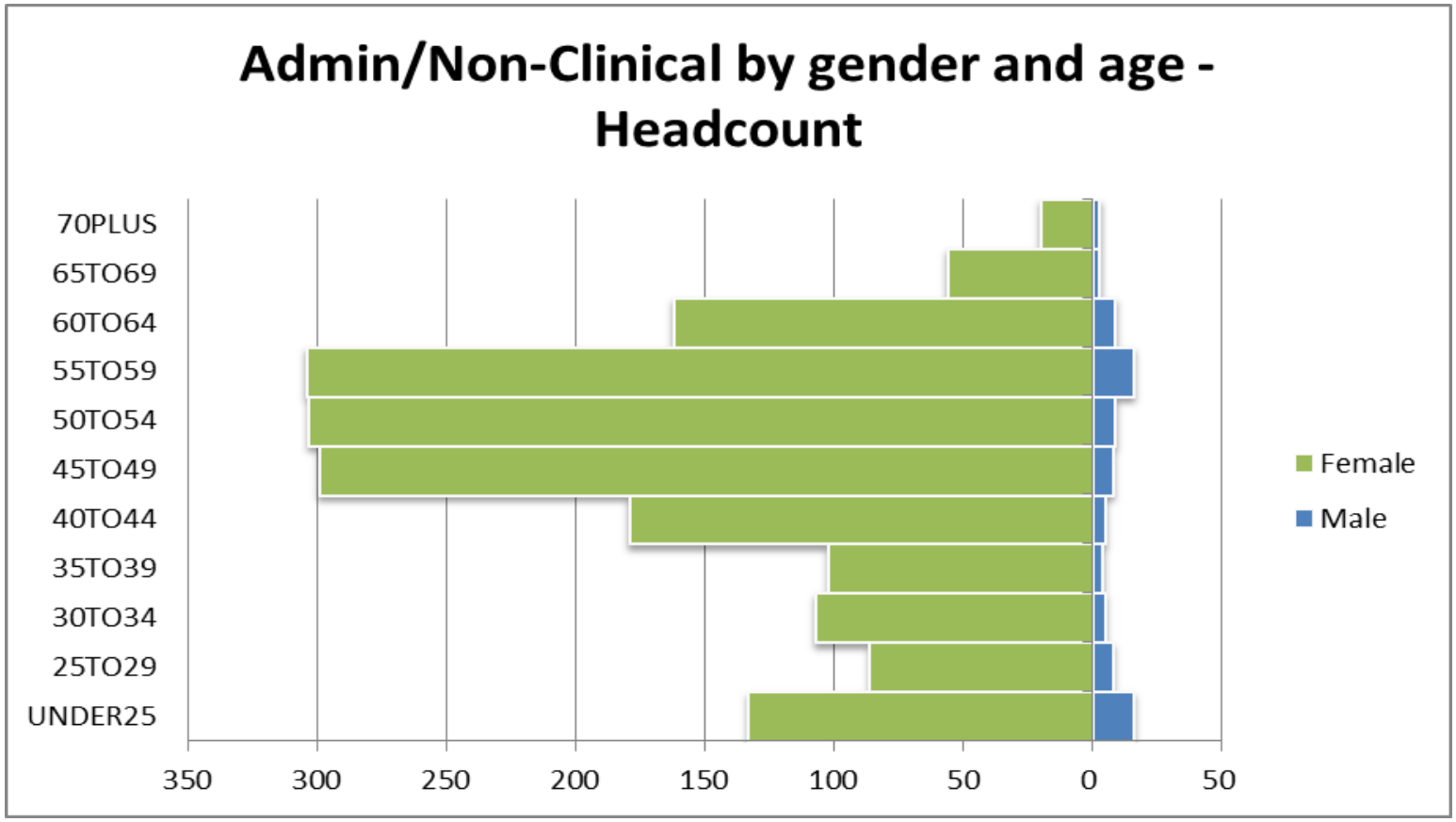
Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – March 2016

Admin/Non-Clinical staff by job role



Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – March 2016

Admin/Non-Clinical by gender and age



Source: Health and Social Care Information Centre, General and Personal Medical Services workforce statistics – March 2016

Appendix 2b – Midlands and East GP Supplier Forecast Model – Scenario 1

Midlands and East GP
2017-2022 Supply Forecast Model – Derbyshire STP

Andrew See - Strategic Workforce Development Manager

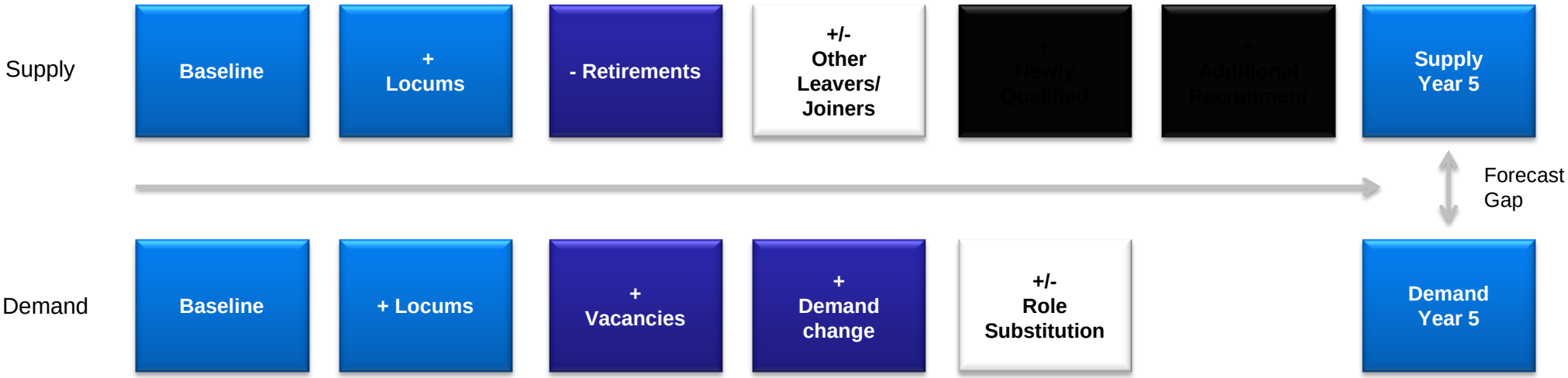
Purpose

- The purpose of the GP supply forecast model is to inform the development of CCG level GP Forward View workforce plans for 2017 – 2019 and facilitate discussions about workforce solutions required to bridge the gap between forecast supply and demand.
- The model will assist with the following:
    - Baseline for General Practice workforce across all sub groups;
    - Forecast supply for General Practitioners (GPs) under chosen supply assumptions;
    - Forecast gap in supply of GPs under chosen demand and supply assumptions;
    - Forecast recruitment levels of other staff working in General Practice required to match future demand.

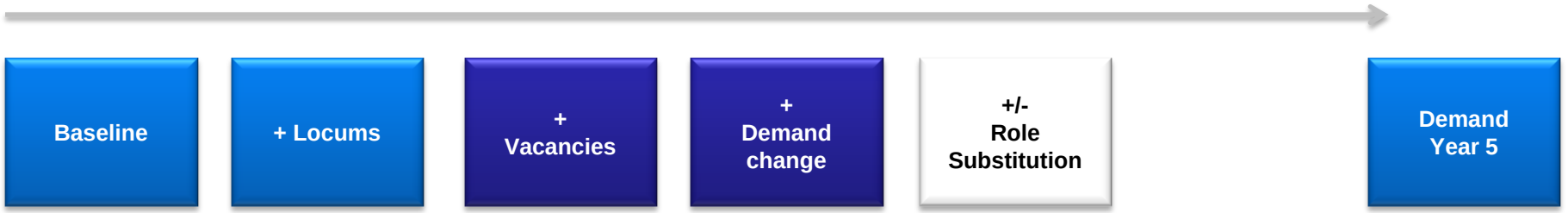
Model Components

- Baseline
- Supply Composition
- Demand Composition

Supply and Demand Composition



Demand



Rate % entered by user

There are 3 options to model demand:

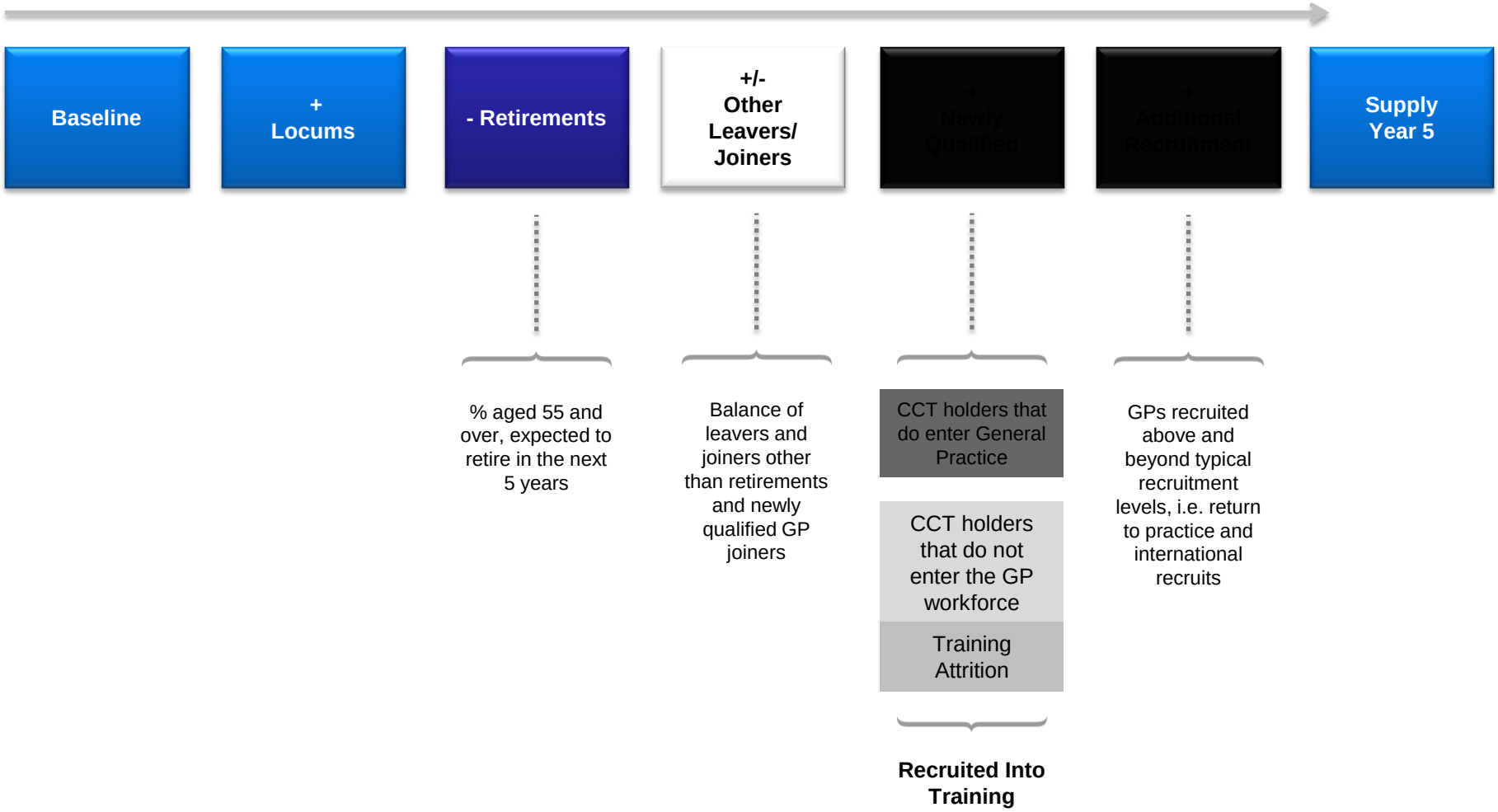
1. In line with change in under 10 and over 55 population

2. CCG workforce Plan

3. GP workload reduced to national average level

Moderate demand forecast by applying assumptions about workforce role substitution. The workforce role substitution entails transfer of workload from one sub group to another at a set substitution rate.

Supply


Baseline
+ Locums
- Retirements
+/- Other Leavers/ Joiners
+ Newly Qualified
+ Additional Recruitment
Supply Year 5
% aged 55 and over, expected to retire in the next 5 years
Balance of leavers and joiners other than retirements and newly qualified GP joiners
CCT holders that do enter General Practice
CCT holders that do not enter the GP workforce
Training Attrition
Recruited Into Training
GPs recruited above and beyond typical recruitment levels, i.e. return to practice and international recruits

GPs vs Other Staff in the model

In the model, certain assumptions are only applied to GPs, these are detailed below:

	Assumption	GP	All other staff
Supply	Locum %	✓	
Supply	Retirement Rate	✓	✓
Supply	CCT holders not joining GP workforce	✓	
Supply	GP other leavers/joiners	✓	
Supply	Additional Recruitment	✓	
Demand	Vacancies	✓	✓
Demand	Demand Growth:		
	Population Change	✓	✓
	Workforce Plan	✓	✓
	Average workload	✓	
Demand	Role Substitution	✓	✓

Appendix 2c – Midlands and East GP Supplier Forecast Model – scenario 2

Midlands and East GP
2017-2022 Supply Forecast Model – Derbyshire STP

Andrew See - Strategic Workforce Development Manager

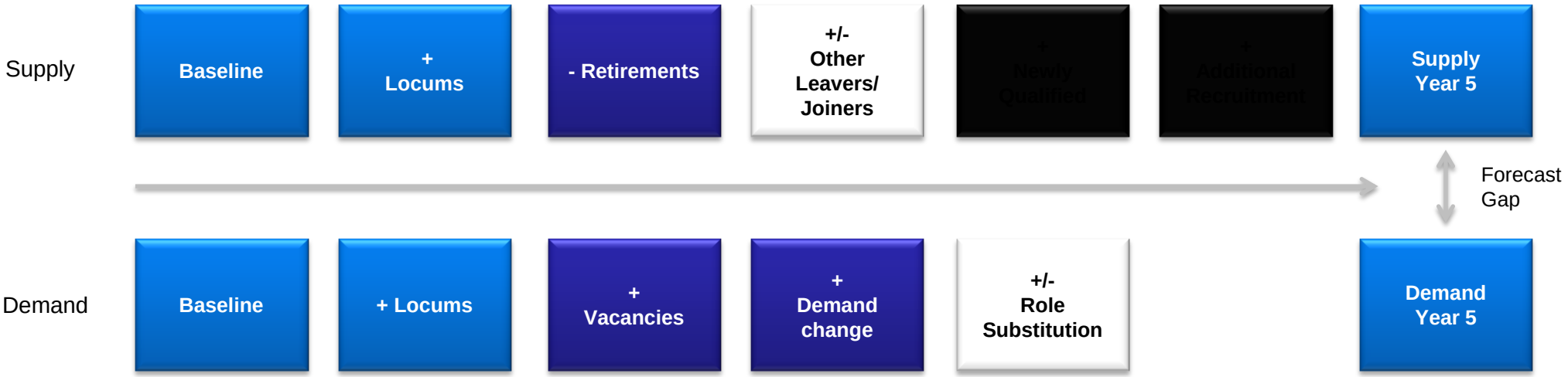
Purpose

- The purpose of the GP supply forecast model is to inform the development of CCG level GP Forward View workforce plans for 2017 – 2019 and facilitate discussions about workforce solutions required to bridge the gap between forecast supply and demand.
- The model will assist with the following:
    - Baseline for General Practice workforce across all sub groups;
    - Forecast supply for General Practitioners (GPs) under chosen supply assumptions;
    - Forecast gap in supply of GPs under chosen demand and supply assumptions;
    - Forecast recruitment levels of other staff working in General Practice required to match future demand.

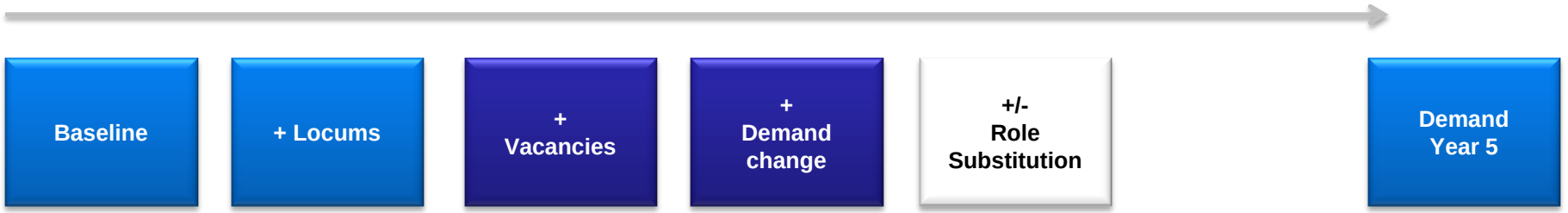
Model Components

- Baseline
- Supply Composition
- Demand Composition

Supply and Demand Composition



Demand



Rate % entered by user

There are 3 options to model demand:

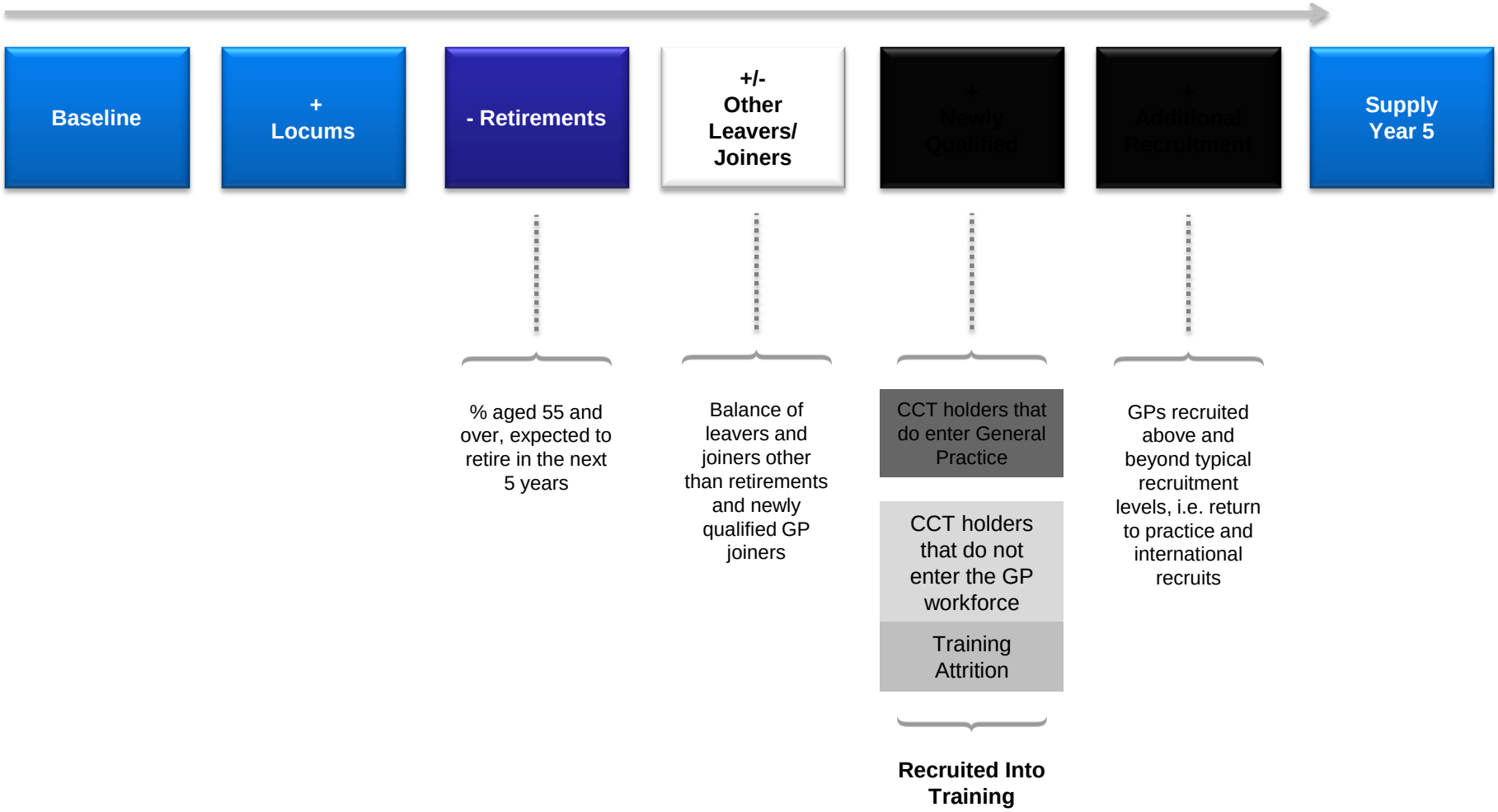
1. In line with change in under 10 and over 55 population

2. CCG workforce Plan

3. GP workload reduced to national average level

Moderate demand forecast by applying assumptions about workforce role substitution. The workforce role substitution entails transfer of workload from one sub group to another at a set substitution rate.

Supply



GPs vs Other Staff in the model

In the model, certain assumptions are only applied to GPs, these are detailed below:

	Assumption	GP	All other staff
Supply	Locum %	✓	
Supply	Retirement Rate	✓	✓
Supply	CCT holders not joining GP workforce	✓	
Supply	GP other leavers/joiners	✓	
Supply	Additional Recruitment	✓	
Demand	Vacancies	✓	✓
Demand	Demand Growth:		
	Population Change	✓	✓
	Workforce Plan	✓	✓
	Average workload	✓	
Demand	Role Substitution	✓	✓

Derbyshire STP – Scenario 2

The following slides show firstly the assumptions used in the model, and secondly, the outputs produced.

Erewash CCG, Hardwick CCG, North Derbyshire CCG and Southern Derbyshire CCG are aggregated together.

Baseline Review

Review Baseline

Please use this page to check your CCG's GP Baseline and enter the percentage of Locums in Total GPs. i.e for a CCG with 90 GP FTE and 10 Locum GP FTE, enter 10%. Once complete, navigate to Scenarios tab to alter assumptions. User only needs to enter a value for the CCGs they wish to model.

If you believe a CCG's Baseline to be incorrect, or would like to change it, please use the contacts on the Introduction tab.

		ALTER BELOW		
CCG	Partnered and Salaried General Medical Practitioner FTE	% of Locums of Total GP + Locums	Locum FTE	Total GP FTE
NHS Erewash CCG	46	10%	5	51
NHS Hardwick CCG	49	10%	5	55
NHS North Derbyshire CCG	173	10%	19	192
NHS Southern Derbyshire CCG	281	10%	31	313

This tab is used to review CCGs baselines and alter Locum use. Baselines are sourced from the March 2016 Primary Care data collection managed by NHS Digital. Locums have been assumed at 10%, however, local knowledge could be gathered at a later stage to inform future supply.

Supply Assumptions 1

Supply Assumptions

Retirement Rate

Choose percentage of staff aged 55 and over that will retire in the next 5 years

GP	100%	Nurse	100%
DPC	100%	Admin	100%

Percentage of CCT holders not joining General Practice Workforce

Choose the percentage of staff that will NOT enter the GP workforce after gaining CCT qualification.

% not joining: Pre Populated

Percentage of staff aged 55 and over that will retire within the next 5 years is set to 100%

Analysis of local training data for Midlands and East region indicates that a significant proportion of new CCT holders do not join England GP workforce. We assume in this model that approximately 30% of new CCT holders leaving programs do not join workforce in the East Midlands.

Supply Assumptions 2

Supply Assumptions

GP other Leavers and Joiners

Choose annual net other GP leavers/joiners rate. This excludes Newly Qualified GPs, Retirees and additional joiners from recruitment schemes. This rate is the usual balance of GPs leaving the CCG to those moving into employment within the CCG.

Annual Net other GP leaver/joiners, % of SIP -1% per year

This assumption is used to set the annual net flow of GPs outside of newly qualified, retirees and additional joiners from recruitment schemes, e.g. voluntary resignations and fixed term contracts ending.

Additional Recruitment

Enter FTE number of GPs joining through Recruitment schemes and international recruitment over the next 5 years. E.g. Retained Doctor Scheme, National GP Induction and Refresher Scheme.

Additional joiners from Recruitment Schemes FTE 4 per CCG over 5 years

This assumption is used to forecast the additional joiners directly attributed to targeted recruitment schemes. NHS England have set a National target of 1,000 Returners/Overseas recruitment. Derbyshire's population share is approximately 15 over 5 years.

Demand Assumptions

Demand Assumptions

Current Vacancies

Enter current vacancy rate for staff groups below

	Vacancy Rate
General Medical Practitioner	12%
Physician Associates	10%
Registered Nurses	10%
Pharmacists	10%
Therapists	10%
Clinical support	10%
NHS Infrastructure support - Managers & senior managers	10%
NHS Infrastructure support - Admin & Estates	10%

Vacancy rates have been collected from a sample of practices within HEE Kent, Surrey and Sussex, as NHS Digital state their publication is incomplete.

Demand

Choose demand option:

1. In line with change in population aged under 10 and over 55
2. Enter Workforce Plan in table on right
3. GP FTE required to reduce GP workload in to the national average workload (based on patients per GP FTE), [applied to GPs only, population change used for other staff]; excludes vacancies

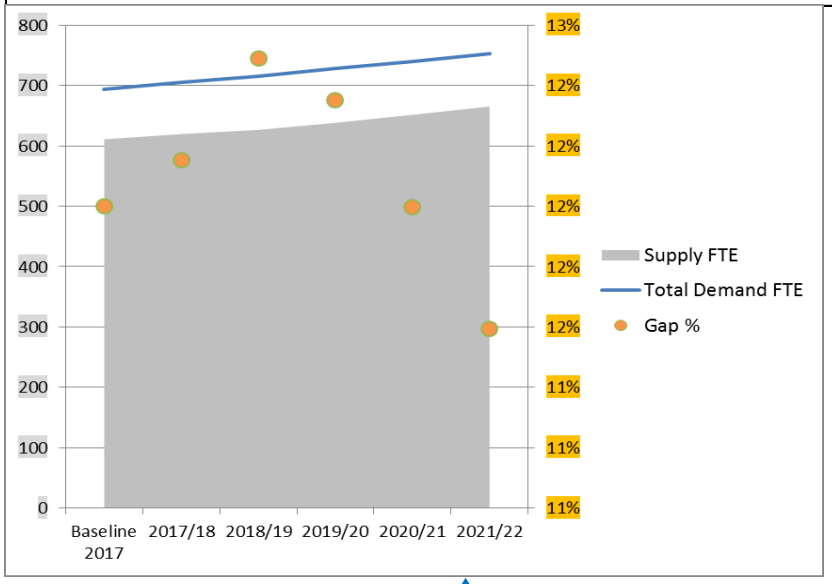
Ages under 10 & over 55 Population Change

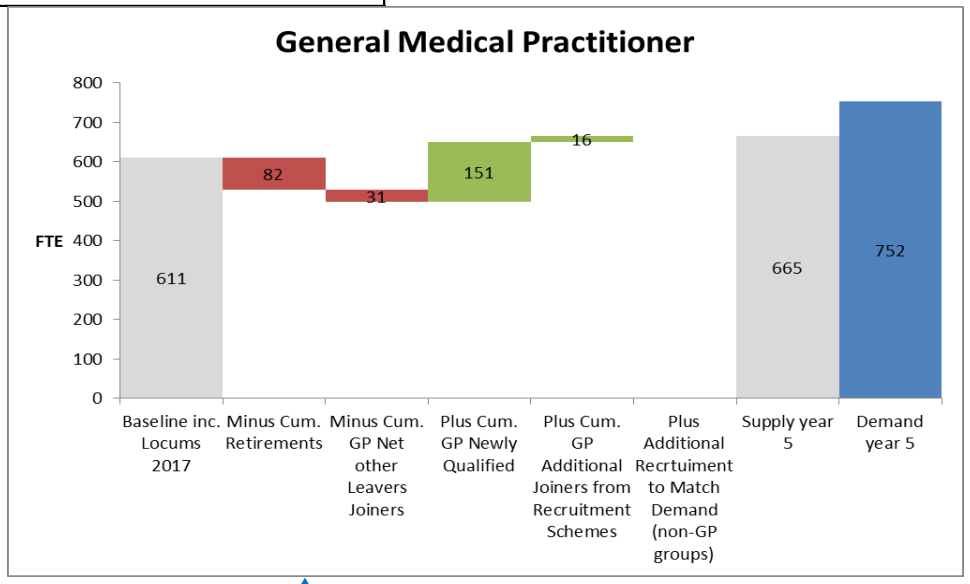
Option 1 has been chosen in this scenario. This reflects high cost/GP time populations.

Output

Baseline inc. Locums Year 0	Minus Cum. Retirements	Minus Cum. GP Net other Leavers Joiners	Plus Cum. GP Newly Qualified	Plus Cum. GP Additional Joiners from Recruitment Schemes	Plus Additional Recruitment to Match Demand (non-GP groups)	Supply year 5	Total Demand year 5
611	-82	-31	151	16	0	665	752

Results of supply/demand assumptions – an undersupply of 87 FTE GPs.





Highlights the gap between supply and demand for each of the 5 years modelled.

Chart to show the individual components that form supply in FTE

Possible solution via role substitution

Role Substitution

Role Substitution

Instructions

1. Review share of time transferred from staff group to staff group
2. Review substitution rates for staff groups where a share of time is transferred to others: substitution rate is the amount of time of one type of health professional required to substitute for one unit of time of another type. E.g. to substitute from GPs to Nurses, enter share in cell C108 and the rate in cell F108.
3. To cancel the impact of role substitution remove % values in column "Share of time transferred"

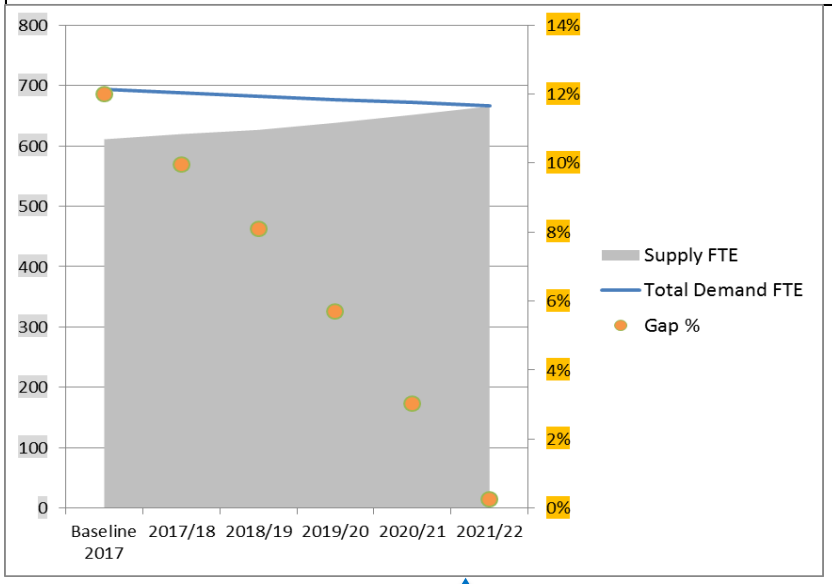
	Share of time transferred	General Medical Practitioner	Physician Associates	Registered Nurses	Pharmacists	Therapists	Clinical support	NHS Infrastructure support - Managers & senior managers	NHS Infrastructure support - Admin & Estates	Mental Health Therapists	**Total impact on other staff**
General Medical Practi	14%	0.0	0.5	0.3	0.5	0.0	0.5	0.0	0.0	0.2	**2.0**
Physician Associates	0%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Registered Nurses	0%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Pharmacists	0%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Therapists	0%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Clinical support	0%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
NHS Infrastructure sup	0%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
NHS Infrastructure sup	0%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**

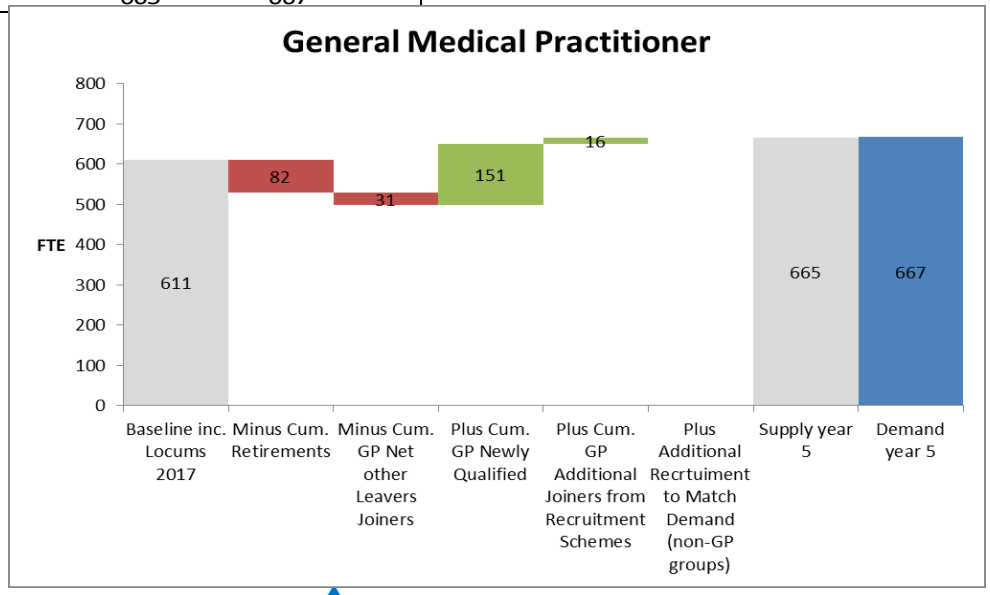
In this solution, the GP supply/demand gap has been substituted on a 2:1 ratio, i.e. it is assumed that twice the time of other job roles equals the GP time. The apportionment of other job roles is illustrative in this example and can be adjusted locally for anticipated role supply.

Adjusted Output

Baseline inc. Locums Year 0	Minus Cum. Retirements	Minus Cum. GP Net other Leavers Joiners	Plus Cum. GP Newly Qualified	Plus Cum. GP Additional Joiners from Recruitment Schemes	Plus Additional Recruitment to Match Demand (non-GP groups)	Supply year 5	Total Demand year 5
611	-82	-31	151	16	0	665	667

Updated results of supply/demand assumptions





Highlights the gap between supply and demand for each of the 5 years modelled.

Chart to show the individual components that form supply in FTE

Appendix 3 GPFV Investment - Derbyshire

GP Forward View - What this means for Derbyshire CCGs ** interpreted from the technical guidance (Planning guidance annex 6)*							
Total Derbyshire		GPFV	Funding source	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Practice infrastructure							
Online GP Consultation Software Systems	Non Recurrent						
National Allocation	Capitation Based	£45m	National	15.0	20.0	10.0	
Funding for nationally procured GP IT systems							
Derbyshire STP Working Assumption				**0.27**	**0.36**	**0.18**	
Estates & Technology Transformation Fund	Non Recurrent	£900m					
*Not agreed - Bids put forward for approval							
Extensions & New Builds (Derbyshire wide figures)			Capital	1.5	16.0		
IT bids submitted for approval (Derbyshire wide figures)			Capital	4.1			
Derbyshire STP Working Assumption				**5.60**	**16.04**		
Care re-design	Total £246m						
Transformational Support - STP	Non Recurrent	£171m	CCG				
£3 per head over 2 years				**1.57**	**1.58**		
Funding to improve access to GP Services	Recurrent		NHSE				
Including 7 day working							
£3.34 per head moving to £6 per head recurrently				**1.46**	**4.10**	**6.35**	**6.39**
Workload							
Training Care Navigators & Medical Assistants	Non recurrent						
National Allocation		£45m	National	10.0	10.0	10.0	10.0
Derbyshire STP Working Assumption				**0.18**	**0.18**	**0.18**	**0.18**
General Practice Resilience Programme	Non recurrent						
National Allocation		£40m	National	8.0	8.0	8.0	
Derbyshire STP Working Assumption				**0.14**	**0.14**	**0.14**	
Services for doctors suffering from burn-out		£16m	National				
Time for Care Programme		£30m	National				
Section 7A Funding increase for public health services-for screening and immunisation.							
Workforce	Total £206m						
Practice Manager Development		£6m	National				
Nurse development strategy		£15m	National				
Growing GP workforce			National				
Increase in funding for GP trainees			HEE				
International recruitment			National				
Clinical pharmacists in general practice			National				
Expansion of physian associates, medical assistants & physiotherapists							
3,000 new fully funded practice based mental health therapists funding.							

Appendix 3 GPFV Investment - Erewash CCG

GP Forward View - What this means for Derbyshire CCGs

** interpreted from the technical guidance (Planning guidance annex 6)*

Erewash CCG		GPFV	Funding source	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Practice infrastructure							
Online GP Consultation Software Systems	Non Recurrent						
National Allocation	Capitation Based	£45m	National	15.0	20.0	10.0	
Funding for nationally procured GP IT systems							
Erewash CCG Working Assumption				**0.03**	**0.03**	**0.02**	
Estates & Technology Transformation Fund	Non Recurrent	£900m					
*Not agreed - Bids put forward for approval							
Extensions & New Builds (Derbyshire wide figures)			Capital		0.07		
IT bids submitted for approval (Derbyshire wide figures)							
Erewash CCG Working Assumption					**0.07**		
Care re-design	Total £246m						
Transformational Support - STP	Non Recurrent	£171m	CCG				
£3 per head over 2 years				**0.15**	**0.15**		
Funding to improve access to GP Services	Recurrent		NHSE				
Including 7 day working							
£3.34 per head moving to £6 per head recurrently				**0.56**	**0.57**	**0.60**	**0.60**
Workload							
Training Care Navigators & Medical Assistants	Non recurrent						
National Allocation		£45m	National	10.0	10.0	10.0	10.0
Erewash CCG Working Assumption				**0.02**	**0.02**	**0.02**	**0.02**
General Practice Resilience Programme	Non recurrent						
National Allocation		£40m	National	8.0	8.0	8.0	
Erewash CCG Working Assumption				**0.01**	**0.01**	**0.01**	
Services for doctors suffering from burn-out		£16m	National				
Time for Care Programme		£30m	National				
Section 7A Funding increase for public health services-for screening and immunisation.							
Workforce	Total £206m						
Practice Manager Development		£6m	National				
Nurse development strategy		£15m	National				
Growing GP workforce			National				
Increase in funding for GP trainees			HEE				
International recruitment			National				
Clinical pharmacists in general practice			National				
Expansion of physian associates, medical assistants & physiotherapists							
3,000 new fully funded practice based mental health therapists funding.							

Appendix 3 GPFV Investment - Hardwick CCG

GP Forward View - What this means for Derbyshire CCGs

** interpreted from the technical guidance (Planning guidance annex 6)*

Hardwick CCG		GPFV	Funding source	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Practice infrastructure							
Online GP Consultation Software Systems	Non Recurrent						
National Allocation	Capitation Based	£45m	National	15.0	20.0	10.0	
Funding for nationally procured GP IT systems							
Hardwick CCG Working Assumption				**0.03**	**0.04**	**0.02**	
Estates & Technology Transformation Fund	Non Recurrent	£900m					
*Not agreed - Bids put forward for approval							
Extensions & New Builds (Derbyshire wide figures)			Capital		0.8		
IT bids submitted for approval (Derbyshire wide figures)							
Hardwick CCG Working Assumption					**0.78**		
Care re-design	Total £246m						
Transformational Support - STP	Non Recurrent	£171m	CCG				
£3 per head over 2 years				**0.16**	**0.16**		
Funding to improve access to GP Services	Recurrent		NHSE				
Including 7 day working							
£3.34 per head moving to £6 per head recurrently				**0.12**	**0.35**	**0.63**	**0.63**
Workload							
Training Care Navigators & Medical Assistants	Non recurrent						
National Allocation		£45m	National	10.0	10.0	10.0	10.0
Hardwick CCG Working Assumption				**0.02**	**0.02**	**0.02**	**0.02**
General Practice Resilience Programme	Non recurrent						
National Allocation		£40m	National	8.0	8.0	8.0	
Hardwick CCG Working Assumption				**0.01**	**0.01**	**0.01**	
Services for doctors suffering from burn-out		£16m	National				
Time for Care Programme		£30m	National				
Section 7A Funding increase for public health services-for screening and immunisation.							
Workforce	Total £206m						
Practice Manager Development		£6m	National				
Nurse development strategy		£15m	National				
Growing GP workforce			National				
Increase in funding for GP trainees			HEE				
International recruitment			National				
Clinical pharmacists in general practice			National				
Expansion of physian associates, medical assistants & physiotherapists							
3,000 new fully funded practice based mental health therapists funding.							

Appendix 3 GPFV Investment - North Derbyshire CCG

GP Forward View - What this means for Derbyshire CCGs ** interpreted from the technical guidance (Planning guidance annex 6)*							
North Derbyshire CCG		GPFV	Funding source	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Practice infrastructure							
Online GP Consultation Software Systems	Non Recurrent						
National Allocation	Capitation Based	£45m	National	15.0	20.0	10.0	
Funding for nationally procured GP IT systems							
North Derbyshire CCG Working Assumption				**0.08**	**0.10**	**0.05**	
Estates & Technology Transformation Fund	Non Recurrent	£900m					
*Not agreed - Bids put forward for approval							
Extensions & New Builds (Derbyshire wide figures)			Capital	0.9	1.4		
IT bids submitted for approval (Derbyshire wide figures)							
North Derbyshire CCG Working Assumption				**0.92**	**1.39**		
Care re-design	Total £246m						
Transformational Support - STP	Non Recurrent	£171m	CCG				
£3 per head over 2 years				**0.44**	**0.44**		
Funding to improve access to GP Services	Recurrent		NHSE				
Including 7 day working							
£3.34 per head moving to £6 per head recurrently					**0.98**	**1.77**	**1.78**
Workload							
Training Care Navigators & Medical Assistants	Non recurrent						
National Allocation		£45m	National	10.0	10.0	10.0	10.0
North Derbyshire CCG Working Assumption				**0.05**	**0.05**	**0.05**	**0.05**
General Practice Resilience Programme	Non recurrent						
National Allocation		£40m	National	8.0	8.0	8.0	
North Derbyshire CCG Working Assumption				**0.04**	**0.04**	**0.04**	
Services for doctors suffering from burn-out		£16m	National				
Time for Care Programme		£30m	National				
Section 7A Funding increase for public health services-for screening and immunisation.							
Workforce	Total £206m						
Practice Manager Development		£6m	National				
Nurse development strategy		£15m	National				
Growing GP workforce			National				
Increase in funding for GP trainees			HEE				
International recruitment			National				
Clinical pharmacists in general practice			National				
Expansion of physian associates, medical assistants & physiotherapists							
3,000 new fully funded practice based mental health therapists funding.							

Appendix 3 GPFV Investment - Southern Derbyshire CCG

GP Forward View - What this means for Derbyshire CCGs ** interpreted from the technical guidance (Planning guidance annex 6)*							
Southern Derbyshire CCG		GPFV	Funding source	17/18 £m	18/19 £m	19/20 £m	20/21 £m
Practice infrastructure							
Online GP Consultation Software Systems	Non Recurrent						
National Allocation	Capitation Based	£45m	National	15.0	20.0	10.0	
Funding for nationally procured GP IT systems							
Southern Derbyshire Working Assumption				**0.14**	**0.19**	**0.09**	
Estates & Technology Transformation Fund	Non Recurrent	£900m					
*Not agreed - Bids put forward for approval							
Extensions & New Builds (Derbyshire wide figures)			Capital	0.6	13.8		
IT bids submitted for approval (Derbyshire wide figures)							
Southern Derbyshire Working Assumption				**0.60**	**13.80**		
Care re-design	Total £246m						
Transformational Support - STP	Non Recurrent	£171m	CCG				
£3 per head over 2 years				**0.83**	**0.83**		
Funding to improve access to GP Services	Recurrent		NHSE				
Including 7 day working							
£3.34 per head moving to £6 per head recurrently				**0.78**	**2.20**	**3.35**	**3.38**
Workload							
Training Care Navigators & Medical Assistants	Non recurrent						
National Allocation		£45m	National	10.0	10.0	10.0	10.0
Southern Derbyshire Working Assumption				**0.09**	**0.09**	**0.09**	**0.09**
General Practice Resilience Programme	Non recurrent						
National Allocation		£40m	National	8.0	8.0	8.0	
Southern Derbyshire Working Assumption				**0.08**	**0.08**	**0.08**	
Services for doctors suffering from burn-out		£16m	National				
Time for Care Programme		£30m	National				
Section 7A Funding increase for public health services-for screening and immunisation.							
Workforce	Total £206m						
Practice Manager Development		£6m	National				
Nurse development strategy		£15m	National				
Growing GP workforce			National				
Increase in funding for GP trainees			HEE				
International recruitment			National				
Clinical pharmacists in general practice			National				
Expansion of physian associates, medical assistants & physiotherapists							
3,000 new fully funded practice based mental health therapists funding.							