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NHS
Rotherham
Clinical Commissioning Group

Rotherham response to the General Practice Forward View

Your life, Your health

1. Our vision for general practice within Rotherham

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

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

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

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

2. Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Executive summary

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

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

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

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

Overall therefore, the CCG is investing an additional £5,720,000 each year in general practice to provide sustainability and bring care closer to home. This amount will increase in 17/18 onwards as we continue our journey to provided extended access for the whole population

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

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

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

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

Steps to Make the Vision a Reality

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

4. Context

4.1 Profile of Primary Medical Care in Rotherham

90% of all NHS contacts are with general practice.

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

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

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

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

With regard to type of contract there are:

23 Personal Medical Services (PMS) practices

7 General Medical Services (GMS) practices

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

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

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

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

4.2 Current General Practice

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

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

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

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

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

4.3 Changes to Contractual Arrangements

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

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

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

- Support fairer distribution of funding at a locality level

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

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

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

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

5. Our Key Priority Areas

5.1 Quality Driven Services

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

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

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

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

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

5.2 Services as local as possible

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

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

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

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

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

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

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

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

5.3 Equality of Service Provision – Enhanced Services

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

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

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

- Dementia
- CEA monitoring

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

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

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

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

5.4 Increasing Appropriate Capacity and Capability

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

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


NHS Rotherham CCG
GP Workforce Q1 April

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

Until fairly recently, practices were almost exclusively run on a GP partner basis, with occasional use of locums to cover study, sickness or holiday absence. More recently, there has been a significant growth in locum and salaried GPs, with fewer being attracted to the partnership model. The primary care workforce is changing. An increasing number of GPs are working outside the traditional model with more sessional and locum GPs and utilisation of different professions, more typically nursing to undertake traditionally GP roles. The gender balance between male and female doctors is also changing which is also impacting on workforce availability as traditionally female GPs have chosen to work part-time. The success of the CCG will be dependent on its ability to embrace, utilise and develop potential across its whole clinical and non-clinical workforce. It will also work with provider organisations and the local authority to harness the skills of the wider primary care health and social care teams including district nursing, social work, pharmacy, podiatry, physiotherapy and others. A workforce plan is in place and incorporates the national 10 point plan – Building the workforce – new deal for GPs. This includes our plans for training administrative staff, upskilling unqualified staff and developing our Practice Managers to have the skills to lead new organisational formats. Rotherham participates in the South Yorkshire and Bassetlaw Workforce Group and is committed to the STP plan for primary care which has been co-produced by the group and Health Education England. The workforce plan for Rotherham is included at Appendix 4.

10 practices have committed to the student nurse training scheme and 8 practices now have apprenticeships. 10 practices have shown an interest in mentoring newly qualified student nurses as there is commitment to capturing the workforce early in their career

instead of general practice being seen as somewhere secondary care or community nurses go later in their career. Unfortunately a bid for funding support for clinical pharmacists was rejected in 2015. Four practices have already directly employed clinical pharmacists in their new workforce models, undertaking medication reviews and long term condition management and we will support the LLP to bid for a further opportunity this year to be able to extend this workforce into more practices who are keen to adopt these new roles.

Whilst some practices have recognised the need to continually train and develop staff to enable nurses and other clinicians to feel empowered and competent to take on new roles, there are practices who have not felt able to fund and/or release time for training to the level required for the cascade of duties from GPs. All practices in Rotherham recognise that the traditional GP practice model has to change and many are already embracing the benefits of skill mix changes to fully utilise the skills of qualified and unqualified nurses. However, there are practices who require support with this both financially and physical presence as primary care does not have the benefit secondary care has of education teams co-ordinating training. It is therefore proposed to use GPFV funding for the LLP to employ a Band 7, experienced Practice Nurse to provide leadership and ensure General Practice nursing teams across Rotherham are equipped to deliver the current and future primary care agenda. This role will also provide an initial point of contact for future work developing stronger links between all nursing teams across the Borough. It is recognised that collective leadership is not present across general practice nursing teams and the value of experienced able leadership is widely recognised and well documented. The workforce report details the current risk we have of 22% of the workforce who are able to retire and have the most knowledge, it is critical that we ensure the current workforce is upskilled along with the work already taking place to attract newly qualified nurses into general practice. As detailed above, we have 10 practices providing placements for student nurses to develop the primary care workforce of the future and also intend to extend training to offer opportunities to secondary care nurses who longer term would wish to work within primary care but as they are normally specialty specific, do not meet the criteria for application. As our plan as an STP is to reduce bed bases and manage patients more within an integrated community environment, we need to start to enable current secondary care staff to access training as in reality it takes at least 2 years for staff to be fully confident in primary care as there is such a breadth of knowledge to gain. It is proposed that the Band 7 nurse takes responsibility for this longer term plan.

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

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

The CCG has considered piloting the use of Emergency Care Practitioners within its model but this would presently mean ceasing one scheme to commence another and there is no agreement to ceasing any of the current schemes which are working hard to reduce admission to hospital (social prescribing, care co-ordination centre, rapid response service). The Emergency Care Practitioner model provides a home visiting service on behalf GPs/ANPs to release capacity in practice and also undertake visiting much earlier in the day to ensure patients requiring admission are admitted timely as currently most home visits take place at the end of morning surgery therefore there is a pressure point in the system for ED and the ambulance

service in transporting patients. There are successful pilots running locally and Rotherham would wish to participate in a pilot for the Emergency Care Practitioner model. It is anticipated that the cost of such a pilot will be in the region of £100k.

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

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

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

The CCG has training leads and spends time with new trainees identifying and promoting the different opportunities for work within Rotherham. These include portfolio careers

enabling new GPs to have more varied roles by also working in secondary care or having a particular specialised interest developed.

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

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

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

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

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

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

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

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

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

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

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

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

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

5.5 Primary Care Access Arrangements

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

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

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

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

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

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

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

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

Integration with GP out-of-hours providers and other urgent care services will help to reduce duplication and confusion about how best to access urgent care. Rotherham CCG has committed to capital funding to build a new emergency centre on the Rotherham Hospital Foundation Trust site. Building work has commenced with a completion date in July 2017, along with significant pathway work between primary and secondary care clinicians to ensure pathways are as seamless and effective as possible. Currently, Rotherham has 7 day access to general practice via the Walk-in Centre. This arrangement will be continued for patients requiring urgent primary care within the new Emergency Centre arrangements however it is acknowledged that there is a gap of provision of routine access at weekends presently and in the future Emergency Care model. As part of this, work is ongoing in relation to the creation of three hubs (North, South and Central) to enable patients with commitments within the week, to access general practice at the weekend in addition to the current arrangements of extended access (morning and evening weekday**). It is proposed to have this arrangement in place in time for Winter 2016 utilising the £3 per head funding identified within baseline and enhancing the directed enhanced service which is currently 21 practices provide 91.3 additional hours outside of core working. The proposal for additional working at weekends will provide an additional 18 hours per week totalling £577,577 spend. In 17/18 will be increasing this to achieve 130 hours per week extended access achieving the requirement of 30 mins per 1000 population.**

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

5.6 New Models of Care

In October 2014, an alliance of NHS organisations published the Five Year Forward View (5YFV). A significant element of this strategy is to review the local healthcare system to consider different models of delivering healthcare. Different variations of the models are now being piloted. Greater Manchester health and social care budgets are now devolved to the region's councils and health groups enabling local control over how budgets are

allocated and with a main purpose to pool resources to improve out of hospital care. In March? 2016 NHS England announced that as part of the 5YFV a sustainability and transformation plan on a wider than place footprint to understand the major local challenges, how these are expected to evolve in the next 5 years and emerging hypotheses for what is driving the gaps and action required. Rotherham is included within the South Yorkshire and Bassetlaw footprint for this plan. Primary care is clearly fundamental within the plan.

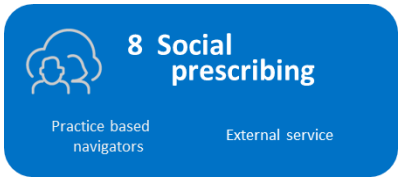
As outlined in 5.5, the CCG has already committed to a new emergency centre which is based on a partnership between urgent care providers in Rotherham and best utilising the different skills of clinicians with primary and secondary care training. The CCG has also committed to transforming community services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

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

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

5.7 Self Care

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



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

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

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

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

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

5.8 Robust Performance Management

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

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

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

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

are clear key performance indicators for the quality standards and an action plan within the mobilisation plan for addressing any shortfalls.

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

5.9 Continued Improvements to Medicines Management

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

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

5.10 Engaging Patients to Ensure Patient Pathways are Optimised

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

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

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

However, PPGs are only one mechanism for patient and public engagement and experience. The CCG also aims to extend engagement, and work with a variety of organisations to improve the patient voice for specific communities, both geographical and communities of interest, for example people with specific long term conditions. If the CCG is to develop new ways of working; it will be vital to ensure that patient experience actively and meaningfully informs new systems and processes. This cannot be done in one way, and may involve any of the following:

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

6. Enablers to Delivering our Strategy

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

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

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

The LLP requires a management structure which is currently lacking of at least a 1 day per week GP to provide clinical leadership, 1wte Band 8a Project Manager (to deliver the

direction of travel identified by the GP lead and its members), 1wte Band 7 Development Nurse (supporting practices with identifying and responding to nurse development requirements. In the longer term, the LLP will need to fund these roles on a substantive basis. It is hoped that once the benefits of federation working are realised that this will be extended to ensure general practice across Rotherham continues to develop by having central access to skills and resources to support practices.

6.2 Primary Care Estates and Premises

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

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

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

Rotherham Metropolitan Borough Council are currently reviewing all ‘government’ estate to ensure it is fit for purpose and utilised appropriately across all services. Whilst this is welcomed by the CCG, many general practices are privately owned by partners in the practice and will not therefore be captured under this review. NHS England have recently procured site surveys of all GP practices to provide CCGs with an assessment of the current estate suitability for primary care. Whilst some estate issues have been identified, the estate is in fairly good order and other than a planned development there are no identified requirements for new healthcare premises. A strategic plan for Rotherham estates has been developed and is included at Appendix 5.

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

6.3 Information Management and Technology

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.4 Access to GPFV funding

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

6.5 Wider primary care contribution

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

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

7. Governance arrangements

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

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

Appendix 1

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

Appendix 2 - GPFV bids/funding requirements

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

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

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

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

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

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

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

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

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

Appendix 4

NHS
Rotherham
Clinical Commissioning Group

GENERAL PRACTICE WORKFORCE PLANNING & REDESIGN

1.0 Introduction

1.1 A third of babies born this year will see their 100th birthday in contrast to 1948 when 50% died before age 45. This evidences the significant improvements seen in healthcare over the last 60 years however it poses a significant risk to our workforce in managing this increased demand. We are 'promised' nationally, an additional 5000 GPs to support these workforce issues however the reality is that less trainees are choosing general practices when they qualify and more GPs are choosing to retire earlier than normal retirement age. The gender balance between male and female doctors is also changing which is also impacting on workforce availability as traditionally female GPs in Rotherham choose to work part-time.

1.2 NHS England has produced a 10 point action plan – Building the workforce, a new deal for GPs to support addressing these workforce issues however, as this is a national document and targeted at the most under-doctored areas first, it is essential that Rotherham CCG has its own strategy which is compliant with the national action plan. NHS England have also now produced a General Practice Forward View (GPFV) offering opportunities to increase the pace of change and all practices are being provided with the opportunity to undertake a programme of work (Productive General Practice) which helps practices review their capacity and release time for care.

1.3 The current silo working of practices is also unsustainable as we move more and more to delivery of equitable services and increased services closer to home. Significant progress is now being made in relation to the delivery of services across Rotherham with a mandated requirement to deliver all LES (except acupuncture, care homes and specialised) by April 2017. The number of main practices has also reduced from 36 in 2015 to 31 in 2016.

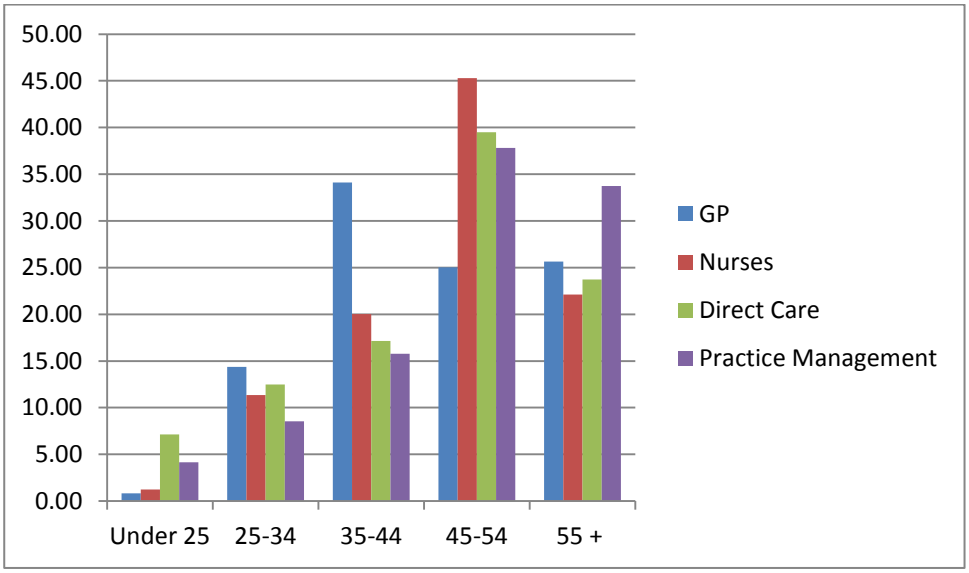
2.0 Current position

2.1 Rotherham currently has 31 general practices which consist of 23 PMS, 1 APMS and 7 GMS practices. Rotherham CCG has been encouraging practices to utilise the Yorkshire & Humber Health Education England workforce tool to enable a broader understanding of workforce issues and to date 28 practices are utilising the tool. For the purposes of this

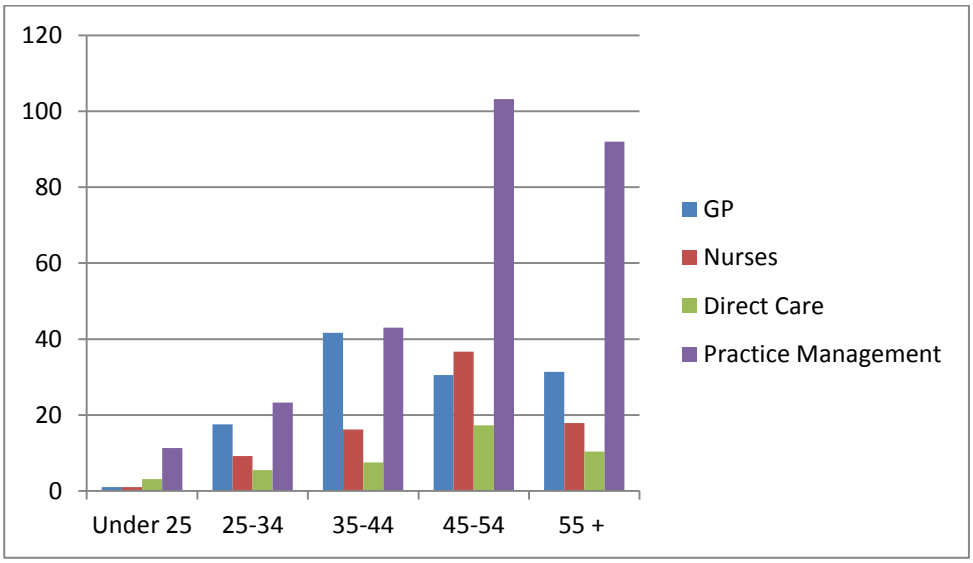
plan therefore we have to assume the picture across Rotherham is consistent with the data we have and extrapolate.

2.2 From current data 45 GPs in Rotherham are over 55 and 27 GPs are over 50, whilst small numbers are continuing to practice way beyond 65, with changes to pension taxation, there is high potential of GPs choosing to retire or reduce working hours much earlier than originally planned. At present, we intake on average 13 GP trainees into Rotherham each year and approximately 50% are appointed to posts in the Rotherham area. On this basis therefore, without any intervention we currently have 8wte GP vacancies and are predicted to have a shortfall of a further 15wte by 2020 (or earlier).

Graph 1 – Age profile -percentage



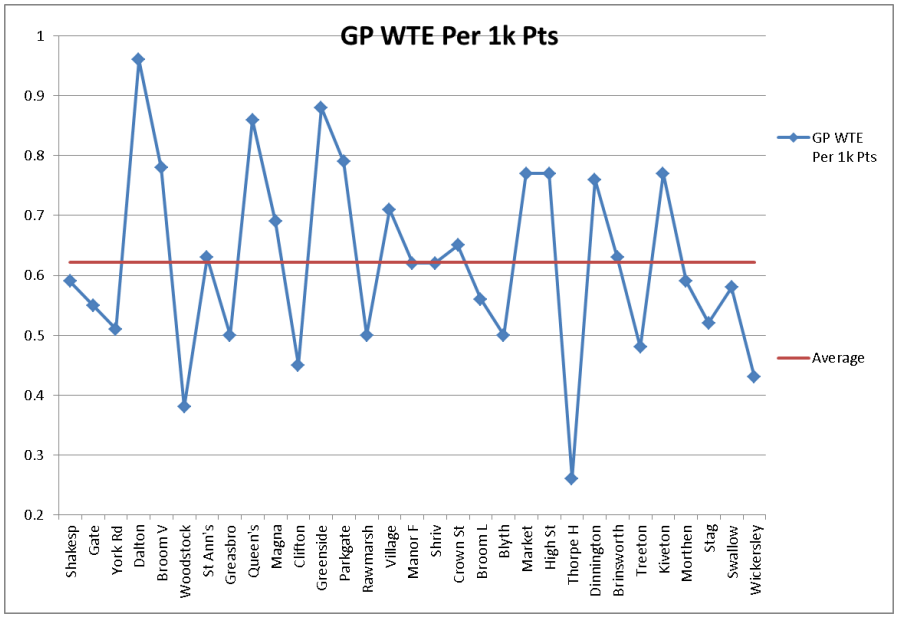
Graph 2 – Age profile - numbers



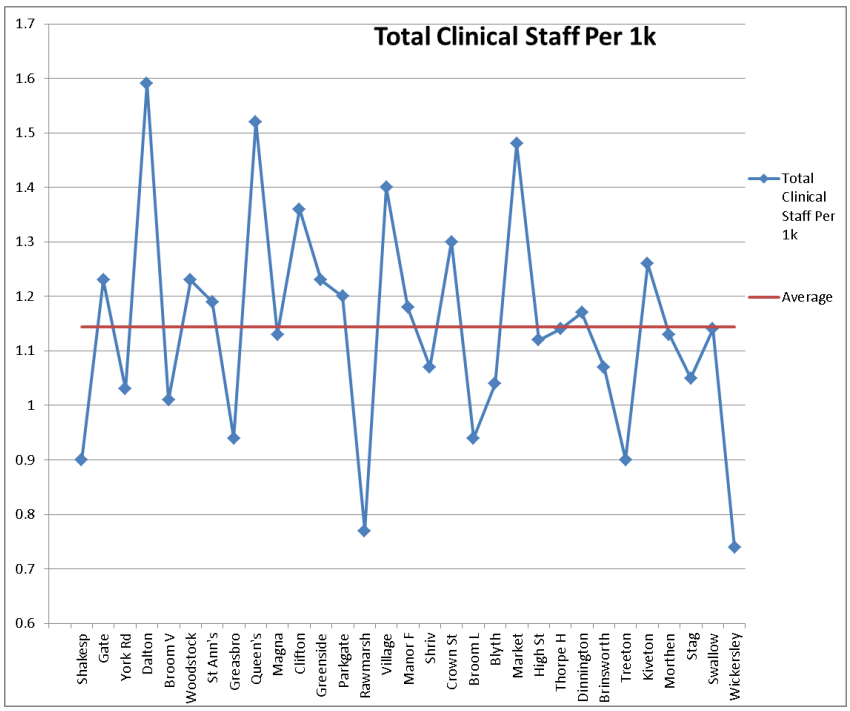
In relation to particularly 'under-doctored' practices, it is of concern that over 50% of practices are below Rotherham average of 0.7wte GPs per 1000 patients. It also shows the significant differences between the staffing profile of practices. For example the Gate

which is predominantly nurse led and evidenced by the way it outlies on the graph with significant more nursing workforce than any other practice. Clifton, Thorpe Hesley, Village and Woodstock Bower have a higher than average nursing workforce evidencing an increased nursing workforce to manage their overall demand. The practices of concern are where they have insufficient GP capacity and from review do not appear to be backfilling with a nursing workforce (they could however have more innovative models around therapy and pharmacy we are not aware of). This indicates disproportionate investment in workforce which must be addressed. A Quality Contract for general practice is currently being implemented and expected workforce numbers have been identified as part of this work.

Graph 3- GPs per 1000 patients in Rotherham



Graph 4 – Clinicians per 1000 patients in Rotherham



3.0 Models of workforce

3.1 Recruitment and retention issues within general practices are well understood, and many practices in Rotherham have already risen to the challenge by reviewing their skill mix and supporting the training and development of both medical and nursing disciplines. However this is not across the board and other than the social enterprise model, there are very small numbers of practices sharing resources (clinical or non-clinical) to deliver their activity. Capacity planning within practices is also limited which makes the following very difficult:

Maximising the supply of GPs and Practice Nurses	**Enabling Skill Mix: distributing the practice workload differently**
Bringing other professionals/healthcare workers into the practice	**Developing new roles as alternatives to the existing GP workforce**
Making it happen – the enabling works	

Radical new models of primary care workforce are emerging, Health Education England reported recently that from data returns, they are seeing the following models emerge:

	GP	Practice Nurse/Advanced Clinical Practitioner	Healthcare Assistant
The conservative model (replacing like for like)	4	2	1
Practices under pressure (evolutionary change)	3	3	2
The extreme scenario (workforce transformation)	1	2	4

3.2 **Developing nursing**

As outlined above, a number of practices are now extending their use of nurses to support practice workload however more can be achieved from the use of Band 1-4 roles within practices. Practices need to operate more clearly defined roles to ensure minutes, which add up to hours are undertaken by the most suitable post within the practice. It is acknowledged that it is difficult to 'carve' staff time out in this way but not unachievable. Enhanced job satisfaction is achieved by enhancing nursing roles so long as the requisite training and education is provided to ensure the team feel sufficiently competent to undertake. We will utilise GPFV funding to support Bands 1-4 to be developed within practices. This will work alongside support with ATP programme in encouraging more practices within Rotherham to train student nurses and employ newly qualified nurses to ensure primary care is seen as a career opportunity from the start and not at the end.

3.3 **Associate Physicians**

Rotherham CCG is supportive of Sheffield Hallam and Sheffield University who have commenced Associate Physician training. This is a 2 year programme which Y & H HEE are now piloting funding a £10k bursary and provide training costs to practices who host trainees. It is hoped during this initial training period that issues relating to prescribing and imaging requesting along with regulation can be resolved. It is intended that this new role is utilised to support practices with an alternative model to advanced clinical nurse practitioners as these roles are also difficult to recruit to. They are not described in the model above as the training schemes are only just commencing in our locality. We will work with the ATP to see if support can be given to practices in a similar way as that for student nurses and newly qualified nurses as this is such a different concept for practices to understand.

3.4 **Practice based pharmacists**

NHS England have supported an initial pilot of practice based pharmacists. This is already an alternative model which was being explored and despite being unsuccessful in the bid for the initial pilot, this has been implemented by 3 Rotherham practices. Woodstock Bower, St Anns and Clifton all now have Clinical Pharmacists working within their practices. Crown Street and Morthern Road are also pursuing this model and it was well supported by GPs at a recent commissioning event. GPs felt that pharmacist support in practice particularly for medication reviews, management of long-term conditions, dealing with hospital discharge letters, managing house bounds and nursing home patients, health promotion along with involvement in managerial roles eg. QOP, CQC work and clinical governance could have a positive impact on GP workload. It has been agreed that the Medicines Management Team at the CCG will provide professional leadership and mentorship to the practice based pharmacists to ensure they do not become professionally isolated and potentially lead to retention issues. There will be an opportunity to bid again for central resources to non-recurrently fund Pharmacists within practices as part of GPFV. It is proposed that 6wte Pharmacists are required to provide additional support into practices and to assess workload impact, training requirements and patient experience. Other organisations are also working in partnership with commercial pharmacies to supply pharmacist support into practices and this will also be considered.

3.5 **Developing our administrative workforce**

We already have a significant number of high quality, committed and dedicated administrative staff who support and care for our patients. But we recognise that their roles could be enhanced to provide more support whilst also enabling this workforce to be more empowered and therefore more likely to be retained. We will utilise GPFV monies to facilitate training sessions in relation to care navigation and medical documentation along with customer care, dementia and carer awareness.

3.6 **Developing our Practice Managers**

The shape of general practice is changing significantly and we our expectation and requirement of Practice Managers is rapidly changing. Some larger practices are changing their model to include specific Finance Managers as it is becoming increasingly difficult to lead on all the areas required within practices. We wish to support the development of this workforce using GPFV monies to enable them to feel sufficiently competent and able to review and embed new ways of working.

4.0 Rotherham workforce requirements

4.1 The CCG has taken a simplistic approach to assessing workforce requirements for the future as this looks at Rotherham as a whole and not in silos per practice. Based on current average information and the conservative model, Rotherham would require the following workforce:

260,000 patients – 173wte GPs, 87wte Advanced Nurse Practitioners/Associate Physicians/Pharmacist/AHPs, 43wte Healthcare/support assistants/phlebotomists, 286wte administrative support, 26wte Practice Managers, 13wte deputy practice/business managers.

4.2 Based on current average information and the evolutionary change model, Rotherham would require the following workforce:

260,000 patients - 130 wte GPs, 130wte Advanced Nurse Practitioners/Associate Physicians/Pharmacist/AHPs, 87wte Healthcare/support assistants/phlebotomists, 286wte administrative support, 26wte Practice Managers, 13wte deputy practice/business managers.

4.3 Based on current average information and the extreme change model, Rotherham would require the following workforce:

260,000 patients – 43wte GPs, 87wte Advanced Nurse Practitioners/Associate Physicians/Pharmacist/AHPs, 173wte Healthcare/support assistants/phlebotomists, 286wte administrative support, 26wte Practice Managers, 13wte deputy practice/business managers.

4.4 Our current workforce data (from data provided) is as follows

	GP HC	GP FTE	GPs per 1k PTs FTE	Pts Per GP FTE	GP Pro-viders HC	GP Pro-viders FTE	Practice Staff FTE	Practice Staff per 1k pts FTE	Nurse FTE	Nurse s Per 1k pts	Direct PT (HCA) Care FTE	Direct Pt Care (HCA) per 1k pts	Admi n FTE	Admin Per 1k pts FTE
Roth	5.03	4.94	0.69	1,453	4.94	3.26	12.06	1.68	2.37	0.33	1.09	0.15	8.26	1.15
Eng	5	4.69	0.65	1,530	3.32	3.02	11.22	1.57	1.91	0.27	1.18	0.16	7.9	1.1

We therefore have 179wte GPs, 85.8wte practice (qualified)staff, 32.4wte Healthcare Assistants (direct patient care) and 299wte administrative support staff. Practice management wte is not known.

The conservative model is not sustainable and it is therefore recommended that practices pursue the evolutionary model which makes much better use of the wider general practice workforce along with new roles. The extreme change model has not been evaluated and is not supported.
Rotherham is therefore severely lacking in qualified clinical practice staff and healthcare assistants when adopting the evolutionary model this is because most practices are continuing to follow the traditional (conservative) model which will be difficult to sustain long term.

4.4 It is essential that practices start to look collaboratively rather than individually at their workforce, there are significant efficiencies which can be achieved by working across traditional practice boundaries. Closer review of how the LLP can support this collaboration is required with hopefully joint working with the CCG to agree new working arrangements which are sustainable. We have also not factored into above the impact of potential 7 day working on practices. At minimum, for our population we would require an additional 94.5 hours GP time per week (if utilising GPs) to facilitate sufficient Saturday capacity, based on a 9 session week this would equate to an additional 2.6wte to the 130wte identified. As the model evolves, review of utilising the extended workforce with GP overview will be considered.

4.5 **Locum bank**

Clearly, longer term the intention is to create models which are less reliant on qualified doctors however in the interim, practices are using expensive locum agencies for their short term requirements which are high cost and at times lower quality. The impact is felt for the CCG as from peer review visits, it has become evident that when a locum is used, referrals to secondary care increase. There was clear support for a bank arrangement from current GP registrars who indicated that they were keen not to settle down into one practice at the end of training. To support practices and improve referrals, it is proposed that the CCG supports the creation of a locum bank, hosted by a practice. The CCG is currently seeking information regarding demand for such a service to create a fully costed proposal. The intention is however for the host practice to recruit full/part-time GPs who will receive a salary rather than payment for sessions to provide employment stability with flexibility in workplace. The full cost will be recharged to the user on a monthly basis with a year end adjustment to ensure the bank is self sufficient. This proposal also provides the opportunity to work in non-training practices to aid recruitment in practices less known to GP trainees.

4.6 The key concern about moving to new models of workforce are the transitional arrangements and ensuring quality of care is not compromised. There is no single solution to address this issue as some changes will have to happen more quickly than others (due to unforeseen circumstances i.e. unexpected vacancies) however a task and finish group will be established to develop proposals for how services are sustained during transition.

5.0 Defining the required workforce

5.1 Capacity planning is an essential tool to ensure capacity is fully understood across general practice. As identified in the introduction, Practices are embarking on a programme of support to help them with skill mix, capacity and demand along with other components. This will also be utilised to define the impact of utilising different roles within practice e.g. using a pharmacist, associate physician, extending skills of healthcare assistants and potential impact of technology to ensure we develop practices which are fit for the future.

6.0 Technology

6.1 We have to fully exploit the technology which is available to us to free up capacity in general practice. The key systems identified from pilots as having most impact to date are telephone and self-care.

6.2 Telephone systems – evidence is now identifying that up to 50% GP time can be saved by a full telephone consultation system. In a recent engagement event, over 90% of the general public supported such a system. Concerns have been raised in relation to capacity to see if required and it is part of the system that sufficient slot capacity is carved out to see those patients who require a face to face on the same day. At present, practices are devising their own different ways of implementing telephone triage/consultation and it is recommended that an approach is agreed and implemented consistently (clearly with the ability to vary for clinical reasons).

6.3 A number of CCGs have implemented telehealth systems to support self care and reduce avoidable attendances in primary and secondary care. These systems can be targeted towards specific long term conditions, for example patients with Hypertension. The GP would target specific suitable patients and offer them the opportunity to sign up to use the system. A set hypertension protocol (following NICE guidelines) is pre-populated, but can be amended to the specific needs of the patient. The patient is then sent text messages requesting BP levels, the patient is then sent advice based on their readings, the advice could be to take the blood pressure on the other arm or immediately make an appointment. The Clinician can review the text messages (sent & received) as well as the data submitted on a chart, an email and / or text message alert can be sent to the clinician should any abnormal readings be submitted. The clinician has the option to send a free text SMS to the patient, for example, requesting they attend an appointment that has been booked for them.

Potential areas to target:

Anti-coagulation
Hypertension
Diabetes
COPD
Heart failure

A pilot of telehealth in five practices commenced in early 2016 and is currently being evaluated with the intention to roll this out to all practices. It is accepted that this is still workload for the practice but it does take less time than current monitoring arrangements. It is also feasible to consider practices collaborating to allocate a suitably qualified (Healthcare Assistant) clinician to this task for a higher population or a whole service can be 'bought in'. There are significant patient satisfaction benefits to operating this system.

It is acknowledged that current payment arrangements for monitoring would need to be reviewed to incentivise use of technology.

7.0 Developing our workforce

7.1 It costs on average £30k every time we recruit a clinician in primary care (Lost output whilst new employee gets up to speed, induction, locum for any gaps in service and cost of recruiting). Understanding this investment is crucial along with acknowledging the personal and professional needs of our workforce. We understand that continuing to develop our workforce not only retains them within their organisation but also ensures the ability to develop services using a wider workforce. Traditionally we attract new GPs from the effectiveness of training, flexibility in sessions along with out proximity to Sheffield. Our nursing workforce traditionally

7.2 We expect each practice to ensure each member of staff receives mandatory training as required along with ensuring there is an annual development plan as part of a structured appraisal process. 37.5 hours structured training per wte each year which includes PLT attendance, robust mentoring/coaching and internal training.

Initial workforce plan agreed:	July 2015
Reviewed:	September 2016
Due for review:	September 2017
Reviewed by:	Head of Co-com

Appendix 5

Quality Healthcare Environments

NHS Property Services

Rotherham CCG Strategic Estates Plan Revised - May 2016

In Confidence

Notes to Strategic Estates Plan

- This document has been produced by NHS PS in conjunction with the NHS Rotherham CCG, NHS England and other NHS and local authority stakeholders
- A number of the property opportunities contained within the review are at outline proposal stage only and are subject to further public engagement
- The costs and benefits set out in the document are indicative and are subject to further planning and viability testing

Contents

Executive Summary

Rotherham CCG Estate Strategy (2015-20*)*

This paper provides a summary of the CCG local estate strategy review process and the proposals to support the NHS 5 Year Forward View:

1. Scope Overview:

- Review only covers NHS PS buildings
- The CCG has a new General Practice Strategy that is being developed which this Strategic Estates Plan (SEP) is a key enabler for delivery and will expand in time to cover the whole of the GP Estate

2. The CCG drivers and challenges:

- Care closer to home in order to reduce hospital admissions and tackle the health inequalities – basing community, mental health, social care and voluntary services together to have '1 team' approach
- CCG has had delegated authority for commissioning general practice services and requires an effective SEP

3. The estate overview:

- 20 properties, comprising 15,200 sq. m
- Costs of £5.2m p/a
- Very few Leasehold opportunities.

4. Key themes emerging from the review:

- Overall the estate is in a good condition.
- The health infrastructure impact of a new 20k person residential development at Waverly.
- There are challenges around vacant space and looking to bring two modern good quality properties to full utilisation.

5. Property Opportunities and savings:

- Disposals opportunities totalling receipts of £265k
- Cumulative running cost saving of £867k over the 5 year period.
- Address the void space at 2 purpose built clinical facilities at Rawmarsh Customer Service Centre and the PDL Bungalows

6. Other property considerations:

- A new health care facility will be delivered in the Waverly area as this new community builds out. NHS PS will support the CCG in the delivery of this facility. NHS PS would likely become the new owner of this property but this is to be confirmed

7. Recommendations

- The strategy and opportunities are endorsed by CCG and NHS Property Services

1. Scope overview

- The CCG has an overall vision of working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities.
- This strategy reviewed the CCG clinical strategy and NHS PS property in the CCG's area – a summary of the key themes is included in Section 4 of this report.
- Rotherham's resident population is estimated at 259,800 who are cared for by a total of 31 GP practices (as at April 2016) alongside a centrally based walk-in centre providing 24/7 access.
- The CCG has a new General Practice Strategy that is being developed which this SEP is a key enabler for delivery this includes new models of working which will be piloted to encourage team working across community, mental health, social care and voluntary services and also involve secondary care to enable care closer to home.. Since April 2015 the CCG has had full delegated authority for commissioning general practice services
- Many general practices are privately owned by partners in the practice, this is starting to become more of an issue as GPs are now more likely to choose to become a salaried GP rather than take on a partnership.
- Dialogue with other NHS stakeholders and the Council has taken place in the development of this strategy and will continue as the opportunities are developed.

2. The CCG drivers and challenges

Health Inequalities and increase in Elderly care needs

- Life expectancy in Rotherham is one year less than the England average.
- Life expectancy varies by eight years between different parts of Rotherham.
- Too many people are admitted to hospital who do not need to be, which results in high costs of treatment.
- Increasing numbers of older people with long term conditions which has a direct impact of health needs.

Clinical Strategy and Financial Implications

- Transforming community care and Care closer to home in order to reduce hospital admissions and tackle the issues listed above the development of hubs will be pivotal to this change. .
- Improved patient pathway so that patients are seen at the right place at the right time.
- Since April 2015 the CCG has had delegated authority for commissioning general practice services and this is a driver for a clear and effective Strategic Estates Plan.
- Maximising the partnership with RMBC in the longer term to deliver optimum estate value for the Rotherham CCG area.
- £75 million efficiency challenge over the next 5 years.

3. The Estate Overview

- Overall the NHS PS estate is in a good condition as the former PCT invested heavily in the buildings with the council on joint medical centres.

20 Holdings / 15.2k sqm NIA

13 Holdings
7510sqm NIA
Health Centre

3 Holdings
3502sqm NIA
Hospitals

0 Holdings
Nursing / Care Home

3 Holdings
4201 sq. NIA
Offices

1 Holdings
(Car Park)
Land without buildings

0 Holdings
Other / Unknown

Top 5 properties (by size - NIA)

- **Rotherham Community HC** (Health Centre) 2914
- **Oak House** (Offices), 2461
- **220 BML (Badsley Moor Lane Hospital)** (Offices), 1740
- **Breathing Space** (Hospital), 1231
- **Aston Joint Service Centre** (Health Centre), 998

Total Cost of Estate

Based on 15/16 costs: £5.2m p.a.

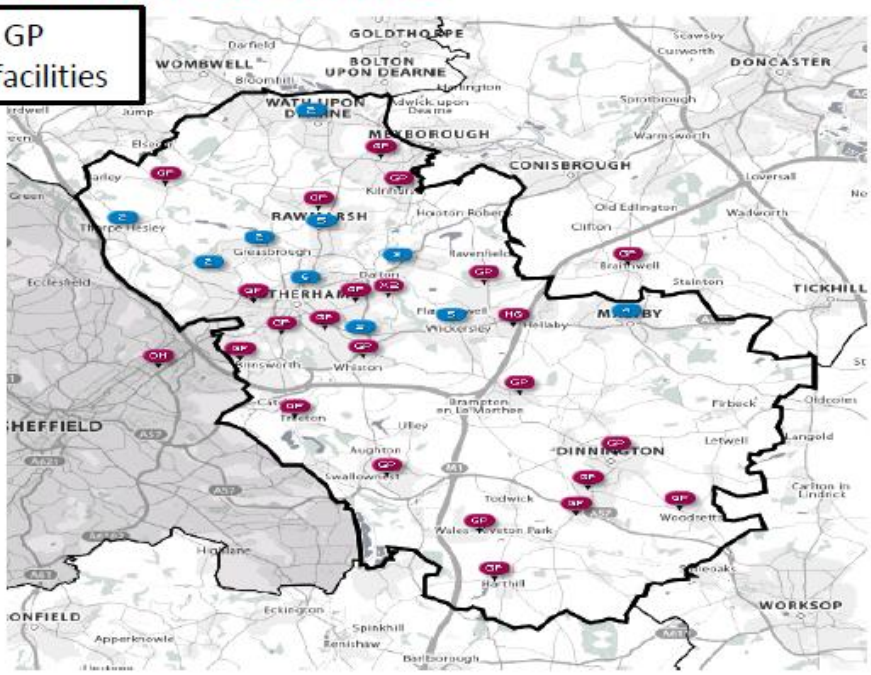
Top 5 Properties by Cost

Property	Running Cost £ p/a	Running Cost £ per m2
Rotherham Community HC (Health Centre)	£2,381k	£817
Oak House (Offices)	£848k	£345
220 BML (Badsley Moor Lane Hospital) (Offices)	£505k	£292.61
Maltby Service centre (Health Centre)	£444k	£779
Aston Joint Service Centre (Health Centre)	£280k	£281
Total is £4.4m p.a. or 76% of Estate Costs		

3. The Estate Overview – Estate Map 1

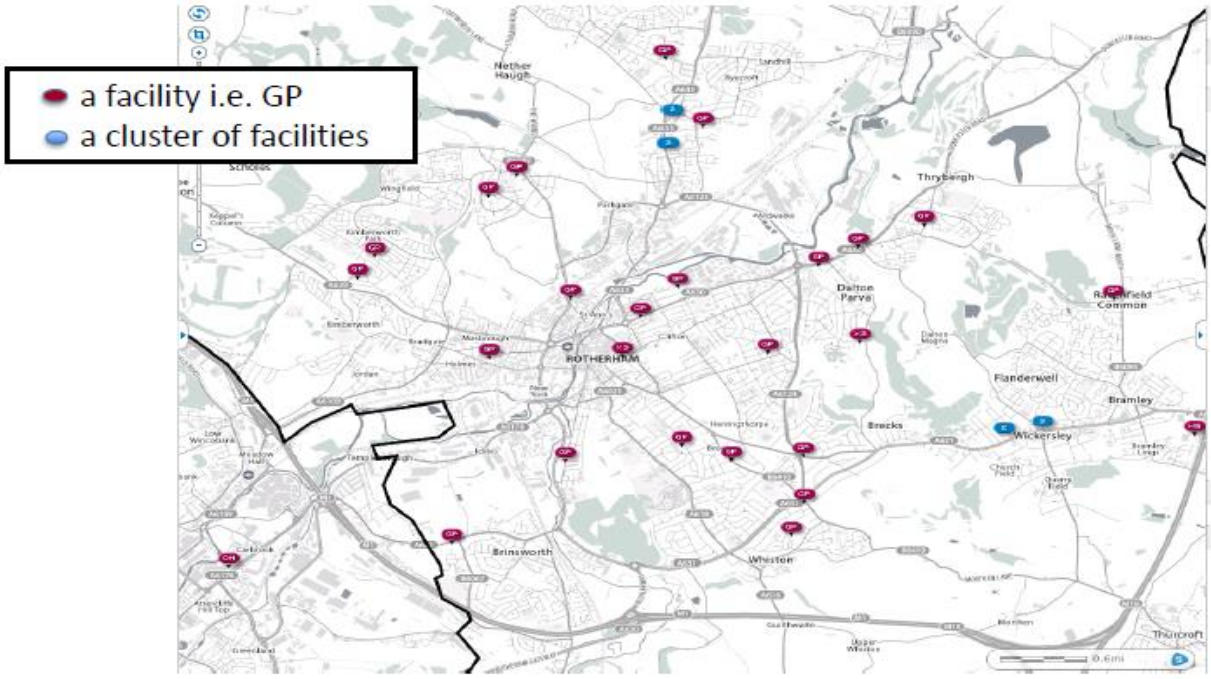
Rotherham CCG Area

- a facility i.e. GP
- a cluster of facilities



3. The Estate Overview – Estate Map 2

Inset of the Rotherham Town Centre Area



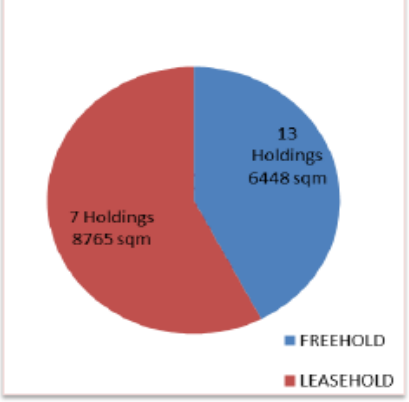
3. The Estate Overview

- Very few lease break opportunities and Oak house is a purpose built health admin building which is in an excellent location and popular with tenants.

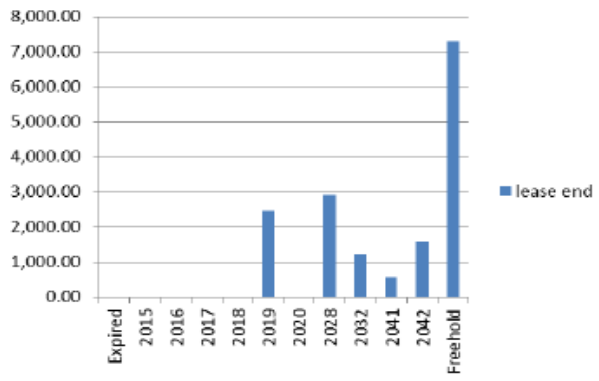
Leasehold Opportunities (5 Years)

- Oak house (CCG HQ and main admin base) end of lease 29.9.19

14.8K NIA sq m (20 Holdings)



Lease End + Break Profile (NIA sq. m)



4. Key themes emerging from the review

1. Immediate Priorities:
- Clinical leadership, both in primary and secondary care
- Delivery of effective out of hospital care to reduce admissions
- Supporting self-care and delivering care as close to home as possible and therefore a fit for purpose local estate
- Better IT to improve communication, access to services and patient education

2. Healthcare planning and Challenges:
The Joint Strategic Needs Assessment and Health and wellbeing objectives are:
- Prevention and early intervention
- Expectations and aspiration
- Dependence to independence - to tackle the marked health I equalities in Rotherham
- Healthy lifestyle – to tackle the marked health I equalities in Rotherham
- Managing long term condition- Rotherham has increasing number of elderly with these
- Reducing poverty -to tackle the marked health I equalities in Rotherham

3. Service Model Developments /Changes:
- Care closer to Home to reduce hospital admissions and tackle the above challenges
- Improved consistency in access to general practice – aspiring to within 24 hours for an urgent appointment and within 5 days for routine appointments

4. Financial considerations:
- The CCG has a £75 million efficiency challenge over the next 5 years
- Efficiencies passed on to all providers who must make 3.5% saving a year
- Finding each additional annual efficiency saving is increasingly challenging
- Rotherham will spend around £14.1 million on public health in 2014/15, commissioned by RMBC

4. Key themes emerging from the review

5. Existing strategies and plans:
- Rotherham Health and Well Being Strategy that will be refreshed by September 2015 delivering the outcomes of the Better Care Fund and working with partners to improve public health outcomes in Rotherham.
- A new General Practice Strategy is being developed which this SEP is a key enabler for delivery.

6. Key site requirements:
Overall the estate is in a good condition as the former PCT invested heavily in the buildings with the council on joint medical centres. However the following are the key challenges the SEP must tackle:

i) Waverly
- The impact of the Waverly residential development (circa 20,000 new patients) and the subsequent new Primary Care provision needed for which the capital finance will be provided by S106 developer contributions.
- Linking to the Waverly development the future of nearby Treeton medical centre (NHS PS owned).
- NHS PS can provide assistance to the CCG regarding Scope of the project and property support to be agreed.

ii) Rawmarsh Customer Service Centre (RMBC owned, NHS PS long lease)
- Rawmarsh Customer Service Centre – The building is currently underutilised with a high vacancy rate (42%) but is an excellent modern purpose built building. A co-location opportunity exists with a cluster of GP practices and/or the vacant space could be marketed. (Options paper needed).

iii) PLD Bungalows (NHS PS owned)
- Are part of the 220 Badley Moor Lane site (NHS PS owned) have recently become vacant (100%). There were purpose built as a residential/day care for learning difficulties. They are part of and central to a large integrated wider health complex at BML that was built on a former hospital site. Given this they will have to retained for some kind of health or health related use and an options paper and/or a planning appraisal will need to be conducted to determine their future use.

iv) GP Estates Issues
- The future of Broom Valley GP (privately owned) which is in a poor condition. (Options paper needed)
- Canklow Road (NHS PS owned) poor quality building, potential to dispose and move to private premises.
- Rosehill medical centre (NHS PS owned) is small and in a poor condition.(options paper needed).
- A new health facility has opened at Dalton and the former Dalton MC (NHS PS owned) can be disposed.

5. Property Strategy Forward View

	As-Is Position	To-be Position
 Clinical Estate	▪ Overall the estate is in a good condition and most sites have had recent investment. ▪ NHS PS have identified with the CCG some sites that are in a poor condition and need replacement or surplus to requirement. ▪ Review of accommodation requirements for bring care closer to home and teams together ▪ A new facility is required at Waverley and the capital development will be funded by developers. ▪ Need to tackle the key void space at Rawmarsh.	▪ Dispose of surplus sites at Dalton Health Centre (new build complete) and review of the poorer quality sites at Rosehill and Canklow Road (options papers needed). ▪ Assess the future of Broom Valley GP (options paper needed). ▪ Fully utilise the Rawmarsh Centre through co-location of nearby by GP practices or sub letting. ▪ Scope the requirements for the new facility at Waverly linked to the existing GP facility in Treeton.
 Admin Estate	▪ Oak house (CCG HQ) has a lease end opportunity, however the CCG have confirmed the property is ideal for them. ▪ The 220 BML is 100% occupied by the council and forms the Learning Disability Service. ▪ PLD Bungalows were purpose built for a service that didn't develop the numbers required to make it viable. They are part of the above complex/site and are vacant and need to be found a new use.	▪ Retain Oak house and 220 BML. ▪ Fully utilise the PLD Bungalows. An options paper and potentially a planning assessment would be required. Then marketing.
 Estate Metrics	Running costs: ▪ NHS PS estate £5.2m p/a Estate footprint: ▪ 11,012sq. m of clinical space across 16 property holdings. ▪ 4,201sq. m of back office space across 3 property holdings.	Running costs: ▪ Target to reduce the ongoing running cost to less than £5m p/a ▪ Around a 4% saving. A cumulative saving of £857k over the 5 year period. Estate footprint by March 2020: - 10,612sq. m. of clinical space across 13 properties. - 4,201sq. m of back office space across 3 property holdings. - Reduction of void.

6. Summary of Property opportunities

Table 1 Summary of financial benefits:

Opportunity Area	Running Costs Savings by Financial Year (£k)						One-off capital receipts	One-off maintenance avoidance
	15/16	16/17	17/18	18/19	19/20	Totals		
• Consolidation and disposal opportunities	63	12	0	0	0	75	£265k	TBC
• Improved utilisation and sub/let savings / maintenance avoidance • Marketing of surplus (void) space	0	126	0	0	0	126	0	TBC
• Leasehold opportunities – - Exits - Regears	0	0	0	0	0	0	0	TBC
Totals	63	138	0	0	0	201	£265	TBC

Summary of non-financial benefits:

- Reconfiguration of the estate to better meet the commissioners needs
- Disposal of property that is surplus to need or is not fit for purpose.
- Full utilisation of quality modern purpose-built estate at Rawmarsh Service Centre and PDL Bungalows at Badsley Moor Lane.

6. Property opportunities & savings

Table 2 Consolidation and disposal opportunities:

Opportunity	Estimated Running Cost savings £k pa	Estimated disposal proceeds £k	Target Financial Year of savings
Disposal of Canklow Road GP Surgery (NHS PS Owned)	£4k	£48k	16/17
Disposal of Dalton Health Centre + Land (NHS PS Owned)	£63k	£125k	15/16
Disposal of Rosehill Medical Centre (NHS PS Owned)	£8k	£92k	16/17
Totals	£75k	£265K	

Canklow Road

Rosehill Medical Centre

6. Property opportunities & savings

Table 3 Improved utilisation and sublet savings:

Opportunity	Estimated Running Cost savings £k pa	Maintenance Avoidance £m pa	Target Financial Year
Option 1 Rawmarsh Service Centre. Improve utilisation by facilitating with the CCG the co location of 3 x privately owned GP practices	£85k	Tbc	16/17
Option 2 Rawmarsh Service Centre. Market the vacant space (or residual space if 1 or more of the GP relocate)	£85k	tbc	16/17
Market the 4 PLD Bungalows at 220 Badsley Moor Lane (offices/residential other)	£41k	TBC	16/17
Totals	£126k	£TBA	

Rawmarsh Customer Service Centre

6. Property opportunities & savings

Table 4 Leasehold exit opportunities

Opportunity	Estimated Running Cost savings £ p/a	Estimated disposal proceeds £ p/a	Target Financial Year
• None (Oak house is the only opportunity, it was purpose built as the PCT HQ and the CCG and other tenants want to remain)	0	0	N/A
Other property Opportunities and considerations: 1) A new health care facility will be delivered in the Waverly area as this new settlement builds out. A facility of al least 1300 sq. m is agreed in the S106. NHS PS will support the CCG in the delivery of this facility. NHS PS would likely become the new owner of this property but this is to be confirmed 2) At the time of writing (September 2015) the CCG has been consulted on Rotherham Metropolitan Borough Council's Local Plan which allocates land for development over the next 15 years. NHS PS will assist the CCG to assess the proposals and make representations regarding the need for additional health care infrastructure to mitigate the increases in patient numbers likely to caused by these allocations at the neighbourhood level.			

Oak House current CCG HQ

7. Investment considerations

Investment considerations:

- NHS PS to offer support to deliver the health care element of the Waverly development where a health care centre of at least 1300 sq. m is stipulated in the S106 signed on 03/03/2011. Negotiations with the Local Planning Authority and developer will take place and a delivery route would be worked up in due course.
- NHS PS could help the CCG scope the requirements for the new facility.
- It is envisaged that this would be a NHS PS asset but developed using capital from developer contributions.
- Currently there is land held by NHS PS adjacent to the Treeton Medical Centre for a new build scheme to replace the ageing building. The practice has so far not indicated that they would like NHS PS to pursue this new build through a customer capital scheme.
- There is potential to link this with the new build at Waverly. Options need to be discussed with the CCG and practice and agreed by the Primary Care sub-committee
- Development of 'hubs' to co-locate services and create a '1 team' approach is likely to require capital investment – awaiting pilot review

8. Financial Analysis

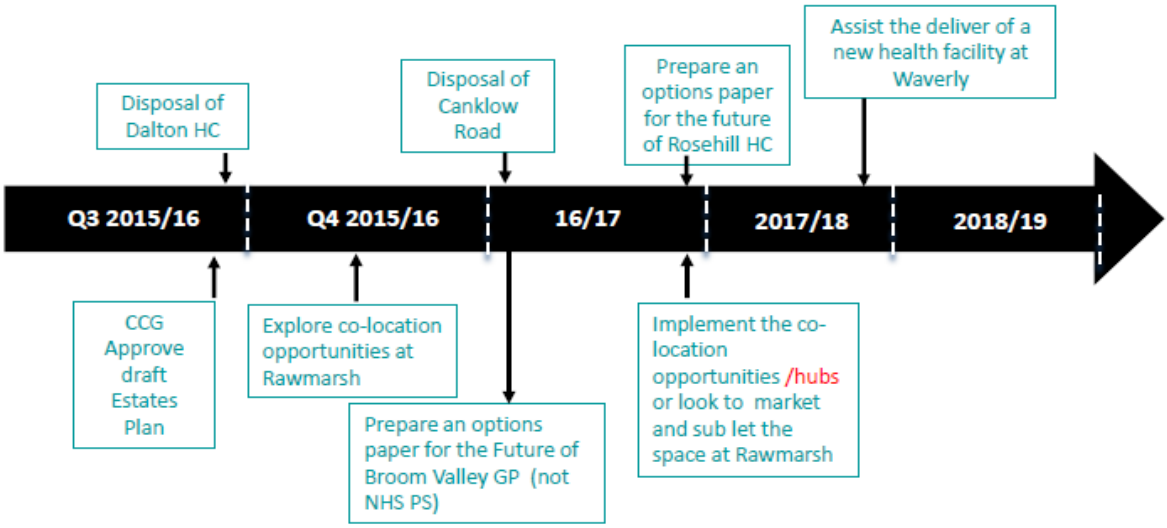
Indicative profile of running costs savings:

- Cost savings profile based on full year benefit from the year of the event with cumulative benefit.
- Disposal proceeds shown in year of receipt

Target financial Year	15/16	16/17	17/18	18/19	20/21	5 Year Total
- 15/16 savings	63	63	63	63	63	315
- 16/17 savings		138	138	138	138	552
- 17-18 savings			0	0	0	0
- 18/19 savings				0	0	0
- 19/20 savings					0	0
Total 5 Year Running Cost savings	63	201	201	201	201	867
Disposal Proceeds £k	125	140	0	0	0	265
Net Benefit £k	**187**	**341**	**201**	**201**	**201**	**1132**

9. Work Plan

- NHS PS is working with the CCG to deliver the strategy.
- Timeline of work programmes and planned disposals



10. Recommendations

Example CCG Estate Strategy (2015 -19): Recommendations for CCG approval:

1. Implementing priority healthcare changes

- The CCG has a new General Practice Strategy that is being developed. This Strategic Estates Plan is a key enabler for delivery.

2. Cost reduction opportunities

- The review has identified costs savings of £265K.
- These costs saving can be made with little impact on service delivery
- The disposals identified will be added to E-Pims and offered to all priority purchasers including the local councils. If no interest is received NHS PS will openly market the properties
- The capital receipts are based on estimates, market valuations will be carried out to ensure the disposals receive best value.

3. Dealing with void space

- NHS PS will look at co-location opportunities with the CCG and individual GPs focused on the Rawmarsh Service Centre in Q4 of 2015/16.
- If this doesn't produce results then NHS PS will actively market the space in 2016/17.
- Following an options appraisal NHS PS will actively market the vacant space at the PDL Bungalows in 2016/17.

4. Improving estate utilisation

- The actions listed in the above section are the key to improving estate utilisation in Rotherham.
- The utilisation will continue to be monitored and reviewed and any significant changes will be addressed by the CCG and NHS PS in line with this strategy.

6. Work Plan

- The plan at section 9 outlines a number of key projects that will need to be progressed to realise the savings.
- These projects need to be worked through utilising NHS PS Asset management teams, Capital and Facilities teams.
- NHS PS and the CCG will work together to drive forward the opportunities and optimise the benefits.

Glossary

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