APPENDIX 1

NHS
Medway Clinical Commissioning Group

Medway CCG General Practice Forward View December 2016

1. Introduction

Medway Clinical Commissioning Group is an active and proactive partner within the Kent and Medway Sustainability and Transformation Plan (K&M STP) and this document sets out Medway CCGs General Proactive Forward View for the local implementation.

The STP Local Care Strategy is developing alongside the CGGs clinical Model, the 'Medway Model'. This is closely aligning with the Kent and Medway Intervention List.

Strengthening and transforming general practice through this model will play a crucial role in the delivery of STP plans. Aligned to the developing models across the Kent and Medway STP, Medway Clinical Commissioning Group (CCG) has been working with Primary Care and its Stakeholders to co design our health and care system.

Our system is being designed to ensure that people will obtain the help they need closer to home. This will allow people to have one point of call for family doctors alongside teams of community nurses, social and mental health services.

These changes will also join up the often confusing array of A&E, GP out of hours, minor injuries clinics, ambulance services and 111 so that our patients know where they can get urgent help easily and effectively, seven days a week.

General Practice will be at the heart of communities with member practices working in extended groups providing support to patients who need help accessing the services that they need.

Having access to a family doctor is one of the great strengths of the NHS. However these services are under increasing strain across the country.

In Medway, as demand has risen, the number of GPs available is not keeping pace with growth in line with national policy, we are taking action now that will secure and stabilise general practice in the future. By doing this we can assure our communities that the services they expect and deserve can be provided in a modern and effective way at a time when the NHS is under increasing pressure.

Our patients don't recognise (or need) the traditional partitions between primary, community, mental health and social care and acute services because they make it harder to provide joined-up care that is preventative, high quality and efficient.

Our Model involves redesigning care around the health of the population, irrespective of existing institutional arrangements. It is about creating a new system of care delivery that is backed up by a new financial and business model.

There is now an urgent need for us to think about how primary care can be delivered in the future because the facts[1] in Medway speak for themselves:

[1] Analysis from SHAPE workforce data

- 38% of the 136 WTE GPs in Medway are over 60 years of age
- There are 51 GP practices and 19 branch practices in Medway
- Of these 20 are single handed (based on WTE) and 7 have WTE between 1 and 2
- Percentage of GP practices, excluding branches where the practice operates with a WTE of 2 or less is 48%
- There are 294,134 patients registered to these GPs. The average list size is 5767
- 3370 houses are planned over the next five years (excludes Lodge Hill at 5,000 currently under review)
- An aging and more medically complex population is resulting in longer than average consultation times. Couple this with the planned housing increase in 5 years demand on primary care will grow further by at least 14%

This report sets out Medway CCGs plan for the 5 Year View and includes:

- The Medway Model co-designed with member practices, partners and providers, setting out a vision for self- care, technology and the wider workforce
- Improving access and investing in Primary Care Services to meet local demand and inequalities in access
- Implementation of 'Time to Care' and the rollout of the 10 High Impact Changes, including alignment to estates and technology investment; workforce development and improved collaboration between providers
- Alignment to Medway CCGs local estates and digital roadmaps which underpin GPFV plans

2. Quality in Primary Care

2.1 Patient Experience and Patient & Public Engagement Strategy (PEPPE)

Medway CCG has made a clear commitment to ensuring that patient experience and public perspectives are embedded into all its activities. The strategy provides a clear framework within which these activities can be conducted.

The strategy is accompanied by an implementation plan that reflects key commissioning intentions and strategic developments containing outcomes, targets and relevant timeframes so that the impact of PEPPE can be measured over time.

The strategy enables Medway CCG to meet its statutory duties and responsibilities in relation to patient and public engagement, ensuring that the commissioning, design, development, delivery and monitoring of healthcare in Medway meet the needs of its population.

By listening to its stakeholders and learning from people's experience of healthcare, Medway CCG will be able to demonstrate how it understands what really matters to people and acts upon this feedback to improve the services it commissions.

The strategy will:

- Support the implementation of Medway CCGs 2017/19 Operational Plan by engaging with communities around priorities and commissioning intentions
- Develop and maintain strategic alliances and partnerships working with Healthwatch and the third sector
- Establish a "community chest" to which small community organisations, who can support improved health and care outcomes, can bid
- Seek to gather, analyse and hold community feedback more systematically so that stakeholder views can be used to inform commissioning activities
- Support the ongoing development of Patient Participation Groups (PPGs) across Medway.

Medway CCG intends to develop and use a range of communication and engagement tools to engage with as many people as possible. A Head of Engagement has been recently appointed who will lead this work going forward.

This approach recognises that there is an important link between the equality, patient experience and patient engagement agendas. It will provide opportunities for different stakeholder groups and individuals to be involved in different ways and at different times. It will build on existing good practice and utilise good practice within the organisation and working with others.

Patient experience intelligence will be managed across and within commissioning teams alongside the work undertaken by Medway CCGs Quality and Safety Team.

2.2 Care Quality Commission

Medway CCG is working with the Care Quality Commission and NHS England to ensure that all General Practices are good or above. Currently of the 51 practices, 4 have not been inspected, 1 practice is Inadequate (recently removed from special measures), 4 required improvement and the remaining 41 are good. This will be monitored by Medway CCG through the established a Clinical Variation Group.

2.3 Clinical Variation

The Clinical Variation Group is chaired by a local GP. Its role is to recognise, evaluate and diminish gaps in clinical variation. The group is supported by a fully developed Primary Care

Dashboard and Quality Outcomes Framework audits. This includes looking at clinical practice, administration and working practices of various practices across Medway.

Initial work utilising the Quality Outcomes Framework and Audit+ have resulted in identifying practices that are currently performing below peer in the following areas:

- COPD (Spirometry & Pulmonary Rehab)
- Hypertension
- Chronic Kidney Disease
- Atrial Fibrillation
- The National Diabetes Audit

11 practices across Medway have been identified to work with in order to improve rates across these areas. Support offered by the group include assistance from the Clinical Lead, as well as two experienced practice managers working as Clinical Variation Managers on a part-time basis until 31st March 2017.

The group will also be using the Medway Health Inequalities document (published January 2016), to ensure that variations in treatments are further reduced. We are working closely with Medway Public Health in order to identify trends in the data and target specific areas and practices going forward. This will also support our developing clinical models.

In April 2017, the team structure will change and 3 clinical variation nurses are being recruited in order to maintain the work started by the Clinical Variation Managers.

2.4 Medicines Management

The Medicines Optimisation Programme continues to improve the quality of medicines used to ensure safe, cost effective, evidence based and rational prescribing for Medway patients. There is close working with practices and nursing homes to reduce unwarranted variation in prescribing and to reduce medicines waste.

In the period 2017/19 the Medicines Optimisation Programme will continue to maintain patient need and safety at the forefront by prioritising self-care promotion and patient education. Local areas of focus include diabetes, prevention of acute kidney injury and the prescribing of analgesia. The current successful work in nursing homes will be extended to offer support to residential homes.

Ongoing work in nursing homes has highlighted areas for further work. The provision and use of dressings both in and out of nursing homes has been a particular focus. Joint reviews have been conducted with our clinical pharmacists in conjunction with members of the tissue viability team for care homes and practices. This has led to further education on

wound care products for GPs, practice staff and community nurses resulting in better management of wounds and a reduction in local spend on wound care products.

The medicines optimisation team are currently working closely with the local dementia support services to ensure appropriate early diagnosis of dementia patients and to reduce inappropriate prescribing in this cohort of patients. In the previous 12 months the Care Homes Pharmacist has discontinued the use of low dose antipsychotics in 43% of total patients reviewed in nursing homes.

We will also be reviewing the evaluation of the recent Health Foundation Clinical Pharmacist Pilot and implementing and rolling out its recommendations.

2.5 Prevention

The NHS England Five Year Forward View, and developing proposals for the Kent & Medway Sustainability and Transformation Plan, emphasise the need to prevent avoidable disease and disability. To be effective, such activities need to be undertaken on a far greater scale than previously and to become a routine part of the role of all front line personnel in both health and social care services.

The five main areas for prevention are:

- smoking cessation
- mental health promotion
- increasing physical activity as part of everyday life
- establishing and maintaining a healthy weight
- drinking alcohol sensibly

In addition, immunisation is second only to clean drinking water as a way of protecting people's health and is a vital component of reducing the risk of developing avoidable infectious diseases. Protecting our children and others at greater risk of infectious diseases because of age of health problems through immunisation is simple, safe and effective.

Screening is also important because it is a simple and safe way of identifying potential health problems at an early stage when they can be more easily remedied or cured. We will work with NHS England to ensure that screening opportunities are maximised.

We will continue to encourage and enable people to be healthier in all aspects of their lives at every opportunity, not just when they seek advice from health and care but across public services. And in addition, it is important that we actively encourage and enable people who do not normally seek such services to live healthier lives. We will support our communities to make informed choices about their health and raise awareness about risks associated with lifestyle choices.

All elements of self-care and prevention will be reflected in the emerging models.

2.6 Care Redesign

Frailty

Drawing on the learning from best practice and the information contained within the Kent Integrated Database, Medway CCG will identify those patients with three or more long term conditions plus those with dementia to ensure that they receive regular reviews of their care to ensure that they maintain their health for as long as possible.

The Yeovil Vanguard has demonstrated a 30% reduction in emergency admissions for their high risk patients that have received enhanced care and reviews from their complex care teams.

Medway CCG has commenced this enhanced care by commissioning the provision of a consultant geriatrician to provide reviews in health living centres and primary care. This will be built upon and extended to cover all those deemed as complex and high risk to ensure that they receive the very best coordinated care and treatment while reducing the demand for acute emergency beds.

Falls

Medway CCG is partnering with Kent Fire and Rescue Service to provide home safety visits for patients who have fallen or who are found to be at risk of falling. An identical scheme has been running for the past 4 years in Canterbury, New Zealand where they have reduced the number of fractured necks of femur by 25%. Medway CCG will evaluate this with an appropriate academic partner given its potential for significant benefit to patients.

Cancer

Cancer is a major cause of illness, disability and death in the UK. Nationally, the incidence of cancer is increasing, whilst mortality rates have declined largely due to improvements in screening and treatment for cancer. However, in Medway cancer mortality rates have been consistently above the England average, despite incidence rates being similar to England, Right Care identifies this as a key area for improvement for Medway CCG.

A paper on ‘Reducing Cancer Mortality in Medway’ was taken to the Medway Health and Wellbeing Board in February 2016. The report provided an overview of cancer in Medway, focusing on lung, breast and colorectal cancer, describing achievements to date and areas for improvement. A recommendation from this report was that a ‘detailed, systematic investigation’ into cancer in Medway is conducted to explore the possible reasons behind the high mortality rate seen locally and to identify areas for action.

The report takes a detailed look at the burden of cancer in Medway by investigating the prevalence, incidence and mortality for the ten commonest cancers locally. A systematic approach is then taken to analysing the most up to date data available on all areas of the cancer patient pathway, covering:

- Prevalence of risk factors for cancer
- Cancer awareness and campaigns
- Screening
- Routes to diagnosis
- Waiting times for referral, diagnosis and treatment
- Staging at diagnosis
- Patient experience during treatment
- Survival

The focus on each of these areas has been included in the joint action plan with Medway Council. The focus on prevention strategies includes working with the Medway health improvement programmes for smoking cessation, weight management and exercise on referral to ensure public awareness of the risk factors for cancer.

Diabetes

Medway CCG will be working with GP practices to highlight and address variation. We are promoting patient structured education that offers practical advice and support to patients around managing their conditions.

Two diabetes specialist nurses will provide support and training to Practices in Medway. Practices identified by the Audit Plus system and as part of the annual National Diabetes Audit with a focus on achievement against the NICE care processes and areas identified by the RightCare programme :

- HbA1c
- Blood Pressure
- Cholesterol
- Serum Creatinine
- Urine Albumin c
- Foot Surveillance
- BMI
- Smoking

100% of Medway practices participated in the National Diabetes Audit in 2015/16. The continued participation will be driven by the delivery of the clinical variation programme.

We will continue to work with partners across primary, secondary and community care to deliver an integrated strategy for Diabetes care and prevention. The strategy development will include input from the South East Clinical Network for Diabetes, Medway Council, Diabetes UK, The Paula Carr Trust and close working with other CCGs across the STP footprint. The focus of the strategy will include:

- Medway FT has adopted an integrated service with a 3 tier model with input from primary care and community care. The Integrated Diabetes Steering Group includes representation from Consultants, Diabetes Specialist Nurses, podiatry nurses, a paediatric nurse and service managers across MFT and Medway Community Healthcare. We will continue to work with the Steering Group on strengthening this model built around the overarching strategy for Diabetic patients in Medway.
- **Screening:** We will work with partners to ensure that diabetic screening service for retinopathy continues to be maximised.
- **Improving structured patient education:** The demand for structured patient education has increased over the last two years. The current service offers advice and support to assist patients in managing their conditions and describes how making lifestyle changes especially with diet will benefit patients. Medway CCG will participate in a joint bid across Kent and Medway for the transformation fund to improve the uptake of structured education.
- **Improving foot care:** We have conducted a needs analysis on foot care against the NICE guidance and will be looking into addressing the gaps in conjunction with the plans for the reconfiguration of Vascular services.
- **Local action on obesity linked to diabetes prevention:** We will continue working with Public Health and building on the work of the Diabetes Prevention Programme with Medway Council.
- **Patient information:** We will continue to work with The Paula Carr Trust on promoting the use of information packs for newly diagnosed patients and utilising the technology available on the Map of Medicine system.
- **Hypoglycaemia pathway:** This project in conjunction with the Kent Surrey Sussex Academic Health Science Network introduces a pathway between SECAmb and GPs to provide notification to GPs following response to hypo episodes that do not result in a conveyance to hospital. By providing a notification to the patients registered GP the pathway enables GPs to undertake a follow up with the patient, within a locally agreed timescale, to assess the event and patients concerns, and implement hypo avoidance plans. These plans can then support reduction in the reoccurrence of hypos by helping patients to self-manage their diabetes and avoid further complications that could potentially result in hospital attendance.
- **Cross cutting programmes:** We will work closely with the Medicines Optimisation Team and Medway Council Community Paediatric Health Team on the cross cutting priorities for Diabetes.

Dementia

In 2015 it was estimated almost 3,000 people in Medway were living with dementia and a considerable increase in this figure is anticipated in future years. Responding to this challenge is a priority, and is highlighted in Medway's Health and Wellbeing Strategy for 2012-2017.

A range of preventative services exist, mainly funded by voluntary contributions and these need to become a core part of the care pathway. A gap analysis undertaken by Medway CCG and Council has highlighted a number of issues for us to address.

Medway CCG and the Council work closely to improve the lives of those people with dementia and services are commissioned through the Partnership Commissioning Team, jointly funded and run by Medway CCG and Council.

Medway CCG is working to increase the number of over 65 years olds diagnosed with dementia to at least 67% of the estimated prevalence. Medway CCG has established a working group to improve the Dementia diagnosis. Between January and September 2016 the diagnosis rate increased from 60.3% to 64.2%, resulting in an additional 135 people receiving a diagnosis. The calculation for the prevalence rate for dementia diagnosis will change with effect from 1st April 2017, this will have a negative impact on Medway CCG and result in a reduction of 6% in the diagnosis rate.

In addition to increasing the rate of diagnosis, Medway CCG will be working with primary care teams to ensure that every patient with a diagnosis of dementia has a documented face to face review every 12 months.

Plans include:

- Conducting regular audits using the audit plus tool to identify patients with suspected/possible dementia, patients receiving dementia drugs but no diagnosis of dementia and patients referred to the memory service but with no diagnosis of dementia.
- We will continue to increase the number of people being diagnosed with dementia, and starting treatment, within six weeks from referral. We have set trajectories in place to ensure improvement is in line with national guidance of 5% each year.
- Ensuring that robust systems are in place to ensure that every patient with a diagnosis of dementia has a yearly face to face review in primary care.
- Focus on personalisation, in particular in relation to rolling out Personal Health Budgets and transforming Dementia Day Services, for instance through key links with Adult Social Care Strategy and Care Act implementation.
- Regular Dementia Friends training sessions to help to raise awareness and tackle misunderstandings.
- Medway Dementia Action Alliance to become self-sustaining by 2017.

- The Joint Dementia Commissioning Plan sets out specific steps to achieve commitment across the system for the design and funding of future care pathways.
- Contacts with key BME community groups will continue to be utilised to develop a more personal approach. This will include further research for groups not yet directly engaged with, for instance LGBT.
- The Integrated Care Home Team which supports nursing homes has been reviewed and a pilot in residential homes will commence.
- An improved partnership with secondary mental health services is in place thanks to liaison with GP-led Local Care Teams. This is part of ongoing work to help GPs identify dementia diagnosis as a priority.
- A strategic review of support services for unpaid carers (including carers of those with dementia) will be completed when re-commissioning will take place. This includes ongoing links with the local branch of the Alzheimer's Society.
- An application by the Dementia Action Alliance (working in partnership with Medway Council and Medway CCG) will be made in December 2016 for Medway to be recognised as a Dementia Friendly Community by the Alzheimer's Society. The impact of and actions achieved by the local Dementia Action Alliance is outlined below.
- A technology pilot has been undertaken, led by a partnership between Medway Telecare Services and Medway Community Libraries, to use GPS technology to enable those with dementia to safely get out and about.
- The pathways involved in dementia care are being mapped and redesigned to develop an integrated care pathway and coherent system of dementia support.
- Dementia advice line for GPs
- Development of a shared care protocol between primary and secondary care for the memory service
- Development of a new referral form for older adult mental health services
- Reviewing the pathway for CT and MRI scans which is currently resulting in long waits for diagnosis
- Improve referral pathways for people receiving a diagnosis of dementia at the acute hospital.
- Identify opportunities for efficiencies/reinvestment through a detailed cost analysis and review of the potential of the Better Care Fund.
- Post diagnostic support test for change approach to be implemented initially in Rainham Healthy Living Centre, working closely with: clinicians, patients, and the voluntary sector. For example, working to develop a drop-in service at the local dementia café.

Increase Access to Psychological Therapies (IAPT)

A national programme for improving access to psychological therapies (IAPT) was launched in 2008. The aim of the IAPT service is to provide a universal primary care psychological therapy service for people registered with a GP and suffering with depression and anxiety

disorders which is integrated within current physical and mental health services. IAPT aims to relieve distress and transform lives by offering NICE approved interventions such as counselling and cognitive behavioural therapy (CBT) for people suffering with depression and anxiety disorders.

It is estimated nationally that around 17.7% of adults aged 18 and older meet the diagnostic criteria for at least one common mental health disorder and at least 15% of those will enter Primary Care Psychological Therapy Services (PCPTS).

Across Medway the adult population of 18-64 year old is 198,816. Of these, 29,601 (15%) (Mental Health Needs Assessment, 2014), may have common mental health disorders and 4,441 (15%) may enter PCPTS.

The development of the IAPT Service has been undertaken considering the needs of the whole population including prevalence and incidence of common mental health disorders.

The Medway CCG will work with primary care to embed the new IAPT service model. We will continue to work with GPs to improve referral into the service much earlier before patients reach crisis point enabling more patients to be seen at step 2. We will work with providers to increase marketing of the IAPT services to improve self-referrals into the service.

Early Intervention to Psychosis (EIP)

Medway CCG is performing well against the new waiting time standard that 50% of patients experiencing a first episode of psychosis commence treatment within two weeks of referral. The EIP service is one service across Kent and Medway and the performance is measured across Kent and Medway. The latest performance figures for August 2016 show that 68% of patients started treatment within two weeks.

The aspiration is to achieve parity of esteem for people with mental health problems and put their care on an equal footing as those with physical health problems.

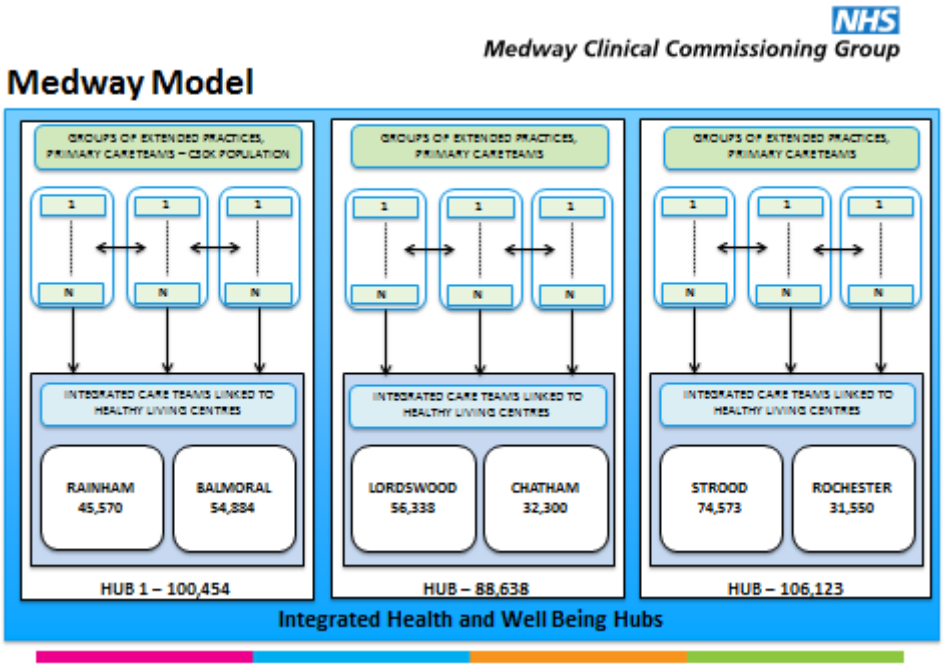
The EIP services will provide the full range of psychological, psychosocial, pharmacological and other interventions shown to be effective in NICE guidelines and quality standards, including support for carers and families. Our vision is to put in place effective and integrated services to address the social and wider needs of people with psychosis to help them live full, hopeful and productive lives.

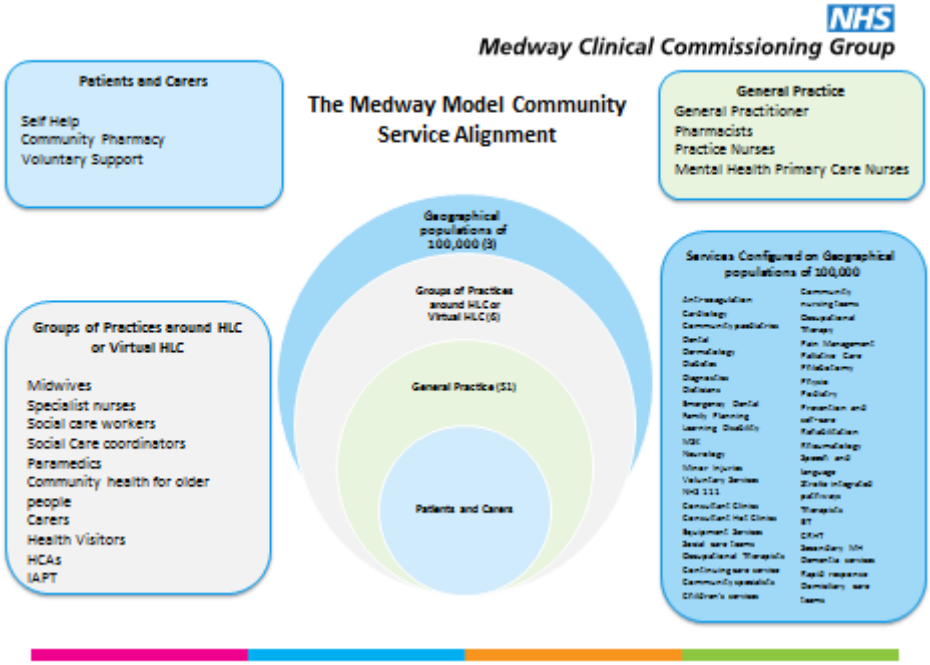
3 New Care Models: The Medway Model

The Medway Model is being developed in alignment with the emerging Models within the Kent and Medway STP. In consultation with or General Practices the model is starting to *ev*olve aligning future patient centred care with co-ordinated multi-disciplinary services wrapped around GP practices.

The Model is being built upon the Kent and Medway Local Care Intervention List

1. Support people and their carers to improve and maintain health and wellbeing by building knowledge and changing behaviours through proactive prevention and engagement
2. Work to ensure a healthy living environment to preserve long term health and well-being e.g. falls prevention, open dialogue, housing, befriending, respite care
3. Bring integrated health and social care into or coordinate it close to the home
4. Provide a rapid response service to get a suitable health or social care worker to a person's home within 2 hours and if appropriate avoid an ambulance or hospital admission
5. Support people in becoming independent through re-enablement
6. Increased organisational and financial support for the voluntary sector
7. Provide single point of access to secure any community and social care package
8. Care support and planning in conjunction with care navigation and case management
9. Timely access to diagnostics to support providing care closer to home
10. Access to expert opinion without referral for outpatient appointment, including making use of GPSI and advanced nurse and therapist roles
11. Facilitation of transitions of care incl. discharge planning
12. Mental Health Liaison providing input on care for patients bridging between both the acute and community setting





Local Care Teams: Groups of Practices around Health Living Centres (HLC) or virtual HLC

The 6 Local Care Teams (LCTs) have already been developed to enable practices to work together and develop a shared responsibility for building improved services across Medway. By working together they are more likely to improve patient outcomes and support integration (or joining up) of the wider health and social care system.

These teams are being developed around local natural geographical networks and communities linked to Healthy Living Centres in Strood, Rochester, Chatham, Lordswood, Gillingham and Rainham. Their main purpose is to focus on the health and social care needs of local communities and through their patient participation groups, ensure that patient voices are heard and acted upon. To do this they will need to work better with all providers, civil society, Healthwatch, and other patient representatives.

By placing collaboration at the centre of what we do, Medway primary care will be able to develop services in line with the "General Practice Forward View" and support the establishment of new model contracts.

The Teams will take the lead in local service design, reduction in clinical variation and the implementation of the 10 High Impact Actions.

Integrated Care and Wellbeing Hubs: Geographical populations of 100,000

Improvement is the backbone of our model. We hope that, over time, the 6 Local Care Teams will consolidate around 3 hubs that will work together on a more formal basis serving a population of about 100k. A single contract will be developed alongside new governance,

business intelligence and assurance frameworks that share digital technology to support better services within our communities.

These Integrated Care and Wellbeing Hubs will be developed locally to reflect current and future services. Local need and the Kent and Medway STP will determine the exact composition and configuration of these hubs, but they will all bring together a range of clinical services alongside wider health and social care expertise in a way that facilitates more 'joined up' ways of working. We know that patients prefer to be treated at or near home so wherever possible and appropriate, we will shift care from a hospital setting to the community and home.

We will expect to demonstrate improved access to services across localities and our estates strategy supports this approach with a focus on utilising the Health Living Centres to achieve this.

The hubs will provide space for primary care services, some out-patient services, community services (including mental health) and the voluntary sector. Where possible all space will be generic and rooms will be used flexibly with shared facilities.

As the models develop Medway CCG will begin reviewing what contract model best aligns and what steps we will support our General Practices to take to enable collaborative working.

We are working with NHS England to ensure that the re procurement of APMS contracts are aligned to our Medway Model

4 Practice Infrastructure

4.1 Estates

Medway CCG continues to develop the estates strategy to deliver the new models of care. We are identifying and valuing the opportunities for estates rationalisation and land disposal (as well as funding sources) and any key interdependencies.

The first draft of the Medway CCG Estates Strategy was submitted to NHS England in December 2015. The strategy was developed with key stakeholders including the Strategic Partnering Board.

The Estates Strategy is an enabler to build resilience and growth into the local system. Key to the Primary Care and Estates Strategy is the creation of Community and Primary Care Hubs.

Estate provision will need to ensure that the scale and configuration of space for is suitable for clinical work as well as the wider team and the supporting activities and can accommodate and support the integrated community service hub model.

The scale of the challenges faced by the Medway CCG locality over the coming years demands a transformational approach to service development and provision and a clear vision for the estate required to support and facilitate that transformation. Current Primary care Estates facilities are generally poor. The current Healthy Living Centres are poorly utilised and have the potential to develop to become Hubs. The vision for future estate is that:

- It is fit for purpose - functional, accessible, clinically and operationally safe, of high quality, appropriate and up to date and contributes to longer term sustainability by being flexible, affordable and well utilised
- It Re-profiles and aligns the physical environment with future needs and responds to growing demand by delivering increased capacity where needed in a range of settings
- It Supports and facilitates closer integration at local level, with improved access to a wider range of services and delivers the concept of 'integrated community services hubs' as a physical entity that will act as the focus of local services
- It Makes the most of what already exists, redeveloping and reconfiguring facilities where possible but investing in new infrastructure where needed

This will be achieved by the development and use of Healthy Living Centres (HLCs) Rochester, Rainham and Lordswood, Central and the development of two further Hubs in the Chatham and Lordswood locality.

Medway CCG has been successful in applying to the latest Estates and Technology Transformation Fund (ETTF). On completion of due diligence Medway CCG will receive capital funding to develop a HLC in Chatham. The full business case will be developed over the next three months. The Build is due to for completion in March 2017.

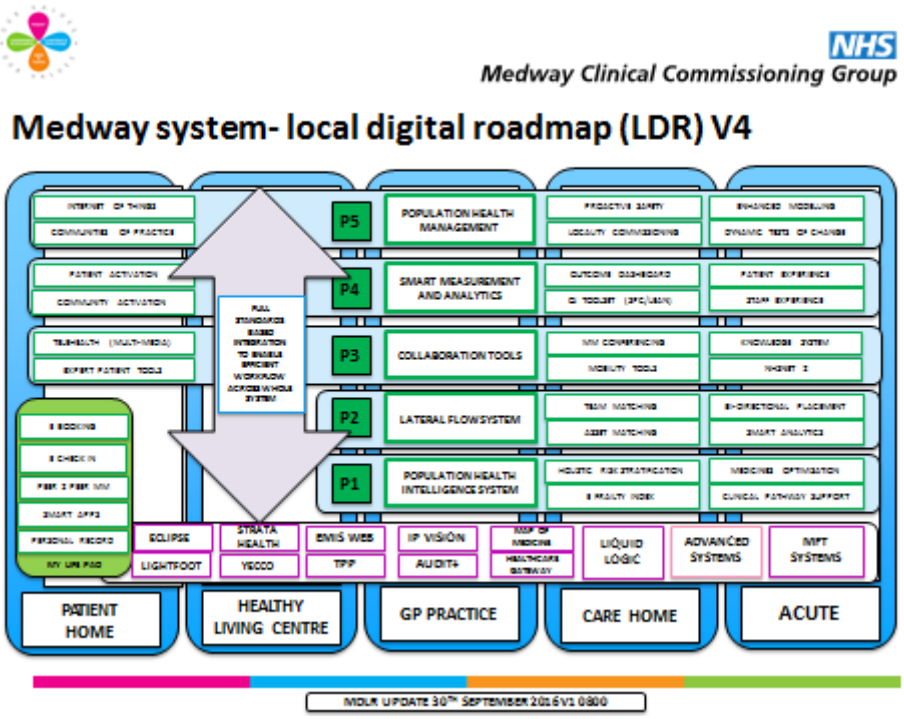
We are also working with Medway Council through the One Public Estate Programme to maximise the new build in Chatham and undertake a feasibility study into a HLC development in Strood.

4.2 Overview of CCG Local Digital Road (LDR) Map

Clinically led improvement, enabled by new technology, is transforming the delivery of health care and our management of population health. Strategic decisions about clinical transformation and the associated investment in information and digital technology help deliver the 'Triple Aim' of health care and make significant gains in quality, efficiency and population health. Information technology can also provide the route to a model of care that generates new value for patients, professionals and organisations

To support this vision the biggest ever investment in technology across the NHS (£4.2bn) will deliver a modern, integrated, paperless NHS which revolutionises the way patients access care from home and empowers people to take control of their healthcare needs.

The Medway Digital Roadmap is an enabler to achieve and support the Medway Model.



The programmes that we are implementing are:

- GP System standardisation

Our General Practices have opted to move to EMIS WEB. Giving the practices interoperability and standardising reporting mechanisms

Implementation timeline	GP SYSTEM VENDOR		
GP practices = 51	EMIS	INPS Vision	TPP
@ 31 Oct 2016	18	30	3
@ 31 Dec 2016	26	22	3
@ 31 Mar 2017	36	12	3
@30 June 2017	45	6	0

- Collaborative GP system model

Medway CCG is encouraging GP collaborative working as part of the strategic commissioning for:

- out of hospital OPD clinics within a multi-disciplinary care setting.
- primary care new service offerings
- primary care - community care integration model.

The importance of being able to work across boundaries within a federation and with other systems will support integrated care models across provider organisations supporting multi-referral sources and clinical pathways through a standard GP system solution. This will support federations looking to offer extended hours working, but also other healthcare economies that are finding new ways of working to offer better, more efficient care to patients. Practices can access an increased range of specialist primary care services – at extended hours – via newly established 'host practices'.

- ICT Infrastructure consolidation (Healthy Living Centres - HLCs)

The four HLC's based in Medway are owned and managed by NHS Property Services. The landlord is not constituted to provide IT facilitated services and this has led to multiple tenants past and present establishing their own independent and discreet IT infrastructure services for their own service operations.

We will standardise and consolidate on WAN / LAN / WiFi for data, video and voice services supported through a single support and management technology partner for both GP practices and co-located health & care providers. This will establish a secure and transparent IT infrastructure supporting federated health and care cross organisational working.

- MIG : record sharing

Current position: Access to the Medway GP records, with a fully compliant Information Sharing Agreement. Medway Community Health - Full API integration with the EPR system operated by provider organisation from September 2016. Medway Out Of Hours GP services – Web based access made available from Sept 2015. Medway Foundation Trust – Live in Ward areas November 2016, plans to roll out to ED and MAU by March 2017.

The CCG are planning to provide access to KMPT Mental Health Trust by June 2017, and subject to IG regulation to SECAmb by Sept 2017.

- SMS (Text reminder services):

This will support the High Impact Action to reduce DNAs.

- Resource & Referral management:

This will provide a Llogistics platform to support whole system safe and effective flow of patients to identified referral and resource facilities. Includes full interoperability with systems and processes across health and care sectors (incl primary care, acute, social care and care homes) full supporting suite of data analytics.

It will establish secure and transparent IT systems, clinical and business processes supporting cross organisational health and care integration through a universal transactional service.

- Order Communications Service (OCS)

This will enable diagnostic tests and results to be sent and received electronically, with all the added data quality benefits.

- Active Directory

Across the Medway CCG GP practices each practice operates its own independent network authentication service – predominantly workgroups. This model has no resilience built in. Active Directory permits user to connect their device to access network services i.e. Mail, file, Internet and clinical applications at their host locations AND also from remote sites subject to network routing services.

We will establish a secure and transparent IT infrastructure supporting federated GP as well as cross organisational working. The goal is to create a cloud based infrastructure that is Medway specific and future proofed for any further organisation changes. In addition simple tasks such as user management will be streamlined to reduce delays in the joiners/leavers process.

- Patient on – line services

The ability for technology to support patients with on – line capability to manage their clinical transactions e.g. appointments, repeat prescribing with primary care services.

Timelines associated with the IT projects are illustrated below

Scheme	Start Date	End Date
GP system standardisation	01/10/16	30/06/17
Federated GP System	01/04/17	30/04/18
ICT infrastructure HLCs	01/04/17	30/04/18
Whole system pathway development	01/11/16	31/07/17
MIG Gateway	01/11/16	31/03/17
Active directory	01/04/17	30/04/18
SMS Text Reminder Service	01/01/17	31/03/18
Resource and referral management	01/11/17	30/11/17
Order Comms	01/07/17	31/12/17
Patient on line	01/04/13	01/04/18

5 Workforce

By September 2017 the Medway CCG will develop a general practice workforce strategy linked to the New Models of Care and the wider Kent and Medway STP. This will include current issues, areas of greatest stress, examples of innovative workforce practices and the future models planned.

We will:

- In January 2017 establish a Workforce Committee to include representatives from the Local Medical Council (LMC) and the Community Education Provider Network (CEPN)
- Working with General Practice undertake a baseline / stocktake that includes assessment of current workforce in general practice, workload demands and identifying practices that are in greatest need of support
- Develop workforce plans which set out future ways of working including the development of multi-disciplinary teams, support for practice nursing and establishing primary care at scale. To include:
- General Practitioners (including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020
- Co funding additional Pharmacists to work in practices by 2020 (1500)
- Improving Access to Psychological Therapies (IAPT) in general practice with 3,000 more therapists in primary care
- Initiatives to attract, recruit and retain GPs and other clinical staff including locally designed and nationally available initiatives
- Actions to ensure GPs are operating at the top of their license, for example through use of clinical pharmacists in a community setting and upskilling other health care professionals to manage less complex health problems
- Actions which facilitate an expanded multi-disciplinary team and greater integration across community services to optimise out of hospital care for patients including access to premises, diagnostics, technology and community assets

We will also work closely with NHS England to access the retained national funds to support workforce developments. This includes:

- International recruitment
- Clinical pharmacists in general practice: This will include evaluation and rollout of the current Clinical Pharmacist Pilot currently being undertaken in Medway CCG. Medway CCG will utilise the central funding once available to agree recruitment and rollout programme across all practices
- Working with HEE and NHS England frameworks and models to support the expansion of physician associates, medical assistants and physiotherapists.
- Training care navigators (sign posting) and medical assistants for all practices (between 50 and 150 receptionists)
- General Practice Resilience Programme

6 Reduce Practice Burdens and Help Release Time: Time to Care Programme

In July 2016, NHS England set out plans to establish a new national General Practice Development Programme Time for Care. The programme will support practices to manage their workload differently, freeing up time – Time for Care – for GPs and improving care for patients. This will help practices implement proven innovations that others have already found useful. These have been expressed as 10 High Impact Actions. In turn, this will help practices lay the foundations for new models of integrated care, and play their part in delivering a sustainable STP and the Medway Model.

We have started to develop clear plans on how we will support the planning and delivery of the programme. Our Programme Director for Primary Care Transformation will work with our General Practices to support the implementation of the 10 High Impact Actions and ensuring that they are facilitated to access availed funding and support. This will be coordinated through our already established Local Care Teams.

The 10 High impact actions to release time to care

1. Active signposting

Patients will be provided with first point of contact which directs them to the most appropriate source of help. Web and app-based portals will provide self-help and self-management resources as well as signposting to the most appropriate professional. Receptionists acting as care navigators can ensure the patient is booked with the right person first time

Benefits for patients

- Improves appointment availability
- Reduces low-value consultations and onward referrals

- Shorter wait to get to see the most appropriate person

Benefits for the practice

- Frees GP time
- Makes more appropriate use of each team member's skills
- Reduces internal referrals

Patient Online

Medway CCG is working NHS England to encourage practices to give patients are given access to a web portal or mobile app. This can provide a number of services, including booking or cancelling appointments, requesting repeat prescriptions, obtaining test results, submitting patient-derived data (e.g. home blood pressure readings), obtaining self-help advice, viewing education materials and consulting a clinician.

Medway CCG intends to work with their practices to ensure 100% uptake by April 2018.

Reception care navigation

Medway CCG will begin the training of practice reception staff to enable them to access information about services, in order to help them direct patients to the most appropriate source of help or advice. This may include services in the community as well as within the practice. This adds value for the patient and may reduce demand for GP appointments.

Medway CCG will work with the Community Education Providers Network (CEPN) locally to build on work that they have already been undertaking in reception training.

We will start the training in March and rollout will be complete by September 2017.

Care and Health Navigation

Medway CCG is already piloting high level care navigation support across the locality. We intend to continue different, more focused models of care and health navigation across groups of extended practices for 6 months from April 2017. This will provide a more supportive signposting and navigation process and directory that receptionists can refer to.

Best Practice: We have been reviewing national evidence including Bromley by Bow who introduced first point of contact, sign posting and care navigators.

2. New consultation types

Medway CCG will work with local practices to pilot new communication methods for some consultations, such as phone, text messaging, e-consultation, email and in the case of patients with long-term conditions, group consultations.

Benefits for patients

- Greater convenience, often no longer requiring time off work/caring duties
- Improves availability of appointments
- More opportunities to build knowledge, skills and confidence for self care

Benefits for practice

- Shorter appointments (e.g. phone consultation average 50% shorter, 66% dealt with entirely on phone)
- More opportunities to support self-care with e-consultations, text message follow-ups and group consultations

Medway CCG will utilise central funding to implement on line consultation systems. Service Specifications are being published by NHS England in December. Medway CCG will procure and rollout the system by March 2019.

Medway CCG will work with local practices to identify local good practice and pilot new ways of working in practices and across clinical hubs. This work will commence in 2017/18.

Best Practice: We have been reviewing national evidence including Clarendon, Salford who introduced new ways of working to communicating with patient significantly increasing on the day capacity to 90%.

3. Reduce DNAs

Medway CCG will work with the practices to maximise the use of appointment slots and improve continuity by reducing DNAs. Changes may include redesigning the appointment system, encouraging patients to write appointment cards themselves, issuing appointment reminders by text message, and making it quick for patients to cancel or rearrange an appointment.

Evidence shows that the most effective means of reducing DNAs appear to be rearranging the appointments system to reduce 'just in case' booking ahead by patients - the DNA rate for these can be as high as 25%. If patients have confidence that, when they need help, they can call on the day, DNAs almost disappear.

Benefits for patients

- Improves appointment availability

Benefits for practice

- Frees up appointments
- Easier to avoid queues developing, through more accurate matching of capacity with demand

Medway CCG is already investing in text messaging software that will support patient reminders, patient appointment and cancellations.

Practices will also be encouraged to adopt easy cancellation access via telephone.

Working with practices to increase access will provide patients with the confidence not to book to far in advance and reduce DNAs

Medway CCG will commence roll out in January 2017 and implement the new software to all practices by March 2018.

Best Practice: We have been reviewing national evidence including Birmingham who introduced text messaging and saw 1 72% reduction in DNAs.

4. Develop the team

Medway CCG will work with Health Education England and local health care education providers to broaden the available workforce in primary care. This will ensure that the demand is reduced on GPs and the patient sees the most appropriate professional. This may include training a senior nurse to provide a minor illness service, employing a community pharmacist, physicians assistants, medical assistants or providing direct access to physiotherapy, counselling or welfare rights advice. This will also look at the most effective use of paramedics.

Benefits for patients

- Improves appointment availability
- Reduces low-value consultations and onward referrals
- Shorter wait to get to see the most appropriate person

Benefits for practice

- Frees up GP time
- Makes more appropriate use of each team member's skills
- Reduces internal referrals
- Improved job satisfaction for administrative staff undertaking enhanced roles

Medway CCG will benchmark its workforce in Primary Care and begin working with HEE to ensure resources are understood.

Medway CCG will continue to establish pathways of care that integrate with community pharmacy. We are currently working with NHS England in reviewing the impact of our current minor ailment scheme.

Based on the outcome of the review we will implement a new scheme that will ensure that best value is provided by a community pharmacy based minor ailments service

Over the next two years. Medway CCG will work with practices to pilot new roles and rollout best practice.

Best Practice: We have been reviewing national evidence including Wakefield connect care by broadening the workforce and ensured that patients were seen by the most appropriate professional. This resulted in a 16% in ambulance conveyance.

5. Productive work flows

Medway CCG will work with GP practices to introduce new ways of working. This work will be supported by the service improvement expertise within the Medway and Swale Centre for Organisational Excellence (MASCOE).

This will include reviewing capacity and demand and reviewing practice processes to reduce waste and improve efficiency.

Benefits for patients

- Improves appointment availability and customer service.
- Reduces errors

Benefits for practice

- Frees time for staff throughout the practice
- Reduces errors and rework
- Improves appointment availability and patient experience

Medway CCG will work with its member practices to ascertain current capacity and demand. This work will commence in January 2017 and complete in March 2017. We will also review and pilot news ways of working over the next two years.

We are also currently assessing the functionality and suitability of Map of Medicine in its current format including governance, processes and benefits of the current system. The aim will be to relaunch the product and complete the programme by July 2017.

E-referral

Medway CCG working with MFT and GPs, Medway CCG will be reviewing its use of Map of Medicine, and aiming for 80% compliance with e-referral by March 2017 and 100% by April 2018.

Best Practice: We have been reviewing national evidence including Sutton EHCH Vanguard who achieved a reduction in respite LOS by 3 days.

6. Personal productivity

Medway CCG will work with practices to ensure that they access the opportunities to support and develop staff. This will include personal resilience and enhanced skills. These will range from service improvement training to improving information systems and productivity.

Benefits for patients

- Improved quality of consultations, with more achieved
- Reduced absence of staff

Benefits for practice

- Frees clinicians to do more in each consultation, with fewer distractions and frustrations
- Improves staff wellbeing and job satisfaction

Best Practice: We are working with nationally renowned Salford Health Matters to embed QI skills.

7. Partnership working

Medway CCG is working with its member practices to develop 'The Medway Model'. This is described in detail in section 5.

We will also look into new ways of achieving primary care support to residential and nursing homes aligning to the framework for improving health in care homes.

Benefits for patients

- Access to expanded range of services wrapped around the patient in the community
- Reduces delays introduced by referrals to different providers

Benefits for practice

- Frees GP time, makes best use of the specific expertise of staff in the practice
- Creates economies of scale and opportunities for new services and organisational models

Best Practice: We have been reviewing national evidence including Symphony Somerset who created partnerships and collaboration s which has resulted in a 37% decrease in admissions for patients with multiple long term conditions.

8. Social Prescribing

Medway CCG already commission and are developing Care Navigation Services. Primary Care can refer to the service that in turn can signpost to non-medical services in the community which increases wellbeing and independence

Medway CCG will be reviewing and enhancing this service during 2017 to recognise the growing need for social prescribing and that the GP is not always the most appropriate person to meet patients' needs, particularly where someone has social needs.

Benefits for patients

- Improved quality of life
- Improved ability to live an independent life

Benefits for practice

- Frees up GP time
- Allows clinicians to do the things that only they can do

Best Practice: We have been reviewing national evidence including Bromley by Bow who now offer over 1500 services.

9. Support self care

Medway CCG will work with Public Health, Primary Care, the Voluntary Sector and its Community Provider aligned to the developing Medway Model to create new ways to support people to play a greater role in their own health and care. This will include care navigation and signposting.

Medway CCG will work with local community pharmacies to make best use of the minor ailment scheme and advice and guidance in 2017.

Medway CCG will be working with community providers and specialist teams to increase patient education and self-management of long term conditions.

Benefits for patients

- Improved ability to live an independent life

Benefits for practice

- Frees GP time, allows them to spend more time doing what only they can do

Best Practice: We have been reviewing national evidence including Toer Hamlets MCP who initiated the Life Activation Programme.

10. Develop QI expertise

Medway and Swale Centre for Organisational Excellence (MaSCOE) has been created to help improve healthcare systems to deliver sustainable high value outcomes for patients, families and carers by eliminating wasteful practices or processes. Working with partners across Medway MASCOE are committed to working with all our communities in Medway and Swale to create innovative, needs based services that provide patients with healthcare where and when they need it.

MASCOE will use a whole systems approach uses quality improvement (QI) methodology to embed the essential quality improvement capabilities across the system in Medway and Swale.

MASCOE will build local capability in quality improvement and aim to accelerate the delivery of the evolving Sustainable Transformation Plan (STP) supported by our emerging Local Digital Roadmap (LDR).

Benefits for patients

- Assurance of continuous improvement in patient safety, efficiency and quality of care

Benefits for practice

- Improved ability to achieve rapid, safe and sustainable improvements to any aspect of care
- Increased staff morale and sense of control

Best Practice: We are working with nationally renowned Salford Health Matters to embed QI skills.

7 Improved Primary Care Access

Medway CCG will start access improvement funds at £3.34 a head in 2018/19 increasing to £6 a head in 2019/20. This will enable Medway CCG to fund extra capacity in line with the Medway Model at extended practice level in to ensure that everyone has access to GP services.

In line with national requirements we will procure extended access in line with the following requirements.

- Timing of appointments:
    - commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day
    - commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs
    - provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week
- Capacity:
    - commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population
- Measurement:
    - Use a nationally commissioned new tool to be introduced during 2017/18 to automatically measure appointment activity by all participating practices, both in-hours and in extended hours. This will enable improvements in matching capacity to times of high demand
- Advertising and ease of access:

    - ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity into the community, so that it is clear to patients how they can access these appointments and associated service
- Ensure ease of access for patients including:
    - all practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services
    - patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments
- Digital:
    - use of digital approaches to support new models of care in general practice
- Inequalities:
    - Issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve in place
- Effective access to wider whole system services:
    - Effective connection to other system services enabling patients to receive the right care from the right professional, including access from and to other primary care and general practice services such as urgent care services

We are already working with our member practices to migrate them to their preferred provider EMIS web. This will facilitate the practices working at scale to achieve extended access.

We will begin to pilot extended access in one Local Care Team (4 practices) utilising some of Medway CCG innovation fund and the central GP Resilience Funding. As the central access funding comes on line we will roll out across Medway CCG.

A further 29 practices will roll out in 2018/19 and the remainder in 2019/20.

8 General Practice Resilience Programme

General Practice Resilience Programme sets out indicative funding allocations of £8 million each year for 2017/18 and 2018/19 for NHS England Regional teams to deliver a menu of support to help practices become more sustainable and resilient.

Medway CCG will work with NHS England local team to ensure this funding is used to target support at areas of greatest need and work in line with the processes set out in the operational guidance to deliver upstream support for practices. We will work with the most needy extended groups of practices to support additional on the day appointments

and improved access. This work will commence in January with the pilot being reviewed after 6 months.

9 Primary Care Funding

9.1 Primary Care Medical Allocations

The NHS England allocations for primary care (medical) have been published for the next five years. This sets out that in 2017/18 and 2018/19 there will be an increase in funding for core local primary medical allocations of £231 million and then a further £188 million on top respectively.

Medway CCG has already received additional funding to support Primary Care Resilience for the remainder of the year. Table One shows the funding amount and how this is being utilised. Table Two shows the capital investment for IT in 2016/17.

Table One: Non Recurrent Investment 2016/17

Programme	Description	Funding Source	000 (2016/17)
Care Navigators/Medical Assistants	Working with local practices and local CEPN to rollout receptionist and signposting training	General Practice Development Fund	26
Gp Resillience Fund	To work with NHSE and GP practices in the Rochester area to increase access to primaery care services in the locality	GP Resillience Programme	100
Winter Access	To increase MEDOCC and WIC centre capacity across the winter period	Winter Funding	100
GPFV	To develop local workfirce and capacity and demand data	GPFV Central Funding	37
Winter Support	Additional support for nursing homes	CCG Baseline TBC	100
Winter Support	24/7 packages to extend discharge to assess and Nursing Homes up front funding to extend discharge to assess for patients that are more dependant	CCG Baseline TBC	40
Winter Support	additional support for a SWOT IDT from MCH £40k	CCG Baseline TBC	40
Winter Support	24/7 packages to extend discharge to assess and NH up front funding to extend discharge to assessfor patients that are more dependent.	CCG Baseline TBC	25
Winter Support	Extended respiratory support and discharge service	CCG Baseline TBC	50
MIG GP Records Access	Shared GP records	Contract Renual Funds	20
Map of Medicine	Pathway Management	Contract Renual Funds	90
SMS Text	GP Surgeries to utilise SMS software	GPSOC LOT 3	40
Total			668

Table Two: capital Investment 2016/17

Programme	Description	Funding Source	000 (2016/17)
GP System Standardisation	GP System Standardisation	ETTF	220
Federated GP system	the importance of being able to work across boundaries within a federation	ETTF	50
Active Directory		ETTF	50
Resource and Referral Management	Resource and Referral Management	ETTF	300
Total			620

Table Three: Recurrent Primary Care Revenue Allocations 2017/18

Area of Spend	Recurrent Funding - £000
GMS/PMS/APMS allocation	£24,490k
NHS England DESs	£1,713k
GPIT - Revenue	£747k
Premises	£4,608k
Other	£4,738k
Total	£36,296k

The GPFV also assumes that there will continue to be increases in CCG funding to general practice (currently totalling around £1.8 billion in 2015/16) at least equal to, and ideally more than, the increases in CCG core allocations which are 2.14% in 2017/18 and 2.15% in 2018/19.

9.2 Transformational support 2017/18 and 2018/19 from CCG allocations

In addition to those allocations, other primary care funding is available for specific purposes as part of the £500 million plus sustainability and transformation package announced in the GPFV, as detailed below, as well as specific extra funding to support improvements in access to general practice, and improvements in estates and technology.

Table Four: Additional Non Recurring Revenue Investment 2017/19

Key Funding Steams	MCCG QIPP £'000 (2017-18)	MCCG QIPP £'000 (2018-19)
£3/head of population Transformational Support	444	444
On line consultation software systems	77	103
Care Navigators/Medical Assistants	51	51
GP Resilience Programme	42	42
Improved Access funding (for CCGs not receiving PMCF/GPAF		1,009
GPFV Implementation Funding	33	33
Total	**647**	**1,682**

Table 5: Additional ETTF Capital Investment Technology 2017/19

Programme	Description	Funding Source	000 (2017/18)	000 (2018/19)
GP System Standardisation	GP System Standardisation	ETTF	300	80
Federated GP system	the importance of being able to work across boundaries within a federation	ETTF	250	
Order Comns	Electronic diagnostics	ETTF	50	
Active Directory		ETTF	100	
Total			700	80

Table 6: Additional ETTF Investment Estates 2017/20

Programme	Description	Funding Source	000 (2017/19)	Type
Estates	Development of Healthy Living Centre Glover Street	ETTF	2.325	Capital
Estates	Development of Healthy Living Centre Glover Street : Business Case Dev	ETTF	95	Revenue
Estates	Development of Healthy Living Centre Glover Street : Revenue Consequences	ETTF	580	Revenue

Table 6: Additional ETTF Investment Estates by year

	16/17	17/18	19/20	Total
Revenue	95	484	96	675
Capital	0	825	1,500	2325
Total	95	1,309	1,596	3,000

In line with national requirements Medway CCG will spend £3 a head as a one off non recurrent investment commencing on 2017/18. This will be allocated over two years in 17/18, 18/19. This funding will come from the NHS England allocations for core funding.

This investment will be targeted at developing the new models of care and to stimulate the implementation of the 10 high impact changes. It will compliment central non recurring funding also targeting the 10 high impact changes.

The allocation of this funding will be aligned with the 10 High Impact Actions. This is illustrated In Appendix One.

9.3 Other funding for general practice

There will also be some non-recurrent funding held nationally to support GPFV commitments in a number of areas, including growing the general practice workforce, premises and the national development programme. In addition, there will be increases in a number of national lines to support the promised increase in investment in general practice set out in the GPFV. This includes:

- Increases in funding for GP trainees funded by Health Education England;
- Increases in funding for nationally procured GP IT systems;
- Increases in the section 7A funding for public health services, which support payments to GPs for screening and immunisation services; and

- 3,000 new fully funded practice-based mental health therapists to help transform the way mental health services are delivered

9.4 Quality Innovation Productivity and Performance (QIPP)

Medway CCG recognises the role that good quality primary care has in driving up quality and reducing costs in the system as a whole.

Appendix Two illustrates how our improvement programmes align to the QIP savings for the next two years.

10 Conclusion

We are working with our member practices to develop our General Practice Overview. The opportunities that it presents are key to creating the required capacity and quality across our locality. Aligned to these developments Primary Care will have the opportunity to redesign the services it delivers and align them to the wider Medway Model. A GANT chart identifying the major programmes and associated timelines is in Appendix Three.