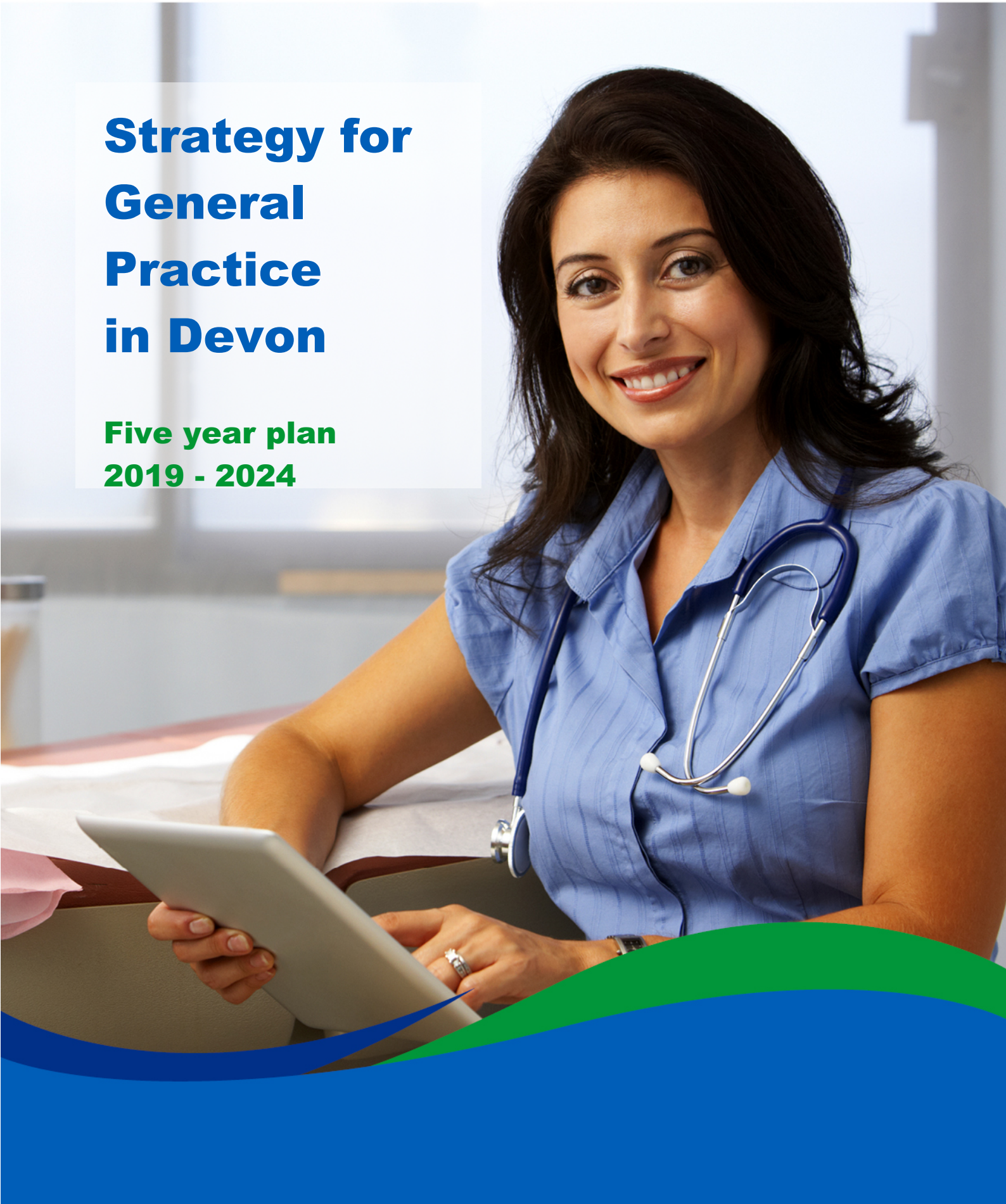
Final

NHS
Devon
Clinical Commissioning Group

Strategy for General Practice in Devon

Five year plan
2019 - 2024



Foreword

We are proud of the excellent primary care services we offer in Devon.

As a GP in Devon for more than 10 years, I see first-hand how my primary care colleagues provide high quality, caring and compassionate services for people in our area.

All Devon GP practices are rated as Good or Outstanding by the Care Quality Commission (CQC) and there are consistently high satisfaction rates in the annual GP Patient Survey locally.

All 127 Devon GP practices are part of one of the newly formed 31 Primary Care Networks and there is increasing joined-up working right across Devon as we head towards a new Integrated Care System.

Devon is leading the way in developing digital solutions for general practice. More than half a million people in Devon can now access online consultations with their GP practice, and Devon has the highest usage of the NHS App.

Our vision is that primary care in Devon will offer each local community a wide and flexible range of information, support and services to enable people to live happy healthy lives.

To do this, we must address a number of challenges. Increasing demand, difficulties in recruitment and retention, and funding that includes estates and IT are areas that need our attention.

This strategy is the baseline for joint working for the next five years. It outlines five priorities that will revolutionise general practice.

1. We will improve patient **access** to care through innovative technology

2. We will develop and retain an agile and engaged **workforce**, with a focus on multi-disciplinary teams to reduce pressures on services and improve outcomes for patients.

3. We will take a **population health management** approach to improve Devon's health and wellbeing, and reduce health inequalities

4. We will develop **Primary Care Networks** to provide more joined-up care close to home

5. We will modernise our **estates and infrastructure** to support and enhance services.

This document focuses on the future delivery of general practice, but primary care is formed of a much more diverse workforce than just those within GP practices. Involvement of all providers, including pharmacists, dentists, optometrists, allied health professionals and the voluntary sector, will ensure we have sustainable primary care in the future.

Dr Paul Johnson
Chair, NHS Devon CCG

Contents

Foreword **2**
Contents **3**
Our vision **4**
Background **6**
Drivers for change 6
Improving the quality of care 8
Our five pillars **9**
1 Better Access 9
2 Workforce 14
3 Population Health Management 18
4 Primary Care Networks 22
5 Modern Infrastructure 24
Finance **27**
Workforce and estates 27
Funding 28
Timeline **29**
Glossary **32**

Our vision

General practice will offer their local community a wide and flexible range of information, support and services to enable people to live happy healthy lives

General Practice in Devon will be delivered from either a single practice or a network of practices typically covering a population of 30k – 50k. They will operate from modern buildings which have a range of co-located services and a multi-disciplinary workforce targeting care to specific needs including prevention and self-care, that have been identified using population health management methodology. These services will be accessed using a digital first approach.

Our patients will have the best outcomes if we work in a truly integrated way. This means each service being able to quickly and easily respond to requests from colleagues for advice or input to an individual patient and, for individuals with more complex needs, working in partnership with a multi-disciplinary team of neighbourhood professionals.

Patients will be supported to take a more active role in improving and managing their own health and will be better informed about which professional is best able to help them.

GPs are at the centre of patients' care, coordinating and overseeing other clinicians and healthcare providers, as well as providing care directly to patients. There will be a wide range of easily accessed and readily available alternatives to GP provided care.

Back office services will be delivered at scale across the practices with digital systems that enable improved efficiency and information sharing across practices and other health and care partners.

Our five pillars

1. We will improve patient **access** to care through innovative technology

- People can access care from an appropriate service when they need it
- Improve patient experience and outcomes, empowering people to take control of their own health
- Improve extended and consistent access to primary care services
- Digital first approach to delivery of services

2. We will develop and retain an agile and engaged **workforce**, with a focus on multi-disciplinary teams to reduce pressures on services and improve outcomes for patients

- GPs and primary care teams are resilient, and have manageable and appropriate workloads
- Primary care can attract and retain the staff it needs
- Integrated community and primary care multidisciplinary teams delivering care

3. We will take a **population health management** approach to improve Devon's health and wellbeing, and reduce health inequalities

- People receive care targeted to their specific needs, including improved prevention and self-care
- Reducing the health inequality gap
- Reduce unwarranted variation and accurate disease prevalence where Devon is an outlier

4. We will develop **Primary Care Networks** to provide more joined-up care close to home

- Working with all practices as part of Primary Care Networks
- Implementing leadership development programmes

5. We will modernise our **estates and infrastructure** to support and enhance services

- Co-located premises with community and voluntary sector services
- Primary care deploys its resources effectively to achieve the best possible outcomes for patients

The benefits of working in this way

For Patients

Co-ordinated services where patients only have to tell their story only

Access to a wide range of services and professionals

- in the community
- In a single coordinated appointment

Access to appointments that work around their life

- shorter waiting times
- convenient appointments
- different ways of accessing appointments using technology

Patients feel in control and have responsibility*:*

- **More influence** for people, providing them with more involvement and decision-making opportunities over how their health and care is planned and managed
- Patients given support to take responsibility for access to **personalised care** and with a focus on self-care and prevention, living healthily, recognising what matters to the person and how their individual strengths, needs and preferences can support better outcomes

For general practice and other providers of care

Greater resilience across general practice by making the best use of shared staff, buildings and other resources, they can help to balance demand and capacity over time

Better work/ life balance with more activity routed directly to appropriate professionals such as clinical pharmacists, social prescribers, physiotherapists

More satisfying work with each professional able to focus on what they do best, spending time with patients where most needed

Improved care and treatment for patients by expanding access to specialist and local support services including social care and the voluntary sector

Greater influence in the wider health system, leading to more informed decisions about where resources are spent

Attractive to **new people to come and work** in general practice in Devon, with greater retention of workforce

For the whole health and care system

Coordinated care through collaboration and cooperation across organisational boundaries and teams with shared accountability

A range of services in a community setting, so patients don't have to default to hospital services

A more population-focused approach to Devon wide decision-making and resource allocation, drawing on primary care expertise as central partners

Resilience across the health and care system

Providing services **that are affordable**

Background

This strategy sets out our ambition and vision for general practice over the next five years (2019-2024).

It describes how we will support GP practices in Devon to provide accessible and coordinated care, with a skilled and motivated workforce who can respond to the current and future needs of our population.

GPs are the first point of contact with the NHS for most people and this strategy relates to those medical services provided by general practice. General practice is often described as the 'front door of the NHS'. Wider primary care providers include dentists, community pharmacists and optometrists. Around 90 per cent of interactions in the NHS take place in primary care.

This strategy defines how a series of actions and enablers in general practice will positively impact on pressures faced by the wider system. For example, this strategy sets out how we will improve access for patients, which in turn can help reduce inappropriate ED attendances locally. By reducing vacancies in primary care and finding solutions for recruitment and retainment, we can help reduce inappropriate referrals in to secondary care.

Drivers for change

National

The NHS Long Term Plan sets a direction of travel for primary care services.

GP practices face many challenges. Nationally, one in six GP posts are vacant. Practices are finding it increasingly difficult to recruit and retain GPs and are seeing this trend extend to other members of the team, such as nurses and practice managers.

There have been increases in NHS funding, but people's needs for services are growing faster.

The new GP Contract has been positively received by many providers in that it addresses some long-standing issues, such as the costs of clinical indemnity.

The introduction of Primary Care Networks (PCNs) is the biggest transformation in more than a generation to the way family doctors work. General practices across Devon will begin working together formally within local PCNs.

As they develop, Networks will recruit multi-disciplinary teams, including pharmacists, physiotherapists, paramedics, physician associates and social prescribing support workers, freeing up GPs to focus on the sickest patients.

PCNs will support each other while offering more specialist care services to patients and taking on a wider range of health professionals. New larger sized business models (Networks, Federations, Super Partnerships) are emerging but traditional practice model (small multi-partnerships) still dominate.

Local

NHS Devon Clinical Commissioning Group has a population of 1.2 million people, living across Devon, Plymouth and Torbay, with an annual budget of £1.8 billion.

The population of Devon is expected to increase by more than 33,000 by 2024, the equivalent of the town of Exmouth. The number of people in Devon aged over 75 years old is expected to rise by more than 20% in the next five years, with the number of people aged over 85 years old expected to rise by more than 11%.

Devon's Long Term Plan describes the challenges the county's health and care system is facing:

- While more people are living longer, it is often in ill-health.
- Preventable illnesses are increasing.
- There are persistent inequalities in life expectancy and health outcomes.
- The population is growing, and the proportion of older people is set to increase, and this will increase the demand for services
- Vital health and care jobs are unfilled, and numbers of working age adults will reduce in future.
- There are continuing pressures on hospital beds.
- There is unwarranted variation in clinical outcomes across wider Devon.

More about the population of Devon can be found in the Joint Strategic Needs Assessment produced by each local authority. Devon has varying levels of deprivation areas and there are differences in health outcomes across the county.

Devon's health and care partners have worked together to produce a Long Term Plan for Devon (Better for You, Better for Devon). It will ensure that Devon's health and care system supports people to live healthier lives, improves physical and mental health outcomes for children, adults, older people and families, promotes wellbeing and reduces health inequalities across the whole of Devon.

This strategy for general practice will form part of the wider Long Term Plan for Devon, with each of the aims and objectives linking directly to the wider aims of the Devon Plan.

Delegated commissioning of primary care medical services

The CCG is a clinically led organisation and all GP practices in Devon form part of our membership. They share with us the views of all the health care professionals within the surgeries as well as those of the community teams with whom they work. Devon practices voted to support the move to delegated commissioning for primary care medical services. In April 2019, the newly formed Devon CCG took over this responsibility from NHS England.

Improving the quality of care

We are supporting practices to improve quality of patient care and in working to reduce variation. Quality and safety is a responsibility of all healthcare organisations, whether commissioner or provider in nature. We view quality as comprising the following components:

- clinical effectiveness,
- patient experience
- patient safety

We will be open and transparent about the quality of primary care in the area and, where appropriate, will publish robust and reliable quality-focussed information.

We will work with partners to triangulate information and knowledge where appropriate to do so, and would expect this to include NHS England, the Care Quality Commission and Local Authorities. This information will include prescribing, referrals and emergency department attendances data.

Work has been undertaken to establish useable quality-focussed tools that identify actual, emerging and possible areas of concern, so that remedial action can be taken on a proactive basis. We will explore how best to extend this to include General Practice.

We will be looking to develop a new series of indicators that measure quality in general practice, based on business intelligence data and analysis. This will include a review of public health data, Care Quality Commission (CQC) data, Quality and Outcomes Framework (QOF), Quality and Equality Impact Assessments (QEIA), yellow card, serious incident/significant event analysis, patient feedback and complaints and the nationally-run GP Patient Survey.

This data will be formally monitored by the CCG's Quality Committee.

What we will do

We will work with practices, PCNs and localities to benchmark outcomes and learn from best practice.

We will implement a comprehensive system of practice and network reviews, including site visits, to learn from best practice and support practices which continue to benchmark poorly we will include involvement of contractor professional representatives where that is either agreed between us or felt by either party to be required.

We will review the sustainability of single-handed practices in Devon during the first year of this strategy to understand the issues they face and ensure we have plans in place to address any risks to provision of services identified.

Our five pillars

We will improve patient **access** to care through technology

We will develop and retain an agile and engaged **workforce**, with a focus on multi-disciplinary teams

We will take a **population health management** approach to improve Devon's health and wellbeing, and reduce health inequalities

We will develop **Primary Care Networks** to provide more joined-up care close to home

We will modernise our **estates and infrastructure** to support and enhance services

1 Better Access

We have worked closely with local providers to identify and develop solutions that allow patients to access care through alternative methods, including community pharmacists, voluntary sector and by using new technology.

In Devon, the 2019 NHS Patient Survey found that 81% of patients were satisfied with the type of appointment they were offered by their GP practice. For those who weren't satisfied, 11% went to A&E, 5% called NHS 111, 9% went to a pharmacist and 33% didn't end up seeing or speaking to anyone. The remaining 42% contacted another service, waited for a different day, or took advice online or from a friend/family member.

The extended access directed enhance service is now part of network level contracts from 2019/20 with the CCG commissioned extended access moving into network contracts in 2020/21. Where opportunities exist, the CCG will encourage PCNs to deliver extended access at a larger scale to make best use of resources but considering patient demographics and geography.

The current model of provision includes 7-day and 24-hour (24/7) access to general practice. The out-of-hours service provides care where a level of need is identified that is most appropriately met by General Practice, but which cannot wait until mainstream General Practice is next available.

Local data and feedback to suggest there is appetite for weekend provision of medical services is variable. Therefore, we will ensure that limited resource is deployed in way that matches demand and is not driven by perceived need alone.

What we will do

We will ensure needs of patients requiring urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends where there is demand or a need (building on overall high levels of patient satisfaction with appointment availability in Devon currently).

Impact measures for better access

We will use the following measures to show the impact of the initiatives included in this section on access to general practice:

- Patients with an urgent clinical need will have access to a consultation on the day and patients with a non-urgent need will be offered a consultation within 7 days.
- Directly bookable GP appointments will be available via all PCNs – the percentages to be made available will be agreed during the planning of each year.
- Improved patient survey results demonstrating improved satisfaction with access, with a 5% increase year-on-year in satisfaction rates across the access sections in the national GP Patient Survey.
- Improved Friends and Family test responses demonstrating improved satisfaction with access – the percentage of improvement will be agreed during the planning of each year.

Digital First in primary care

Digital is an essential enabling function to allow for radical transformation in service delivery and patient care by creating greater efficiency, better quality and improved safety. The importance of a digital enabling strategy to deliver modern general practice in a challenged NHS has never been clearer. No viable future health and care system is possible without digital innovation, design and support throughout. The vision is to 'Support citizens and clinicians by using information and technology seamlessly, safely, quickly and innovatively', Devon's digital strategy is designed to transform health and care with clear priorities for digital transformation supported by four workstreams:

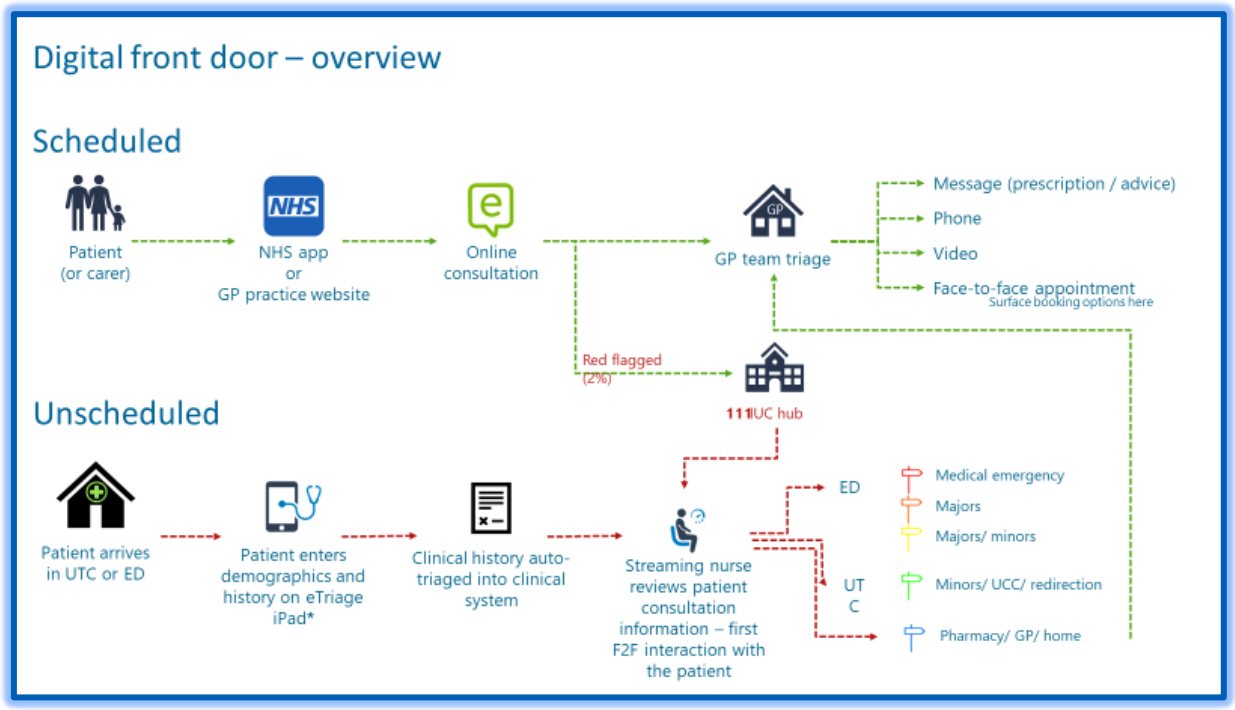
- Feels like one system: A shift to shared, consolidated and integrated records
- Technology together: Shared infrastructure and technical design
- The digital citizen: Increasing access to services and self-care online
- Harnessing information: Advances in data analytics, intelligence and governance

What we will do

We will adopt a 'digital first' approach. Where possible, the first contact with general practice services will be digital, there will be digital connectivity between organisations.

Everyone can expect that their personal and medical history is available wherever they touch health and care systems. They will be supported digitally for self-care and technology will be doing some of the routine work previously undertaken by staff.

We are committed to helping develop an end-to-end digital patient journey through scheduled and unscheduled care, sharing our learning and understanding. The model we will adopt in Devon is shown in the diagram below:



What we will do

Devon will continue to lead the way in digital innovation. The Digital Accelerator project will be expanded in scope to cover the whole of Devon, allowing quicker access to primary care by delivering online consultations and better utilisation of resources. To facilitate this, new workforce models will be developed for GPs and other clinicians to deliver online services, scalable across the county and beyond.

We will enable GP practices to embrace and embed the functionality of the NHS App, supporting patients to access self-care, clinical advice, book appointments, order repeat prescriptions, access their medical records, choose preferences for data sharing and organ donation.

Promoting digital activation amongst all groups of patients including a digital guidebook developed by Healthwatch to help patients navigate the NHS and the potential for Digital Drop in surgeries at practices run by the voluntary sector

The Digital Patient

NHS App

The NHS App will become the digital front door to the NHS, offering a gateway for patients allowing them to access self-care and clinical advice, book appointments, order repeat prescriptions, access their medical records, choose preferences for data sharing and organ donation. Devon has the highest use of the NHS App nationally, with more than 4,000 downloads to date.

93% of GP practices in Devon are live on the NHS App, providing a simple and secure way for people to access a range of NHS services on their smartphone or tablet.

	%eligible live GP pop registered for NHS App	Total App registrations	GP registered pop aged 13+ years (Live Practices)	Total GP registered patients aged 13+ years	% Live practices	% GP pop registered for POL	GP pop registered for POL	Total POMI patient size
Devon	0.50%	5,467	1,053,876	1,103,292	93%	26.69%	324,814	1,216,834

NHS Digital figures for NHS App in Devon November 2019

The NHS App will help practices meet their targets for registering patients to GP online services as set out in the GP contract. The app doesn't change the online services that are already available. It's a new way of accessing them that can encourage uptake.

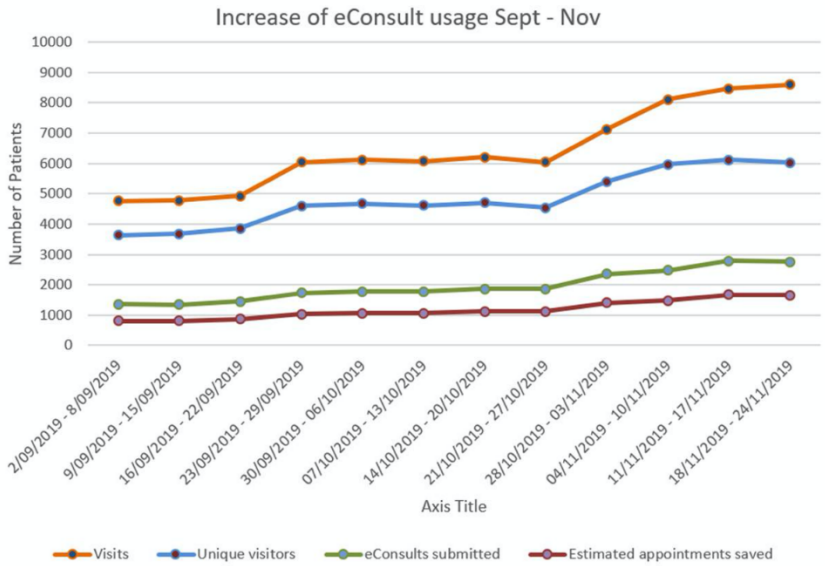
Most people can verify their identity through the NHS App, rather than having to visit the practice. This is more convenient for patients and saves time for practices. More patients booking appointments online can also save practices time and money.

Making more specialist appointments available online, improving access, can also help towards Quality and Outcomes Framework and Enhanced Services targets.

Online consultations

Access to clinical advice and capacity to meet demand are constant challenges facing general practice. Online consultation platforms aim to provide convenient access to clinical advice for patients while providing efficiency savings for clinicians.

Devon is leading the way with online consultations. Every month, more than 5,500 people consult with their GP online to get healthcare advice and treatment more quickly. This has saved more than 3,000 unnecessary face-to-face appointments.



eConsult figures reported via digital accelerator project September 2019 – November 2019

As well as being a more convenient and faster access to general practice, online consultations have several benefits:

- Reduced administrative workload for practice staff
- Improved communication between patients and practices
- Reduced travel for patients
- Expanded health knowledge for patients
- Increased information sharing and operational efficiencies for practices
- Increased patient satisfaction and reduction of missed appointments
- Improved access to care services

What we currently do

Online consultations in Plymouth
Patients in Plymouth have a digital first option for services in a selection of the city's GP practices. The project, which is one of a number of nationally funded Digital Accelerators, is looking at the challenges faced during adoption of new technology, implementation and creating change. It is exploring new ways of working for clinicians to help increase capacity. The project will:

- Drive and increase online consultation at practices.
- Trial and implement a multidisciplinary care 'Hub and Spoke' model which can provide additional capacity for practices.
- Utilise the principles of crowdsourcing from an available network. They will have the capacity to deliver flexible, remote working to support practices under pressure, to free up GPs to focus on the patients who require a face-to-face consultation.
- Provide a full blueprint that can be adapted and implemented into any practice within the UK.

Impact Measures for Digital First

- Full adoption of a digital front door model using eConsult by all practices with 5% of consultations taking place through eConsult by March 2020 and 20% by March 2025
- In accordance with national targets, all practices will have enabled the NHS App by June 2020 – the target level of patient usage and activations will be agreed during each planning cycle
- In accordance with national targets, all patients will have the right to effective online and video consultation by April 2021
- In accordance with national targets, all patients will have online access to their full record from April 2020
- In accordance with national targets, all practices will be offering and promoting electronic ordering of repeat prescriptions and using electronic repeat dispensing for all patients for whom it is clinically appropriate by April 2020
- There will be an increase in the percentage of appointments available for online booking agreed during each planning round building on the 25% of appointments are available by July 2019.
- A 5% year-on-year increase in patient satisfaction with online access, measured in the GP Patient Survey

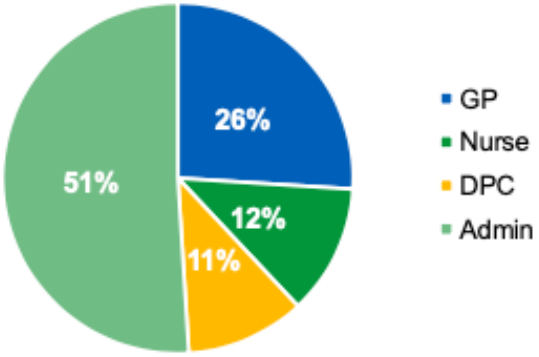
2 Workforce

The key element to delivery of this general practice strategy, is recognition of the need to develop and retain an agile and engaged workforce. In ensuring delivery of high-quality care, we recognise the importance of excellent training and development for our workforce. Our focus is on providing the appropriate support for our workforce from recruitment through to retirement.

In general practice, the biggest workforce challenges are on GP and practice nursing roles. Current training data indicates that there are not enough students currently in training to replace those who are likely to retire over the next 20 years. Unless the numbers of people in training increase substantially, up to 50% of our current workforce in Devon could be lost by 2035.

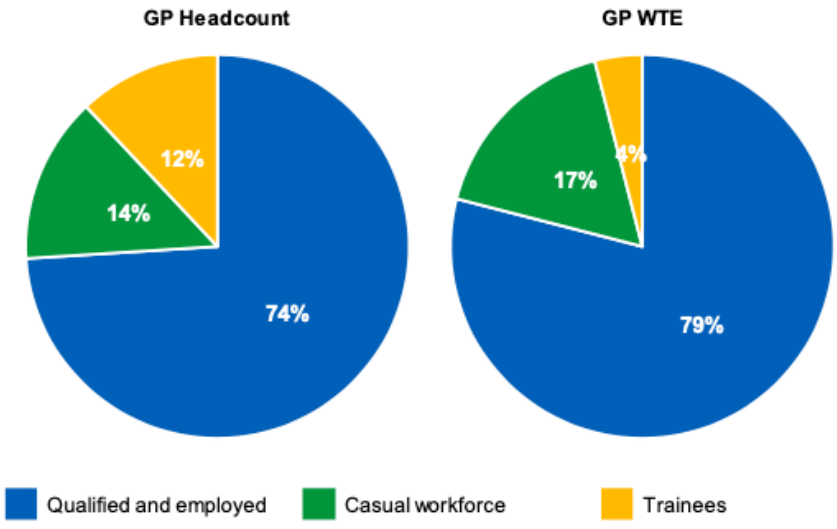
The continued challenges in recruiting GPs has highlighted that greater reliance on other clinical roles must become a priority. Only 23% of the clinical workforce relates to non-GP roles and this must increase significantly to ensure a sustainable service for the future.

Roles in primary care (general practice, nurse, direct primary care and administration)



GP workforce

There are approximately 660 whole-time equivalent (WTE) GPs in Devon. Sessional GPs (locums) represent 4% of the overall full-time equivalent (FTE). However, this group represents 14% of the overall headcount. This could potentially be an untapped resource. Understanding why this group prefer locum working and providing alternative solutions is vital to creating greater stability within this workforce group. The projected growth of GPs is limited over the period of this strategy to the difficulty in recruitment.



Nursing workforce

There are approximately 400 nursing staff in general practice in Devon. Primary care has generally been attractive to experienced mid-career nurses. We are committed to developing a stronger pipeline by encouraging practices to recruit post-graduation nurses in to general practice. This approach will be supported by working closely with the Devon Training Hub to ensure these new recruits are able to fulfil the full remit of duties required in practice as quickly as possible.

In Devon practice nurses account for 74% of the overall nursing workforce FTE, but 78% of the overall headcount. The majority of these nurses work part time and could represent an untapped resource. Advanced Nurse Practitioners represent 20% of the current workforce and the majority work full time. The combined Nurse Specialist and External Nurse group (representing 6% of the nursing workforce), are recognised as the specialists in chronic disease management and mental health.

Some of the newer roles such as Physician Associates and Nursing Associates have yet to fully embraced by general practice. Both roles support the wider clinical staff group and provide an opportunity for practices to introduce varied roles into their current workforce models. The opportunity for these to be joint roles across primary and secondary care is being explored to increase collaboration across the sectors and optimise the available funding channels.

Support staff

Support staff vacancies are amongst the lowest of the staff groups. Over the next five years, there will be opportunities for closer working and sharing of resources to support the system with its challenges. These opportunities will see more teams working on behalf of the wider system rather than for a single organisation and this may include teams being centralised or co-located.

What we will do

We will work closely with partners, including the Academic Health Science Network, both Exeter and Plymouth Medical Schools, Plymouth and Exeter Universities and the Devon Training Hub, to take forward emerging action plans drawn up in response to our improving understanding of anticipated workforce needs and also barriers to commencing a career within primary care settings.

This will include actions to address career attractiveness, recruitment to and retention within associated professions, and the offering of opportunities that vary from the traditional models.

We will undertake a capacity and capability analysis which will identify any skills gaps and shortages to inform development needs and also enable us to work effectively with training providers to provide an effective pipeline of skills in readiness to meet future requirements. Where skills gaps are identified, we will consider first the opportunity to improve service delivery through digital solutions while also enabling our clinicians to work at the top of their licence.

Our aspiration will be to first stabilise, then future-proof workforce, embracing new and different roles and associated qualifications, including associate physicians, revised nursing roles and varying the application of pharmacists' skillsets.

Access to accurate data is vital to supporting us in identifying and forecasting workforce challenges. From the data currently available, we have established that more individuals want to work more flexibly, achieving a greater work/life balance. We are working closely with practices to improve the accuracy of the data submitted through the National Workforce Reporting Tool so that we have a clearer picture of vacancies across general practice.

Developing new roles

The current general practice workforce is continually evolving to incorporate new roles, which not only aim to deliver the new GP contract, but also provide the most appropriate care for our patients.

As we continue to skill mix the teams providing care, more patients attending their general practice will have the opportunity to see an expanded multi-disciplinary team with advanced training in diagnosis and treatment in their specialist areas. This signals a fundamental change in how patients will experience general practice, consulting with a broader team that is better suited to meeting patient needs.

These new care teams will include clinical pharmacists, physician associates, physiotherapists, paramedics and social prescribers. This will improve access to care, enhance patient safety and streamline patient pathways, ensuring that holistic care is delivered more efficiently.

What we will do

Establishing Primary Care Network teams

Each PCN will, over the next three years, expand the multi-disciplinary team comprising:

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

Recruitment and retention

As challenges to recruit and retain a resilient workforce continue, it is vital we utilise the current workforce in the most effective way to meet the needs of our population.

Where practicable, tasks and activities will be digitalised, allowing the workforce to focus on the delivery of patient care. Specialist knowledge and skills will be utilised in the areas of greatest need by teams who can react and adapt to a changing environment.

What we currently do

Plymouth Trailblazer scheme
Devon CCG and HEE have funded for four sessions of Post-CCT GP Fellow time so the Trailblazer Scheme can be piloted in Plymouth. Newly qualified GPs who accept a substantive contract in a practice within the highest 20% deprivation index can apply for these post-CCT sessions.

The fellow sessions are used for private study, coaching, peer support groups, structured teaching sessions, and general reflection time, they work 4-8 clinical sessions, with two protected sessions.

For this pilot, the Trailblazer fellows have access to VTS sessions focused on subjects most relevant to inner city medicine including:

- Health inequalities
- Personality disorder
- Functional illness/chronic pain
- Substance misuse
- Asylum seeker mental health

What we will do

Working in partnership with the PCNs we will:

- Attend local, regional and national job fayres promoting Devon as a place to work
- Continue to build on the success of the GP retainer scheme
- Make the GP fellowship scheme available across Devon
- Expand the portfolio and rotational working opportunities to staff working in general practice
- Work with the PCNs to develop a range of flexible working approaches
- We will continue to participate in the international recruitment of GPs initiative
- We will continue with supporting implementation of the 10-point practice nurse plan
- Continue with the NHS England retention scheme
- Expand the GP post training fellow pilot to cover the whole of Devon

Impact measures for workforce

We will identify a range of measures to monitor the impact of the workforce initiatives. These measures will cover:

- Robust workforce data available from and about general practice workforce
- Reduction in stress related absences
- Better staff retention and positive feedback from staff surveys
- Reduced vacancies
- Reduced time to fill vacancies
- Appropriate use of the skill mix in wider multi-disciplinary teams, with an increase of Allied Health Professionals AHPs completing tasks within general practice
- A steady programme of funded estates developments which enable integrated working
- Fewer requests to the CCG for support via the resilience fund in relation to workforce issues, which is one of our current indicators of a practice that is struggling
- Better sharing and adoption of good practice in services
- Each PCN will have a five year workforce plan by December 2020 (with next 12 months plan in place by March 2020)
- Increase number of trained staff coming directly into general practice after completion of the graduate scheme

To set measures for all of these we need a clear base line. Targets will be set in each annual business plan.

3 Population Health Management

A Population Health Management (PHM) approach will help to address Devon's complex and multifaceted health and wellbeing challenges. It will increase the understanding of how and why different health and social care services are used and provide a richer understanding of the underlying needs for services across organisational boundaries.

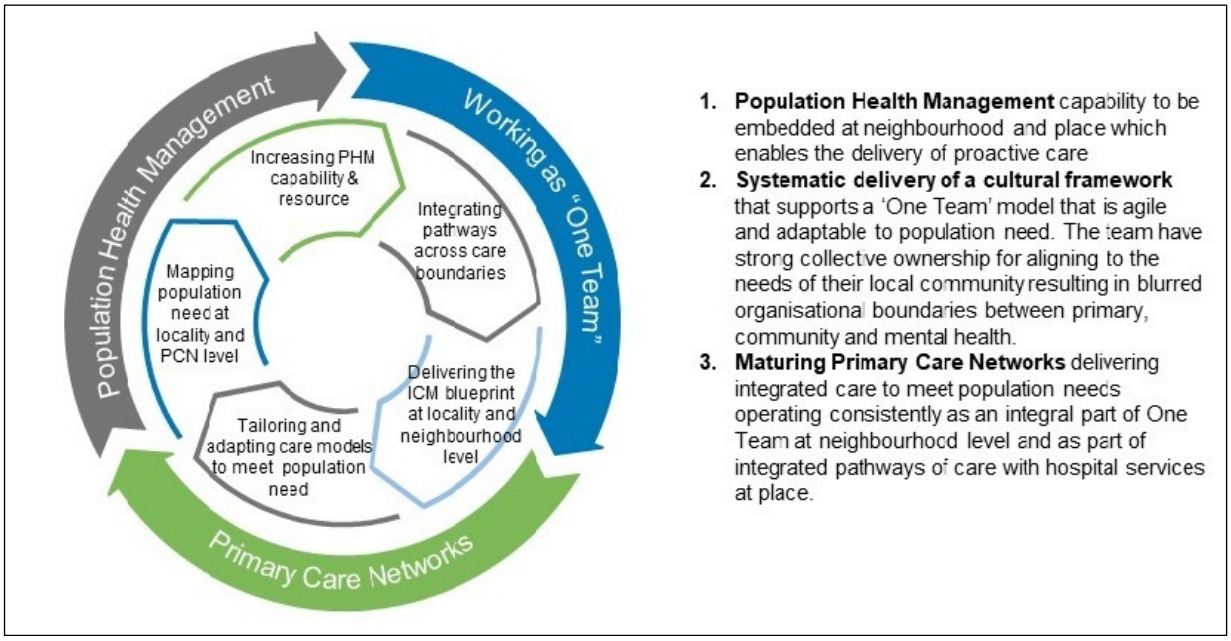


Diagram 1: Population Health Management Approach

Population Health Management will focus on:

- Infrastructure to ensure the basic building blocks of population health management are in place.
- Opportunities to improve care, quality, efficiency and equity throughout Devon.
- Care models focused on proactive interventions to improve health and reduce inequalities.

The expected outcomes and benefits are:

- Increasingly evidence-based decisions that inform the most efficient allocation of resources to prevent illness, improve care and lower costs.
- Financial improvement and improved health outcomes through prevention, early detection and intervention.
- Better monitoring and evaluation of the impact of interventions to improve outcomes or reduce inequalities, and upscaling to maximise benefits.

Through participation of partners, the opportunity of data linkage across organisations and staff capacity building. Taking a systematic approach to population health management will support effectiveness of Primary Care Networks and the Integrated Care Model. Participating in Wave 2 of NHS England's Population Health Management Development Programme will enable the development of technical capabilities and infrastructure. They will be used as the platform and driver for the local programme focused on delivery of the priorities for Devon and national commitments. The local programme will embed PHM approaches and targeted interventions within integrated care teams, using these teams as the central mechanism for changing practice and culture across the system.

Harnessing the power of information

The proliferation of data and information captured within the GP IT Systems and the potential to connect that with other datasets from across our system gives us an opportunity to develop solutions to these problems through the creation of a Learning Health System.

Augmented intelligence through tools such a clinical decision support system has the potential to address these challenges whilst providing bespoke personalised care and avoiding clinician burnout.

What we will do

We will create a cultural change which understands the power of data to drive a virtuous cycle of quality improvement. This will not be done in isolation but as part of the wider system and links in with the One Devon Data Set. All PCNs will receive data to inform decision-making and meet the needs of the population they cover. PCNs will develop population-specific services in response to this.

Risk Stratification

Population health management provides the ability to understand variation through benchmarking and comparisons to improve clinical outcomes. It will help identify people who are currently well, but at risk of developing long-term conditions. This targeted approach will work at two levels: individual (known individual risk factors) and population (known risks in certain populations and communities).

This approach will help to prevent or delay the onset of long-term conditions, their functional consequences and the progression of frailty. Population health management will therefore enable more people to benefit from early identification and treatment, personalised care planning, self-management support, medicine management and secondary prevention services. The care model that PHM enables will support improvements in patient activation (people's knowledge, skills and confidence to self-manage) and better self-management will stop, or delay, progression of frailty and functional impairment or disability.

Multi-Disciplinary Team Approach

Multi-disciplinary teams are already working effectively in many parts of general practice. This will be scaled up across all networks and include a greater number of professionals e.g. allied health professionals, social workers and other people e.g. voluntary sector within these teams to ensure that the right person can support the patient in the right way at the right time.

We will work with GPs to build multi-disciplinary teams around their leadership, with teams which will support delivery.

Quality Outcomes Framework (QOF)

We will to empower and support professionals working in primary care to focus on quality improvement, we have agreed to introduce provision in the QOF to support professionally led quality improvement cycles, within and between practices. Our purpose is to support activities that are highly valued by patients and professionals, do not easily lend themselves to traditional QOF metrics, and which are expected to improve significantly the quality of care.

As at September 2019 in Devon our practices achieved on average 97.6% QOF achievement with a range of achievement of 77% – 100%. We aim to work with practices to ensure all practices are within the top decile.

What we will do

In Devon, we will work in partnership with the practices and PCNs to ensure that the opportunities of the revised Quality and Outcomes Framework are fully realised and that practices reach the maximum points attainment which will ensure the quality of care is improved.

Prevention

The Devon health and care system has had prevention at the heart of its priorities for several years. The Devon STP has invested £2million recurrently in 2019/20, alongside local authorities' public health funding, in a prioritised prevention programme to increase pace and scale of delivery. General Practice is often the best placed service to support this work.

The results of local engagement show that people want to take responsibility for staying well and independent for as long as possible in their own communities. The prevention programme will work towards this by enabling people to better manage their risk factors or conditions.

The priorities for prevention which we will work with General Practice to embed are:

- Making Every Contact count (MECC) - an approach to behaviour change that utilises the millions of day-to-day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations.
- Healthy lifestyles - Focus on reducing smoking, alcohol, obesity and increasing physical activity
- Falls and frailty - Using frailty indexes and falls assessments to reduce incidence of falls
- Social prescribing development support
- Children and young people's emotional health and wellbeing - Range of elements including community-based support, online help, training, bereavement support and support for families
- Adult Mental Health - Focus on suicide prevention and preventing poor mental health
- Multiple complex needs - Transformation of the system response to people with complex needs.
- Focus on identification and response to sexual violence and domestic violence and abuse.
- Long Term conditions - Focus on reducing diabetes, CVD and respiratory conditions.
- Personalisation - Supporting empowerment and the better integration of services across health, social care and the voluntary and community sector.
- Improved use of IT in population health management – To enable PCNs to look at the population health metrics for their communities.

Self-care

Developing truly effective preventative approaches means helping people take more control of their own health, improving their life experience and reducing the need for reactive intervention by healthcare professionals in future periods.

We want to enable self-care so that patients take greater control over their health and wellbeing, while being able to readily access the right services conveniently located when they need them, and this will be a cornerstone of developing a healthcare system that is sustainable as a result of using our available resources in an optimal way that adequately and appropriately supports a population in which a growing number of people have complex healthcare needs.

What we will do

We will empower patients who are willing and able to self-care with support and information through the new social prescribing workforce. We will also strive to reach those most vulnerable in our population and work with them to improve their health.

There will be a wider range of affiliated community-based professionals providing care and support as part of an enhanced patient offer. This will be both at practice and network level. Where appropriate patients will be directed to voluntary sector personnel both to deliver care and facilitate self-care using available technological solutions where appropriate. Clinical record keeping will wherever possible be on a shared clinical system.

Delivery will, naturally, though not exclusively, be most effectively delivered where multi-agency teams are co-located or otherwise in close proximity.

Social Prescribing

There has been a drift towards medicalisation of some of the impacts of the wider determinants of health, such that the GP surgery is seen as a focal point for the community. As a result, this leads to many patient contacts with GPs that do not necessarily result in a resolution for the patient.

We are developing programmes to help local people struggling with long-term health conditions; build confidence and learn how to manage their condition(s), including mental health issues such as anxiety, stress and depression, better. The HOPE Programme (Help Overcoming Problems Effectively) is based on a course developed by the University of Coventry to help people cope better with long-term medical conditions.

The programme helps people to focus on themselves as a person, not as a long-term condition. It helps them to discover new strengths and rediscover old ones to keep yourself well. It also aims to boost self-confidence and resilience, to help people cope better emotionally, psychologically and practically with your condition.

What we currently do

Wellbeing Exeter

Wellbeing Exeter is a partnership of public, voluntary and community sector organisations working together to explore better ways of supporting the 40% of patients who visit their GP with social problems rather than medical problems.

The approach offers social prescribing, in combination with asset-based community development to enable individuals and communities to improve and promote their own health and wellbeing. Central to the Wellbeing Exeter model is the development of community resilience within the city, alongside the social prescribing work.

Wellbeing Exeter is successfully delivering the type of support that is needed, for patients within primary care. Through signposting and one-on-work, Wellbeing Exeter is helping people to improve their mental wellbeing, reduce loneliness, re-engage with their community and manage their own health.

Impact measures of population health management

We will agree with the PCNs a range of measures to monitor the impact of the population health initiatives. These measures will cover areas such as:

- Improved long-term conditions management (proxy prevalence)
- How all PCNs will use risk stratification to identify patients at most risk of hospitalisation
- How all PCNs will use a multi-disciplinary team approach to manage high risk patients
- Social prescribing will be offered to all patients where appropriate
- Increased use of social prescribing through programmes such as HOPE
- Increased achievement of the Quality Outcomes Framework
- Reduction in inappropriate ED attendances
- Reduction in emergency admissions from exacerbations of long-term conditions

Targets will be set in each annual business plan.

4 Primary Care Networks

Primary Care Networks are a pillar of the future of general practice. We know that there is considerable appetite in our local system for increased collaboration – between practices, as well as with associated health and social care providers, the voluntary and third sectors, and patients.

With all practices in Devon working as part of a Primary Care Network (PCN) this will support the personal and local nature of general practice and continuity of care that is at the heart of person-centred care close to home. PCNs will preserve local practices as the first point of contact for patients and enhance their resilience for the future. PCNs will enable:

- an extended range of services with access to specialist advice;
- a focus on population health management for physical and mental health;
- the development of tailored care for people with multi-morbidity and frailty
- peer review and clinical governance;
- investment in IT and other technologies;
- increased resilience, better able to respond to fluctuations in demand and capacity;
- better representation of general practice as a provider in system-level conversations
- career development and support for professional and other staff, including portfolio careers
- strong engagement with local communities

PCNs will be supported to provide fully integrated community-based health and care working seamlessly with their community and social care colleagues. Services will be introduced in line with the Devon Long Term Plan primary care goals, designed to improve quality and phased in over the coming years:

During 2020

- Structured medication review
- Enhanced health in care homes
- Anticipatory care (with community services)
- Personalised care
- Supporting early cancer diagnosis

During 2021

- Cardiovascular disease prevention and diagnosis, through case finding
- Locally agreed actions to tackle inequalities

By 2023/24, Primary Care Networks will have:

- Stabilised general practice locally
- Helped solve the capacity gap and improved skill-mix by growing the wider workforce with additional staff as well as increasing GP and nurse numbers
- Seen further local investment
- Dissolved the divide between primary and community care, with PCNs looking out to community partners not just into fellow practices
- Systematically delivered new services to support implementation of the Devon Long Term Plan and achieved clear, positive and quantified impacts for people, patients and the wider NHS.

Primary Care Network Development

Implementing this strategy and the Devon Long Term Plan requires the development of effective PCNs. To help all PCNs mature and thrive, we need to put in place high quality support.

National funding has been made available to support: (a) PCN development and (b) a specific Clinical Director development programme. The funds are intended to help PCNs make early progress against their objectives as determined following a joint review of the maturity matrix – for example supporting much closer practical collaboration between PCNs and their community partners, including preparatory activity for the forthcoming national service specifications.

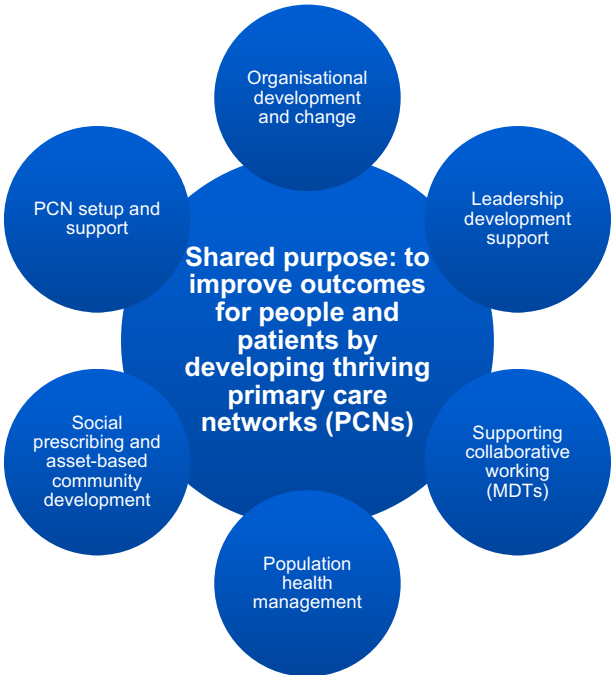
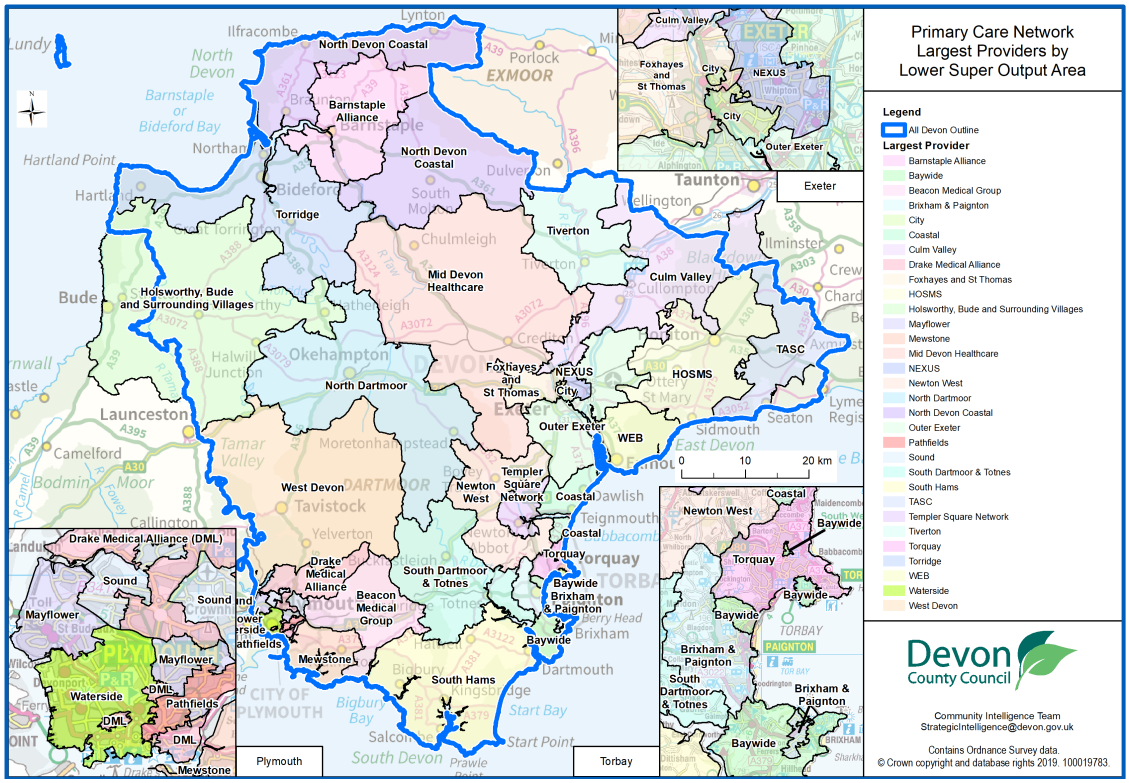


Diagram: Development support domains

We have developed our approach to PCN development in partnership with the PCN clinical directors and LMC. We are working with clinical directors and their PCN colleagues to put in place development plans that are relevant and tailored to their PCN and will subsequently support the implementation of these plans. Where appropriate we will ensure that these plans are not only relevant to the needs of the PCN, but that they also align.

The current PCN coverage is shown in the map below, the boundaries of the PCNs are not exact. A description of the configuration of each PCN is available here:

Map of Primary Care Networks in Devon



Impact Measures for Primary Care Networks

We will identify a range of measures to monitor the impact of PCNs. These measures will cover:

- Improvement in relevant patient satisfaction results, measured in GP Patient Survey
- Improved long term conditions management, measured in Quality and Outcomes Framework (QOF)
- Reduced morbidity
- Reduced vacancy numbers for staff working in general practice
- Increased number of new recruits and retention in general practice
- Improved staff survey results for general practice, with improved reported outcomes for staff engagement, morale and wellbeing.
- Proactive involvement in population health management
- Increased ability for PCNs to work as key members of multi-disciplinary teams

Targets will be set in each annual business plan.

5 Modern Infrastructure

Estates

A primary care estate investment plan has been prepared to ensure we have an estate that is fit for purpose. The plan identifies an estimated future capital requirement of £80m for this five-year planning period and also where specific primary care community plans need to be developed.

The plan, developed over a series of workshops with stakeholder engagement, has considered future housing development, current property condition, future service changes, Primary Care Network provision and local factors. For those practices identified as priorities, Project Initiation Documents will be produced in readiness for applications for capital funding. The work in developing the General Practice Estate Investment Plan has considered the impacts of digital transformation together with the new models of care which will see a focus on multi-disciplinary teams and new roles supporting primary care.

These factors will impact on the estate requirement for delivering the primary care for the future. A strengthened primary care service will support out of hospital care and reduce the pressure on emergency hospital services. The development of the investment plan is also considering the accommodation requirements of the integrated care model.

As the models of delivery are developed and implemented, we will continue to take advantage of the opportunities created by co-location of services, the sharing of estates, and joint development projects with co-location being our preferred estates solution.

An example of system working is the capital investment of £1.6m in Dartmouth for a new health and well-being centre incorporating a GP practice which is expected to be completed in June 2021. This work is supported by Torbay Hospital and South Hams District Council.

Through the STP Estates Group and the Primary Care Estates Group, all key parties, including Local Authorities are fully engaged in delivering the estates agenda and supporting the delivery of the Long Term Plan objectives. The Local Planning Authorities have also been committed to supporting the development of the Primary Care Estates Investment Plan by actively participating and providing local housing development information to the series of workshops dedicated to identifying future primary care estate requirements.

Work is in progress to expand the good relationships with the local planning authorities into a collaborative approach for optimising the opportunities associated with the local councils planning processes.

Feels like One System

Electronic health records (EHRs) are the foundation upon which we build a modern, safe, efficient and responsive health service and general practice has long led the way in the move from paper to digital record keeping,

The GP record forms a core component of our emerging Local Integrated Health and Care Record Exemplar work (LHCRE-One South West) to create a comprehensive patient record that is accessible across all health and social care organisations.

The Devon STP Digital Strategy describes how we will roll-out eHRs across health and care organisations.

What we will do

We will improve system-wide access to general practice patient information using existing systems including Summary Care Record Additional Information (SCR-AI), Medical Interoperability Gateway (MIG) and GP IT System Viewers.

We will support the national GP Connect interoperability programme to improve flow of information between practices and organisations, while encouraging a consolidation of eHRs between practices making it feel like one system.

Shared Digital Infrastructure

As general practice forms networks and closer links with multi-disciplinary teams across multiple organisations as well as developing new ways of working, common platforms will be required to create efficient, standardised, safe and effective communication and management.

A shared cloud-based information management system will be deployed across practices to enable closer working with functionality such as back office processes, policies and procedures document management, clinical and referral guidelines, rota planning, communications/notices, eLearning and appraisal management.

What we currently do

East Devon Health shared intranet

East Devon Health (EDH) have implemented GP TeamNet across 13 practices to work together more effectively and efficiently through the use of technology. As a cloud-based information management system, GP TeamNet allows teams to work across multiple locations, standardising processes and procedures by providing a common platform for communication, administration support, mandatory training, risk management and monitoring.

Practices have found an improvement in patient safety/quality, significant reduction in emails, printing and storage and more effective document control.

Popular functions include a CQC tracker, Significant Event Audit (SEA) tool, Continuous Professional Development (CPD) monitoring and reminders, annual leave requests/rota planning.

Shared back office

Opportunities will be identified for the provision back office services across multiple practices and PCNs for example payroll, mandatory training, HR services. These services could be provided at scale by existing system partners e.g. acute trusts. These services are likely to be provided at a cheaper cost and consistently across multiple partners which will support sharing and rotating staff.

IT support services for general practice are an existing example of providing shared services across practices, PCNs and other health and care partners.

Impact measures for modern infrastructure

We will use the following measures to show the impact of the initiatives included in this section:

- Improved patient satisfaction, particularly in the areas of access and online services
- Number of building projects completed from the estates investment plan
- Increase in buildings with co-located services
- Each PCN to have shared intranet and same clinical system

To set measures for all of these we need a clear base line. Targets will be set in each annual business plan.

Finance

Funding for general practice comes from a range of sources and these are specifically earmarked for parts of the primary care system. The CCG will ensure each funding source is used appropriately in line with this strategy for general practice.

Primary Care Network funding is set over the five-year period of the NHS Long Term Plan.

By 2023/24, the national PCN contract is expected to create national entitlements worth £1.8 billion. This would equate to approximately £1.47 million for an average network of 50,000 patients, in return for the commitments and priorities specified in the NHS Long Term Plan.

Of this funding, £1.235 billion is new investment, with the balance of £564 million currently investment in enhanced access, extended hours, and the £1.50 per patient CCG investment for core PCN funding as per the DES specification.

The NHS Long Term Plan further identifies the need for the balancing of investment towards community and primary care services, as well as mental health. This is also factored in to the Devon Long Term Plan, although the plans are currently at strategic level and specific investment plans are to be developed.

Workforce and estates

Workforce and Primary Care Networks

One of the key parts of the new GP contract investment plan is the Primary Care Network Directed Enhanced Service (DES).

Of the £1.8 billion investment for Primary Care Networks, £891 million will be invested in workforce initiatives through the PCN DES.

Intended Funding for Additional Role Reimbursement

	2019/20	2020/21	2021/22	2022/23	2023/24
National	£110m	£257m	£415m	£634m	£891m
Average PCN (50,000 population)	£92k	£213k	£342k	£519k	£726k

The CCG will continue to support the development of Primary Care Networks, investing funding as pass-through payments to general practice. During 2019/20 and 2020/21 the CCG will invest £920k in the development of PCNs and clinical directors.

Funding has already been invested during 2019/20 in the development of fellowships and workforce initiatives. This includes funding for GP retention, resilience, online consultation, and training.

As well as this central funding, the CCG has supported the engagement in international GP recruitment drives and initiatives and will continue to do so as part of this strategy.

Estates and infrastructure

The CCG will maximise the opportunities available from the use of the Estates and Technology Transformation Fund (ETTF) in investments in estates and infrastructure in Devon.

Priorities for primary care estates have been reviewed and set out in the local estates strategy and these are considered as part of any opportunities for national capital.

The CCG will continue to track opportunities to attract capital resources in order to deliver the priorities set out in this strategy. A continuous focus on delivering efficiencies will also enable the support of capital developments with the associated revenue consequences.

Funding

Primary care allocations

NHS England have published five year allocations for CCGs. This means an uplift over the five year period of 33.48%. The 2019/20 uplift was the greatest at 9.28%, and further uplifts vary at between 4-6%. Further analysis is required to link the uplifts to the new GP contract investments.

Devon CCG delegated primary medical care allocations

Year	2019/18	2019/20	2020/21	2021/22	2022/23	2023/24
Allocation	£151 million	£165 million	£173 million	£184 million	£193 million	£202 million
Uplift		9.28%	5.22%	6.05%	4.67%	4.59%

PMS Premium

The CCG is committed to reinvesting the Primary Medical Services (PMS) Premium in primary medical care services.

The principles that govern this reinvestment have been agreed locally to ensure there is no inequity of the reinvestment in general practice between the two former CCGs in Devon.

Locally enhanced services

The Devon Long Term Plan recognises that population growth will have a significant impact on general practice. We will make additional funding and investment for primary care available through locally enhanced services through reinvestment of the PMS Premium. This will increase the overall locally enhanced services commissioned by the CCG for Devon GP practices.

The NHS Long Term Plan identifies the need for the balancing of investment towards community and primary care services, as well as mental health. This is described in the NHS Long Term Plan at strategic level, and as the detail is developed would expect investment in enhanced services to include the expansion of shared care services in particular.

The CCG continues with the strategy for the harmonisation and equalisation of enhanced service payments across both former CCG areas.

How activity in the strategy will be funded

As targets for activity are set in each annual business plan, planned activity will be costed and matched in line with either allocated funding streams or through seeking alternative funding options from the full range of resources available to the CCG.

Timeline

	2019-20	2020-21	2021-22	2022-23	2023-24
Quality		New quality indicators, with benchmarked outcomes and learning from best practice.			
		Implementation of a system of practice and PCN reviews, including site visits. This will include support for practices who struggle to meet indicator. Support for practices from specialist or professional representatives where it is agreed or felt by either party to be required.			
		Sustainability review of single-handed practices in Devon to understand the issues and challenges they face and ensure plans in place to address any identified risks.			
Better Access	Urgent and routine appointments in general practice are available in the evenings and at weekends, where there is demand or a need.		‘Digital first’ approach adopted.		
			Primary Care Network-level delivery of combined extended access offer.		
			Medical records are available wherever patients interact with health and care services.		
		The Digital Accelerator project will be expanded to the whole of Devon. This will enable quicker access to general practice by delivering online consultations and better utilisation of resources.			
	General practice embeds functionality of the NHS App, enabling patients to access self-care and clinical advice, book appointments, order repeat prescriptions, access their medical records, choose preferences for data sharing and organ donation.				
		Promoting digital access amongst all groups of patients, including a digital guidebook developed by Healthwatch			

	2019-20	2020-21	2021-22	2022-23	2023-24
Workforce	Establish Primary Care Network teams to include community pharmacists and social prescribing link workers.	Work closely with system partners on action plans to improving understanding of anticipated workforce needs.			
		Capacity and capability analysis completed.			
		Primary Care Network multi-disciplinary teams expanded to include physiotherapist, physician associates and community paramedics.			
		Primary Care Network and Clinical Commissioning Group work together to: • Attend local, regional and national job fayres promoting Devon as a place to work • Continue to build on the success of the GP retainer scheme • Make the GP fellowship scheme available across Devon • Expand the portfolio and rotational working opportunities to staff working in general practice • Develop a range of flexible working approaches • Participate in the international recruitment of GPs initiative • Implement the 10-point general practice nurse plan • Expand the GP post-training fellow pilot to cover the whole of Devon			
Population Health Management		Implement quality improvement. All Primary Care Networks will receive data to help inform decision-making. PCNs implementing population-specific services.	Patients empowered to self-care with support and information through the new social prescribing workforce. PCNs and CCG working with the most vulnerable people to improve health.		
		Quality and Outcomes Framework maximum points attainment achieved.			
			Wide range of affiliated community-based professionals providing care and support as part of an enhanced patient offer. Patients will be supported to access voluntary sector services for both delivery of care and access to digital services.		

	2019-20	2020-21	2021-22	2022-23	2023-24
Primary Care Networks	Implementation of Primary Care Network development plan.				
		Primary Care Networks will implement: • Structured medication reviews • Enhanced health in care homes • Anticipatory care (with community services) • Personalised care • Supporting early cancer diagnosis.	Primary Care Networks will implement: • Cardiovascular disease prevention and diagnosis, through case finding • Locally agreed actions to tackle inequalities.	Primary Care Networks will: • Stabilise general practice locally • Help solve the capacity and skills gap through a wider workforce, with increased GPs and nurses • See further local investment • Integrate primary and community care • Systematically deliver new services to support implementation of the Devon Long Term Plan.	
Infrastructure		System-wide access to general practice patient information.			
	Develop and agree prioritised estate investment plan.	Implementation of estates investment plan.			
		Implementation of national GP Connect interoperability programme.			

Glossary

AHP	Allied Health Professional
CCG	Clinical Commissioning Group
CCT	Certificate of Completion of Training
CPD	Continuous Professional Development
CQC	Care Quality Commission
DES	Directed enhanced service
ED	Emergency Department
EHR	Electronic health record
ETTF	Estates and Technology Transformation Fund
FTE	Full-time equivalent
GP	General practitioner
HEE	Health Education England
HOPE	Helping individuals overcome problems effectively
LES	Locally enhanced service
LHCRE	Local Integrated Health and Care Record
LDC	Local Dental Committee
LMC	Local Medical Committee
LOC	Local Optical Committee
LPC	Local Pharmaceutical Committee
LTC	Long term condition
LTP	Long term plan
MECC	Making Every Contact Count
MIG	Medical Interoperability Gateway
PCN	Primary Care Network
PHM	Population health management
PMS	Primary medical services
POD	Prescription Ordering Direct
PPG	Patient Participation Group
QEIA	Quality and Equality Impact Assessment
QOF	Quality and Outcomes Framework
SCR	Summary Care Record
SCR-AI	Summary Care Record – Additional Information
SEA	Significant Event Audit
STOMP	Stopping over medication of people
STP	Sustainability and Transformation Partnership
VTS	Vocational training scheme