NHS
Wolverhampton
Clinical Commissioning Group

**Meeting of the Public Primary Care Commissioning Committee**
**Tuesday 1st October 2019 – 14:00-15:30**

**PA025 Marston Room, Ground Floor, Technology Centre,**
**Wolverhampton Science Park WV10 9RU**

# A G E N D A

| | | | | |
|---|---|---|---|---|
| *1.* | *Welcome and Introductions* | | *Chair* | ***Verbal*** |
| *2.* | *Apologies* | | *Chair* | ***Verbal*** |
| *3.* | *Declarations of Interest* | | *Chair* | ***Verbal*** |
| *4.* | *Minutes of previous meeting – 3rd September 2019* | | *All* | ***Enc 4*** |
| *5.* | *Matters arising from previous minutes* | | **Chair** | Verbal |
| *6.* | *Committee Action Points* | | **Chair** | Enc 6 |
| *7.* | *Primary Care Update Reports* | | | |
| ***7 a*** | ***Primary Care Quality Report*** | ***A*** | *Liz Corrigan* | ***Enc 7 a*** |
| ***7 b*** | ***Primary Care Operational Management Group Update*** | ***A*** | *Mike Hastings* | ***Enc 7 b*** |
| ***7 c*** | ***Draft Comms & Engagement Strategy*** | ***A*** | *Mike Hastings* | ***Enc 7 c*** |
| ***7 d*** | ***Digital First Primary Care update*** | ***A*** | *Sarah Southall* | ***Verbal*** |
| ***7 e*** | ***Wolverhampton Primary Care Strategy 2019-2021*** | ***D*** | *Sarah Southall* | ***Enc 7 e*** |
| ***7 f*** | ***Primary Care Contracting Update*** | ***A*** | *Gill Shelley* | ***Verbal*** |
| *8.* | **Any Other Business** | | | |

*Date of Next Meeting:*

***Tues 5th Nov 2019 – Extraordinary Meeting – Venue TBC***

***Tuesday 3rd December 2019 at 15:30 - PA025, Marston Room, Ground Floor, Technology Centre, Wolverhampton Science Park WV10 9RU***

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**WOLVERHAMPTON CLINICAL COMMISSIONING GROUP**

**PRIMARY CARE COMMISSIONING COMMITTEE (PUBLIC)**

**Tuesday 3rd September 2019 at 1.30pm**
**PA125 Stephenson Room, Technology Centre,**
**Wolverhampton Science Park WV10 9RU**

**MEMBERS ~**

**Wolverhampton CCG ~**

| Name | Position | Present |
|---|---|---|
| Sue McKie | Chair (voting) | Yes |
| Les Trigg | Lay Member (Vice Chair) (voting) | No |
| Steven Marshall | Director of Strategy & Transformation (voting) | Yes |
| Sally Roberts | Chief Nurse & Director of Quality (voting) | No |
| Dr Salma Reehana | Clinical Chair of the Governing Body (non-voting) | No |
| Dr David Bush | Locality Chair / GP (non-voting) | Yes |
| Dr Manjit Kainth | Locality Chair / GP (non-voting) | No |

**NHS England ~**

| | | |
|---|---|---|
| Bal Dhami | Senior Contracts Manager – Primary Care, NHSE | No |

**Non-Voting Observers ~**

| | | |
|---|---|---|
| Tracy Cresswell | Wolverhampton Healthwatch Representative | No |
| Dr Ankush Mittal | Consultant in Public Health | Yes |
| Dr B Mehta | Wolverhampton LMC | No |
| Jeff Blankley | Chair of Wolverhampton LPC | Yes |

**In attendance ~**

| | | |
|---|---|---|
| Helen Hibbs | Chief Officer (WCCG) | Yes |
| Tony Gallagher | Director of Finance | Yes |
| Liz Corrigan (on behalf of Sally Roberts) | Primary Care Quality Assurance Co-ordinator | Yes |
| Mike Hastings | Director of Operations (WCCG) | Yes |
| Peter McKenzie | Corporate Operations Manager (WCCG) | Yes |
| Sarah Southall | Head of Primary Care (WCCG) | Yes |
| Gill Shelley | Primary Care Contracts Manager (WCCG) | Yes |
| Diane North | Primary Care Commissioning Committee Admin | Yes |

## Welcome and Introductions

WPCC543 The Chair welcomed attendees to the meeting and introductions followed.

It was noted that Dr Ankush Mittal would attend for Public Health going forward (previously John Denley).

Liz Corrigan was also attending on behalf of Sally Roberts and therefore remained for the duration of the meeting.

## Apologies

WPCC544 Apologies were received from the following members

Les Trigg, Vice Chair

Dr Salma Reehana, Clinical Chair of Governing Body, CCG

Sally Roberts, Chief Nurse & Director of Quality (Mrs Corrigan in attendance)

John Denley, Director of Public Health (Dr Ankush Mittal in attendance)

Dr Manjit Kainth, Locality Chair/GP

Tracy Cresswell, Wolverhampton Healthwatch Representative

## Declarations of Interest

WPCC545 The Chair declared she no longer had an interest in items relating to Primary Care as her role with the Child Death Overview Panel for Walsall and Wolverhampton had ended last week.

Helen Hibbs declared that she had an interest in the item relating to the merger of Parkfields and would leave the meeting during this discussion.

## Minutes of the Meeting held on the 2nd July 2019

WPCC546 The minutes of the meeting held on 2 July 2019 were agreed as an accurate record.

**RESOLVED: That the above was noted.**

## Matters Arising from Previous Minutes

WPCC547 There were no matters arising.

**RESOLVED: That the above was noted.**

**Committee Action Points**

WPCC548 **Action 37 (Minute No: WPCC525) – Wolverhampton Primary Care Strategy update**
Item on today's agenda, therefore action closed.

**Action 38 (Minute No: WPCC526) – STP Primary Care Strategy Update**
Item on today's agenda, therefore action closed.

**Action 39 (Minute No: WPCC481) – Tettenhall Medical Practice – Wood Road Branch Closure**
A further update to be provided today as part of the Primary Care Contracting report. Action remains open, as the public consultation has been extended to15th September 2019. To be discussed again in November.

**Action 40 (Minute No: WPCC540) – Quality Assured Spirometry**
A further update on the implementation of the Spirometry service to be provided to committee in October.

**Action 41 (Minute No: WPCC541) – Practice Resilience Funding**
It was confirmed that the proposals suggested by the Operational Management Group that were put forward to the GP Forward View (GPFV) Programme Board on 28th August 2019 were approved. There is £40,000 available for resilience support for Practices in Wolverhampton. A report has been submitted to the Private meeting today. Action closed.

**RESOLVED: That the above was noted.**

**Primary Care Update Reports:**

**Q1 Finance Report Apr-Jun 2019**

WPCC549 Mr Gallagher advised that the report was the first to committee in the new format. It showed a more granular analysis of spend within Primary Care and included areas outside of delegated commissioning such as the prescribing incentive scheme.

Future reports would describe why the variances had occurred and what actions would be taken to address them. The current status showed as breakeven largely a consequence of not having received all the claims in relation to the last financial year. The intention was to create a non-recurrent reserve against which to plan non-recurrent schemes. It was likely that primary care would underspend again this financial year with a probable value of £1m however this would become clearer after the end August when all claims were received. The intention was to give committee early sight of

the underspend in order to have time to take remedial action and spend within the original budget. Last year it had been January when the underspend of £900,000 had been realised.

The next update would show the exact value of the development reserves and would be looking for non-recurrent schemes and/or options to bring schemes forward from new financial year. The report format had been sighted already at Finance and Performance (F&P) committee so the question today was, did it meet this committee's needs or was supplementary detail required.

A question was raised, as August had now passed whether the value of the underspend was known. Mr Gallagher advised that it would be the middle of September before an update at month six could be provided.

**RESOLVED: That the report and highlights above were noted.**

**Primary Care Quality Report**

WPCC550 An overview of the report was provided by Mrs Corrigan.

A number of items submitted via Quality matters had been forwarded to the NHSE Practice and Performers Information Gathering Group (PPIG). These were things that would be easily resolved and weren't major issues.

An Information Governance (IG) issue was raised about blood forms being given to the wrong patient. It was felt this was predominately human error with a requirement for more vigilance. Mr McKenzie advised that under the new commissioning arrangements for IG support the Commissioning Support Unit (CSU) would now be responsible for providing support to practices and would be putting on training sessions and he would speak to the CSU to ensure these issues are covered. Members suggested that such issues could be taken forward via several routes such as the Group Leads meeting to reiterate the triple check; Primary Care Leads, Clinical Directors, the Learning newsletter which goes to Practice Managers and GPs, Quality and Safety meetings, Practice Managers forum, Practice makes Perfect and the Practice nurses forum.

Breaches had been reported to the CCG by the phlebotomy service at the hospital. Dr Bush suggested a solution could be not to give patients forms at all but use the information on the ICE system.

Work was being undertaken with Public Health to increase the under 65 year's flu vaccine. There would be a slight delay in the delivery of the under 65s vaccine, the Quadrivalent, and waiting on final dates.

Information on people's MMR and flu call and recall and uptake rates had been added to the collective contracting template because this had been

flagged up as low performance and the CCG was working with Public Health to improve this. Public health advised that the UK had been taken off the World Health Organisation measles elimination status achieved in 2017 but that Public confidence in the vaccine was higher now than before so there was a perception it could potentially be an access to care issue.

Another practice had been identified by CQC as requiring improvement and was being monitored as an ongoing issue. Currently there were three practices requiring improvement, none were inadequate. Action plans were in place and practices were actively working through the plans.

The Practice Nurse strategy for the Black Country was due to be launched on 3rd October at Himley Hall with national speakers in attendance.

The Practice Nurse retention was running alongside the GP retention programme and the workstreams identified were approved at the GP Forward View (GPFV) meeting on 28th August 2019.

A series of training was planned on topics such as blood collection tubes, cytology, and immunisation. The Association for Respiratory Technology & Physiology (ARTP) Spirometry training is due to start on 3rd September 2019 with 20 candidates signed up. Full training hub cover provided by Sandwell was now in place, which has reduced the risk around it.

**RESOLVED: That the report and highlights above were noted.**

**Primary Care Operational Management Group Update**

WPCC551 Mr McKenzie presented on behalf of Mr Hastings who would join the meeting later.

- The CCG continued to support Tettenhall Medical Practice with their patient consultation regarding their intention to close the Wood Road branch.
- Building work at East Park was on track to be completed by the end of the financial year. The Newbridge building work was complete. There had been a workshop in July to discuss having a Hub for the North-East.
- There had been a meeting with the Care Quality Commission (CQC) around some of the issues highlighted in the Quality report such as support provided to practices and programme of inspections. Work with the CQC and Local Authority will continue to make improvements.

An issue was raised by Ms Shelley with regard to item 10, Primary Care contracting in relation to Dr Mudigonda having 13 actions outstanding around CQC registration. This was incorrect and it was actually 13 actions outstanding from their contract monitoring review visit, one of which was around their CQC registration which had since been resolved

and the issue around the Practice fridge had also since been resolved.

**RESOLVED: That the update was noted.**

**Primary Care Contracting Update**

WPCC552 Ms Shelley presented the report, which provided an update on the Tettenhall Medical Practice branch closure. The consultation process that had been due to finish on 31st July had now been extended to 15th September to allow for a further consultation session with the public on 11th September and for comments from the Local Authority Health Overview and Scrutiny committee (on 12th September) to be fed into the consultation process.

A public meeting outside of the Practice and CCG consultation was held by the local community chaired by Eleanor Smith, the local MP. The meeting was well attended with circa 180-200 people.

The application to close Wood Road surgery will be presented to this committee in November.

Included in the report also was information on GMS contract variations and the Spirometry Enhanced Service giving details of which Primary Care Networks (PCNs) would be delivering the service.

Ms Southall added with regards to Spirometry that at the time of the report being compiled it was based on the networks that had expressed an interest and confirmed their delegates for the training. Since then the Royal Wolverhampton Trust (RWT) had confirmed that they would not be taking part but that Unity East & West and the North network would. RWT have access to the Spirometry service in-house.

**RESOLVED: That the update was noted**

**Merger of Parkfields Medical Centre with Grove Medical Centre (Health & Beyond Partnership)**

WPCC553 *Helen Hibbs left the meeting*

Ms Shelley presented her report to inform the committee of the request to merge the 2 Practices and to gain committee approval to go ahead.

The CCG had been served an application by Parkfields Medical Centre to merge with Grove Medical Practice, part of the Health & Beyond Group. Background information including the geographical locations of the Practices was provided. Benefits to patients included increased access, patient choice of clinician, full range of enhanced services, appointments at

any site.

Public and patient engagement had been undertaken in the form of leaflets, notices in Practice, messages on prescriptions, use of the local pharmacist, Practice website, 1 to 1 discussion, practice meetings, Patient Participation Group, and letters. Feedback from patients had been positive, keen to make use of the increase access. The Practice submitted a business plan appended to the report along with an Equality Impact Assessment.

Ms McKie read out comments submitted by Dr Kainth in an email commenting on Practice mergers asking when did big become too big and whether services would actually be better under a larger arrangement than a smaller one and whether there was any data around this. Discussion ensued but it was felt that the only real measure would be patient outcomes. Dr Mittal stated that at The Royal Wolverhampton Trust there was a patient population of circa 60,000 and this could serve as an example of larger working.

Ms Southall highlighted that an important factor in the Parkfields merger was the workforce challenges they were facing, in particular the recruitment and retention of GPs. This meant the practice had opted for a merger with another larger and more robust and delivery resilient Practice which could only be a positive move for patients.

A question was asked that on page 4 of the Business Case where it stated there would be no immediate change to service delivery and whether it could be read into that that, there may be future changes to service delivery.

Ms Southall replied to the effect that having had lengthy discussions with both Practices about their intentions there were two GPs who were planning to retire so the intention was to maintain the status quo whilst learning about the practices to ensure they got the medical model right. The Grove had already recruited a number of newly qualified GPs who would spread their wings into Parkfields and Woodcross as those GPs exit. The merger was not expected to affect patient access to a female GP.

In order to mitigate the risk pertaining to the systems merger and data collection the merger needed to be timely and was planned to go ahead before December 2019.

No objections were received from committee with regard to the merger. It was felt that there was still a need to support smaller, local practices operating in the traditional way.

**RESOLVED: Approval for the merger of Parkfields and Grove Medical Centre was given.**

**RESOLVED: That the update was noted.**

*Helen Hibbs returned to the meeting*

**Milestone Review Board (Q1 2019/20)**

WPCC554 Ms Southall began by saying that the Milestone Review Board had met in April and the final Assurance report was based on Quarter 1 which was then considered at the July meeting so the updated Assurance Pack appended was based on the outputs of the Milestone Review Board in July and there was also one new risk in response to the Digital First Primary Care national consultation.

The recruitment of Social Prescribing Link Workers was covered under the new roles of the PCNs Direct Enhanced Service (DES). The Wolverhampton Primary Care strategy appended had also been updated.

**Primary Care Assurance Pack (Q1 2019/20) Appendix 1**
The Milestone Review Board had considered the assurances within the pack with a number of suggested changes as detailed on page 3 of the report in relation to Bowel screening and Right Care packs utilisation. The Board had noted the new risk in relation to GP at Hand which is a London based practice as detailed in Appendix 2.

Report highlights included the progress that had been made in relation to digital transformation with online & video consultation continuing to be rolled out to Practices with currently 70% of them having the functionality with a target of 100% by December 2019 enabling them to offer such consultation types should patients wish to access them.

In relation to workforce the GP Nursing strategy had been approved for the STP. A number of retention schemes for practice nurses had been developed and there would be a single point of access nurse recruited for the Black County to ensure nurses had the support they needed in the workplace. A number of co-designed events which nurses had actively participated were detailed in the STP update. Training was planned for Healthcare Assistants and Spirometry and there was protected learning time sessions for Practice Managers.

The pack detailed the progress that Primary Care Networks (PCNs) were making which was based on the assurance statements and NHS England. The Quarter 1 level of assurance given along with plans for Quarter 2.

The commissioned services section of the report confirmed the Contract and Quality Review meetings that were in place for our commissioned services, confirming providers and meeting frequency. Referrals to the Social Prescribing provider had increased in quarter one however there was concern over the referral rates from within PCNs with measures taking place in Quarter 2 to address this.

A request was made by the Chair in relation to the Quarter 1 data which

stated that 51% of clients referred into Social Prescribing were over 60 and 49% 18-60, whether there could be a more detailed breakdown of the 18-60 group. Ms Southall agreed to this. The service did not allow self-referrals but received referrals from other professionals within the health and social care system. **Action 42 SS**

It was confirmed that the current referrals were for the embedded 5 Social prescribers. A question was raised regards to the additional 6 prescribers shortly to be coming in if there would be 6 times worth of social prescribing referrals expected. Ms Southall confirmed that the PCNs were very keen to have their own Social Prescriber to do targeted work with specific cohorts of patients. The expectation from Clinical Directors was that the new Social Prescribing Link workers (in post by 28 September) would be embedded within the networks whereas the existing service, currently receiving 2 referrals a day, sat outside of this. Ms Southall explained that the 2 referrals per day were solely new referrals and workers still had a caseload existing patients.
Discussion ensued about the other services currently on offer including Primary Care counselling from Relate and whether there was already sufficient IAPT provision and whether the provision was being used appropriately. Ms Southall felt that from a Social prescribing perspective it was too early to say whether there was too much provision as needed to allow Clinical Directors to demonstrate demand at network level. It was suggested by Ms Southall to do a feature on Social Prescribing for the December meeting. **Action 43 SS**

Ms Southall advised that next year from April 2020, the networks would have the opportunity to opt for additionally based on their own preferences, whether for more social prescribers, first contact practitioners or clinical pharmacists.

Public Health agreed that as data intelligence indicated there were many people with life problems and that social wellbeing was traditionally seen as the domain of the Local Authority and with carers, for example, only a quarter saying they had enough social contact and there were 7,000 registered carers so if there was any future spare capacity this might be one route for it.

Sound Doctor utilisation rates had increased greatly which, it was felt, was due to the use of text messaging and links being sent to cohorts of patients.

Care Navigation, a review session was due to take place later this month with a relaunch of care navigation. There had been a number of practices not recording navigation actively through their clinical systems which was being addressed.

Utilisation of Choose and Book Advice and Guidance remained an issue and discussions were taking place on how to liaise with consultants within the Trust.

Workflow optimisation, GPs and staff had taken part in some workflow training last year and the model had now been introduced where non-clinical staff were coding correspondence with the intention to free up GP time. A number of practices that should be providing evidence at audit were not quite there and this was being worked on.

Types and numbers of GP home visits were provided at Programme Board in October 19. The pilot had been extended until end October 19. The evaluation report would detail the destination of the patients and the cost of intervention.

There were no further comments around the report.

**GP at Hand Briefing Note – Appendix 2**

The report on Digital First Primary Care informed that following a consultation led nationally from June to August 23rd, there was a call to action shared with Clinical & Executive Directors in regard to the contractual change that NHS England were exploring.

There was a view at national level that Primary Care should be digital first rather than face-to-face appointments and within the Hammersmith & Fulham CCG was a practice that had grown its list size significantly to in excess of 50,000 patients with a significant number of them being out of area. Patients tend to work in the London area but live elsewhere where they were originally registered with a GP.

A practice in Birmingham was currently working with another provider of such infrastructure. Birmingham and Solihull CCG (BSOL) had experienced a significant impact on their day to day working and could potentially lose numbers of patients. Fortnightly conference calls were taking place involving Birmingham and Solihull (BSOL) CCG, Hammersmith & Fulham CCG, NHS England, Public Health England as there are significant issues with patient pathways particularly in relation to immunisation and screening programmes. Measures were in place to try and mitigate this in the Birmingham branch. The rate of patient registration for the BSOL practice was initially capped at 2,300, which had recently been lifted by NHS England with patients now able to register. The rate of registration had not been as rapid as initially expected but with fresher's week approaching registrations might exceed the initial cap.

GP at Hand, a GMS practice in Hammersmith & Fulham had a rapid expansion plan that has been suppressed by NHS England at this point but would be reconsidered for later in September. The Practice seeked to recruit registrants from surrounding areas which could affect Wolverhampton, Stafford, Telford and the Shropshire Boarders as patients who live and work within 40 minutes of the new branch opening in Birmingham would be eligible to register.

The report provided detail of the patient cohort that tended to register with this type of practice and these patients would be registered as out of area

patients and moved from their current registration to Hammersmith & Fulham CCG. The consultation would seek to rectify this and out of area registrations would be changed to place of residence to mitigate the financial consequences. The consultation had now ended and all responses were being considered.

The availability of digital technologies was now available at Practices within Wolverhampton but could be better utilised so the call to action was to remind Clinical Directors to increase this. A typical practice with a list size of around 6000 patients could lose a large cohort of 21-30 year olds possibly up to 800 patients if it grew at the rate it did in London.

Ms Southall stressed the importance of recognising the implication of the consultation, Digital First being the mantra that was being taken by NHS England, which would inform changes to contracting. If Wolverhampton were to be viewed as an under adopted area, which currently it was, it could potentially be subject to an APMS contract being imposed for one of the providers to be brought in to recruit patients to the Digital First model. Wolverhampton had responded firmly that it did not feel there was a need for another practice.

The issue was being taken seriously by the CCG Executives and the Clinical Directors and an amber risk had been raised but if registrations from the Wolverhampton population increased the risk would also increase. If another practice similar to that opening in Birmingham were to open within Wolverhampton there could be significant implications for the CCG.

It was felt that Practices using the technology currently in place was a very different thing to the GP at Hand offer. Ms Southall advised there would be a meeting on 9th September 2019 with Clinical Directors as to whether they would like to explore a Black Country model by collaborating with Livi, GP at Hand or Push Doctor and costs were being sourced by the Lead.

It was felt that the twenty minute response time on offer, was more of a triage service, than a consultation and in effect was no better than the referral being dealt with by telephone.

Another member stated that of the younger patients who register with such a service that 40% move back after time and to offer a “blended” service of traditional and digital within existing practices would be better.

Steps to be taken included a review of advertising and promotion of availability of such types of appointments within practices and monitoring the numbers of registrations.

A further update on Digital First Primary Care would be provided to committee in October. **Action 44 SS**

**Wolverhampton Primary Care Strategy 2019-2021 – Appendix 3**
The strategy had been updated and, given the time available, it was taken

that the report had been read by members with any feedback to please be provided it to Sarah Southall by close of day on Friday 13th September 2019 prior to the strategy being recommended for adoption by the Governing Body.

**RESOLVED:**

1) **That, pending any comments from members prior to 13 September, the revised Primary Care Strategy be recommended to the Governing Body for ratification.**

2) **That the update was noted.**

**STP Primary Care Strategy**

WPCC555

It was taken that the report had been read by members with any feedback to be please provided it to Sarah Southall by close of day on Friday 13th September 2019. The strategy has now been approved by NHS England.

**RESOLVED: That the update was noted.**

**STP GP Forward View Programme Board update**

WPCC556

Many of the items discussed at the STP GP Forward View Programme Board had already been covered at today's committee. Including online consultations, resilience funding approval, GP and Nursing strategy launch. There were many funding allocations that sat within the Programme Board and a synopsis of these discussions would be available by Friday 6th September and circulated to members. **Action 45 SS**

Funding had been allocated to various different projects including mentoring for new GPs, General Practice Nursing and GP fellowships with further details to be provided at future meetings. An event was planned for 10th October 2019 to provide network support for GPs returning to Practice and mid-career GPs. With regard to Portfolio careers all the PCNs were invited to access funding this year for portfolio careers that are beneficial to the PCN i.e. population health needs and specialisms.

**RESOLVED: That the update was noted.**

**Any other Business**

WPCC557

Discussion was had regarding the frequency of future meetings and it was decided to hold a meeting in October, December and February 2020 with an extraordinary meeting in November 2019.

**Date of Next Meeting**

WPCC558

**Tuesday 1st October 2019, PA025 Marston Room, Ground Floor, Technology Centre, University of Wolverhampton Science Park WV10 9RU**

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**Primary Care Commissioning Committee Actions Log (Public)**

| Action No | Date of meeting | Minute Number | Item Title | Item | By When | By Whom | Action Update |
|---|---|---|---|---|---|---|---|
| 39 | 05/03/2019 moved from private to public actions 04/06/19 | WPCC481 | Tettenhall Medical Practice - Wood Road Branch Closure | An Update to be provided at the conclusion of the consultation period | Dec-19 | Gill Shelley | **03/09/19: Public consultation has been extended to 15th Sept 2019 and an update will be provided following this.**<br><br>04/06/19 Action inherited from Private action Log. Update to be provided at conclusion of consultation. Consultation ends Aug, report to be presented to committee in Sept.<br>07.05.19 It was confirmed that the consultation on the closure of Tettenhall Medical Practice, Wood Road branch commenced today 07.05.19.<br>02.04.19 Arden & GEM CSU to support Tettenhall Medical Practice with the 90 day consultation period. Findings to be presented to Sept committee. |
| 40 | 02 July 2019 | WPCC540 | Quality Assured Spirometry Business Case | An update on Spirometry service implementation to be provided to the Oct/Nov committee (dependant on if meetings go forward bi-monthly) | Oct-19 | Claire Morrissey | |
| 42 | 03 September 2019 | WPCC554 | Social Prescribing Further level of data | Within the Quarterly Milestone Review Board Q1 Assurance Report under Social Prescribing it was requested by the Chair that a breakdown of referrals for clients 18-60 years be provided in order to identify numbers of younger people using the service | Oct-19 | Sarah Southall | |
| 43 | 03 September 2019 | WPCC554 | Social Prescribing | A feature on Social Prescribing to include progress on PCN embedded workers to be provided to the Dec meeting | Dec-19 | Sarah Southall | |
| 44 | 03 September 2019 | WPCC554 | Digital First Primary Care | An update on progress to be provided to committee in October | Oct-19 | Sarah Southall | |
| 45 | 03 September 2019 | WPCC556 | STP GP Forward View Programme Board | Funding allocations and a synopisis of discussions from the 6th September Programme Board to be circulated to members | Oct-19 | Sarah Southall | |
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NHS
Wolverhampton
Clinical Commissioning Group

# WOLVERHAMPTON CCG

## PRIMARY CARE COMMISSIONING COMMITTEE
## 1st October 2019

| | |
|---|---|
| **TITLE OF REPORT:** | Primary Care Quality Report |
| **AUTHOR(s) OF REPORT:** | Liz Corrigan |
| **MANAGEMENT LEAD:** | Yvonne Higgins |
| **PURPOSE OF REPORT:** | To provide an overview of activity in primary care, and assurances around mitigation and actions taken where issues have arisen. |
| **ACTION REQUIRED:** | ☐ **Decision**<br>☒ **Assurance** |
| **PUBLIC OR PRIVATE:** | This Report is intended for the public domain. |
| **KEY POINTS:** | Overview of Primary Care Activity |
| **RECOMMENDATION:** | Assurance only |
| **LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:** | |
| 1. Improving the quality and safety of the services we commission | Providing information around activity in primary care and highlighting actions taken around management and mitigation of risks |
| 2. Reducing Health Inequalities in Wolverhampton | |
| 3. System effectiveness delivered within our financial envelope | |

## 1. BACKGROUND AND CURRENT SITUATION

**PRIMARY CARE QUALITY DASHBOARD**

**RAG Ratings:** 1a Business as usual; 1b Monitoring; 2 Recovery Action Plan in place; 3 RAP and escalation

| Issue | Comments | Highlights for August 2019 | Mitigation for September 2019 | Date of expected achievement of performance | RAG rating |
|---|---|---|---|---|---|
| **Serious Incidents** | All RCAs are reviewed at SISG and escalated to PPIGG if appropriate. | One incident referred to PPIGG<br>Another potential SI identified | One further incident to be reported to PPIGG | 31st October 2019 | 1b |
| **Quality Matters** | All issues being addressed by appropriate teams at the CCG and trust that has raised the issue. For review at PPIGG as relevant | Five incidents open, three are overdue and have been chased, three relate to IG breaches re: blood forms, one to inappropriate referral and one to staff behaviour | 12 open quality matters<br>There have been several clinical incidents noted that are being followed up<br>One incident is due to be reported to PPIGG | 31st October 2019 | 1a |
| **Escalation to NHSE** | Four incidents due to be reviewed at PPIGG from Quality Matters | One incident referred to PPIGG awaiting outcome | One incident to be reported to PPIGG previous incident to be managed at CCG level | 31st October 2019 | 1b |
| **Infection Prevention** | IP audit cycle has recommenced for 2019/20 | Eight practices audited, every practice improved from previous annual audit. Issues identified relate to waste management, environment and PPE. | Five practices audited all practices have either maintained good rating or improved | On going | 1a |
| **Flu Programme** | Flu planning meetings have recommenced for 2019/20 flu season | Sufficient vaccine is available in the city but MHRA rules will not be relaxed this year.<br>Monthly CCG/PH meetings have recommenced.<br>Monthly NHSE teleconferences have commenced | Flu vaccines are due to be delivered from middle of September onwards with QIV being delivered from late September | 31st March 2020 | 1b |

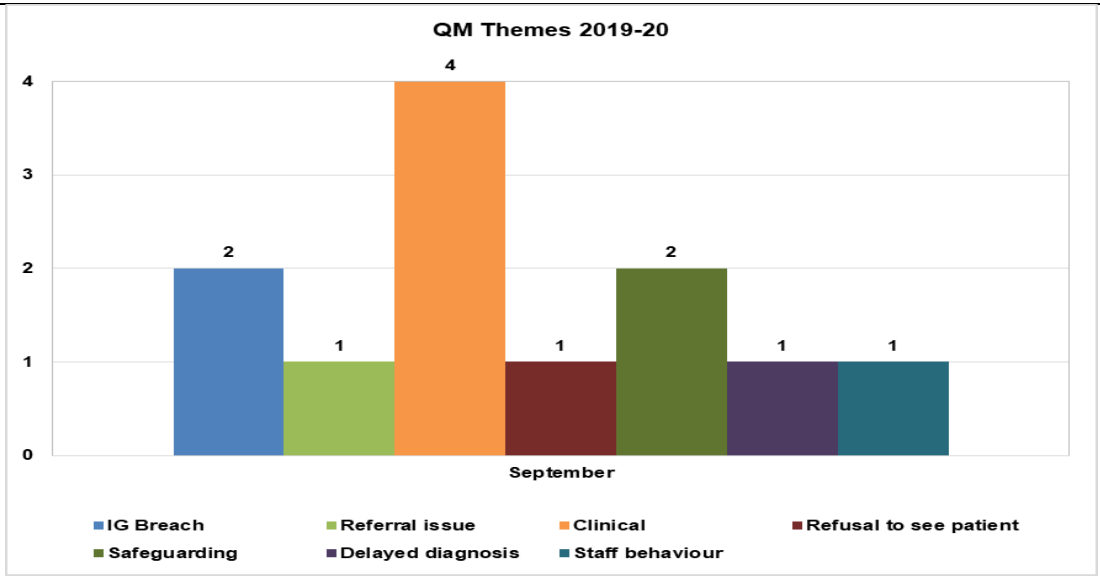
| | | | | | |
|---|---|---|---|---|---|
| **Vaccination Programme** | Vaccination programmes continue to be monitored | There are plans to add MMR uptake to collaborative contracting visit agenda as an ongoing item and to share data with locality managers | Work continues to monitor uptake via contract visits and Immform with quarterly meetings with NHSE | On-going | 1b |
| **Sepsis/ECOLI** | Planning continues around training for practices in reduction of gram negative infection – collaboration with IP team, prescribing and continence teams.<br>Some practices have still not identified a sepsis lead and this is being chased. | Ongoing work against action plan | Ongoing work against action plan – training for nurses due to take place in November | 30th November 2019 | |
| **MHRA** | No issues at present. | No further update | No further update | None at present | 1a |
| **Complaints** | No issues at present – quarterly report due July 2019 | Seven complaints received in Q4<br>• 6 closed 1 open<br>• 2 relate to the same practice<br>• 4 not-upheld; 1 partially upheld; 1 upheld<br><br>Themes include:<br>• Prescriptions<br>• Communication<br>• Clinical treatment and errors<br>• Staff attitude –this area the number of complaints has significantly reduced | No new complaint data at present | On going | 1a |
| **FFT** | Slightly lower uptake in July, most probably due to summer holidays | In July 2019<br>• 6 practices did not submit<br>• 2 submitted fewer than 5 responses<br>Uptake was 2.2% compared with 0.9% regionally and 0.5% locally. | In August 2019 (July data)<br>• 2 practices did not submit<br>• 3 submitted fewer than 5 responses | On-going | 1a |

| | | | | | |
|---|---|---|---|---|---|
| | | Practices have been reminded to nominate someone to upload their data if the main person is on leave.<br>Full report to be provided next month | Uptake was 2.0% compared with 0.8% regionally and 0.6% nationally.<br>Triangulation with GP survey data to take place | | |
| **NICE Assurance** | No actions at present – next NICE meeting in August 2019 | Next meeting in September | Awaiting new information | None at present | 1a |
| **Collaborative contracting visits** | All practices now complete new cycle to commence in October 2019 | All practices now complete, 5 action plans outstanding (minor issues only).<br>Template reviewed again for new cycle from October. | New cycle to begin in October 2019 | On going | 1b |
| **CQC** | Monitoring of practices and support continues. | Three practices now have a requires improvement rating, these are being supported by CCG Quality and Primary Care teams | CQC have identified practices due for inspection in the next quarter and work with CCG around this. Telephone follow up continues for other practices CQC share outcomes and concerns | On going | 1b |
| **Workforce Activity** | Work continues to promote primary care as a desirable place to work and to promote current programmes | GP strategy launch planning continues – venue now Himley Hall.<br>GPN retention plan work streams under development. | GPN retention programme steering group set up. NHSE have invited STP to work with them at national level. | On-going<br>Strategy 3rd October | 1a |
| **Workforce Numbers** | Awaiting NHS Digital workforce data release. | No change to status – data available but this is from September 2018 which is not new data. | No change in status | On-going | 1b |
| **Training and Development** | None flagged at present | Further flu training will be held in September<br>Spirometry training is due in September and December | Spirometry and MERIT training has commenced – this will be managed by training providers. | On-going | 1a |

| | | | | | |
|---|---|---|---|---|---|
| | | Immunisation training for HCAs will be available c/o Training Hub<br>MERIT Diabetes training is being provided by pharma<br>PMP will include immunisations and cytology | Immunisation training for HCAs has been provided by Dudley Training Hub.<br>PMP continues.<br>Non-clinical training continues. | | |
| **Training Hub/HEE/HEI update** | To continue monitoring, risk reduced and closed. | Sandwell CCG are now providing Training Hub cover, GPN facilitation remains with Dudley TH no issues noted | Nancy Szilvasi is now in post to support Wolverhampton and Walsall.<br>Move towards one lead hub with spoke hub to support continues | On-going | 1a |

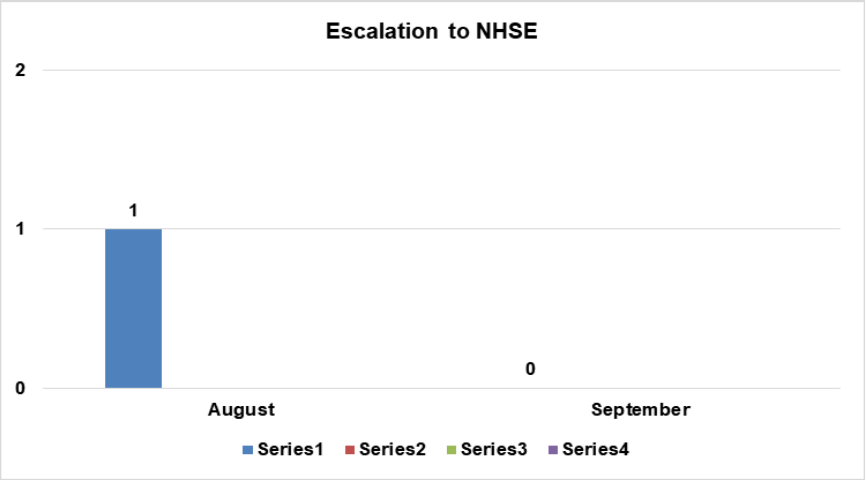
## 2. PRIMARY CARE QUALITY REPORT

### 2.1. PATIENT SAFETY

| Measure | Trend | Assurance/Analysis |
|---|---|---|
| **Serious Incidents** | N/A – not enough data to display a graph/trend<br><br>There has been one serious incident so far this year – unexpected death that was investigated by NHSE and closed. A second vaccine fridge incident has been identified recently – this does not meet the threshold and will be managed by West Midlands Screening and Immunisation Team | **Incidents:**<br>• One vaccine incident being monitored.<br>• All incidents are reviewed by serious incident scrutiny group<br>• Incidents are also reviewed by NHSE PPIGG group |
| **Quality Matters** |  | • There are currently 12 open Quality Matters (QM)<br>• 3 Quality Matters were closed in August<br>• 0 open QMs are overdue.<br>• One incident is due to be referred to PPIGG – IG breach.<br><br>QM is monitored daily by quality team and discussions are held with contracting and governance when required. |

| Monthly Variance | August | September | Percentage |
|---|---|---|---|
| New issues | 4 | 2 | 40% |
| Open issues | 2 | 10 | 62% |
| Overdue issues | 2 | 0 | 13% |
| Closed issues | 4 | 3 | 30% |

**Escalation to NHS England**




- One incident is due to be reported to PPIGG but has not been at present

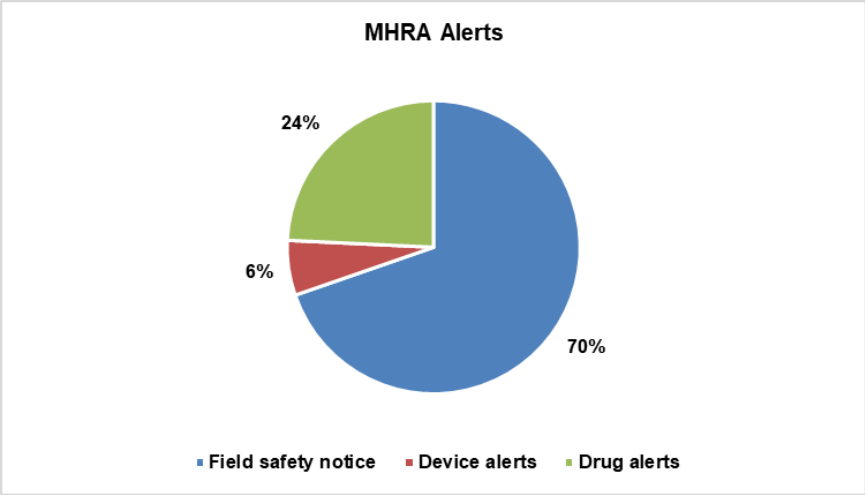


## 2.2. INFECTION PREVENTION

| Measure | Trend | Assurance/Analysis |
|---|---|---|
| **IP Audits** | New audit cycle commenced – please see attached IP audit report with proposed dates and current audit status/comparison with 2018/19 (Appendix 1) – please note red cells in column E relate to blank values.<br><br>Main issues identified relate to:<br>• Refurbishment needed | • **IP Audit Ratings:** Gold 97-100%; Silver 91-96%; Bronze 85-90%; No rating ≤84%.<br>• Work will continue with RWT IP team in regards to addressing themes and trends. |

| | | |
|---|---|---|
| | • Sinks need replacing<br>• Blinds need replacing<br>• PPE should be wall mounted<br>• Carpets in situ need removing<br>• Equipment e.g. couches and fabric chairs need replacing<br>• Mandatory training needs to be up to date<br>• Cleaning audits should be available<br>• Toilets need refurbishing<br>• Replacing wooden skirting boards<br>• General de-cluttering | |
| **MRSA Bacteraemia** | One community case identified in June but no indication of origin e.g. GP, in data – no additional cases noted. | • Unclear origin of MRSA from June, no further cases<br>• No other areas of concern to report. |
| **Influenza vaccination programme** | The delay in QIV (under 65) flu vaccine is not as marked as previously thought but risk identified and recorded on register<br>Flu season in Australia is currently earlier than usual with more cases identified but has now plateaued.<br>Local plans around marketing, delivery and monitoring of vaccinations in collaboration with Public Health and GP/pharmacy partners now underway. | • Flu planning group met on September 2nd.<br>• WM teleconference held on 12th September (see additional notes)<br>• Bi-weekly meetings being held between CCG and public health.<br>• Flu Fighters comics have been shared across the Black Country currently with Vaccination UK to be distributed with consent forms and letters<br>• Work to make delivery across PCNs possible being developed by NHSE. |
| **Vaccination programme** | MMR uptake continues to be monitored<br>Work to be undertaken around pertussis uptake in pregnant women | • To continue to work with PH around uptake.<br>• To work with colleagues across the Black Country (particularly Dudley who have a very good uptake) to share good practice.<br>• To feedback and receive data from regional screening and immunisation board. |
| **Sepsis** | No data at present | • Training for practice nurses is arranged for November 2019. |

## 2.2. MHRA Alerts

| Measure | Trend | Assurance/Analysis |
|---|---|---|
| **MHRA Alerts** |   | No concerns to report at present |

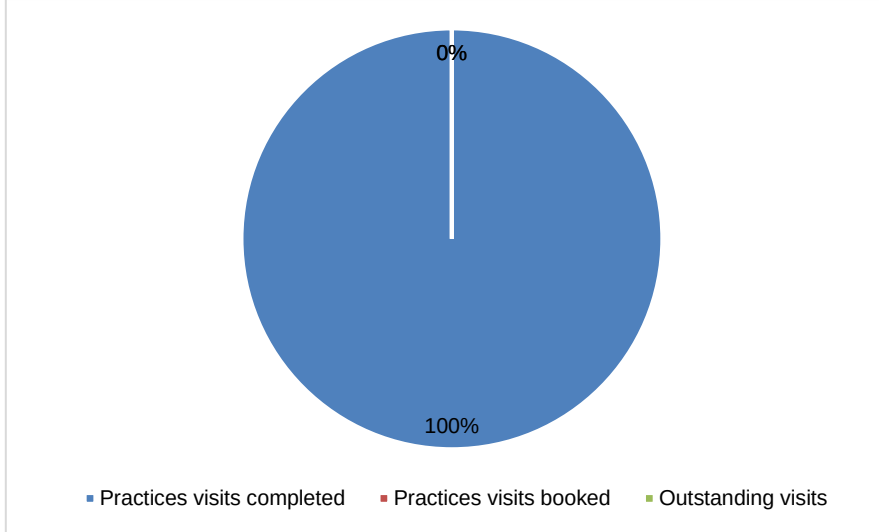
| | Aug | Sept | Total | Percentage |
|---|---|---|---|---|
| Field safety notice | 1 | 1 | 23 | 70% |
| Device alerts | 0 | 0 | 2 | 6% |
| Drug alerts | 0 | 1 | 8 | 24% |
| | | | 33 | |

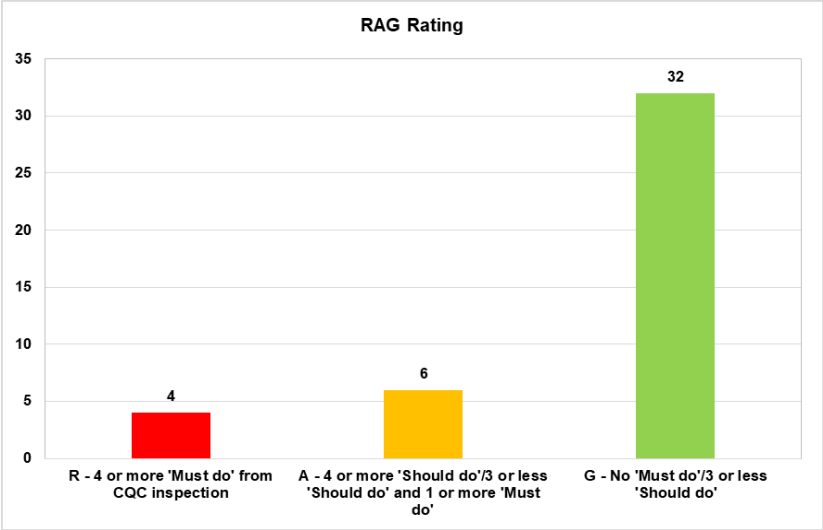
## 2.3. PATIENT EXPERIENCE

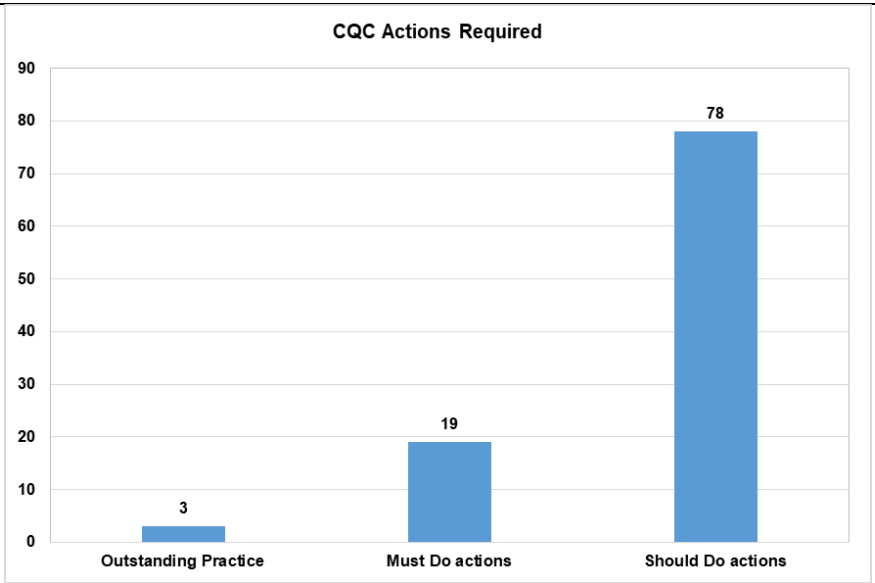
<table>
<tr><th>Measure</th><th>Trend</th><th>Assurance/Analysis</th></tr>
<tr><td>Complaints</td><td></td><td>No new complaints data available at present – awaiting Q3 data from NHS England.</td></tr>
<tr><td>Friends and Family Test</td><td>
<table>
<tr><th>Percentage</th><th>June</th><th>July</th><th>West Midlands</th><th>England</th></tr>
<tr><td>Total number of practices</td><td>40</td><td>40</td><td>1358</td><td>6996</td></tr>
<tr><td rowspan="2">Practices responded</td><td>85.0%</td><td>95.0%</td><td rowspan="2">65%</td><td rowspan="2">61.0%</td></tr>
<tr><td>34</td><td>37</td></tr>
<tr><td rowspan="2">No submission</td><td>15.0%</td><td>5.0%</td><td rowspan="2">35.0%</td><td rowspan="2">39.0%</td></tr>
<tr><td>6</td><td>2</td></tr>
<tr><td rowspan="2">Zero submission (zero value submitted)</td><td>0.0%</td><td>0.0%</td><td rowspan="2">N/A</td><td rowspan="2">N/A</td></tr>
<tr><td>0</td><td>0</td></tr>
<tr><td rowspan="2">Suppressed data (1-4 responses submitted)</td><td>5.0%</td><td>7.5%</td><td rowspan="2">14.9%</td><td rowspan="2">12.8%</td></tr>
<tr><td>2</td><td>3</td></tr>
<tr><td rowspan="2">Total number with no data (no/zero submission and supressed data)</td><td>20.0%</td><td>12.5%</td><td rowspan="2">44.7%</td><td rowspan="2">46.8%</td></tr>
<tr><td>8</td><td>5</td></tr>
<tr><td>Response rate</td><td>2.2%</td><td>2.0%</td><td>0.8%</td><td>0.6%</td></tr>
</table>
</td><td>
<ul>
<li>Uptake remains significantly higher than regional and national uptake.</li>
<li>Total non-responders 5 practices (no data, zero data or supressed data) – still significantly lower than regional and national average. All practices have been contacted.</li>
<li>Uptake is reviewed on a monthly basis by the Quality Team and Primary Care Contract Manager.</li>
<li>For highest and lowest uptake the locality managers have been advised.</li>
<li>Full report attached as appendix 1</li>
</ul>
</td></tr>
</table>

## 2.4. CLINICAL EFFECTIVENESS

### NICE Assurance – Updated Quarterly

| Measure | Trend | Assurance/Analysis |
|---|---|---|
| **Collaborative Contracting visits** |  | Visit schedule for this cycle is now complete – new cycle due to commence in October with visits discussed at Primary Care Operational Management Group and undertaken due to intelligence shared.<br><br>Slightly amended template including a section on celebrating good practice and sharing examples of good documentation. Flu activity and MMR uptake will also be included. |

| | | |
|---|---|---|
| **CQC ratings** |  | CQC continue to liaise with CCG to support the inspection process. Three practices in total for Wolverhampton have a requires improvement rating assurances have been provided by those sites. Two have had a revisit, one is being supported by CCG team.<br><br>Outstanding actions are managed by inspectors via 3 monthly virtual or face to face review.<br><br>Inspections by year:<br>2014 – 2<br>2015 – 2<br>2016 – 13<br>2017 – 13<br>2018 – 9<br>2019 – 3<br><br>Several practices are due an inspection due to changes in provider and next inspections have been shared with CCG for discussion. |


CQC Actions Required
90
80
70
60
50
40
30
20
10
0
3
19
78
Outstanding Practice
Must Do actions
Should Do actions

| CQC Ratings by Domain | Overall | Safe | Effective | Caring | Responsive | Well-led | People with long term conditions | Families, children and young people | Older people | Working age people (including those recently retired and students) | People experiencing poor mental health (including people with dementia) | People whose circumstances may make them vulnerable |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Outstanding | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Good | 39 | 35 | 40 | 41 | 41 | 39 | 39 | 39 | 39 | 39 | 39 | 39 |
| Requires Improvement | 3 | 7 | 2 | 1 | 1 | 2 | 3 | 3 | 3 | 3 | 3 | 3 |
| Inadequate | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 |



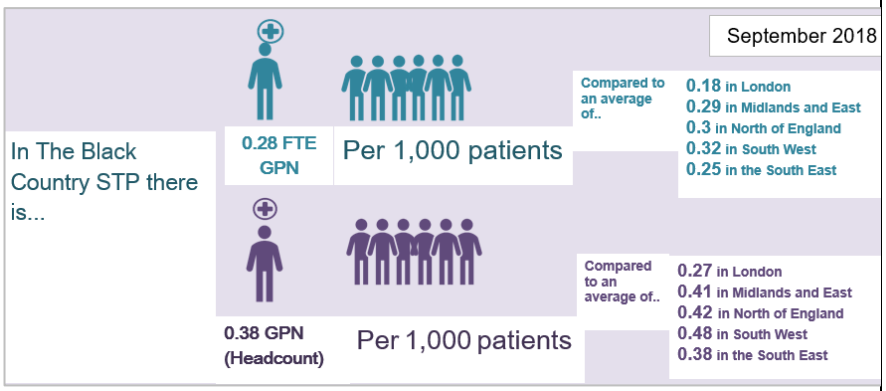
## 2.5. WORKFORCE DEVELOPMENT

### 2.5.1. Workforce Activity

| Measure | Assurance/Analysis |
|---|---|
| **Recruitment and retention** | • STP project manager and project support in post to support GP and GPN retention programme alongside other workforce work streams<br>• GP retention programme continues – mentorship, first fives, pre-retirement and portfolio careers work streams underway, mid-career work to commence<br>• The practice nurse retention programme has received funding approval at STP GPFV board level – steering group for work streams has been set up. STP has been invited to participate in the national pilot programme which includes additional support. Invitation to speak at a national event.<br>• HCA apprenticeship programme has 5 staff who have commenced or due to commence and one practice who is interested in larger scale HCA training and the employment of business and administration apprentices and upskilling HCAs to NAs – additional training to support this to commence |
| **GPN 10 Point Action Plan** | • Action 1, 2, 4, 5, 7, 8, 9 and 10: GPN strategy has been approved launch currently being arranged. This now forms part of STP Primary Care Strategy. |

| | |
|---|---|
| | • Action 1: Work experience pilot ran between 1st and 5th July with Public Health, CCG and Pharmacies. Good feedback from all parties, evaluation has been shared to extend next year.<br>• Action 2, 4 and 10: Digital Clinical Supervision pilot, has now finished but the sessions are continuing in Wolverhampton face to face and via Skype with technical problems persisting.<br>• Action 4: GPN Strategy supports GPN involvement in PCN boards at strategic level and leadership programmes such as Rosalind Franklin.<br>• Action 3: there are currently 17 practices and the CCG itself offering student nurse placements with another three expressing an interest, but there is some movement of mentors due to job changes.<br>• Action 4: nurses are due to commence Fundamentals of General Practice Nursing in January.<br>• Action 5: Further work is being developed to promote the Return to Practice programme via Futureproof.<br>• Action 7: Nurse Education forum continues on a monthly basis with plans to develop this further next year to include HCAs - a change in venue should be noted due to increased costs at current venue. Planned sessions include Cytology, Frailty and hydration, COPD, cancer care reviews, pain management, complaints and serious incident training and wound care.<br>• Action 9: The CCG can support 3 Nursing Associate apprenticeships with backfill in primary care, comms have been developed and circulated - no candidates at present despite active recruitment.<br>• Action 9: HCA apprenticeships programme has commenced with two candidates started in April and 4 further candidates identified as part of a pipeline programme in one practice, recruitment continues.<br>• Action 10: The Nurse Retention plan has now been collated with work streams being planned as part of the GPN Strategy – task and finish group to meet on 19th September, funding agreed and invitation to take part in national programme<br>• All Actions - GPN Strategy Launch will take place on 3rd October at Himley Hall in Dudley. |

## 2.5.2. Workforce Numbers

| Measure | Trend | Assurance/Analysis |
|---|---|---|
| **Workforce Numbers** | No data at present – awaiting figures from NHS Digital<br>  <br> | Figures taken from NHS Digital data are for September 2018 with the next update due imminently. Local figures are monitored via dashboard |



## 2.5.3. Training and Development

| Measure | Assurance/Analysis |
|---|---|
| **GP** | • GP retention programme continues<br>• Work continues around portfolio careers programme with a number of candidates expressing and interest<br>• Work undertaken with trainees around preferred place of work and aspirations |
| **Nurse/HCA/Nursing Associate** | • CCG GPN Leads meeting hosted by Wolverhampton CCG with rolling chair (currently with Worcestershire CCG)<br>• Strategy launch booked for 3rd October – good uptake already, speakers confirmed<br>• Practice Makes Perfect continues.<br>• Cytology training arranged for October in collaboration with CRUK, RWT and PHE<br>• Apprenticeship programmes are up and running – HEE keen for NA apprenticeships to be expanded considerably<br>• Spirometry training commenced with 15 candidates<br>• Uptake for sponsored places being monitored – 2 for specialist practice and potentially 4 for Fundamentals in January<br>• Funding for all GPN retention programmes identified |

| | |
|---|---|
| | • Funding for NMP and HCA training identified<br>• Additional funding available for newly qualified nurses and new to general practice nurses |
| **Other professionals** | • HEE have JDs available for all new primary care roles<br>• There are varied models of employing new roles within PCNs being proposed from maintaining current provision and buying cover, to direct employment to a proposed social enterprise model<br>• Pharmacist networks under development.<br>• Two Physicians Associates in post with two more to follow<br>• Staff side discussions underway c/o HEE around new roles particularly paramedics re: concern over capacity in WMAS |
| **Non-clinical staff** | • GPFV training continues<br>• Care navigation training being developed further to include signposting to non-GP professionals in practice<br>• Personalised care training being rolled out<br>• Practice resilience training is available at STP level.<br>• PMs have requested their own forum be developed<br>• Work continues across the STP to ensure equality of opportunity for development |



### 2.5.4. Partnership Update

| | Exceptions and assurance |
|---|---|
| **Black Country Training Hub** | • Sandwell TH now providing cover for Wolverhampton and Walsall CCGs with two project managers in post<br>• Training Hubs actively working with PCNs to identify workforce and training needs<br>• Digital Nurse Champion project continues – third cohort to commence in September TH lead<br>• Digital work undertaken with video by Doreen Tipton and other videos to follow<br>• |
| **LWAB/HEE** | • LWAB money – 25% ring fenced for primary care<br>• HEE exploring group consultations.<br>• Development around training hubs continues.<br>• Work around digital leadership and nurse champions continues.<br>• Work around population health management commenced with links with PHE<br>• Joint working with BSOL being considered<br>• Volunteering work being explored |
| **Higher/Further Education** | • Fundamentals starting in January in Wolverhampton and September in BCU |

| | |
|---|---|
| | • SP degree starting in September – 2 candidates<br>• ACP – no candidates this year |

## 3. CLINICAL VIEW

N/A



## 4. PATIENT AND PUBLIC VIEW

N/A

## 5. KEY RISKS AND MITIGATIONS

All risks addressed through Quality and Safety, Primary Care and Workforce Risk registers.

## 6. IMPACT ASSESSMENT

### *6.1. Financial and Resource Implications*

N/A

### *6.2. Quality and Safety Implications*

Report is also delivered to Quality and Safety Committee – quality implications are addressed via this group.

***6.3. Equality Implications***

N/A

***6.4. Legal and Policy Implications***

N/A

***6.5. Other Implications***

N/A

**Name: Liz Corrigan**
**Job Title: Primary Care Quality Assurance Coordinator**
**Date: 23/07/2019**



**REPORT SIGN-OFF CHECKLIST**

**This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.**

| | **Details/ Name** | **Date** |
|---|---|---|
| Clinical View | **N/A** | |
| Public/ Patient View | **N/A** | |
| Finance Implications discussed with Finance Team | **N/A** | |
| Quality Implications discussed with Quality and Risk Team | **N/A** | |
| Equality Implications discussed with CSU Equality and Inclusion Service | **N/A** | |
| Information Governance implications discussed with IG Support Officer | **N/A** | |
| Legal/ Policy implications discussed with Corporate Operations Manager | **N/A** | |
| Other Implications (Medicines management, estates, HR, IM&T etc.) | **N/A** | |

| | | |
|---|---|---|
| Any relevant data requirements discussed with CSU Business Intelligence | **N/A** | |
| **Signed off by Report Owner (Must be completed)** | **Yvonne Higgins** | **20/09/2019** |

NHS
Wolverhampton
Clinical Commissioning Group

# WOLVERHAMPTON CCG
# PRIMARY CARE COMMISSIONING COMMITTEE
# 1st October 2019

| | |
|---|---|
| **TITLE OF REPORT:** | Primary Care Operational Management Group Update |
| **AUTHOR(s) OF REPORT:** | Mike Hastings, Director of Operations |
| **MANAGEMENT LEAD:** | Mike Hastings, Director of Operations |
| **PURPOSE OF REPORT:** | To provide the Committee with an update on the Primary Care Operational Management Group. |
| **ACTION REQUIRED:** | ☐ **Decision**<br>☒ **Assurance** |
| **PUBLIC OR PRIVATE:** | This report is intended for the public domain. |
| **KEY POINTS:** | • The CCG continues to support Lower Green General Practice with their consultation process pertaining to their request to close their Wood Road branch<br>• Plans are continuing to develop around Probert Road<br>• Collaborative Contracting meetings are continuing with good outcomes |
| **RECOMMENDATION:** | To provide the Committee with an update on the Primary Care Operational Management Group. |
| **LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:** | |
| 1. Improving the quality and safety of the services we commission | The Primary Care Operational Management Group monitors the quality and safety of General Practice. |
| 2. Reducing Health Inequalities in Wolverhampton | The Primary Care Operational Management Group work with clinical groups within Primary Care to transform delivery. |
| 3. System effectiveness delivered within our financial envelope | Operational issues are managed to enable Primary Care Strategy delivery. |

## 1. BACKGROUND AND CURRENT SITUATION

1.1. Notes from the last Primary Care Operational Management Group are set out below.

**Primary Care Operational Management Group**
**Wednesday 11th September 2019 at 1.00pm**

**CCG Main Meeting Room, Wolverhampton Science Park, WV10 9RU**

**Present**

| | | |
|---|---|---|
| Jo Reynolds | (JR) | WCCG Primary Care Transformation Manager |
| Mandy Sarai | (MS) | WCCG Business Support Officer |
| Jane Worton | (JW) | WCCG Primary Care Liaison Manager (Chair) |
| Bal Dhami | (BD) | Senior Contacts Manager (Primary Care)NHS England |
| Liz Corrigan | (LC) | WCCG Primary Care Quality Assurance Coordinator |
| Peter McKenzie | (PMck) | WCCG Corporate Operations Manager |
| Gill Shelley | (GS) | WCCG Primary Care Contracts Manager |
| Ramsey Singh | (RS) | WCCG IM&T Infrastructure Project Manager |
| Sarah Southall | (SS) | Head of Primary Care (Wolverhampton CCG) & GPFV |
| Tracey Cresswell | (TC) | Health Watch Manager |

| Item | | |
|---|---|---|
| **1.** | **Welcome and Introductions** | |
| **2.** | **Apologies**<br>Apologies for absence were received from: Yvette Delany; Mike Hastings, Tally Kalea, Hemant Patel and Phil Strickland. | |
| **3.** | **Declarations of Interest**<br>There were no declarations of interest to be noted. | |
| **4.**<br>**4.1**<br><br><br><br><br><br><br><br><br><br>**4.2** | **Primary Care Operational Management Group Minutes**<br><u>Notes from Wednesday 3rd July 2019</u><br>The minutes taken from the meeting on Wednesday 3rd July 2019 were signed off and recorded as an accurate record subject to the following amendment' being made on page 4 under item 10.2.<br><br>**Action: Content of Primary Care Operational Management Group meeting update report to be reviewed for the Primary Care Commissioning Committee.**<br><br><u>Action Log</u><br>Items on the action log were discussed. | PMck |
| **5.**<br>**5.1** | **Notes of the Clinical Reference Group Meeting**<br><u>Clinical Reference Notes Tuesday 18th June 2019.</u><br>No comments were noted by the group. | |
| **6.**<br>**6.1** | **Risk Profile**<br><u>Risk Register</u><br><br><u>Business Continuity</u><br>Is due for review and is being chased.<br><br><u>Doc man</u><br>Prestwood Road surgery is due to be reviewed. | |
| **7.** | **Matters Arising** | |

| | | |
|---|---|---|
| | There were no matters arising. | |
| **8.** | **Primary Care Updates** | |
| **8.1** | Review of Primary Care Matrix<br>The Wood Road Consultation continues. A Public meeting has been scheduled for Wednesday 11th September 2019. The drop in session will be held between 4-8pm. High level of attendance is expected. Following on from this a paper will be going to the Health Scrutiny Panel on 12 September 2019. This will also be taking place at Linden House due to a high number of attendees. The Consultation is due to close on 15th September 2019. Following on from this, a consultation analysis report will be compiled by CSU which will then be taken to a public Primary Care Commissioning Committee on the 5th November 2019. | |
| **8.2** | Forward Plan for Practice System Migrations Mergers and Closures<br>RS gave an update. Practices in Wolverhampton have all been set up on the EMIS System. Moving forward there are a couple of migrations scheduled. Orders have been put through for Bilston Urban Village, Ettingshall, Health & Beyond and Parkfields. | |
| **8.3** | Estates Update/LEF<br>Clinical Void Space work is near completion. There is very little space now void in Wolverhampton. Office space at the Gem Centre is being looked at by the Estates Team for possible utilisation.<br><br>Oxley and Bilston Workshops have taken place. Stakeholders continue to engage positively. Accord plan to redevelop Probert Court by 2021 and have shared plans which are currently being reviewed by Health and the Estates Team.<br><br>Other practice developments have been proposed and these are being discussed with the relevant CCG team. | |
| **8.4** | Primary Care Networks (PCN)<br>Primary Care Networks are currently going through a self- assessment process, to include a maturity matrix and development plan. This will include any interdependencies and development required to work with wider partners, and any training needs the networks may have. Funding has been allocated to each PCN to enable this, and options for support have been circulated. All PCNs are taking part in the Time for Care programme and will have their induction session on 24th September. One PCN will be taking part in the Dartmouth Programme.<br><br>Extended Access appointments at network level has a level of underutilisation. A campaign at both CCH and PCN level is in place that will encompass promotion of appointment availability, to enable patient awareness.<br><br>The Digital First national consultation closed on 23rd August, there has been needs identified in supporting patients to understand how Primary Care is changing and what is available to them.<br><br>**Action: Information around patient appointments to be sent to Health watch** | |

| | | |
|---|---|---|
| | Primary Care STP Update | |
| **8.5** | A number of offers in place for GPs retention, including a Workforce fair here on 21st September. CCG will be encouraging practices to come forward with their vacancies so that we can showcase to GPs what vacancies are available in Wolverhampton and the wider Black Country. Other offers including Mentoring and Portfolio careers are being received at network level.<br><br>Resilience funding has been allocated to practices as discussed in the previous meeting, and has been approved at PCCC. | |
| | Care Quality Commission Update | |
| **8.6** | The ongoing mergers within Wolverhampton have required re-registration and therefore changes to the scheduling of inspections. Inspection carried out at Coalway Road went quite well.<br><br>Annual Reviews continue, most recent Wolverhampton Doctors Limited and Duncan Street Primary Care Partnership. | |
| | Public Health Update | |
| **8.7** | It was noted that Matt Leak had replaced Steve Barlow's role in Public Health.<br><br>**Action: MS to send ML details of the Primary Care Operational Group Meetings.** | |
| | NHS England Update | |
| **8.8** | Heads of Primary Care Meeting will take place next week which informs feedback to all CCG's. Currently in the process of coming together for NHSE and NHSI. Bringing together regions. This will then impact on the individual teams that provide service to the CCGs.<br><br>Discussion took place around the Review of PCASTT MoU meeting which due to take place on 20 September 2019. It was noted that as there was currently no written documentation to review, this meeting should be postponed. | |
| | Primary Care Assurance Update | |
| **8.9** | JW outlined the GMS Practice Level and Primary Care Network assurance plans.<br><br>The first cycle of the Collaborative Contract meetings has now been completed. Some action plans are outstanding. 39 practice visits have been completed which are being monitored by the contract review visit tracker. Following the completion of the programme a meeting took place with representatives from~~;~~ Operations, Quality and Primary Care Contracting to discuss improvements to both the template and process. Sections have been added to the template around levels of safeguarding to clinical and non -clinical staff. LC advised that a section around Vaccination activity has also been added. | **MS** |

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| 8.10 | Examples of good practices had been noted during the review programme and a section to record this has been included within the template. The CCG will continue to carry out one practice visit per month with 2 members of CCG staff present. Public Health will continue to be invited to attend the visit. However they will be required to produce and monitor their own action plans.<br><br>Primary Care Networks – national guidance published maturity matrix, will be used for bi monthly 1:1 meetings between the CCG Primary Care Team and the Clinical Directors. This is scheduled to take place at the end of September at a Forum that will measure and monitor development of the matrix.<br><br><u>Primary Care Dashboard</u><br>There is a requirement that the networks are supported in developing services that reflect the needs of their local population.<br>Data will be summarised with headlines presented quarterly at this meeting<br>**Action: Dashboard to be put on the agenda quarterly**. | SS/JR |
| 9.<br>9.1<br><br><br><br><br><br><br><br><br><br><br>9.2 | **Primary Care Quality Update**<br><u>Primary Care Quality Report</u><br><br><u>Quality Matters</u><br>LC to do some training with practices nurses regarding IG breaches.<br><br><u>Serious Incidents</u><br>No major incidents to report. 1 incident did go to PAG.<br><br><u>Infection Prevention</u><br>The Audit cycle has been restarted. Most practices have improved or continued to do well.<br><br><u>Flu Planning</u><br>Continuing with Meeting on a monthly basis. Meeting being held with Public Health bi-weekly.<br><br><u>Vaccines</u><br>There is going to be a big push on MMR. There is a National Programme to increase the number of people who have had 2 MMR Vaccines. The main focus is on children. Seems to be a big gap in those aged between 15-20 year olds.<br><br><u>Friends and Family tests</u><br>Intake is really good. This will continue to be monitored next month. Not a major concern.<br>LC to follow up with practices that have not completed actions.<br>Action: Identify practices that have negative responses<br><br><u>Workforce Activity</u><br>General Practice Nurse strategy will be launched on 3rd October 2019 at Himley Hall. | |

| | | |
|---|---|---|
| 9.3 | Training Hub Cover<br>Cover for the training hub will be provided in the Wolverhampton and Walsall area.<br><br>Collaborative Working Model: Practice Issues and Communication Log<br>This item has been covered under section 9 under Quality Matters. | |
| 10.<br>10.1<br><br>10.2<br><br>10.3 | **Primary Care Contracting**<br>Collaborative Contract Review Programme<br>JW presented her report and discussions took place.<br><br>Next Practice Visits<br>The meeting discussed the practices which were to receive collaborative contract review visits in the next 3 months and the following were agreed.<br><br>Primary Care Contracting Update<br>Application for Merger of Parkfields with Health and Beyond has been received. The paper was approved by the Primary Care Commissioning Committee.<br>Following on from this the papers will go to the Primary Care Commissioning committee on 1st October 2019 with a letter for committee decision. | |
| 11.<br>11.1<br><br><br><br><br><br>11.2 | **Discussion Items**<br>Post Payment Verification of Enhanced Services 18/19<br>Process and template is in place around QOF post payments verifications for 18/19. It is proposed to carry this out in November. The areas of focus have been confirmed as minor injuries, and post and pre op care for next year.<br><br>Still waiting for some data to come in to the practices, following on from this a report will come back here and Primary Care Commissioning Committee.<br><br>Healthwatch Wolverhampton Report<br>TC presented her report at the meeting.<br><br>Action: Healthwatch report to be presented at the PC OMG on a quarterly basis The next update is due at the January 2020 meeting. | |
| 12. | **Any other Business**<br>There were no items raised under Any other Business. | |
| 13. | **Date and time of Next Meeting –Wednesday 23rd October 2019 at 13:30-15:00 in the Main Meeting Room** | |

## 2. CLINICAL VIEW

2.1. A clinical representative from LMC attends the meetings and gives views on all discussions.

## 3. PATIENT AND PUBLIC VIEW

3.1. Patient and public views are sought as required**.**

## 4. KEY RISKS AND MITIGATIONS

4.1. Project risks are reviewed as escalated from the programme.

## 5. IMPACT ASSESSMENT

***Financial and Resource Implications***

5.1. The group has no authority to make decisions regarding Finance.

***Quality and Safety Implications***

5.2. A quality representative is a member of the Group.

***Equality Implications***

5.3. Equality and Inclusion views are sought as required. ***Legal and Policy Implications***

5.4. Governance views are sought as required.

***Other Implications***

5.5. Medicines Management, Estates, HR and IM&T views are sought as required.

**Name: Mike Hastings**
**Job Title: Director of Operations**
**Date: 18.4.19**

**REPORT SIGN-OFF CHECKLIST**

| **This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.** | **Details/ Name** | **Date** |
|---|---|---|
| Clinical View | N/A | |
| Public/ Patient View | N/A | |

| | | |
|---|---|---|
| Finance Implications discussed with Finance Team | N/A | |
| Quality Implications discussed with Quality and Risk Team | N/A | |
| Equality Implications discussed with CSU Equality and Inclusion Service | N/A | |
| Information Governance implications discussed with IG Support Officer | N/A | |
| Legal/ Policy implications discussed with Corporate Operations Manager | N/A | |
| Other Implications (Medicines management, estates, HR, IM&T etc.) | N/A | |
| Any relevant data requirements discussed with CSU Business Intelligence | N/A | |
| **Signed off by Report Owner (Must be completed)** | **Mike Hastings** | **23/9/19** |

NHS
Wolverhampton
Clinical Commissioning Group

# WOLVERHAMPTON CCG

## Primary Care Commissioning Committee
## 1 October 2019

| | |
|---|---|
| **TITLE OF REPORT:** | Primary Care Communications and Engagement Draft Strategy |
| **AUTHOR(s) OF REPORT:** | Helen Cook, Communications and Engagement Manager |
| **MANAGEMENT LEAD:** | Mike Hastings – Director of Operations |
| **PURPOSE OF REPORT:** | This report updates the Primary Care Commissioning Committee on the draft strategy for Communications and Engagement for Primary Care |
| **ACTION REQUIRED:** | ☐ **Decision**<br>☒ **Assurance/Information** |
| **PUBLIC OR PRIVATE:** | This report is intended for the public domain |
| **KEY POINTS:** | • The strategy is currently in draft format and pulled together by the Communications and Engagement Team, following contributions from Strategy and Development team<br>• This strategy is subject to final comments from commissioning managers and from PPI Lay Member<br>• This strategy is subject to final comments |
| **RECOMMENDATION:** | • **Receive** and **discuss** this report<br>• **Note** the action being taken |
| **LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:** | |
| 1. Improving the quality and safety of the services we commission | Involves and actively engages patients and the public.<br>Uses the Engagement Cycle.<br>Works in partnership with others. |
| 2. Reducing Health Inequalities in Wolverhampton | Involves and actively engages patients and the public. Uses the Engagement Cycle.<br>Works in partnership with others.<br>Delivering key mandate requirements and NHS Constitution standards. |
| 3. System effectiveness delivered within our financial envelope | Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework. |

## 1. BACKGROUND AND CURRENT SITUATION

The current Communications and Engagement Strategy concludes at the end of 2019. The strategy has enabled us to develop and deliver comprehensive communications and engagement work within the CCG, with patients and public and with our stakeholders. With the changing NHS landscape (both locally and nationally) and the requirement to deliver the NHS Long Term Plan, it is now necessary to formulate a new strategy to reflect these changes.

## 2. DRAFT STRATEGY

2.1. The enclosed draft strategy has been developed to replace the current CCG Communications & Engagement strategy. This strategy includes a specific section to outline the delivery of Communications and Engagement to support current Primary Care changes, the delivery of the NHS Long Term Plan and the development of local place-based care.

2.2. The draft strategy has been pulled together by the Communications and Engagement Team, following contributions from Strategy and Development team.

2.3. It is to be noted that this draft strategy is subject to final comments from commissioning managers to ensure that it will meet their needs to help to inform future commissioning decisions

2.4. It is also to be noted that this draft strategy is subject to final comments from the PPI Lay Member.

## 3. CLINICAL VIEW

GP members are key to the success of the CCG and their involvement in the decision-making process, engagement framework and the commissioning cycle is paramount to clinically-led commissioning.

## 4. PATIENT AND PUBLIC VIEW

4.1 Patient, carers, committee members and stakeholders are all involved in the engagement framework, the commissioning cycle, committees and consultation work of the CCG.

## 5. KEY RISKS AND MITIGATIONS

5.1. N/A

## 6. IMPACT ASSESSMENT

***Financial and Resource Implications*** - None known

***Quality and Safety Implications*** - Any patient stories (soft intelligence) received are passed onto Quality & Safety team for use in improvements to quality of services.

***Equality Implications*** - Any engagement or consultations undertaken have all equality and inclusion issues considered fully.

***Legal and Policy Implications*** - N/A

***Other Implications*** - N/A

**Name:** Mike Hastings –
**Job Title** Director of Operations
**Date:** 24 September 2019

**ATTACHED:**

Draft Comms & Engagement Strategy

**RELEVANT BACKGROUND PAPERS**

NHS Act 2006 (Section 242) – consultation and engagement
NHS Five Year Forward View – Engaging Local people
NHS Constitution 2016 – patients' rights to be involved
NHS Five year Forward View (Including national/CCG policies and frameworks)
NHS The General Practice Forward View (GP Forward View), April 2016
NHS Patient and Public Participation in Commissioning health and social care. 2017. PG Ref 06663
NHS Long Term Plan. 2019

**REPORT SIGN-OFF CHECKLIST**

**This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.**

| | **Details/ Name** | **Date** |
|---|---|---|
| Clinical View | | |
| Public/ Patient View | | |
| Finance Implications discussed with Finance Team | | |
| Quality Implications discussed with Quality and Risk Team | | |
| Equality Implications discussed with CSU Equality and Inclusion Service | | |
| Information Governance implications discussed with IG Support Officer | | |
| Legal/ Policy implications discussed with Corporate Operations Manager | | |
| Other Implications (Medicines management, estates, HR, IM&T etc.) | | |
| Any relevant data requirements discussed with CSU Business Intelligence | | |
| **Signed off by Report Owner (Must be completed)** | **Mike Hastings** | **25 Sept 2019** |

NHS
Wolverhampton
Clinical Commissioning Group

# COMMUNICATIONS AND PARTICIPATION STRATEGY

## 2019/20

# Introduction

This strategy sets out Wolverhampton CCG's priorities for communications and participation activity over the coming two years. It looks at the context in which we will deliver communications and participation, including the delivery of the NHSE Long Term Plan, the development of integrated care, and the growth of primary care networks and place-based care.

It also lists our communications and participation principles, draws on our partnership working across the Black Country and beyond, and looks at the tools, techniques and channels we will use to deliver communications and participation.

We are using this strategy to build on our achievements over the past five years. During this time, we have honed our processes and provided clear, timely information to our many stakeholders and audiences through multiple channels. We have also developed trusted processes for engaging and consulting local people and communities, our staff, GP members and providers about what matters to them.

Most importantly, we have embedded a culture of participation within the CCG so that all our staff understand the importance of public and patient involvement in our commissioning decisions.

This is activity that has helped make Wolverhampton an outstanding CCG for four successive years and we believe it will continue to support our activity over the coming two years as we work with or partners to integrate health and social care in Wolverhampton and across the Black Country.

## Purpose of our Communications and Participation Strategy

- Outline our communications and engagement priorities for the next two years
- Uphold and promote Wolverhampton CCG's vision, values and organisation priorities, in particular, the delivery of its operating plan [link/footnote to relevant docs]
- Support the CCG in delivering our commitment to partners in the Black Country integrated care system [link/footnote to STP clinical strategy]
- Support the development of place-based care in Wolverhampton
- Demonstrate how we will involve local people and communities, colleagues, GP members and providers, with an emphasis on the needs of hard to reach groups.
- Set out how we will fulfil our statutory duties
- Summarise our communications and engagement processes and channels

# A Changing NHS

We have developed this communications and participation strategy against a background of major changes to the way the health service works. The NHS England Long Term Plan, released in January 2019, set out a pathway for integrating care nationally, regionally and locally.

Key elements for Wolverhampton CCG are:

- Black Country integration – more specialist services that can be delivered best at scale, via the Sustainability and Transformation Partnership (STP) and the Black Country Joint Commissioning Committee (JCC).
- Wolverhampton place-based care – shifting towards an Integrated Care Alliance (ICA) that will bring health, social care, community and voluntary organisations together to achieve improved health and wellbeing.
- Primary care networks – bringing GP practices together to provide more services in the community to a population of circa 30,000-50,000 people. PCNs are the building blocks of place-based care and key to preserving the integrity of NHS service provision

## Transforming primary care

Over the next two years, a key focus for our participation and communications activity will be the development of PCNs as they become the nerve centres of the Wolverhampton Integrated Care Alliance – our model for place-based care.

We will support the development of PCNs and their capacity to deliver more services in primary and community settings in collaboration with social care partners. We will do this through a range of channels (see pX) including surveys and face-to-face engagement with Wolverhampton residents to secure feedback on what matters to them when it comes to the provision of local healthcare. We have also adjusted our Participation Framework to take account of the changing role of practice-based Patient Participation Groups as they work within PCNs (see pX)

The feedback we receive will be used to shape our commissioning intentions and provide residents in Wolverhampton with a seamless healthcare journey, closer to home, making sure they receive the right care, at the right time, in the right place.

Our initial engagement around PCNs will focus on people's current experience of NHS services, what they feel needs improving and how they would like to access services in the future. Therefore, we will also be able to use participation feedback to shape our digital services agenda.

# Our Communications and Participation Principles and Objectives

A set of principles underpins everything we do, guide our work and set the standards for the relationships the CCG has with all its stakeholders. They are:

### Trust and know-how
We will engender confidence and provide reassurance that we are good custodians of the local NHS. We will always explain who we are and what we do. The CCG's website will be a 'one-stop shop' for all the CCG's documents, activities and participation opportunities.

### Timely and easy-to-understand
We will communicate in a timely manner using easy-to-understand language

### Participation wherever possible
We will involve people where reasonably possible, promoting opportunities for people to get involved and arranging them to suit different interests and lifestyles. We will always use feedback to help us make decisions and show people how they have influenced the CCG.

### Quality surveillance
We will gather patient experience themes through all that we do, supporting the CCG to act and respond in line with its duties.

### Inclusive
We are committed to equality and diversity in all aspects of employment and service delivery. We will work towards eliminating discrimination, advancing equality of opportunity, and fostering good relations in the course of our work. Wherever possible, we focus on understanding the needs of hard to reach groups and community.

### Working together, not in competition
We will work with our partners and share knowledge and experiences to help guide our work. The CCG and its partners will always aim to speak with one voice. This is especially important given the development of the Black Country Integrated Care System and the Wolverhampton Integrated Care Alliance and we will fulfil our contribution to both.

### High quality and fulfilling statutory duties
Our communications and participation will meet statutory requirements, such has the NHS Act 2006, section 242 (duty to engage on changes to services), along with industry best practice, such as NHS Institute for Innovation and Improvement engagement cycle.

The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006, especially with regard to how CCGs will function. These amendments include two complementary duties for CCGs with respect to patient and public participation.

These principles ensure all our communications and participation activity is of the high standard that local people, our staff, members and other stakeholders expect of the NHS in Wolverhampton. They frame the way in which we report our communication and participation activity to the NHS, our Governing Body and local people and they support us in achieving an 'outstanding' rating from NHS England.

## Working in Partnership

The progress of integrated care is putting greater emphasis on our partnership working.

- Sustainability and Transformation Partnership – bringing together health and social care partners across the Black Country
- Black Country Joint Commissioning Committee – working with neighbouring CCGs to commission services at scale
- Better Care Fund – redesigning care pathways and promoting integration to allow health and care in Wolverhampton to work more closely together pooling budgets where possible
- Integrated Care Alliance and Primary Care Networks – shifting resources out of hospital so more people are cared for at home and in their community.
- Healthwatch, voluntary sector, housing and patient groups

Our communications and engagement also need to be delivered in partnership as set out in our principles. We already contribute to the Black Country and West Birmingham STP communications and engagement activity

The STP is comprised of 18 NHS and local authority organisations working together to provide better integrated and improved health and social care for people living in Wolverhampton, Walsall, Dudley, Sandwell and West Birmingham.

Communications and engagement leads from the different partner organisations meet regularly and leadership for communications and engagement activities for the different work streams has been allocated to the leads from the different organisations. The communications and engagement lead from Wolverhampton CCG supports the mental health work stream

All partners have signed up to a communications agreement, called a concordat, to ensure consistent messages about the STP are circulated across the Black Country and West Birmingham. All messages are based on the following principles:

- Partnership
- Innovation
- Local community
- Involving local people
- Better health and care.

It is this collaborative approach to communications and participation that ensures the success of our activities.

The STP and local care alliances are also in the process of developing a communications and engagement strategy.

# Participation and Communications Objectives 2019-21

- Continue to develop our reputation with partners, GP members, patients and public as a high performing organisation that is responsive to patient need and trusted to deliver high quality services and value for money
- Build continuous and meaningful engagement with our stakeholders using effective two way channels including surveys, formal consultation, engagement events, publications and online/digital tools. Ensure we are listening to our hard to reach groups and communities. Use the feedback we receive to inform our decisions.
- Raise awareness of the CCG's activities including our work in partnership with the Black Country and West Birmingham STP and Wolverhampton ICA
- Use our communications and engagement to support Wolverhampton residents in making healthy choices by providing accessible information and guidance.
- Provide advice and support for CCG staff to support their engagement and communications with stakeholders as part of the CCG's commissioning process.

# Stakeholders

This strategy will oversee how we interact with our five main stakeholder groups:

- Staff - everyone who is employed by us, or who works alongside us, such as CSU staff or external consultants.
- GP members - GPs, Practice Managers, Practice Nurses and support staff working within the CCG's 40 member practices.
- Commissioning partners – including City of Wolverhampton Council and other Black Country JCC, STP and Better Care Fund partners.
- Public bodies, individuals, voluntary/ community groups, third sector and providers that we work with in carrying out our statutory duties and transforming health and social care.
- Patients and public - current and future NHS service users registered with a GP member practice in the city, including carers.

Our understanding of our stakeholders and their needs will be based on: demographic information provided by Public Health in the Joint Strategic Needs Assessment, information the CCG holds and publishes on its website as part of its Public Sector Equality Duty; data from our health providers, and our stakeholder mapping expertise. This enables us to analyse the differing communications and engagement needs of our different stakeholder groups and develop the appropriate tools and messages for them.

The CCG will use these data sets to ensure our participation tools and messages are appropriate for different stakeholder groups and give due regard to the population and localities in question.

## Using participation and communications to reduce health inequalities

Our approach to participation and communication supports our determination to reduce inequality in healthcare in Wolverhampton. We are committed to designing and implementing policies and procedures, and commissioning services that meet the diverse needs of our local population and workforce, such that no one is placed at a disadvantage over others.

We report on our progress in our Annual Equality Report. This sets out our key actions and progress to date, and demonstrates that equality, inclusion and human rights remain at the heart of what we do. In this way, the CCG ensures the best possible outcomes for the local community, our staff and those seldom heard groups who experience health inequalities.

Ultimately the whole CCG approach is designed to ensure that Equality, Inclusion and Human Rights remains at the heart of what we do. By doing so, the CCG ensures the best possible outcomes for the local community; CCG staff and especially those seldom heard groups who experience Health Inequalities.

The CCG's participation activities also link to the NHS Equality Delivery System 2 (EDS2) framework and our equality objectives. Our objectives for 2018-21 are:

- To work towards a comprehensive understanding of the barriers to accessing services experienced by patients. To work to reduce the barriers identified with partner organisations and stakeholders.
- Ensure that due regard is given to the needs of the CCG's population during service change, including vulnerable and hard to reach groups, through effective engagement aligned with the profile of the population affected by particular changes.
- Use the findings from the NHS Workforce Race Equality Standard, Workforce Disability Equality Standard and the Staff Survey reporting requirement to inform a broader action plan to develop inclusive, supportive values and competencies across the workforce.
- CCG leadership will, as system leaders, continue to champion improved outcomes for vulnerable groups and tackle health inequalities across Wolverhampton and the Black Country

Our Annual Equalities Report and information about our equality objectives can be found on our website [add link].

# Our Legal Responsibilities

We have a range of statutory duties that we must meet under the Health and Social Care Act 2012. Most relevant to this strategy is our statutory duty to involve local people in:

- Planning services
- Developing our proposals for service change
- Taking decisions that may affect how services operate

We also have a duty to consult the City of Wolverhampton Council Overview and Scrutiny Committee and the Health and Wellbeing Board on any proposal for substantial development or variation of health services.

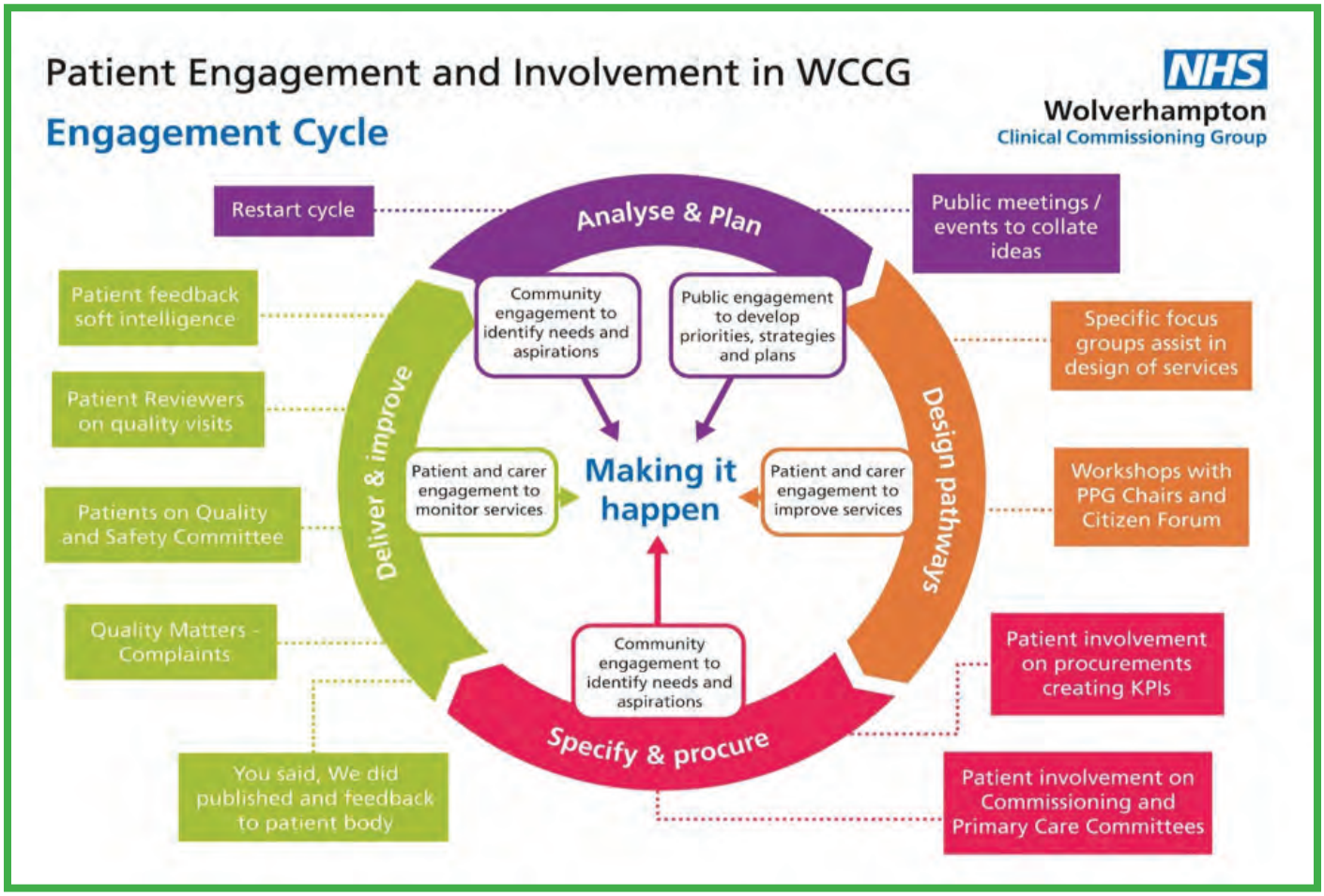
In addition, the Health and Social Care Act 2012 places specific duties on CCGs to reduce health inequalities. For more detail on our statutory duties and responsibilities see Appendix 1.

# Involving Local People in our commissioning decisions

Our primary function as a CCG is to commission healthcare services for the people we serve. The nature and practice of commissioning is likely to change fundamentally over the next few years as care becomes more integrated both within Wolverhampton on a place-based level, and across the Black Country and West Birmingham STP footprint. We are already commissioning more care such as learning disabilities and maternity services, across the Black Country and this will increase.

We will continue to follow the annual commissioning cycle: learning about the city's health needs, choosing and buying the right services to meet these needs and monitoring services to ensure they work well. Our Communications and Participation Strategy in ensures feedback from all stakeholders supports our decision making at every stage. Our Engagement Cycle (Figure 1) illustrates how the cycle guides our work and outlines how we engage with people at each stage of commissioning.

*Figure 1: Wolverhampton CCG commissioning cycle*

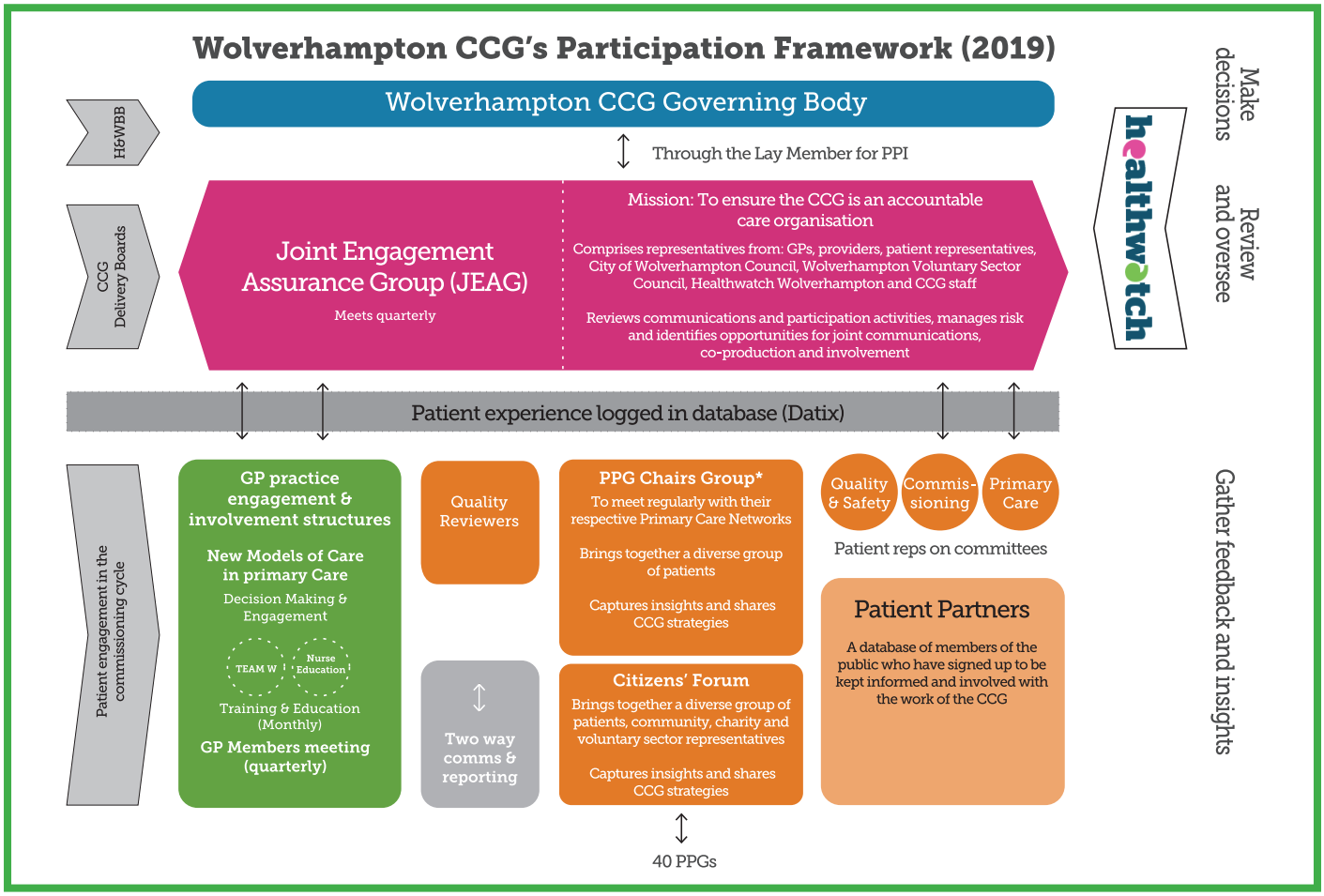


# Participation Framework

Commissioning decisions are clinically-led with Primary Care Networks expected to take a key role in the process. We have a comprehensive framework for participation (Figure 2), that enables us to gather information robustly, triangulate and report the insight we receive from patients and community groups.

Through this framework, which comprises a range of forums, the CCG collaborates with a diverse range of representative groups – residents, PPGs, patients, community groups, clinicians and allied health professionals, and Healthwatch. The groups can report their experiences, but also scrutinise and influence the CCG's plans and strategies, which are presented by CCG leaders to these groups.

*Figure 2: Wolverhampton CCG Participation Framework*




* PGGC Chairs Group: aligned to the Primary Care Network (PCN) DES, section 4.4.4. Networks are responsible for meeting their PPGs with support from the CCG. The CCG will hold regular update meetings with Chairs from each PCN

All the activities that take place within our Participation Framework are there specifically to enable our stakeholders to work with us to:

- Understand our health priorities and the areas of greatest need
- Improve the way services work together
- Draw-up specifications for the services we wish to buy and evaluate proposals from potential providers of care, such as hospitals
- Monitor and improve services by learning from people's experience and feedback

We have updated our Participation Framework for 2019-21 in recognition of the progress primary care networks are making and the impact this has on the role of PPGs. For example, the PPG Chairs Group is now aligned to primary care networks which are responsible for meeting their PPGs regularly. The CCG will support PCNs in meeting this duty and hold regular update briefings for the CCG Chairs Group. Integration of care across a Black Country footprint and the development of an Integrated Care System is likely to result in further changes to our Participation Framework, For example, we are working with our STP partners to develop a Citizens Forum that will enable us to receive regular, detailed patient and public feedback on Black Country-wide plans to transform care.

Robust reporting, demonstrating the value of participation, underpins the engagement activity that takes place within the commissioning cycle. We will continue to record and report on the impact of participation and engagement in our decision-making, showing the extent to which decisions have been influenced by the feedback we have received.

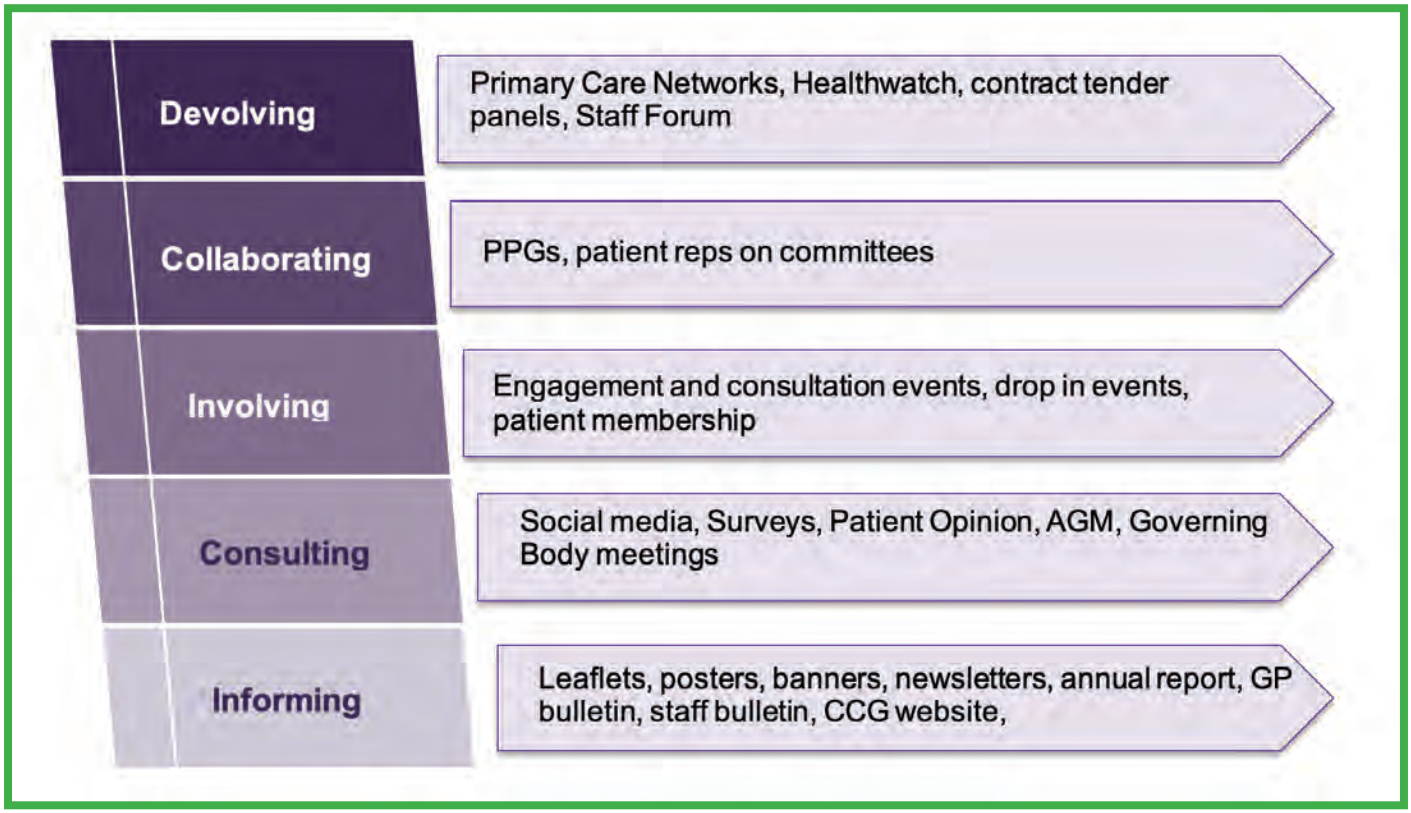
# Delivering our participation and communications strategy

Our participation and communications strategy is delivered by our Communications and Engagement Service, which we purchase from NHS Arden & GEM CSU. This includes an embedded Head of Communications and Engagement, a support officer and access to the Arden & GEM communications and engagement 'hub' team.

However, the strength of our communications and participation lies in our collaborative approach to delivery both within the CCG and across our partner organisations. All our staff including our safeguarding, quality and commissioning teams, understand the importance of a robust approach to participation and take an active role. We also work closely with the communications and engagement teams in partner organisations to ensure consistent and timely communications across the City of Wolverhampton and the wider Black Country health economy.

We use a full range of tools, processes and channels to deliver our communications and participation and ensure we inform and listen to all our stakeholder groups (Figure 3). These include surveys, events, forums, printed material and digital/online tools. With each new project or activity, we ensure we understand the key information different stakeholder groups needs and that we use the tools, channels and messages that are appropriate for them. See Fig 3.

*Figure 3: Communications and participation tools*




All activity is underpinned by robust planning and oversight which ensures we understand what outcomes we are trying to achieve and follow best practice processes at all times.
Our planning and delivery are further supported by a set of policies and procedures that include:

- Media handling and crisis management protocols (appendix 2)
- Social media policy (appendix 3)
- NHS brand guidelines [add link]
- Consultation Institute guidelines for public consultation [add link]

The service reports to the Governing Body via the Lay Member for PPI. Reports are linked to the CCG's Business Assurance Framework and assure our Governing Body that the CCG meets its duty to involve patients and public in their care and commissioning decisions. In addition, the service provides annual returns to NHSE via the Improvement and Assessment Framework, which has rated the CCG's engagement activity as good.

# Appendix 1:
# **Our Legal Duties**

| Participation theme/duty | What we will do | Relevant Act |
|---|---|---|
| Involve patients in decisions about their care | • Provide personalised care planning, including 'patient choice' and the option of a personal health budget<br>• Shared decision making regarding individual episodes of care and longer-term care.<br>• Provide self-care and self-management support to help patients manage their health better and prevent illness.<br>• Develop targeted information and support to give patients more control of their health | • S.14U of the NHS Act 2006 (as amended)<br>- Duty to promote involvement of each patient<br>• S.13H of the NHS Act 2006 (as amended)<br>- Duty to promote involvement of each patient |
| Involve patients in commissioning processes and decisions | • Work with stakeholders throughout our Participation Framework to:<br>• Identify local health needs<br>• Co-develop plans to address health needs and challenges<br>• Gather and act on patient experience insight to maintain service quality and safety, or to develop proposals to change how a service is delivered<br>• Shape our procurement process, helping us to set specifications or criteria for services we wish to renew or buy, and assessing tenders.<br>• Consult as appropriate on any proposal that may affect services or how they are delivered – but look at each project individually | • S.14Z2 of the NHS Act 2006 (as amended)<br>- Public involvement and consultation by clinical commissioning groups<br>• S.13Q of the NHS Act 2006 (as amended)<br>- Public involvement and consultation by the Board<br>• Chapter 2, Section 242 of the NHS Act 2006 – Duty to involve<br>• Cabinet Office Consultation Principles |
| Remove or minimise disadvantages suffered by those who share one of the nine protected characteristics | • Work with the Wolverhampton Equalities Group to develop inclusive and accessible consultation and participation approach.<br>• Annually assess our Patient Partners membership to ensure it represents the demography of the wider community.<br>• Ask respondents to complete surveys or expression of interest forms for their characteristics so that we can verify the reach and inclusivity of our participation methods. | • Equality Act 2010<br>• Section 149 of the Equality Act 2010<br>• Section 2 and 3 of the Equality Act (specific duties) regulations 2011<br>• Human Rights Act 1998<br>• Sections 14P, 14T, and 1 4Z1 Health and Social Care Act 2012 – Duties to promote NHS Constitution, reduce inequalities and promote integration |
| Consult the relevant Local Authority Health Scrutiny Committee around the planning and delivery of service change in certain circumstances | • Share and discuss any proposals on service change with the city's Health & Wellbeing Board and Health Scrutiny Committee.<br>• Share and discuss proposed consultation plans and methods with the city's Health & Wellbeing Board and Health Scrutiny Committee prior to commencing a 12-week consultation. | • S.244 of the NHS Act 2006 (as amended) |

# Appendix 2: **Media Protocol Responding to Media Enquiries**

To contact the communications and engagement team there is a dedicated telephone number 0121 611 0611 and email address agem.communications@nhs.net. Any calls received out-of-office hours are directed to the on-call communications team, tel: 01522 537887;
email: agem.communications@nhs.net

To enable the communications and engagement team to respond accurately and swiftly, all journalists who contact us by phone will be asked to email their enquiry and their deadline to agem.communications@nhs.net

### Reactive media

Media statements must be approved by the appropriate CCG lead and copied into the Accountable Officer and/or appropriate VSM so they can request amendments, if necessary. No statement should be sent out to the media without being signed off by all relevant parties.
All media enquiries are logged and responses kept on file.

### Interview handling

Any journalist requesting an interview with a CCG or CSU representative should be asked to email their request to agem.communications@nhs.net. Interview requests should include the following information:

- Name of the programme or publication/website
- Broadcast/publication date and time
- Whether the programme is live or pre-recorded (for broadcast media)
- When the journalist would like to carry out the interview – date and time
- Name of the presenter or interviewer
- How long the interview is scheduled to last
- Questions the interviewer wants to ask
- Names of other people/organisations being interviewed for this feature/news item

## Proactive media work

The communications and engagement team supports proactive media work across the CCG, and is the first point of contact for drafting and distributing news releases and arranging interviews.

All news releases must be signed off by the appropriate CCG lead, and other partners as required, before being issued to the media.

If a news release requires a quote, this should be approved by the spokesperson before it is issued to the media. The spokesperson should see, and have the opportunity to comment on, the entire news release.

News releases are issued to the relevant press, posted on the CCG website (www.wolverhamptonccg.nhs.uk) and shared via social media, including the CCG's Twitter feed.

## Use of images

Any members of the public who are photographed for publicity purposes should sign consent forms before the pictures can be used. Completed consent forms should be returned to the communications and engagement team, who will scan them so that electronic versions can be kept on record.

Work such as photographs, video, written word and sound recordings have copyright protection. Photographs from the internet or any other sources should not be used without the written permission of the copyright owner. Using resources without permission could potentially lead to court action for infringing copyright.

## Crisis management

In the event of a crisis, the communications and engagement team will manage the media as follows:

- Holding statement to be agreed and issued within four hours
- Timetable of future responses to be agreed
- CCG Governing Body, CSU senior management team, NHS England and Public Health England (if necessary) communications teams to be informed as soon as possible
- A log kept of all media request
- Media to be monitored on a regular basis with cuttings logged, stored and circulated.

# Appendix 3:
# Social Media Policy

These guidelines cover the use of social media by Wolverhampton Clinical Commissioning Group (WCCG). They are deliberately framed in broad terms to help WCCG staff use these tools for the good of the organisation

## Introduction

Social media is the term commonly given to websites and online tools which allow users to interact with each other in some way by sharing information, opinions, knowledge and interests. It involves building communities or networks, encouraging participation and engagement.

WCCG recognises that its employees have a right to a private life that is distinct and separate from their working lives. This distinction can become blurred through the use of social media, including smart phone applications, and other online activities. These guidelines are therefore intended to provide advice to all employees, to ensure that their online activities do not interfere with their working lives.

Employees should be aware that any failure to follow this policy could be subject to investigation under the WCCG disciplinary policy.

## Guidelines

These guidelines should be followed by all WCCG staff, including interns, apprentices, and volunteers, as well as interim and agency staff. They cover normal working hours, but also extend to personal time when any public reference to the WCCG is made.

The guidelines apply across all social media platforms, including but not limited to:

- Twitter
- Facebook
- LinkedIn
- YouTube
- Flickr
- Pinterest
- Instagram
- Tumblr
- Smartphone applications, such as Snapchat, WhatsApp

## Social media use

During work hours, social media activity should be limited to where it is directly related to your role, or current project. It is not appropriate, for example, to use Facebook or Smartphone applications during working hours for personal use.

## Privacy Settings

It is important to take precautions when using social media as anyone can access and use social media. A small minority of users will take the opportunity to promote extreme views or cause trouble.

You should carefully consider who you allow to join your network and who you disclose personal information to. Adjusting your privacy settings on a social networking site will restrict who can access your profile and will prevent strangers finding out personal information about you.

## Personal opinions

If you choose to identify that you work for WCCG on a personal social account you should be aware that members of the public may associate your personal thoughts, actions and behaviours with WCCG and indeed the wider NHS. Any comments made on social media about colleagues, managers or patients stand to be linked to the workplace.

## Behaviour/Bullying and Harassment/ Equality and Diversity

Personal accounts that are not private should not be used to publically criticise colleagues, or vent grievances, which should be directed in the first instance to your line manager. WCCG will not tolerate these behaviours in their workforce. Activities that might be classed as discriminatory will also be investigated.

## Confidentiality

WCCG staff must not publish sensitive or confidential information via any form of social media. If you are unsure of whether something is classed as confidential/sensitive, ask your line manager.

# COMMUNICATIONS AND PARTICIPATION STRATEGY

2019/20

**WOLVERHAMPTON CCG**

**Primary Care Commissioning Committee**
**October 2019**

| | |
|---|---|
| **TITLE OF REPORT:** | Primary Care Strategy (V1.5 Final) |
| **AUTHOR(s) OF REPORT:** | Sarah Southall, Head of Primary Care |
| **MANAGEMENT LEAD:** | Sarah Southall, Head of Primary Care |
| **PURPOSE OF REPORT:** | To seek approval from the committee for the Primary Care Strategy attached. |
| **ACTION REQUIRED:** | ☒ **Decision** ☐ **Assurance** |
| **PUBLIC OR PRIVATE:** | Public |
| **KEY POINTS:** | • Further to the committee receiving a draft version of the Wolverhampton Primary Care Strategy in September comments have been received resulting in minor amendment to the document.<br>• The final document is attached for further consideration and approval. |
| **RECOMMENDATION:** | 1. The committee note that minor amendments have been made to the strategy since they have sight of the document in September.<br>2. The committee are required to confirm their approval of the document to enable implementation to take place as per Appendix 1 of the Strategy (page 29),<br>3. The committee will be kept sighted on progress being made to achieve the delivery objectives detailed in Appendix 1 via Quarterly Assurance Reports of the Milestone Review Board. |
| **LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:** | 1 Improving the quality and safety of services we commission.<br>2 Reducing health inequalities in Wolverhampton.<br>3 System effectiveness delivered within our financial envelope. |

Enclosure: Primary Care Strategy (V1.5)

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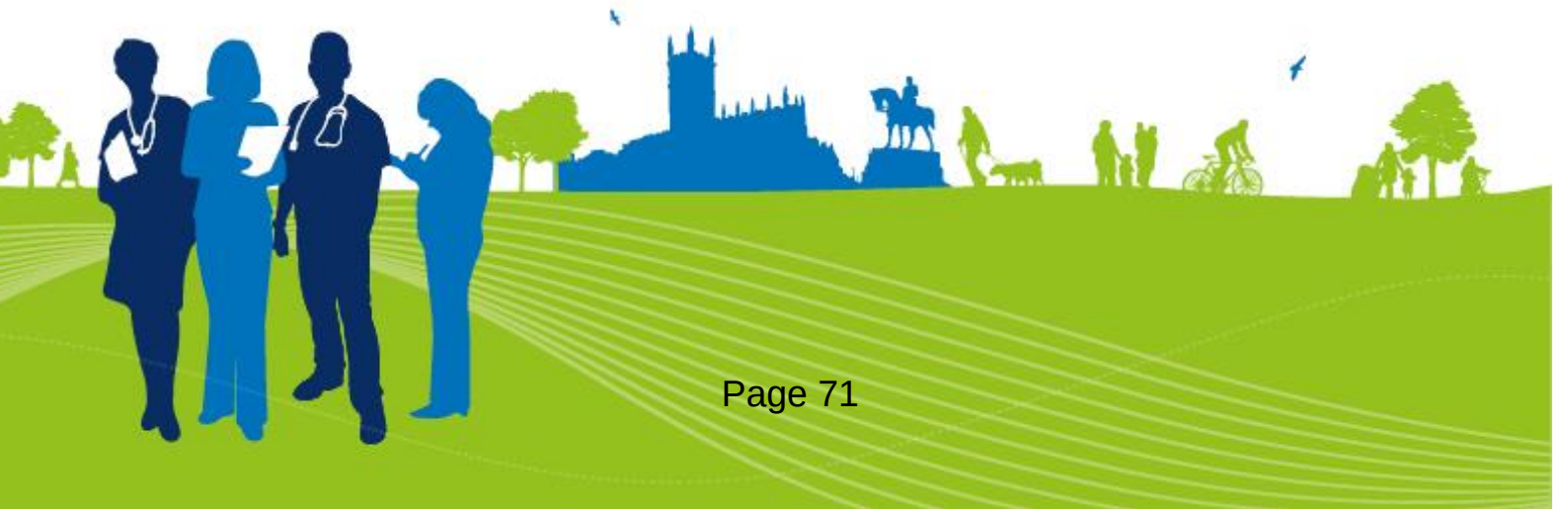
NHS
Wolverhampton
Clinical Commissioning Group

# Primary Care Strategy 2019 - 2021

**August 2019**

**Version 1.5 FINAL**



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## 1.0 Introduction

The first primary care strategy was published by Wolverhampton CCG in 2016, in anticipation of being fully authorised to commission Primary Care (General Practice) in March of the following year. The strategy laid out a series of aspirations:-

- The over-arching outcomes following the implementation of the Primary Care Strategy
- Our plans for a fundamental shift to treating more people in a community setting (as part of the Right Care, Right Place, Right Time overall CCG strategy)
- How General practice will operate at greater scale, underpinned by network alliance; non-clinical support between and amongst practices; GP IT; workforce and estates
- The influence that General Practice hold as the gateway to commissioned activity in Wolverhampton (Practices as Commissioners)
- How Procurement and Contacting for new services will be deployed in the emerging and forming GP networks.

In pursuing this strategy, much progress has been made and this revised document provides us with the opportunity to consider progress made and the next steps in recognition of national policy changes and in particular the NHS Long Term Plan that advocates Primary Care being the bedrock on which all other services should be built.

## 2.0 Context

### 2.1 The National Directives and Plans

The NHS Long Term plan, released in early 2019, sets out the new vision for the NHS for the next ten years. This vision, seeks to develop New Models of Care in which patients get more options, better support and effective joined-up care, at the right time, in the optimal care setting. This way, care will be more pro-active, and people will be able to take more control of their own physical and mental health and wellbeing.

The Long-term Plan describes what changes need to be made by all healthcare services such as the development of new job roles and how digital solutions such as Apps will support patients to access care in new and different ways, to give patients an all-round better experience of care

There are 5 major changes identified which build on the aspirations outlined in the GP Five Year Forward View (2016).These are:

## 2.2 Local - Wolverhampton

**Our vision for the future is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources.**

In order to achieve this, we have five priorities for the coming year:

- continue to commission high quality, safe healthcare services within our budget;
- focus on prevention and early treatment;
- ensure our services are cost effective and sustainable;
- align our clinical priorities, as appropriate, to the Black Country and West Birmingham STP/ICS;
- Build on our Primary Care Networks (PCNs), wrapping community, social care and mental health services wrapped around them

For Wolverhampton CCG, this means focusing on maintaining work currently underway in key priority areas, both locally and regionally, as well as supporting planned transitions to an Integrated Care System (ICS) and integrated care provision for the four 'places' of the Black County and West Birmingham Sustainability and Transformation Partnership (BCWB STP) – Wolverhampton, Walsall, Dudley and Sandwell and West Birmingham. This focus will enable us to align the CCG with the ICS as it develops, transitioning to the local, regional and national healthcare system set out in the NHS's Long-Term Plan (LTP).

The City of Wolverhampton's population has been growing in recent years, and now stands at in excess of 290,000 in April 2019.

The city is ethnically diverse, with 35.5% of residents in 2011 being of BAME (Black and Minority Ethnic) heritage. Furthermore, 16.4% of the population in 2011 were not born in the UK. Many religions are followed, and the city has the second-highest proportion of Sikh residents in the country. A fifth of the population is disabled, similar to the English average using Experian's Mosaic classification system (updated in early 2016) provides the following profile. The largest proportion of households in the city are the 'Family Basics' group (18,585 or 17.8%) who are described as "families with limited resources who have to budget to make ends meet". The second most common household type is Transient Renters (15,798 or 15.2%), households comprised of "single people privately renting low cost homes for the short term". The third most common household is Modest Traditions (13,188 or 12.7%), who are "mature homeowners of value homes enjoying stable lifestyles".

## 3.0 Challenges

Wolverhampton has a number of health challenges relating deprivation including childhood obesity, child poverty, infant mortality (higher than the England average but improving) but with fewer secondary school age pupils having tried/smoking. Further details can be found in the city's Joint Health & Wellbeing Strategy 2018-23.

Through adopting a collaborative approach between the CCG, Public Health and our practice groups NHS Health Checks are at the highest rate they've ever been in the city having been one of the worst performing CCGs/Local Authorities in England in 2016/17.

*Compared with benchmark:* Better Similar Worse Not compared

*Quintiles:* Best Worst Not applicable

*Recent trends:* – Could not be calculated; No significant change; Increasing / Getting worse; Increasing / Getting better; Decreasing / Getting worse; Decreasing / Getting better; Increasing; Decreasing

Export table as image  Export table as CSV file

Benchmark Value: Worst, 25th Percentile, 75th Percentile, Best

| Indicator | Period | Wolves | | | Region | England | England | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Value | Worst | Range | Best |
| 0.1i - Healthy life expectancy at birth (Male) New data | 2015 - 17 | – | - | 58.2 | 62.1 | 63.4 | 54.7 | | 69.8 |
| 0.1i - Healthy life expectancy at birth (Female) New data | 2015 - 17 | – | - | 58.7 | 62.9 | 63.8 | 53.5 | | 71.6 |
| 0.1ii - Life expectancy at birth (Male) | 2015 - 17 | – | - | 77.2 | 78.8 | 79.6 | 74.2 | | 83.2 |
| 0.1ii - Life expectancy at birth (Female) | 2015 - 17 | – | - | 81.3 | 82.7 | 83.1 | 79.5 | | 86.5 |
| 0.1ii - Life expectancy at 65 (Male) | 2015 - 17 | – | - | 17.6 | 18.5 | 18.8 | 16.1 | | 22.1 |
| 0.1ii - Life expectancy at 65 (Female) | 2015 - 17 | – | - | 20.1 | 20.9 | 21.1 | 18.7 | | 24.1 |
| 0.2ii - Number of UTLAs where inequality in life expectancy at birth has decreased (Male) | 2015 - 17 | – | - | - | - | 59 | - | *Insufficient number of values for a spine chart* | - |
| 0.2ii - Number of UTLAs where inequality in life expectancy at birth has decreased (Female) | 2015 - 17 | – | - | - | - | 39 | - | *Insufficient number of values for a spine chart* | - |
| 0.2iii - Inequality in life expectancy at birth (Male) | 2015 - 17 | – | - | 7.5 | 9.5 | 9.4 | 14.8 | | 3.7 |
| 0.2iii - Inequality in life expectancy at birth (Female) | 2015 - 17 | – | - | 6.1 | 7.4 | 7.4 | 14.3 | | 2.0 |
| 0.2iii - Inequality in life expectancy at 65 (Male) | 2015 - 17 | – | - | 5.6 | 4.9 | 4.9 | 8.5 | | 1.6 |
| 0.2iii - Inequality in life expectancy at 65 (Female) | 2015 - 17 | – | - | 3.7 | 4.6 | 4.5 | 9.6 | | -0.5 |

We know that Primary Care plays an important role in improving the health of local populations, but we also recognise that changing how patients receive care will be a collective responsibility with patients not just the responsibility of Primary Care Networks and the Practitioners that work within them. We have to continue to develop and implement a programme of at scale initiatives.

We are introducing a genuine parity of esteem through transformation of services, policy change and societal attitude.

Responding to the NHS 10-year Plan's focus on Mental Health we are creating a system where patients have easier access to services:-

- early diagnosis and prevention
- have smoother transition from child to adult mental health services
- grow stronger, and early links with education
- ensure that primary care is supported to help but does not become the default for every patients
- make sure that all patients in crisis have support 24/7
- can access same day emergency and can get help to prevent suicide when they feel this is the only option left to them.

**3.1 Reduce Inequalities**

Improvements in life expectancy are a key success indicator and focus for all the partners within Wolverhampton. To achieve these, the council and public-sector partners will be working together to transform health outcomes across the city. Public Health will support and provide external advice to partners beyond the NHS and social care in taking a place-based approach.

Key to extending the reach of public health will be a primary care service equipped with the skills to engage, influence and persuade, with the ability to tell the story using data and evidence, whilst continually strengthening relationships.

Although the City of Wolverhampton is younger than the English average, it still has challenges from an aging population, and by 2041 is projcted that 60,935 residents will be aged 65+, which is a rise of 42%.

In response to the future challenges which all services will experience the City of Wolverhampton has a Health and Wellbeing programme, which we fully support and are a key partner in developing and delivering. The Joint Health and Wellbeing Strategy 2018-2023 has created three overarching priorities are thematically grouped as follows:-

| | |
|---|---|
| Growing Well | • **Priority 1 Early Years - s**upporting patents to be active in their child's development<br>• **Priority 2 Children and young people's mental wellbeing and resilience-** Working to improve children and young people's mental health |
| Living Well | • **Priority 3 Workforce- s**upporting people to stay healthy throughout their working lives, and helping people stay in work when they experience health problems (mental or physical). Develop, attract and retain high quality staff to ensure a health and social care workforce equipped for the future.<br>• **Priority 4 City Centre** – Improving the city centre e.g. transport links that enable walking and cycling, reducing rough sleeping and tackling problems associated with alcohol misuse and public safety.<br>• **Priority 5 Embedding prevention across the system** – Enabling people to live longer and healthier lives by helping them change their lifestyle and improving the environment in which they live. |
| Ageing Well | • **Priority 6 Integrated Care; frailty and End of Life** – Health partners working together more effectively, in particular, for people who are frail or at the end of life.<br>• **Priority 7 Dementia Friendly City** – Working together to enable the City to be Dementia Friendly for people living with Dementia and their families. |

## 3.2 What we have achieved so far

We are piloting initiatives, chosen as part of our previous strategy with the aim of both improving general primary care services and supporting a shift of care into the community.

Over the last 2 years Primary Care services have put in place:-

- Practices actively engaging to afford more resilience at practice level leading to improved patient care.
- Improved access to Primary Care providing additional appointments through introducing hubs in the community with appointments available until 8 pm weekdays plus weekends and bank holidays.
- More services available at weekends including dedicated nurse appointments, pharmacy reviews, phlebotomy and other specialist clinics available for patients to access.
- Primary care counselling service for patients to access in a timely manner closer to home and without referral to mental health services.
- A Special Access Service for patients who have been excluded from General Practice lists as a result of violent or aggressive behaviour.
- A local Quality Outcomes Framework (QOF+) focussing on the prevention and treatment of conditions including diabetes, obesity, alcohol, hypothyroidism, COPD and Asthma and also included in the scheme are physical health checks for patients recorded on learning disability or serious mental illness register(s) and finally an initiative to improve bowel cancer screening.
- Supporting patients to be treated at home or in a nursing home when previously they would have been treated in a hospital
- Increased palliative care services available to those who wish to die in their place of choice
- Improvements in the health and social care of people with Long Term Conditions including:
- Diabetes, CVD (AF diagnosis, warfarin treatment and NOACs, hypertension, heart failure and stroke, cardiac rehab following MI) and COPD
- Improved the health and social care of people living with frailty by providing targeted interventions
- A strong emphasis on putting the patient at the centre of our planning and encouraging primary care to work together to achieve improved population-based health and well-being

## 3.3 Our Vision for Primary Care

Supporting the continued improvement and development of Primary Care in Wolverhampton is one of our main priorities over the next 2 years which we will achieve through implementing this strategy.

This strategy is intended to reflect our ambitious programme of system-wide, large-scale change and recognises the importance of primary care as the foundation of our entire health system.

***Our vision for the future is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources.***

However, it's important to recognise there will be a continued focus on general practice services and will not directly cover other primary care services such as dentistry and ophthalmology. This reflects the fact that the CCG's membership is comprised of general practitioners and the CCG's responsibility to ensure the continuous improvement of primary medical services. These other services are still being commissioned by NHS England however, how these change in response to the 10 Year Plan, and changes to any plans will be undertaken in due course.

1. **Priorities for Developing Primary Care**
   - Setting up Primary Care Networks
   - Population health management
   - Improving access in general practice
   - Mature Primary Care Networks through implementation of the Network Directly Enhanced Service
   - Active involvement in the development of the Integrated Care System

2. **Our Clinical Priorities for Primary Care**
   - Frailty
   - Children and Young People
   - End of Life Care
   - Mental Health

3. **NHS Long Term Plan**
   - Boost out of hospital care
   - Reduce pressure on emergency hospital services
   - Control over your own health and more personalised care
   - Digitally enabled primary and outpatient care
   - Focus on population health – moving to Integrated Care Systems everywhere

The Long-Term Plan has committed to increase available funding for community and primary care. We will use this additional funding on improving our services e.g. developing our Primary Care Networks is fundamental to the success of this strategy.

Supporting the continued improvement and development of Primary Care is a key ambition for Wolverhampton CCG, reflected in our work programmes however introducing reforms to Primary Care will not occur over night and will bring with them both structural and operational challenges.

## 4.0 Opportunities

### 4.1 Primary Care Networks

In Wolverhampton we have worked with General Practice to put the foundations in place for practices working as networks. A primary care network (PCN) consists of groups of general practices working together across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. These networks provide care for populations between 30 – 50k patients. There is a greater opportunity for GP practices to provide a wider range of services situated closer to the patient's residence.

In operating in such a way, network of practices will be in a position provide a wider range of primary care services to patients, involving a wider set of staff roles than might be feasible in individual practices, for example, 'First Contact Physiotherapy, extended

access and social prescribing. Networks will receive specific funding for clinical pharmacists and social prescribing link workers in 2019/20, with funding for physiotherapists, physician associates and paramedics in subsequent years.

These networks will be the footprint around which integrated community-based teams and community and mental health services will develop. Networks will use data to assess the needs of the local population and identify people who would benefit from targeted, proactive support.

Although the GP practice will be part of a wider network of practices, they will still retain their unique identity and relationship with their own patients and continue to provide local services to their patients.

Since national guidance was published in March 2019, the CCG have worked closely with practice groups to formalise working arrangements as Primary Care Networks. In May 2019 the CCG approved 6 applications from groups of practices which contractually formalises their working relationships via the Network 'Directly Enhanced Service' (DES).

It is expected that these 6 primary care networks will strengthen and develop their services based on population health need. There are four overarching Programme areas that national directives are steering local deployment.

**PCN Development**
All six networks will be supported by the CCG to mature in a timely manner to the CCGs acknowledges the challenges of competing priorities PCNs will face All PCN will be required to identify, from available data, their population health needs and prepare a full DES Network Agreement in June that addresses each of the following:-

Schedule 1 – Network Specifics
Schedule 2 – Additional Terms
Schedule 3 - Activities
Schedule 4 – Financial Arrangements
Schedule 5 - Workforce
Schedule 6 – Insolvency Events
Schedule 7 – Arrangements with organisations outside the network

Network agreements will be regularly updated to reflect the maturity and the changes that arise in the implementation phase. The Network DES recognises that practice remain independent and there may be occasions when a practice may leave or join a network. These changes will be proposed to the CCG Commissioning Committee to ensure that the requirements of the Network DES (specification and guidance) have been met prior to any change.

By the end of 2019/20 there will be new national service specifications attached to the Network DES to be enacted in 2020/21 the DES will continue to be developed over subsequent years as part of the 5 year deal for GPs.

The speed of collaboration will be critical to the maturity and effectiveness of each of our networks in Wolverhampton. This has been a core component of the 5 year strategy in the Wolverhampton Clinical Strategy and practices are now well placed to develop at pace. The CCG has been and will continue to be committed to supporting and encouraging PCN development along with other stakeholders and partners and strive to

achieve better services for patients. The PCN situation for Wolverhampton is hlighlighted in the table below

| Name | Composition |
|---|---|
| Wolverhampton North Network | 7 practices \| 52,584 patients |
| Unity East Network | 8 practices \| 32,867 patients |
| Wolverhampton South East Network | 7 practices \| 56,933 patients |
| Royal Wolverhampton Trust Network | 8 practices \| 55,516 patients |
| Unity West Network | 5 practices \| 38,197 patients |
| Wolverhampton Total Health | 6 practices \| 56,321 patients |

A copy of our networks composition can be found in Appendix 2.

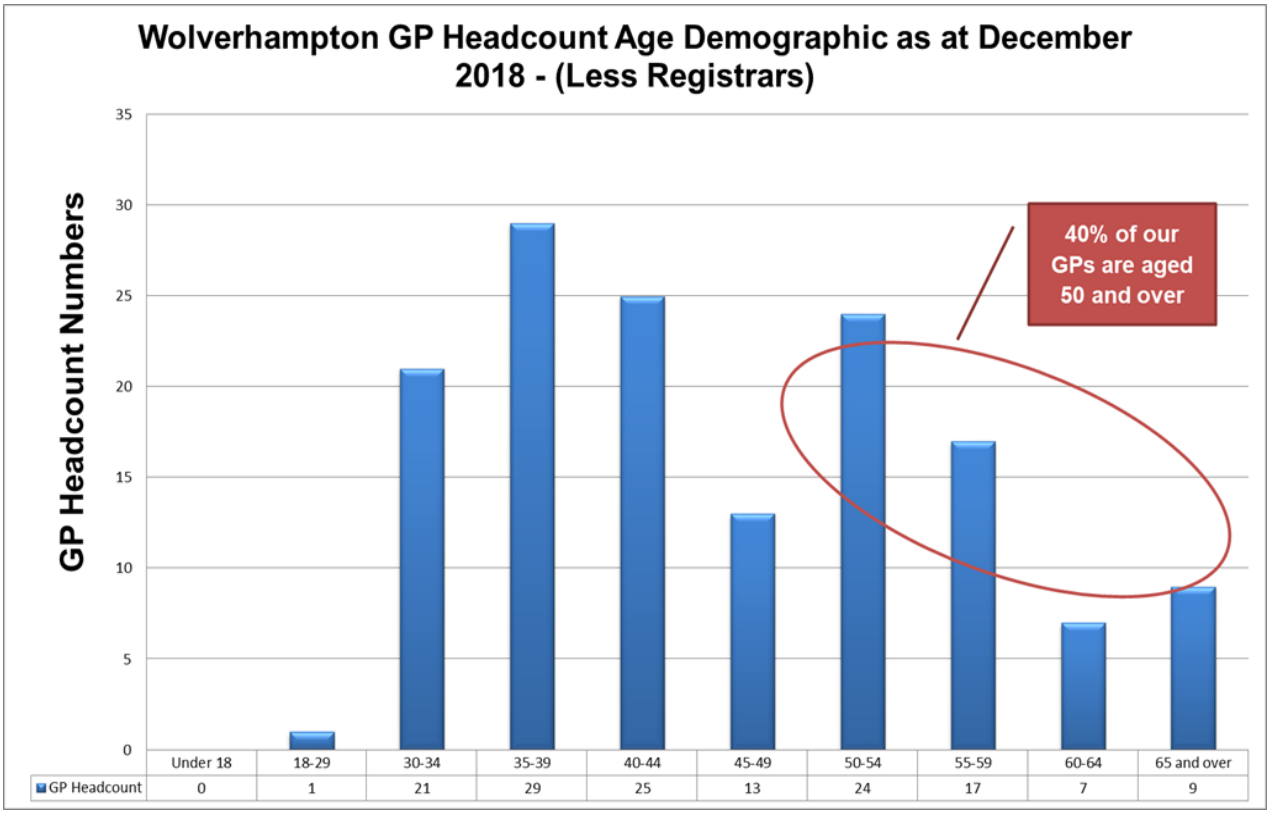
**4.2 Workforce**

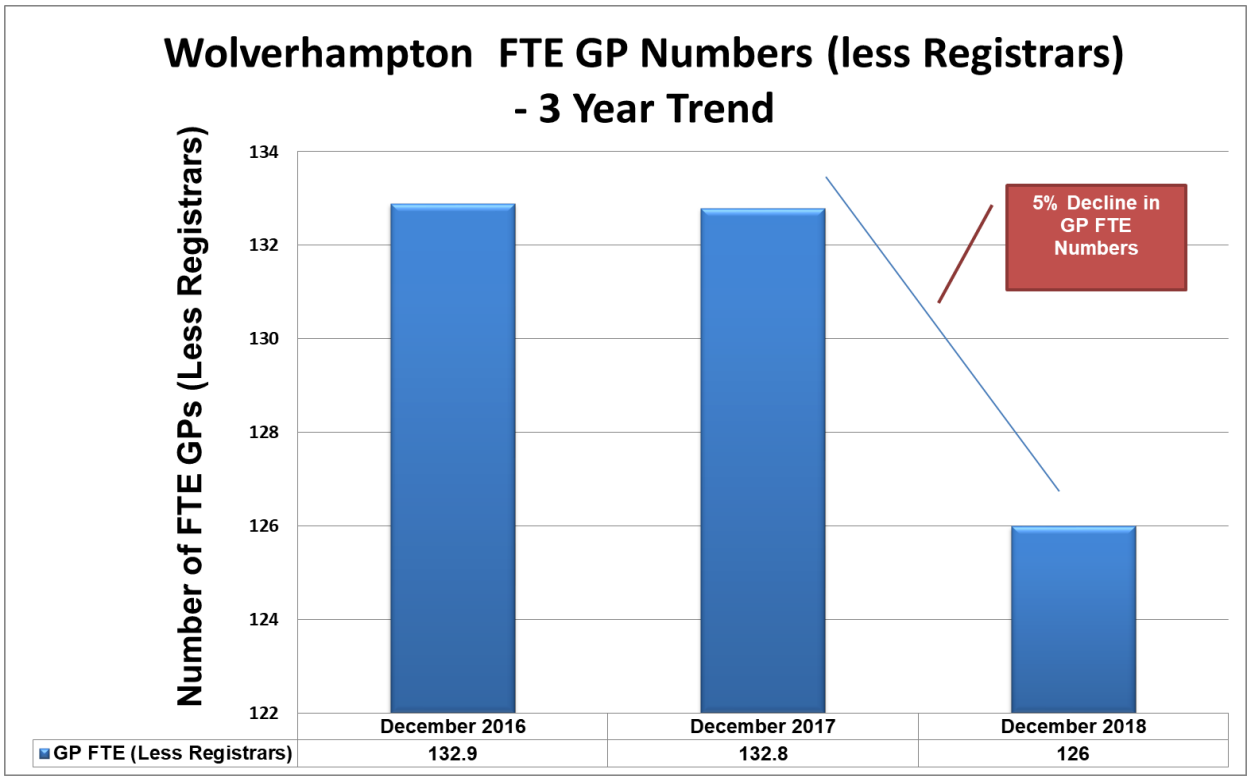
The increase in demand General Practitioners face has been a significant cause for concern due to the number of GPs either leaving the profession or newly qualified Doctors not wanting to enter the Primary Care.

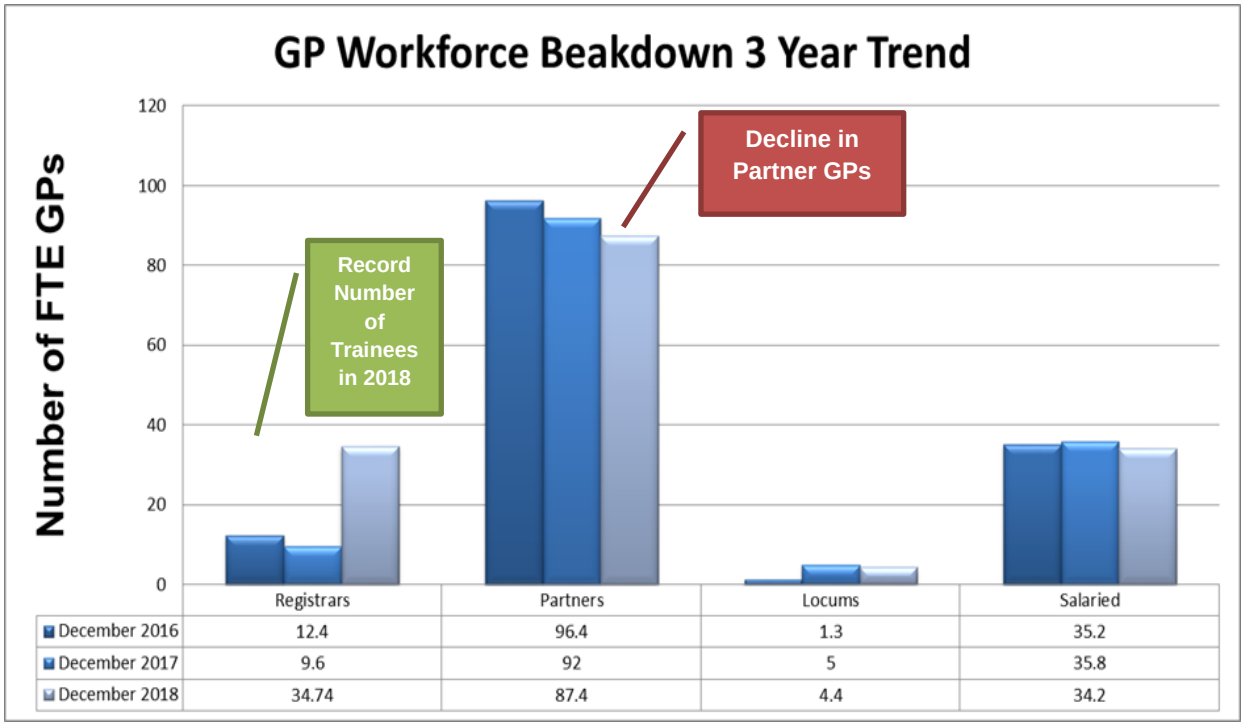
In addition, there are added complexities with the aging workforce profile of GPs. This has been recognised through the partnership work between the Black Country and NHS England and Intensive Support Site funding has allowed the greater interaction and co-design of a series of initiatives to attract and retain GPs in the Black Country. In Wolverhampton we are establishing stronger links with our training practices and Training Programme Directors to support GP Trainees to complete their training and find substantive employment in the area.

The CCG does recognise also the importance of close working with GPs to ensure we achieve a sensible flow of GPs both at early, mid and late career – the objective being to keep GPs in the profession in order to sustain an even distribution across the age profile.

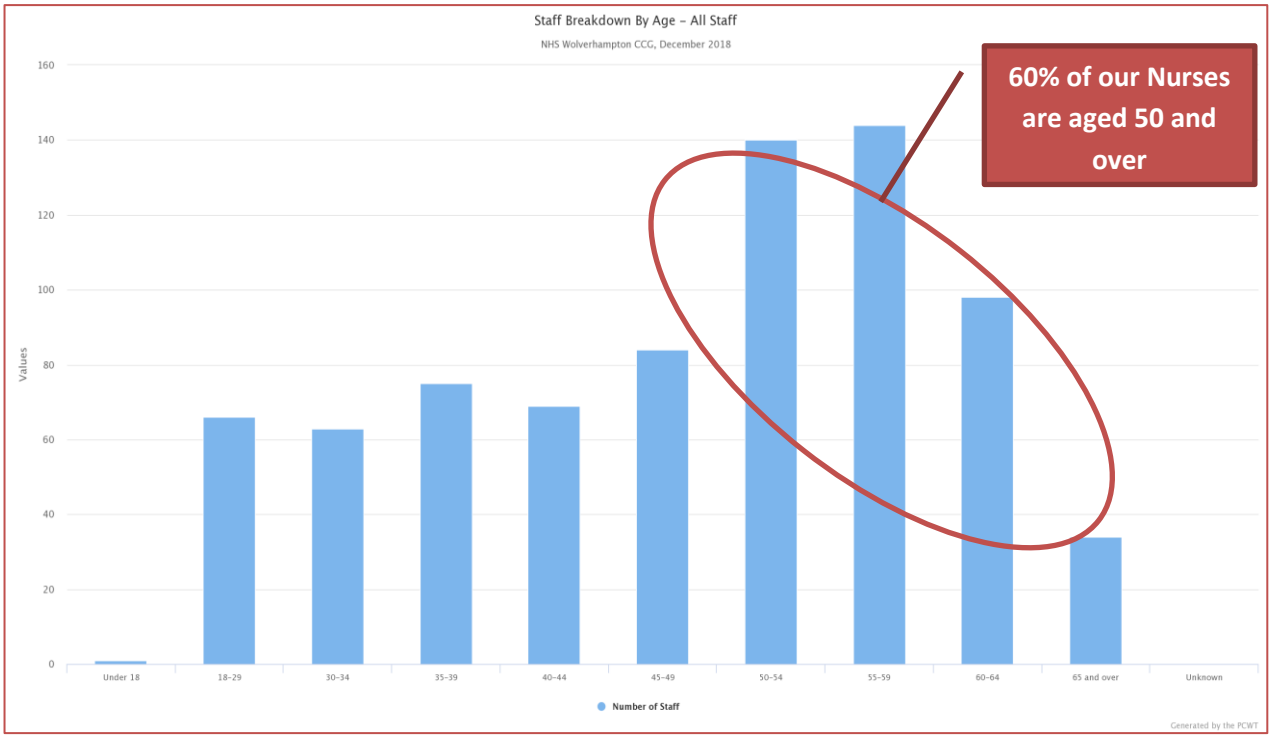
There are a number of GP workforce retention initiatives that are actively promoted and being accessed by Wolverhampton GPs affording mentoring, networking and portfolio careers and also access to expert advice on career planning and other support for GPs who wish to return to practice and want to be part of our membership.


Wolverhampton GP Headcount Age Demographic as at December 2018 - (Less Registrars)
GP Headcount Numbers
35
30
25
20
15
10
5
0
40% of our GPs are aged 50 and over
Under 18
18-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65 and over
GP Headcount
0
1
21
29
25
13
24
17
7
9


Wolverhampton FTE GP Numbers (less Registrars) - 3 Year Trend
Number of FTE GPs (Less Registrars)
134
132
130
128
126
124
122
5% Decline in GP FTE Numbers
December 2016
December 2017
December 2018
GP FTE (Less Registrars)
132.9
132.8
126




Similarly, the practice nurses age profile emphasises the importance of working with practices to develop and promote general practice nursing as a career for the future. A high proportion of practice nurses are nearing retirement. Through our local engagement with the workforce and educational providers, a suite of retention projects will be co-designed to improve practice nurse retention. Improved rates of student placements have begun to be realised however, more work needs to be done to develop and strengthen our workforce. The STP General Practice Nurse Strategy is also due to be launched in September 2019.



There will be an expansion of nursing and other undergraduate training places and there will be an increase in international recruitment. There will also be an increase in the number of volunteers.

### 4.3 Estates

Our estates plans have been developed in response to the national and local drivers for change and by building on our progress to date, we will continue to develop a fit for purpose estate and support management system to:-

- Improve the capability and capacity for Primary Care provision to address population growth and demographic change
- Support and enable the delivery of clinical strategies and new models of care
- Deliver better service integration, improvements in service efficiency and better outcomes for our residents
- Improve the effective utilisation of the estate
- Increase efficiencies and ensure value for money both from our existing estate and from any investments in estate developments
- Improve the quality, flexibility and condition of the estate
- Reduce risk and improve service resilience at local and system levels
- Rationalise and dispose of surplus or unfit estate.

Our estates team will, through our governance systems and continuing stakeholder engagement, ensure that the plans remain as live documents and will be updated to reflect emerging new models of care, changing need and funding resources.

There is close collaboration between the estates function, primary care commissioners and the locality planning infrastructure. The Local Estates Forum and other planning forums ensure close collaboration with the wider health and care stakeholders. The estate strategy will continue to be service led and will enable us to achieve clinical and service aims and plans.

The CCG will maintain a focus on the efficient management and utilisation of and value for money from the existing estate. There are many alternatives available other than new or extended buildings.

### 4.4 Digital

The Long-Term Plan clearly articulated the need for improved access for patients, including patients having better access to their health care records. This will be implemented through an integrated online triage solution, accessible via the NHS Patient Access app and also directly through the patient access portal on the GP Practices websites. Improving patient choice will further be expanded through the deployment of an online Video Consultation solution. Patients will have the option of choosing the type of consultation they receive and this will also support patients who struggle to access services directly at the practice.

The development of the Insight Shared Care Record will allow clinicians access to patients' full records as they move between healthcare professionals.

The 111 service will be able to book patients directly into GP appointments at practices with Wolverhampton.

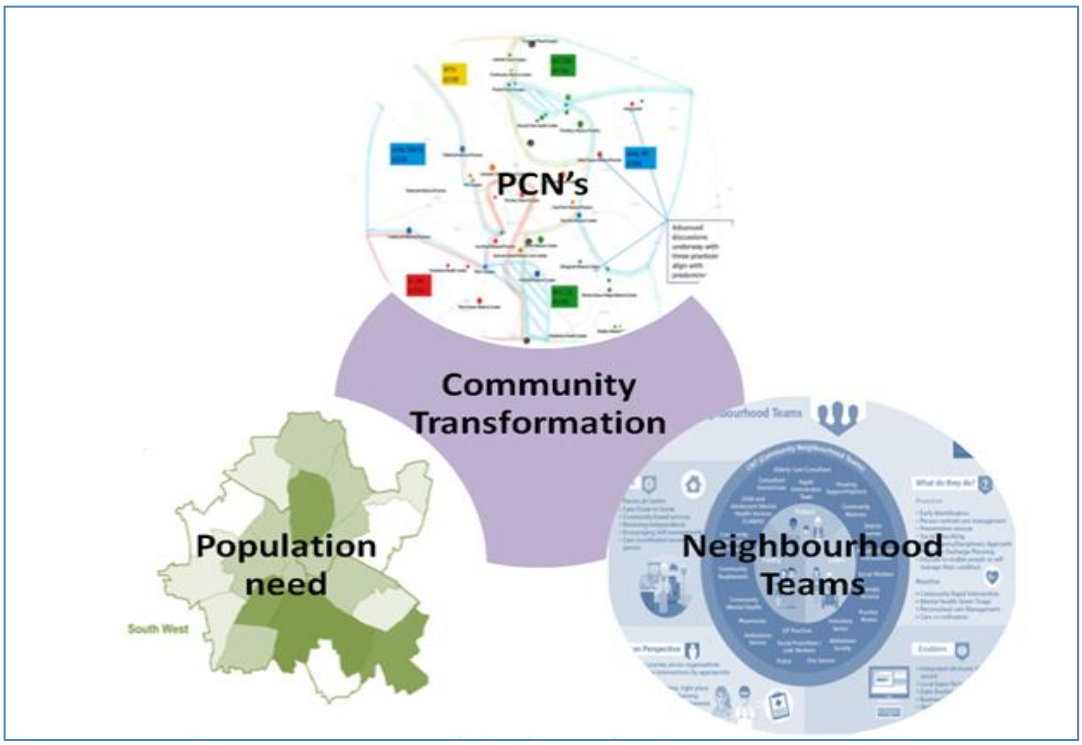
Through the HSCN programme the CCG is installing a brand-new network infrastructure replacing the old broadband N3 lines with scale able IPVPN lines that will allow the network to expand with the requirements of the organisation moving forward.

### 4.5 Inter-dependencies with the NHS Long Term Plan

#### 4.5.1 Boost out of hospital care and move to greater collaborative working between Primary and Community Health Services

Wolverhampton is committed to continuing and building upon the work already achieved in developing system wide health and care integration with a strong focus on care closer to home but going forward, with a much stronger emphasis on 'wrapping' this integration around Primary Care. The NHS Long Term plan investment into developing Primary Care Networks supports the journey that Wolverhampton has already been already embarked on. A key shift over the life of this strategy, supported by Wolverhampton's Integrated Care Alliance will bring into place, will see:-

- A transformed Community Services supporting PCNs in Wolverhampton that will offer:-
    - Improvements in care for patients at the end of life, and the need to reduce the numbers of patients dying in an acute bed where this is unavoidable
    - Increased capacity within community services and admission avoidance initiatives
    - Aligned care provision with population need
    - Integrated locality hubs to maximise joint working opportunities with system partners including Adult Social Care, Housing, Mental Health and the Voluntary Sector (one of which has been fully operational since December 2018)
    - Flexible, viable and sustainable community services now and in the future
    - The further professional development of community nursing services to provide care which matches patients needs

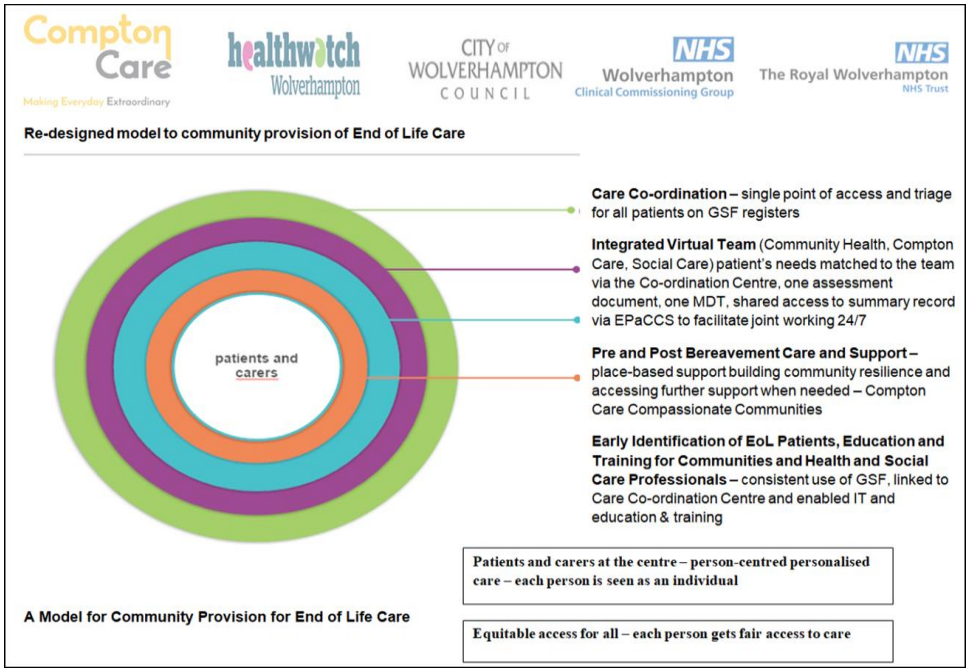



- Fully integrated, structured, Community Multi-Disciplinary Team (MDT) approaches that will enable each Primary Care Network to access social care, voluntary sector, housing, mental health and community health skills, knowledge and expertise. This will prevent patient escalating into acute care where possible and work with patients

who have been accessing acute services but who can be better supported closer to home and in their communities. For the population of Wolverhampton, this means more integrated, person centred care. The MDT approach is already in progress with over 50% of practices across the city active now and plans in place for the remainder to go live during 2019/2020.

- Each practice will benefit from ongoing development of the Rapid Intervention Team to enable more patients to be triaged and treated in their own homes.

- A new model for community based end of life care




- We will work with our PCN's to help them identify priorities for their development and gain access to the support offers that become available, including organisational development that will support the ongoing integration of Community bases services with PCNs

- The introduction of healthy ageing coordinators at a PCN level working across the system to reduce/delay the progression of frailty

### 4.5.2 Reduction in pressure on emergency hospital services

Wolverhampton will continue to actively promote primary and community-focused alternatives to hospital for unplanned care. There has already been substantial resources and pathways designed to prevent hospital attendance for those at risk of unnecessary hospitalisation. We will continue to improve and develop:

- Improved access to out of core GP hours over and above the General Medical Services contract.

- Integrated MDTs in primary care for patients identified requiring a multi-disciplinary approach to assure the appropriate care at home in the community and away from urgent/emergency care where appropriate. Primary Care MDT co-ordination, will make use of personalised care plan and a shared care record across Health, Social Care and Mental Health providers.

- Additional primary care sessions during bank holidays.
- Urgent Treatment Centres (UTC) to more appropriately manage primary care patients who attend the acute site.
- Integrated NHS 111 with the UTC to allow direct booking of primary care appointments as an alternative to emergency department attendance.
- A Primary Care in-reach approach to support care for residents in care homes as part of the wider development of multi-disciplinary team working enabling patients to be treated in their usual place of residence without the need for them to be conveyed to hospital.

**4.5.3 More control over your own health and more personalised care when you need it**

Personalised care is one of the five major practical changes to the NHS that will take place over the next five years, as set out in the NHS Long-Term Plan. Primary care and PCNs are well place to support individuals to manage their own personal health and care.

Primary care will play a pivotal role in this in a number of ways:

- Implementing social prescribing within PCNs
- Expanding on good practice models such as health coaching and programmes such as Make Every Contact Count.
- Introducing Shared Decision Making (SDM) with patients.
- Ensuring that patients have personalised care plans where appropriate concentrating on “what matters to me”.
- Ensuring a co-ordinated, multi-disciplinary approach to managing personalisation at a “universal” and “targeted” level

We have adopted an approach to delivering the personalisation agenda based on 6 nationally recognised evidence-based components. These include:

- Shared decision making.
- Personalised care and support planning.
- Enabling choice, including the legal rights to choose.
- Social prescribing and community-based support.
- Supported self-management.
- Personal health budgets and Integrated personal budget

Going forward our aim is that we:

1. Progress Policing and Community Safety Partnerships (PCSP)/ health coaching training programme across the entire STP.
2. Deliver two strategic co-production events for people across the STP so they are aware of the work we are undertaking to support them in managing their own health and well-being.
3. Strengthen peer support offers by using outputs from peer support mapping and commission facilitation training for groups through the four local Community and Voluntary Services.
4. Engage with commissioners over strategic direction and ensure contracts support on-going personalisation.
5. Plan and deliver a training programme for health coaching and personalised care support through the year.
6. Explore PHBs for high intensity users and integrated personal budgets for children and young people with Education Health and Care (EHC) plans.

### 4.5.4 Digitally enabled primary and outpatient care will become main stream

Effective digital solutions should be the norm rather than the exception. Our digital infrastructure will support patients to use digital solutions to access information on their conditions, make bookings into their local GP practice (and soon PCNs), place orders for repeat prescriptions and understand their health needs through online digital support for example, smoking cessation and weight management.

We will seek to align national and local priorities at scale to support improved clinical outcomes. For example, having virtual MDT consultations with both primary and secondary care health professionals so that care can be jointly planned for the patient.

Digital is a key enabler for improvement and in turn, aligned to the NHS Triple Aim. Wolverhampton forms part of an STP Digital Workstream which will realise the opportunity to align organisational priorities for digital with the overarching objectives for primary care as detailed within both the STP Clinical and Primary Care strategies.

Specific work to be undertaken over the life of this Strategy is as follows:-

- **On-Line Consultation** - consulting with patients using technology including email, skype, text and telephone. Wolverhampton Practices are expanding on their online consultation facilities to enable functionality to be made available to all practices over the life of this Strategy and twin tracking this technical work with proactive on-site marketing and engagement for GP practices and patients in order to maximise the uptake and opportunity

- **NHS App** - NHS App will continue to be a national platform providing people with a 'front door' into a range of online health and care services. Wolverhampton is committed to promoting and ensuring digitally enabled services are interoperable with the NHS App. It is already proving to be an important platform in enabling the public fast and reliable access to i.a. NHS 111, practice appointment booking, renewal of prescriptions and viewing of GP medical records. The NHS App will further evolve through seamless integration with the smartest and most effective applications, tools and services on the market. Wolverhampton will:-

    - Ensure that all practices in our area have GP Online Services access technically enabled within their system Ensure all practices have reviewed their GP Online services settings to ensure they are appropriate for patient use
    - Ensure all relevant staff are briefed on the NHS App rollout and requirements for supporting patients
    - Review 111 Online provision to ensure appropriate for potential increased usage/activity from exposure within the NHS App

- **Extended Access NHS 111 Direct Booking**
  Wolverhampton will work with Practices and Providers to ensure full coverage by September 2019. This work enables 111 to have access to directly book appointments into locally provided extended access hubs.

- **A Black Country and West Birmingham wide interoperability platform** aimed at data sharing across a wider footprint of providers is underway. Through a Walsall and Wolverhampton collaboration, a project is in delivery implementing a repository based shared care platform. This will lead to introduction of a wider shared care record and identification. Ensuring information captured within clinical care settings is appropriately and securely shared will not only enhance care but also provide management information to support secondary usage such as commissioning and public health activities.

- **Working with partners, patients and providers to develop and promote digital solutions for patients and staff** that enable:-
  - Access to more self-management/help tools such as Apps and videos that support the management of Long Term Conditions such as Asthma and Diabetes
  - Access to digital networks/groups for patients and staff to enable peer support and information sharing
  - Maximising the use of digital media to promote the local area as a great place to live and work to help attract and retaining staff in Primary Care

**4.5.5 We will increasingly focus on population health – moving to Integrated Care Systems everywhere**

Our Local place-based Integrated Care Alliances (ICA) is being developed and implemented in support of the clinical strategy. This is an emerging vehicle for bringing together health and care services for our populations

We have committed to use all the enablers we have at our disposal to make integration a reality:-

- We will use our commissioning strategy as a lever for change. We recognise the unique opportunities this allows, and the innovative approaches that will support this strategy.
- Through our introduction of PCNs we will be able to support local decisions on how services are provided and support network and neighbourhood-based delivery models.
- Through our approach to place-based care we will promote integration and joint working with local authority and social care colleagues. Joint working and where appropriate joint appointments will be encouraged.
- We will undertake system transformation across all partners to re-enforce a one system principle,. Made up from primary, community and intermediate care teams this will increase the capacity and responsiveness of our services to those who need it.

## 5.0 Primary Care Services

We have supported the new deal for General Practice, the new Contract (2019) and funding arrangements which include:-

- Network DES funding is predicated on practices confirming their willingness to collaborate and work together as a network (not necessarily merging existing contracts) whilst maintaining their independence. The network application process concluded in May 2019 and 6 networks have been approved for the city. Funding will flow to the Network's nominated provider as set out within the respective Network Agreement.
- Individual practices who have signed up to the Network DES will receive an additional payment for engagement with the Primary Care Network Scheme. This is the only funding that is paid directly to practices for participation in the DES.
- In support of the DES NHS England will invest in a number of new roles, importantly the introduction of a Clinical Director in each network and a proportion of funding for this role on a basis of 0.25 WTE per 50,000 patients, at national average GP salary (including on-costs). This will be provided on a sliding scale based on network size and will rise in subsequent years.
- Funding for new roles including Social Prescribing Links Workers (100%) and other professionals including Clinical Pharmacists, Physicians Associates, First Contact Practitioners and Paramedics (75% contribution).

New roles will be introduced over a 3 year period and will be key to networks maturity and will equip them with the workforce they need to tackle population health needs that can be met in the community.

## 5.1 Finance

Financial planning for Primary Medical Services spanning the next 5 years forms part of the CCGs overall financial plan. The plan includes allocations for the Network Contract DES (£1.50 per registered patient) intended to support the day-to-day operation of the network and Practice Engagement Payment (£1.76 per registered patient).

The following table shows the financial breakdown for primary care funds based on the new GP contract payments and other allocations that have been confirmed for the GP Five Year Forward View (GPFV):

| Descriptor | Source | Value | Payee |
|---|---|---|---|
| **Network DES** | CCG Discretionary | £1.50 per patient | Network |
| **Practice Engagement Payment** | CCG Delegated | £1.76 per patient | Practice |
| **Improving Access Fund** | NHS England | £6 per patient | CCGs |
| **GPFV (Resilience, Retention, Admin & Clerical, Online Consultation, Practice Nursing)** | NHS England | 19/20 £1,167<br>20/21 £1,274 | STP (Wolverhampton CCG) - [Plan in place] |
| **GFPV Achieving Sustainable GP Workforce Targeted Retention (Four Pillars)** | NHS England | 19/20 £127k | STP (Wolverhampton CCG) - [Plan in place] |
| **GPFV First 5s** | NHS England | 19/20 £50k | STP (Wolverhampton CCG) - [Plan in place] |
| **Social Prescribing 100% Funding** | NHS England | 19/20 x 1<br>20/21 x 2<br>21/22 x 3 | Per Network |
| **Clinical Pharmacist(s) 70% Funding** | NHS England | 19/20 x 1<br>20/21 x 2<br>21/22 x | Per Network |
| **Clinical Director Funding 0.25/1day per week** | NHS England | 19/20 £0.51 per patient<br>20/21 £0.57 per patient | Network |
| **First Contact Practitioner (70%)** | NHS England | 20/21 x 1<br>21/22 x 2 | Network |
| **Physicians Associate (70%)** | NHS England | 20/21 x 1<br>21/22 x 2 | |

## 5.2 Directed Enhanced Services

One of the most critical parts of developing our Primary Care Network is how funding will be allocated. The main mechanism is through an agreement called a Directed Enhanced Services (DES), also being referred to as the 'Primary Care Network Contract'. The DES details how the funding will be allocated by services and the diagram below highlights which ones we are focusing on and what we need to consider implementing this effectively.

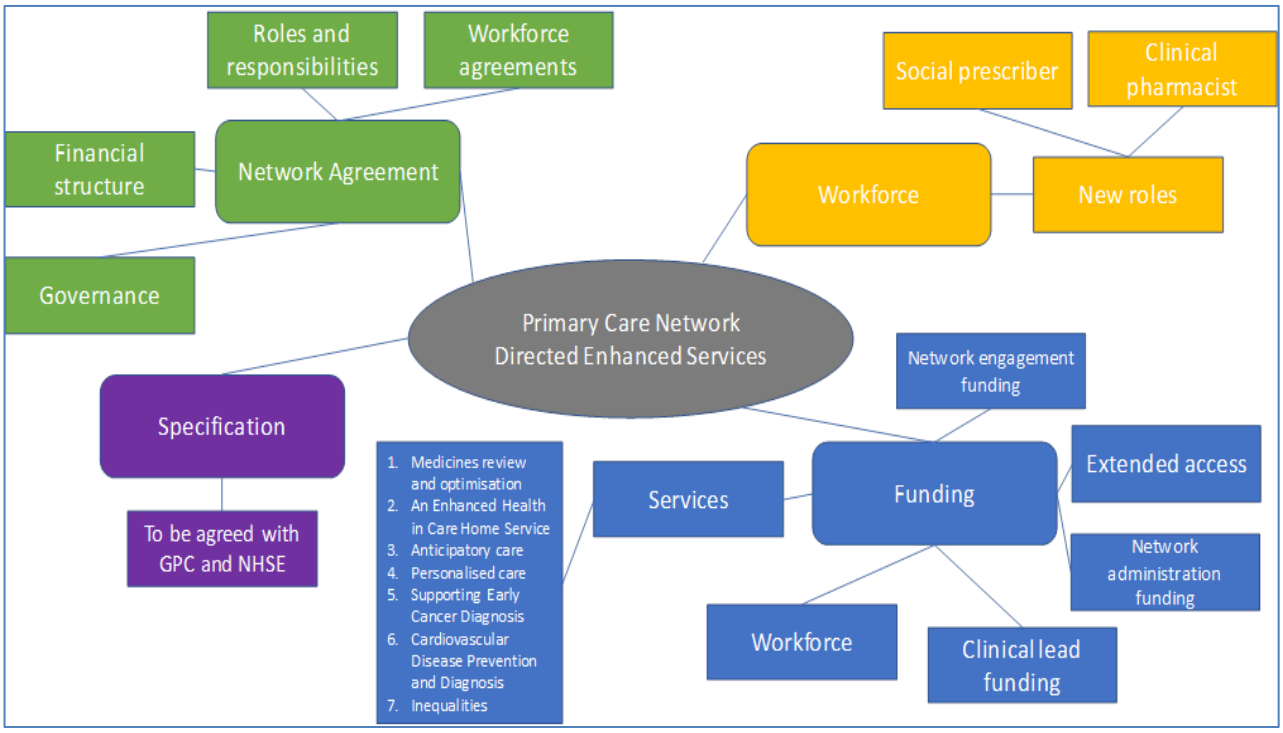
Having agreed, signed off contracts for services and the new way of working begun, the networks will have a good level of financial security. This security means that the networks can focus on formation and the delivery of front-line patient care without having to worry about current funding streams.

Other DES Specifications that the CCG actively encourage practices to participate in are as follows:-

- Learning Disability Health Checks
- Minor Surgery
- Vaccination Programmes (Shingles Catch Up, Pertussis, Meningococcal Freshers, Seasonal Influenza & Pneumococcal Polysaccharide Vaccination Programme 2019/20)
- Extended Access (till July 2019)

Practices are required to 'sign up' to these direct with NHS England and collaborative monitoring takes place in year with the CCG. NHS England may alter/vary their offer in years beyond 2019/20.

Public Health also commission services from General Practice, primarily NHS Health Checks.




## 5.3 Quality Outcomes Framework (National)

NHS England commission a national framework for general medical services contract holders in England. This is a voluntary scheme comprising of a collection of clinical and public health indicators organised by disease or intervention categories and have been selected representing care that is principally the responsibility of general practice and there is good evidence of health benefits that are likely to result from improved care provided in primary care.

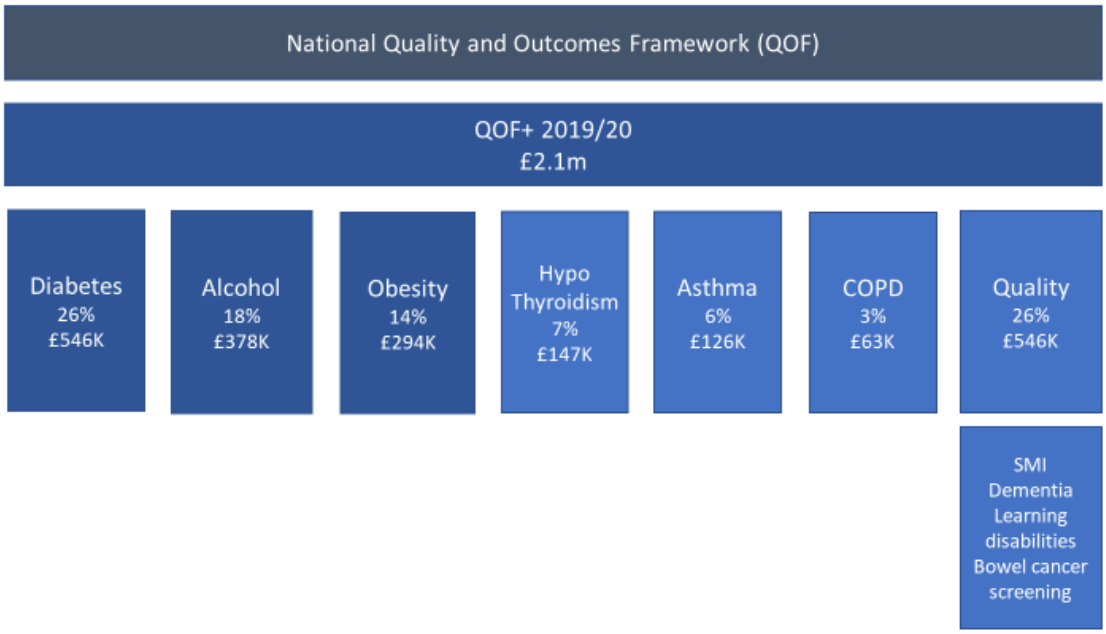
There are a number of clinical domains including atrial fibrillation, heart failure and hypertension and dementia and mental health. Nationally In 2019 more indicators will be added to some domains including diabetes, blood pressure control and cervical screening. A new quality improvement domain (QI) that focuses on prescribing safety and end of life care have also been introduced but the QI domain is likely to be subject to change year on year.

## 5.4 Quality Outcomes Framework (QOF+ Local)

Locally, the CCG introduced QOF+ in 2018/19 with particular focus on prevention of deterioration and/or ill health. The scheme was designed in conjunction with GPs from within the membership and designed to complement work already taking place in QOF whilst tackling areas of concern in the city.

The initial priorities including diabetes, alcohol and obesity and comprised of 19 indicators for practices to work towards the scheme has been developed further in 2019/20 and spans other priorities including COPD, Asthma, Hypothyroidism and a small compliment of quality requirements.

There are now 34 indicators and the value of the scheme has increased to £2.1 m in 2019/20.




## 5.5 Local Enhanced Services

The CCG invests additional local funding based on population health needs, these are of course prioritised to ensure

- QOF+
- Minor Surgery (Networks)
- Improving Access
- Minor Injury
- Basket of Services

All practices are actively encouraged to participate at practice and/or network level affording patients localised care delivery, closer to home.

## 5.6 Our Approach to Integration

The Long-Term Plan states that by 2021 Integrated Care Systems (ICSs) will cover the whole country.

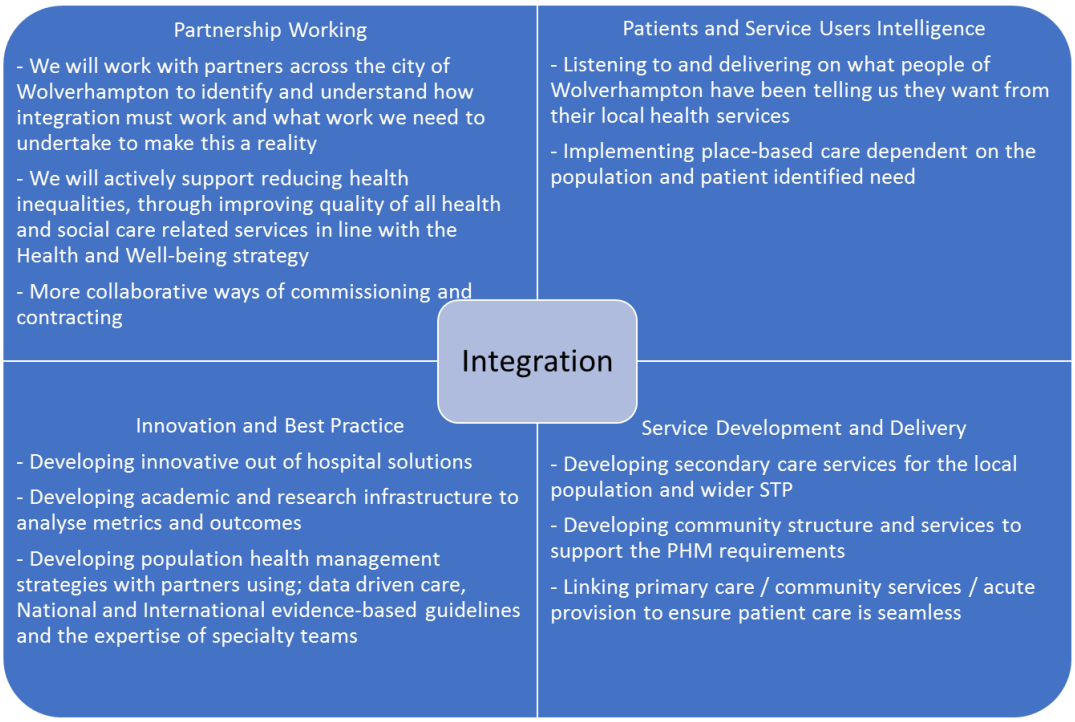
Nationally there has been the development of a new integration framework. We are a committed partner within the Black Country and are supporting the development and adoption of this new Integrated Care approach has been created to ensure that all associated organisations:

- Are committed to working in partnership in the best way possible to support our service users, carers and their families
- Support the development of integrated care for more specialist services
- Listen and co-produce services with our service users and stakeholders
- Play a pro-active role in developing the Wolverhampton Integrated Care Approach.

We also recognise that integration is an important enabler within Primary Care Networks and our aims for delivering integrated care within Wolverhampton can be split into the following areas:

- Partnership Working
- Patients & Service User Intelligence
- Innovation & Best Practice
- Service Development & Delivery

The illustration below provides more detail about how integration will be achieved for each component.




As part of the integration plan, the CCG will support the development of Multi-Speciality Community Provider and Primary and Acute Care Systems which will deliver new ways of delivering more integrated services in primary care and community settings.

Clinicians have identified a range of clinical priorities with the overall objective of improving experiences of care for patients first and foremost whilst also improving the way in which primary and secondary care professionals work seamlessly to improve care for their patients.

We are continuing to Integrate systems by ensuring we place Primary Care at the centre of the patient's pathway and work with, for example Local Authorities and the third sector taking advantage of their experience and knowledge for example contributing and signing up to key frameworks such as the Social Care Green Paper.

To help us to continue to meet our aspirations will draw on a number of key support functions to help deliver on the above. These include workforce development, contract management, IT and estates. By doing this we will ensure that any new service development or pathway changes are robust and that the needs of the patients and the staff will be met.

We use data and population health analysis to understand the needs of our patients. Through this we have targeted our resources into long-term conditions such as diabetes, alcohol abuse, obesity and cancer screening (QOF+). We are also redesigning key pathways, developing new roles and improving the way in which care is delivered we aim to strengthen all our primary care services, which will in turn help us to improve the health of patients and to continue to deliver an improved and consistent level of service.

## 6.0 Work Streams and Delivery Programme

In order to deliver the priorities detailed in this strategy a comprehensive programme of work has been developed to enable the CCG to meet the challenges and opportunities - our aims and aspirations outlined within this strategy. The over-arching work programme, which will be delivered over the next 2 years, has been developed from; conversations with patients on their experiences, from clinicians on where they know patient care can be improved, from internal teams, from data and information that is constantly reviewed as well as national priorities. A summary of the improvements that will be realised over the next 2 years are summarised in Appendix 1.

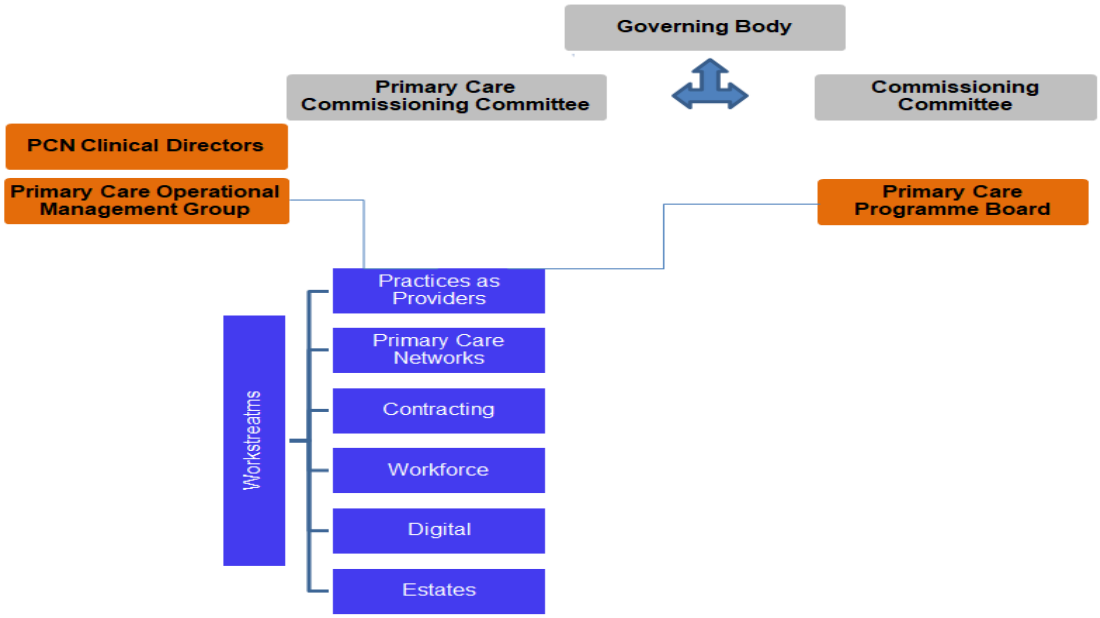
### 6.1 Our Delivery Programme

The changes within Primary Care are happening at a pace not seen before within the NHS. Formation of Networks, introduction of new Primary Care roles for staff such as the Physicians Associate, changes to contracts and new contracting and funding flows all make the need for good, robust governance and therefore accountability vital.

Being able to continually demonstrate that we consider these changes in Primary Care and the impacts on patients, individuals and our organisation is of paramount importance. This focus on accountability helps to keep the organisation transparent and ensure that the services it commissions are safe and deliver quality that all would expect in the 21st Century.

We do this through our clinical and non-clinical advocates as part of our Board and sub-committees. At the forefront of this is our commitment to ensuring we really 'hear' our patients and the experiences of care they had received by our services. Our engagement processes must therefore be robust and effective to reflect this.

As a CCG we have implemented the below accountability structure so that we are able to demonstrate to all stakeholders how we make decisions and how we hold ourselves to those decisions. This also aids us to have oversight on service changes and understand what the impact on our populations will be.




This structure also supports us with effective communication and information sharing between and across all stakeholders.

## 6.2 Measuring and Monitoring Quality in Primary Care

The Primary Care Contract Review process will be a significant influence in the measurement of practice and network quality to ensure our Primary Medical Services Contracts (GMS, PMS and APMS) are robust and are delivering the outcomes they said they would. We have implemented an on-going programme of contract monitoring and review visits this enables us to make declarations to NHS England with confidence.

The responsible committee will be regularly updated on practice and network performance using data and assurance measures that will demonstrate if networks are maturing in line with national guidance. There are a wide variety of indicators used to measure how well practices and networks are achieving and those in need of support.

As this strategy shows, the aim is to increase the support to patients, within primary and community settings so they are better equipped to manage their own health needs.

Our focus on areas such as diabetes prevention and management, asthma and respiratory conditions, maternity and parenting support and online therapies for common mental health problems will, in part, help to achieve this and also social prescribing, as part of the Network requirements to further support care being delivered in the community and closer to patients' homes. Social prescribers are included in both our workforce plans and Network structures.

## 6.3 Communication, Engagement and Participation

We recognise that robust engagement processes and procedures will be essential to ensuring we meet our operational priorities. We remain committed to engaging with local people and communities in a meaningful way that enables us to understand their needs and improve their experience of care.

Over the past 12 months we have worked across Wolverhampton to strengthen our communication and engagement processes. This is enabling us to involve local people in Wolverhampton-wide service change. Our commissioning intentions are based partially

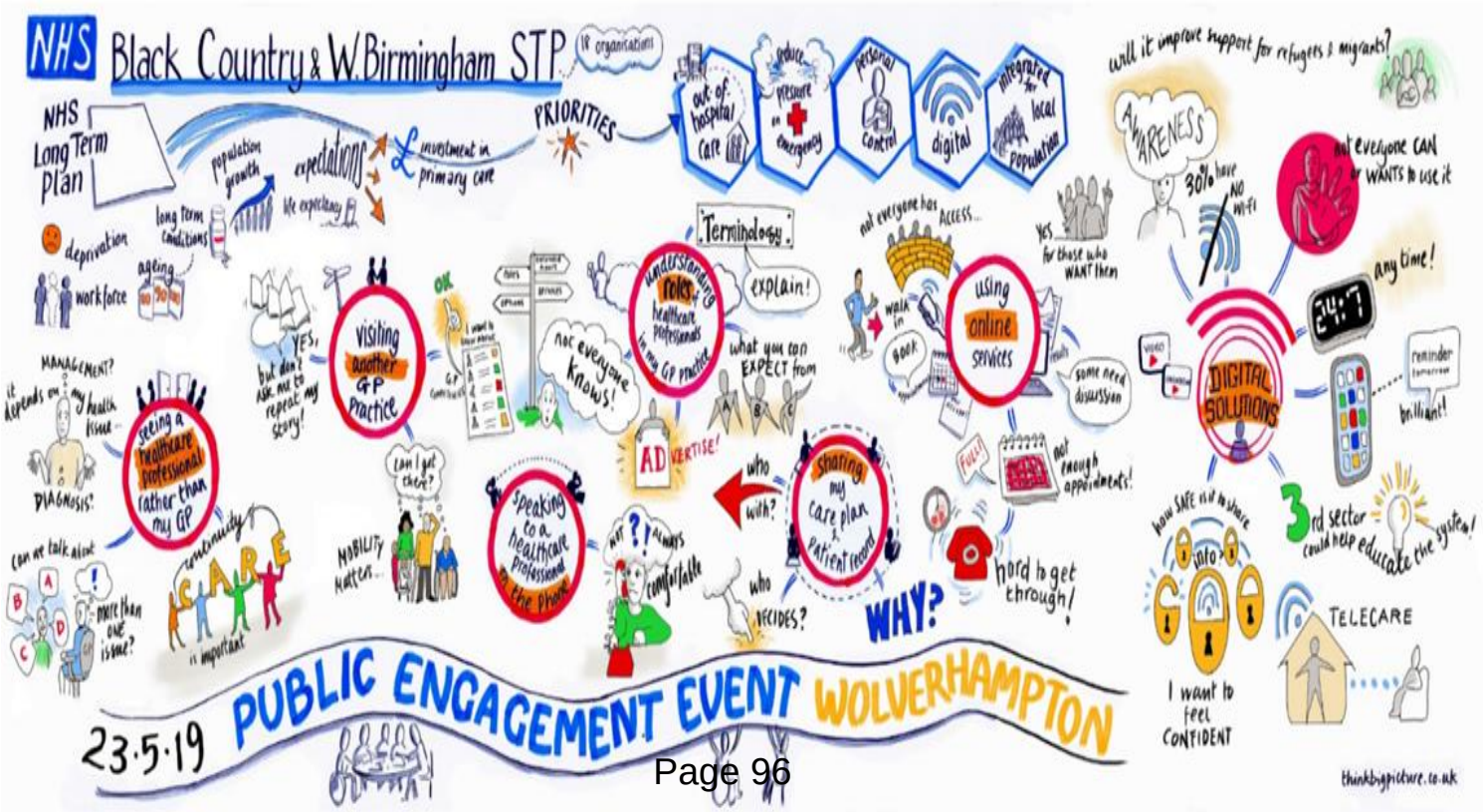
on what we have heard from our community. There are a plethora of ongoing engagement sessions that take place across the city, some disease specific others more generic.

Engagement sessions held during the summer of 2019 regarding Primary Care services have confirmed what patients would like to see:-

- Easy access to urgent GP services 24 hours a day 7 days a week – different individuals wanting this provided in different ways, but the key themes were urgent and preferably with a GP who has access to information about their health problems
- Less urgent access to as wide a range of services as possible close to home available at their own or another practice within the Primary Care Network. This would also include specific types of clinic including diabetes, respiratory etc.
- Variety of health professionals in primary care for minor ailments, provided they had the training required and were able to make easy onward referrals to the GP or other services. Patients with multiple long term conditions were more hesitant to see alternative health professionals as they thought it was important that the health professional understood their history and they valued consistent, face to face care.

Groups felt that they needed further education to understand the solutions being investigated and what this would mean in practice. They also felt that if results were made available electronically they may need support to understand them and it may not be suitable to make all results available online. Concerns were raised regarding data security and the level of information being made available between care groups and professionals it was felt that more detailed information could be shared face to face in MDT meetings and any information sharing between groups and professionals must meet data security requirements.

This illustration was prepared based on one of a number of engagement events that took place over the summer 2019 and helped to capture the thoughts and views of patients and the public.



We are continuing to engage locally about both health and social care services delivered locally, and across the Black Country footprint. We will build on the collective work we have undertaken with partners so that we continue to play our part in delivering integrated care by place and across the Black Country. In this way, we will ensure Wolverhampton residents have a role in the developing health and care landscape and that their voices are heard.

We will continue to use the outcomes from engagement events and forthcoming events to help shape how we integrate our services and deliver first class care.

We will continue to draw on a range of two-way communication channels and engagement techniques to reach and listen to our target groups, including:

- Regular stakeholder mapping – to refine our understanding of the communities we need to engagement with
- Outreach activity such as events and roadshows
- Press and public relations including regular content for print and broadcast media, where appropriate
- Social media
- Newsletters and other communications collateral
- Surveys and formal consultations

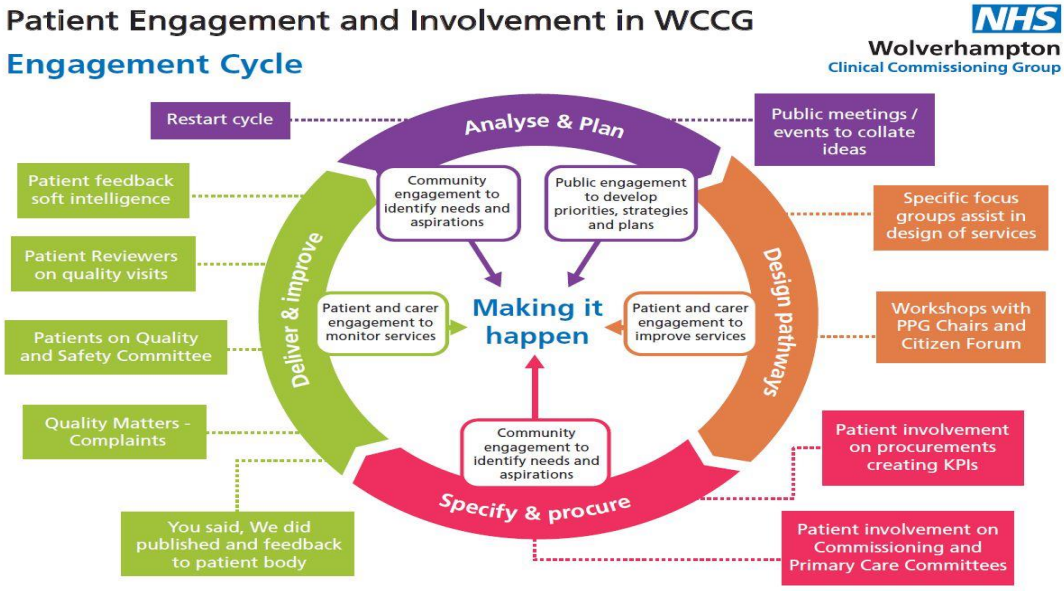
The Primary Care Team have a series of engagement activities scheduled for 2019 and also plan to extend into 2021 these briefly comprise of the following areas of importance although this is not an exhaustive list:-

- Frailty & OTs in general practice
- End of Life Care
- Paediatric Pathways
- Primary Care Network Development
- Different Consultation Types & New Roles in General Practice
- Redesign of Wound Care Services

Engaging with and involving our CCG colleagues will have additional focus over the coming year as we understand the implications of the Long-Term Plan for the future of clinical commissioning groups. We know that colleagues welcome regular staff briefings, which are led by our Accountable Officer. Our staff have the opportunity to engage with the Executive Team on their floor walks or take time for a brief chat 'Coffee with the Chair' which is held monthly.

Engagement with the

community in line with the CCGs Engagement Strategy will continue. Primary Care is one of a number of influencing factors that forms the basis for both the engagement and commissioning cycles.

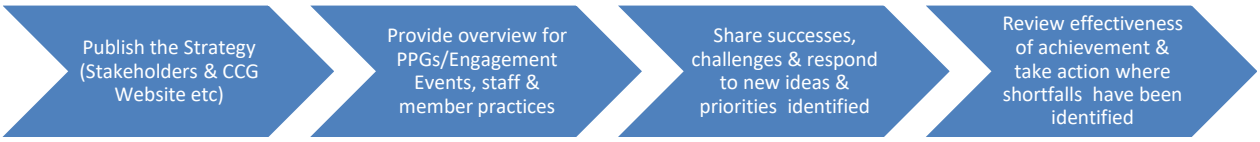



## 6.4 Implementing the Strategy and Monitoring our Progress

There are many priorities identified in this strategy. In order for the priorities to be worked through sufficiently they will all be captured in the CCGs Work Programmes, many firmly rooted within the Primary Care Team. There are six task and finish groups that have defined work programmes to manage the workload in a prioritised and co-ordinated way. The activities arising from the individual work programmes will be routinely reviewed by the responsible executive(s) and committees in order for timely assurance to be provided to the CCGs Governing Body. Periodic reports will be provided for the entire programme to the Milestone Review Board. A robust programme management office approach has been adopted to ensure that delivery & non-achievement are actively captured and reported.

The assurance reporting provided to Milestone Review Board (quarterly) is intended to provide a balanced view of delivery (and non-delivery) across all priorities from each respective task and finish group.

Following approval by the responsible Committee, Primary Care Commissioning Committee there will be a series of activities that take place to ensure the strategy reaches a range of stakeholders as defined in the diagram below:-




Engagement events will be taking place on an ongoing basis based on the CCGs Commissioning Intentions, Primary Care Network activities and other associated CCG engagement priorities with both staff and the local community to ensure that the work programmes understood and the benefits are being realised to meet the needs of our community.

## 6.5 Conclusion

Primary care is now more important than ever and despite the challenges faced and significant pressure and constrained resources local people have access to comprehensive and universal healthcare which is free at the point of need. This is testament to our hardworking, committed staff in practices who try to provide the very best care they can.

This strategy and the Black Country STP Primary Care Strategy (2019) define an improvement journey for the exceptional healthcare our population deserves and that everyone can access. We believe that we should develop a true partnership between the users of our service, their carers, our public and our primary care providers, to strive to achieve better health care.

We know that primary care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing on-going mental and physical health conditions and helping people recover from episodes of ill health and injury. Through growing new workforce roles, introducing new primary care models and utilising digital and estate solutions, we will change how we deliver care to our population.

However, there are significant challenges being faced by primary care, in particular general practice. We need to radically rethink primary care if we are to deliver sustainability beyond the current decade. This is due to the increase in workload with the uncertainty of future workforce and the need to manage increasing numbers of people with multiple and complex health needs.

Our vision for primary care in Wolverhampton is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources. The deliverability of the strategy is twinned with the commitments defined in the STP Long Term Plan and Primary Care Strategy that pave the way for system transformation over the next 5 years although reliant on the foundations within this strategy to achieve those longer term objectives. All of these documents are designed to give us the best chance to make care accessible for patients and ensure as far as possible that the developments and service improvements are delivered to the highest standards possible with the resource we have available to us.

**Appendix 1**
**Primary Care - High Level Delivery Plan**

| | 2019/20 | 2020/21 |
|---|---|---|
| **Developing Primary Care** | **July** : Primary Care Networks Established<br>**August :** 75 minutes per 1,000 patients additional appointments at network level<br>**September** : Assessments against maturity matrix<br>**September** : Population Health Data & Interpretation informing PCN Development Plans<br>**October** : Prioritising population health management<br>**November** : Range of consultation types readily available & NHS App interface with practice clinical systems<br>**October - March** : Network(s) actively participating in development programmes & sourcing specialist support | **April :** Continuation of advertising campaign to raise network profile(s) & different consultation types<br>**April** : Additional roles eg Social Prescribing, Clinical Pharmacists & Physicians Associates<br>**April** : 111 Direct Booking (practice & network)<br>**Summer** : Digital appointments actively offered/accepted by patients with improvement trajectory<br>**September** : Review of PCN development needs & maturity matrix<br>**Autumn** : Population Health Management early benefits realisation |
| **Clinical Priorities for Primary Care** | **Summer/Autumn** : Portfolio Career Applications & targetted population management within networks<br>**Winter :** Integrated Care ie Frailty Co-ordinators appointed and EOL model mobilisation commences<br>**November** : Paediatrics?<br>**January** : SMI & LD Health Checks<br>**March** : Investment and development in local primary care framework based on population health priorities | **Spring :** New primary in reach support to care homes<br>**Spring** : Wolverhampton Shared Care Record?<br>**April** : Consistent provision of home visiting service across the city<br>**Summer** : End of Life Community Model fully implemented and MDT Meetings in all networks involving aligned professionals<br>**Winter** : Personalised care planning embedded across the city |
| **NHS Long Term Plan** | **Winter** : Collaboration and reconfiguration : Community Services wrapped around PCNs including mental health<br>**January** : Primary Care Networks embedded & maturing place/system<br>**Spring** : New specifications primary care clinical priority areas including care homes | **Spring :** population is aware of the range of other options available for accessing urgent care and will understand how they can access these<br>**Summer** : Improved care co-ordination ie EOL<br>**Autumn** : Risk stratification used universally & full use of digital technology in care settings<br>**Winter** : Integrated Care System finalised ready for go live April 2021 |

**Appendix 2**
**Primary Care Networks Composition – Wolverhampton**

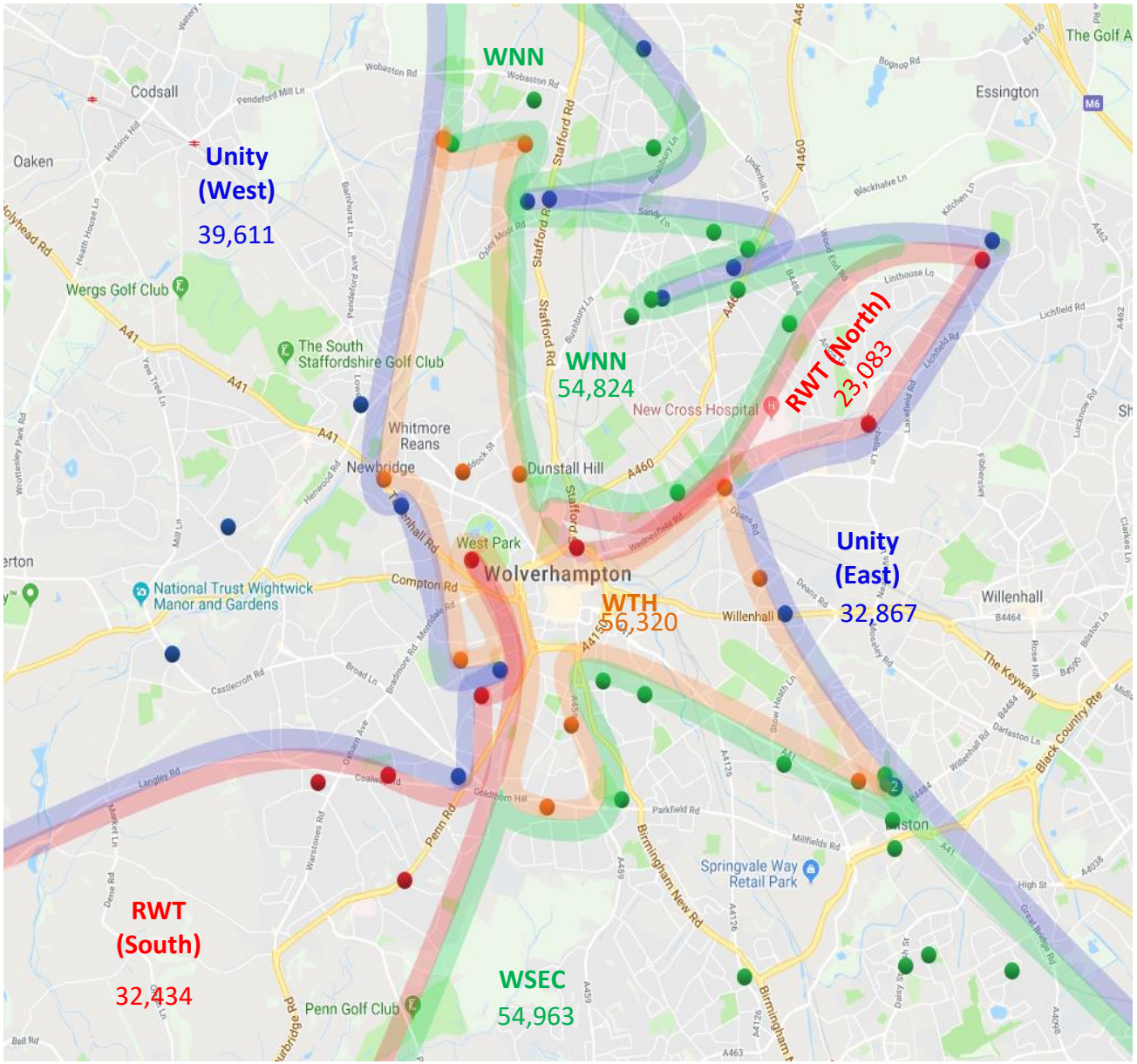
| Unity East Network | |
|---|---|
| • Ashmore Park Health Centre | • Dr Fowler- Oxley Surgery |
| • I H Medical Bilston Health Centre | • Mayfield Medical Centre |
| • Poplars Medical Practice | • Primrose Lane |
| • Probert Road Surgery | • The Bilston Family Practice |

| Unity West Network | |
|---|---|
| • Castlecroft Medical Practice | • Dr Whitehouse- The Surgery |
| • Pennfields Health Centre (IH) | • Penn Surgery |
| • Tettenhall Medical Practice | |

| Wolverhampton Total Health | |
|---|---|
| • Duncan Street | • East Park Medical Practice |
| • Fordhouses Medical Practice | • Newbridge Surgery |
| • Tudor Medical Centre & Branches | • Whitmore Reans Health Centre (& Branches) |

| Wolverhampton North Network | |
|---|---|
| • Ashfield Road Surgery | • Cannock Road Medical Practice |
| • Beats Grove Surgery | • MGS Medical Practice |
| • Forestbury Medical Practice | • Showell Park Health & Walk-in-Centre |
| • The Surgery, Woden Road | |

| Wolverhampton South East Collaborative | |
|---|---|
| • Bilston Health Centre | • Bilston Urban Village Medical Centre |
| • Ettingshall Medical Centre | • Hill Street Surgery |
| • Health and Beyond | |
| • Parkfields | |

| RWT PCN | |
|---|---|
| • Alfred Squire Medical Practice | • Coalway Road Surgery |
| • Lea Road Medical Practice | • Penn Manor Medical Centre |
| • The Surgery, Wednesfield | • Thornley Street Surgery |
| • Warstones Health Centre | • West Park Surgery |

| | |
|---|---|
| Unity East Network | Dr K Krishan |
| Unity West Network | Dr K Ahmed |
| Wolverhampton Total Health | Dr G Pickavance |
| Wolverhampton North Network | Dr S Rafiq |
| Wolverhampton South East | Dr R Mohindroo |
| RWT PCN | Dr J Burrell |