NHS
Wolverhampton
Clinical Commissioning Group

Primary Care Strategy 2019 - 2021

August 2019

Version 1.4 FINAL DRAFT

Contents

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.

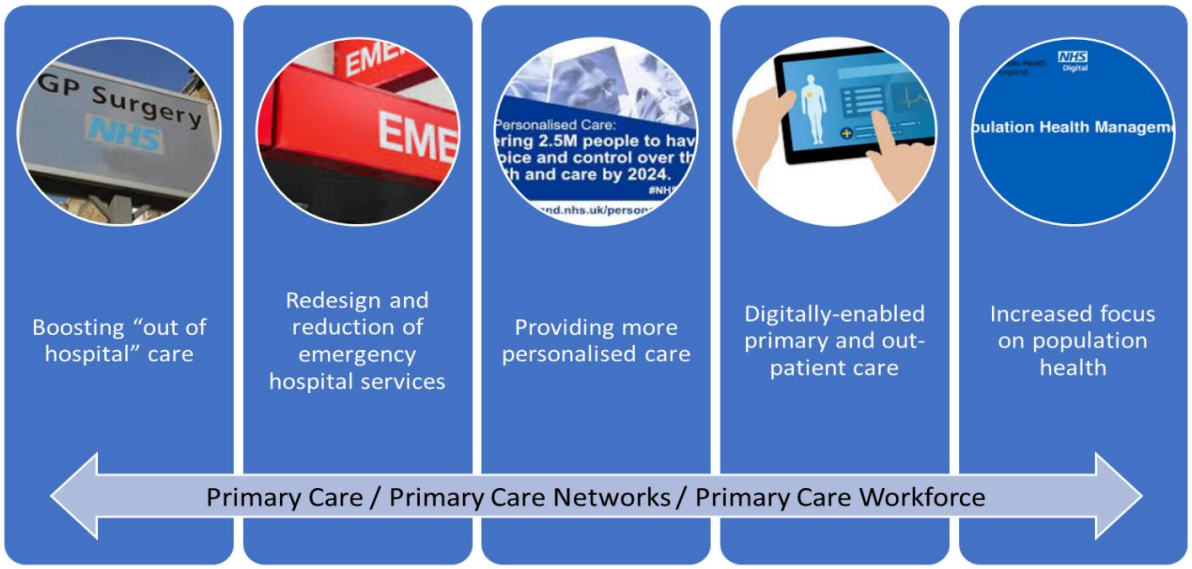
2.0 Context

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).

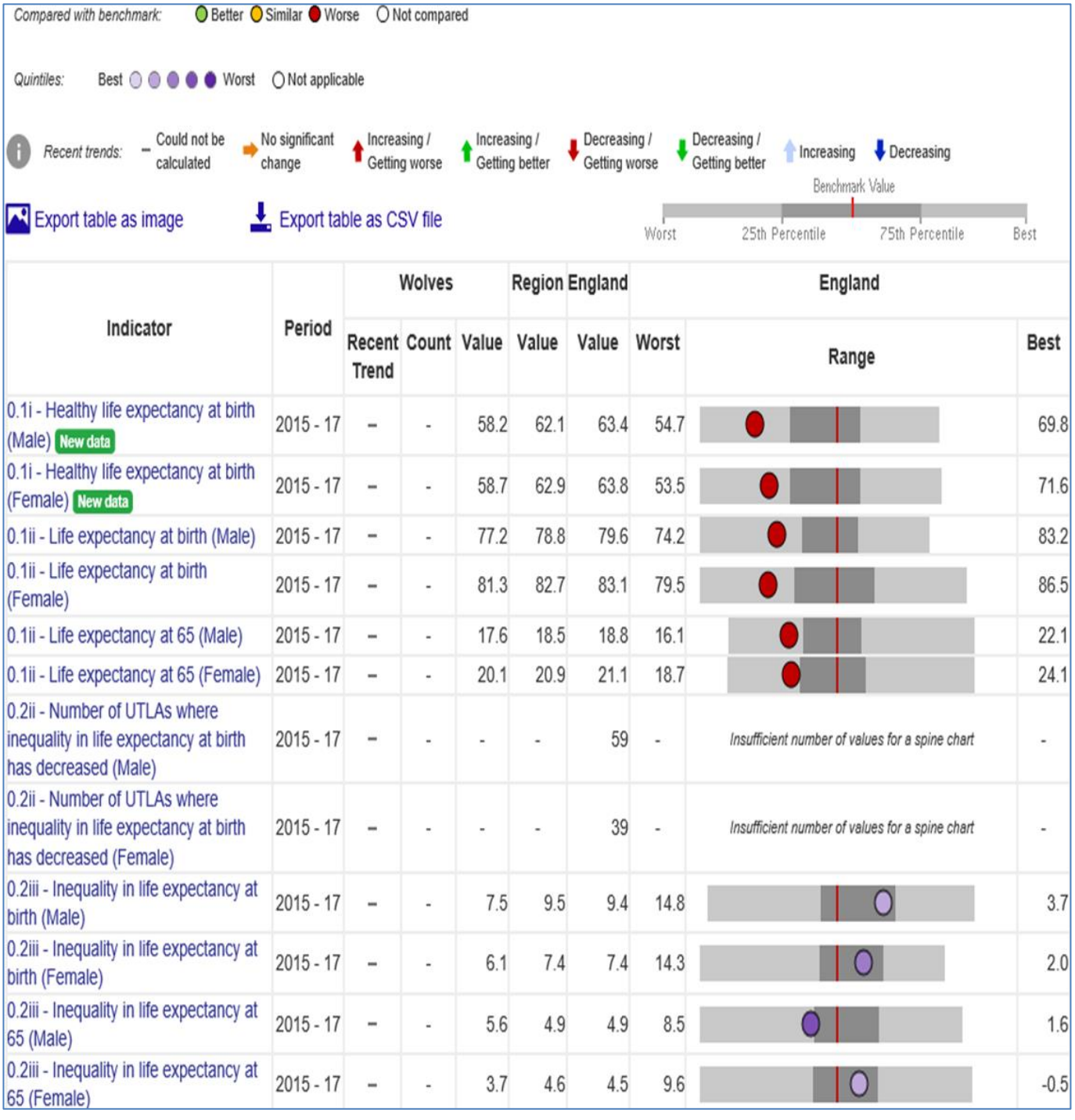
The City of Wolverhampton's population has been growing in recent years, and now stands at in excess of 290,000 in April 2019.

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.



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 of patients not just be 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:-

- get 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 • **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. • **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. • **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. • **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 and improve 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 patients on learning disability or serious mental illness register(s) and finally cancer screening too.
- The Supporting of 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 the frail elderly
- 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 DES
   - 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 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 these6 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
Vertical Integration	8 practices | 55,516 patients
Unity West Network	5 practices | 38,197 patients
Wolverhampton Total Health	6 practices | 56,321 patients

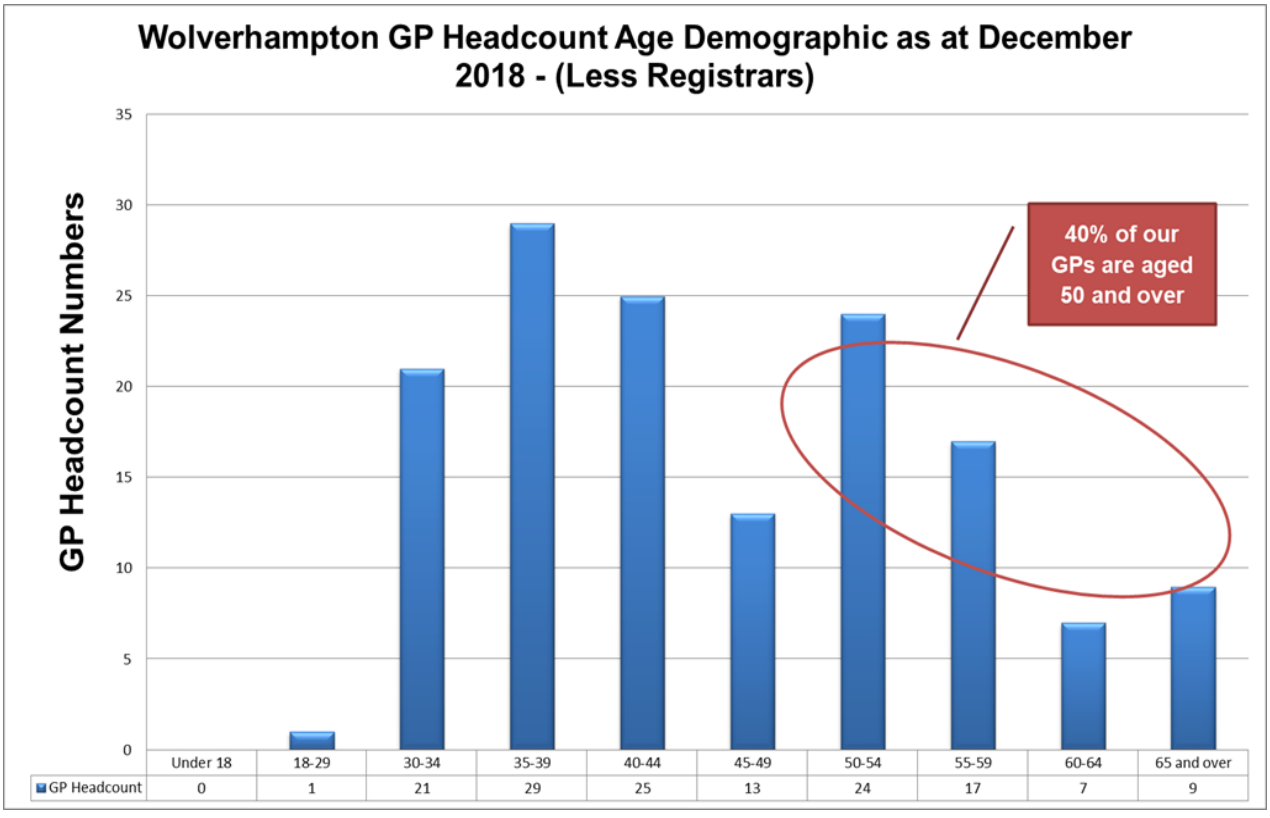
4.2 Workforce

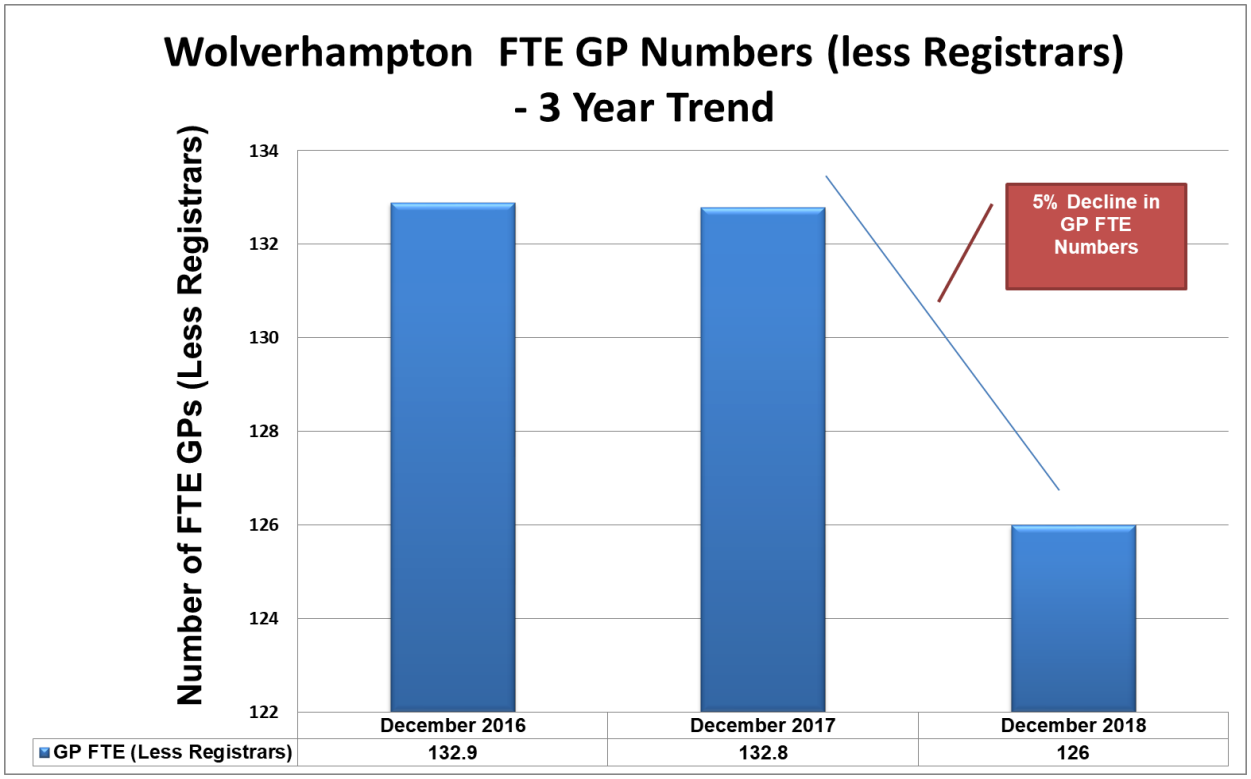
The increase in demand General Practitioners face has been a significant cause for concern due to the number of GPs either leaving the profession or newly qualified Doctors not wanting to enter the Primary Care.

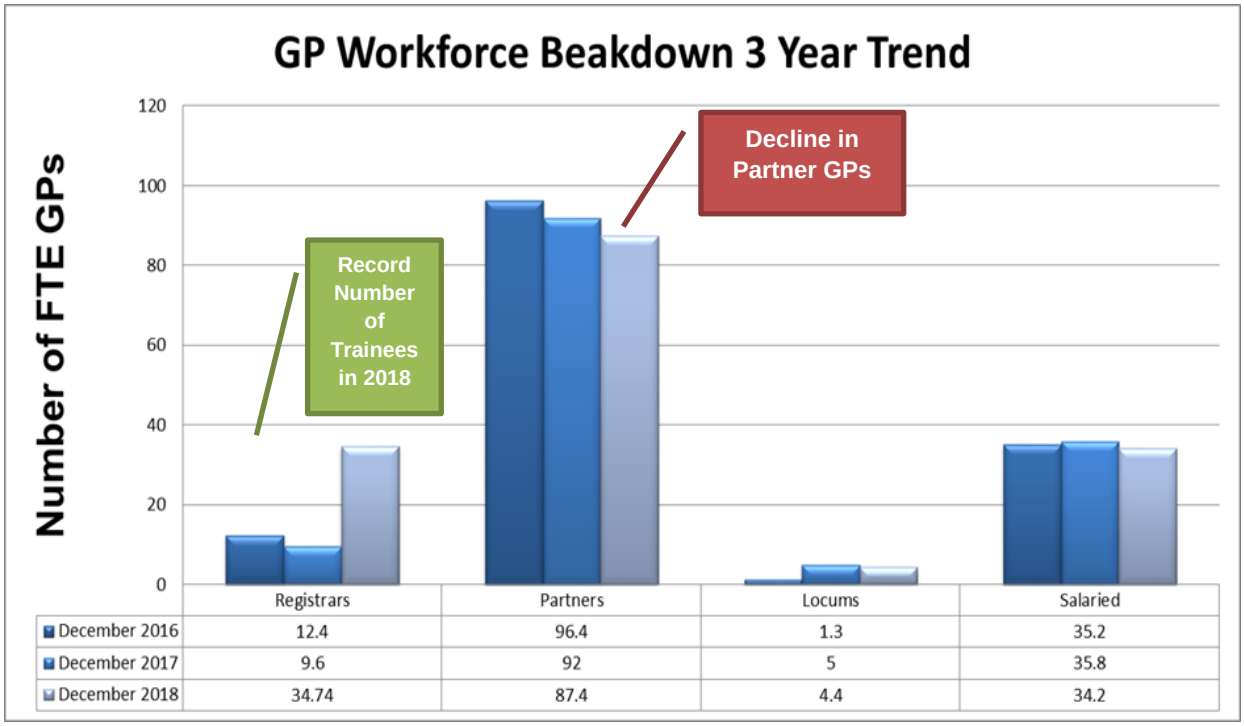
In addition, there are added complexities with the aging workforce profile of GPs. This has been recognised through the partnership work between the Black Country and NHS England and Intensive Support Site funding has allowed the greater interaction and co-design of a series of initiatives to attract 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.

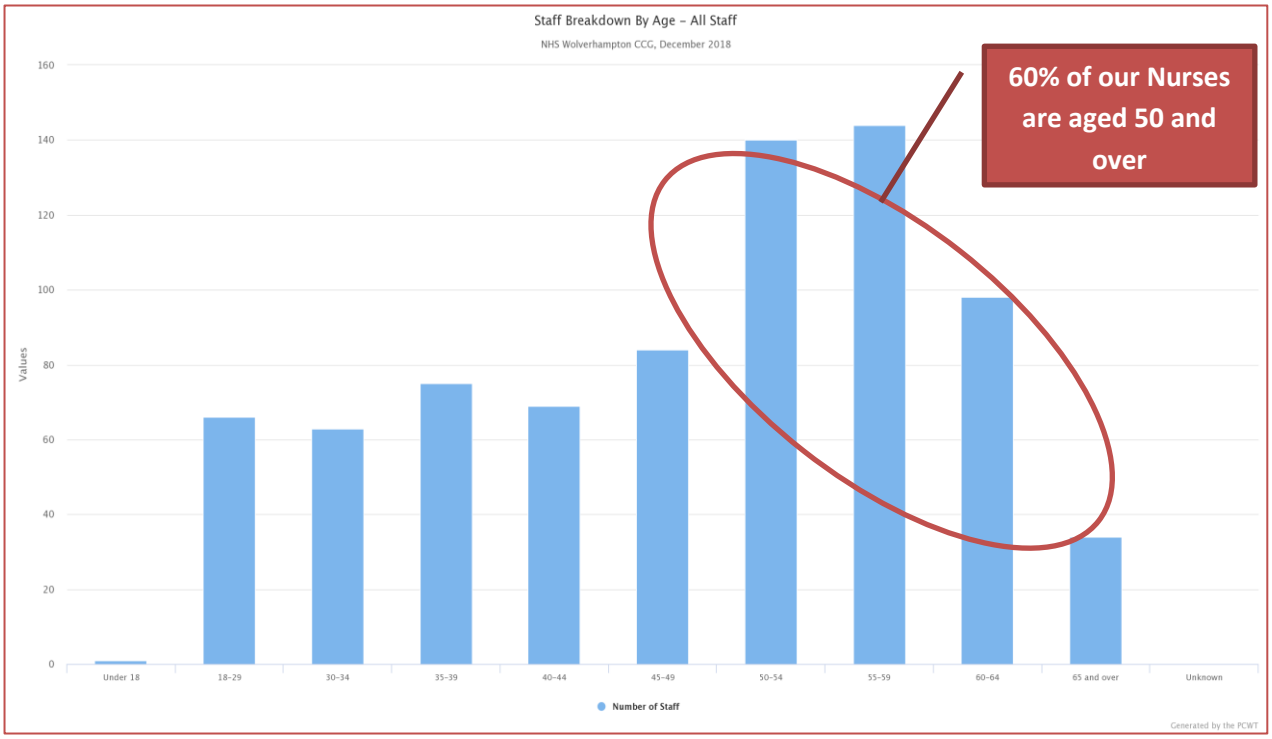
There are a number of GP workforce retention initiatives that are actively promoted and being accessed by Wolverhampton GPs affording mentoring, networking and portfolio careers and also access to expert advice on career planning and other support for GPs who wish to return to practice and want to be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







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. he 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 the estates strategy 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.

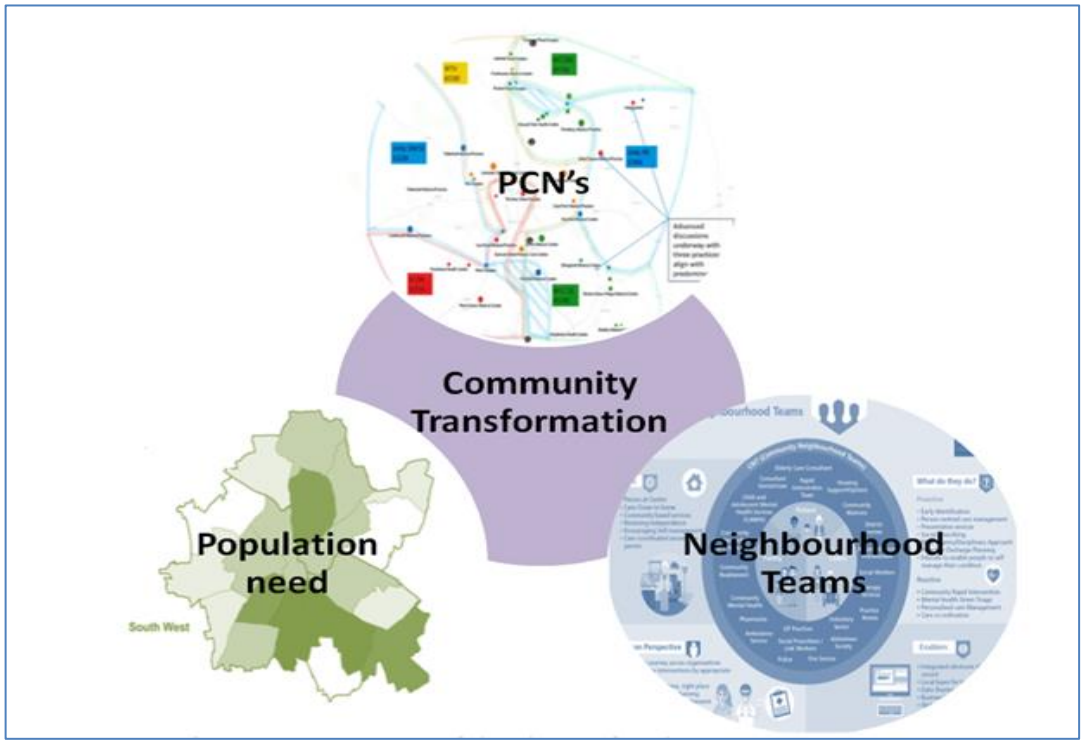
Through the HSCN programme the CCG is installing a brand-new network infrastructure replacing the old broadband N3 lines with scale able IPVPN lines that will allow the network to expand with the requirements of the organisation moving forward.

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:-

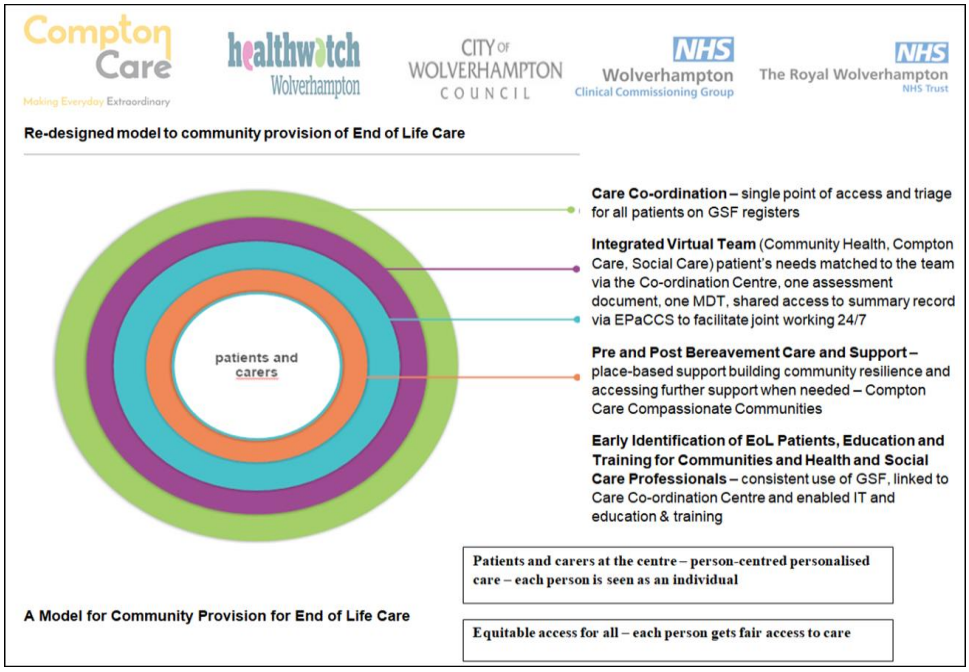
- A transformed Community Services supporting PCNs in Wolverhampton that will offer:-
    - Improvements for patients at the end of life, and the need to reduce the numbers of patients dying in an acute bed
    - Increased capacity within community services and admission avoidance initiatives
    - Aligned 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



- 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 appropriate 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 a home visiting service to enable more patients to be triaged and treated in their own homes.

- A new end of life community based model of delivery



- 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

4.5.2 Reduction in pressure on emergency hospital services

Wolverhampton will continue to promote actively 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 plana 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 and nursing home patients to be treated without the need to convey into hospital supplemented by rapid support at times of an exacerbation of a condition

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 nationalS 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 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 20/21 x 2 21/22 x 3	Per Network
Clinical Pharmacist(s) 70% Funding	NHS England	19/20 x 1 20/21 x 2 21/22 x	Per Network
Clinical Director Funding 0.25/1day per week	NHS England	19/20 £0.51 per patient 20/21 £0.57 per patient	Network
First Contact Practitioner (70%)	NHS England	20/21 x 1 21/22 x 2	Network
Physicians Associate (70%)	NHS England	20/21 x 1 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.

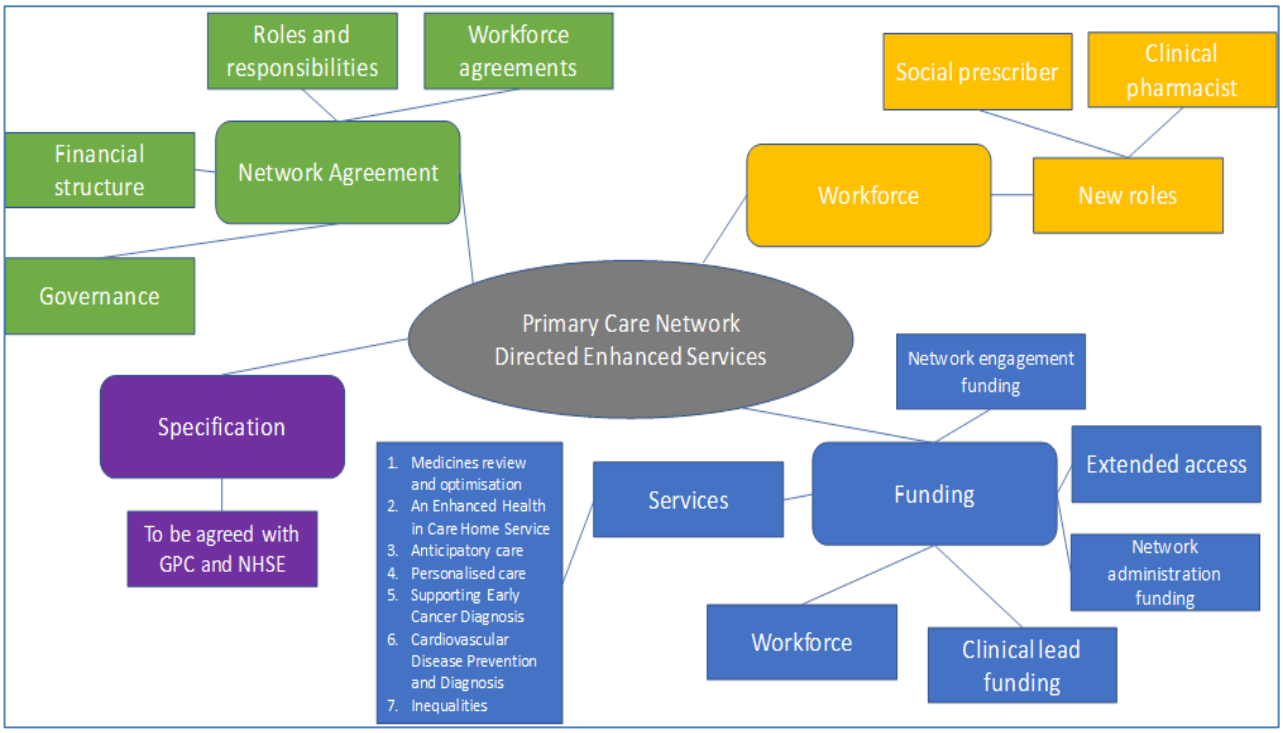
Having agreed, signed off contracts for services and the new way of working begun, the networks will have a good level of financial security. This security means that the networks can focus on formation and the delivery of front-line patient care without having to worry about current funding streams.

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.

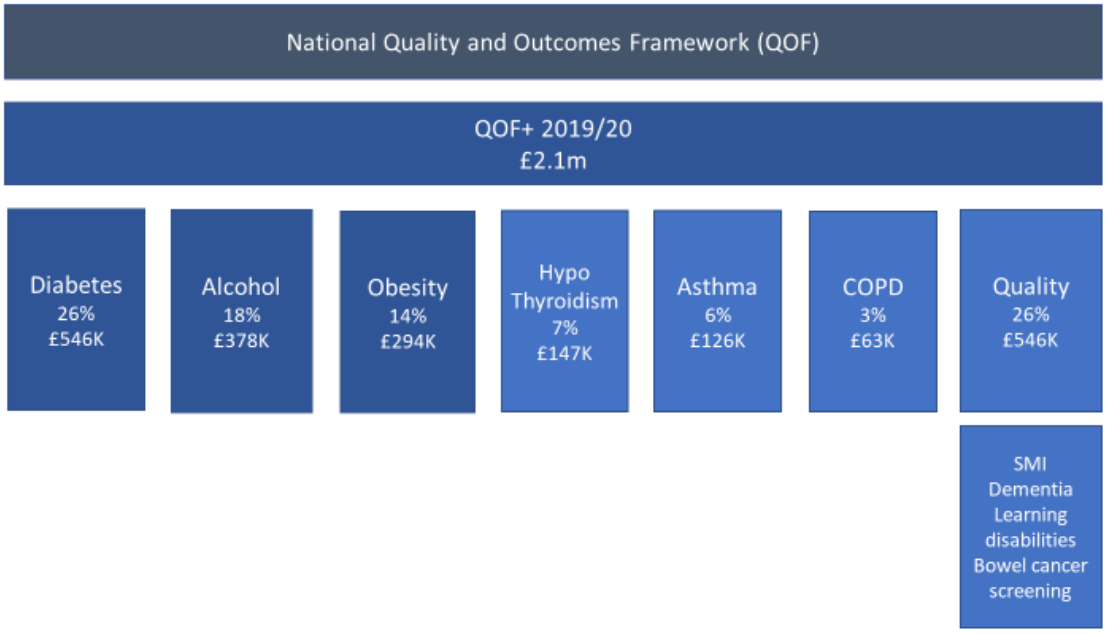
There are a number of clinical domains including atrial fibrillation, heart failure and hypertension and dementia and mental health. Nationally In 2019 more indicators will be added to some domains including diabetes, blood pressure control and cervical screening. A new quality improvement domain (QI) 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.

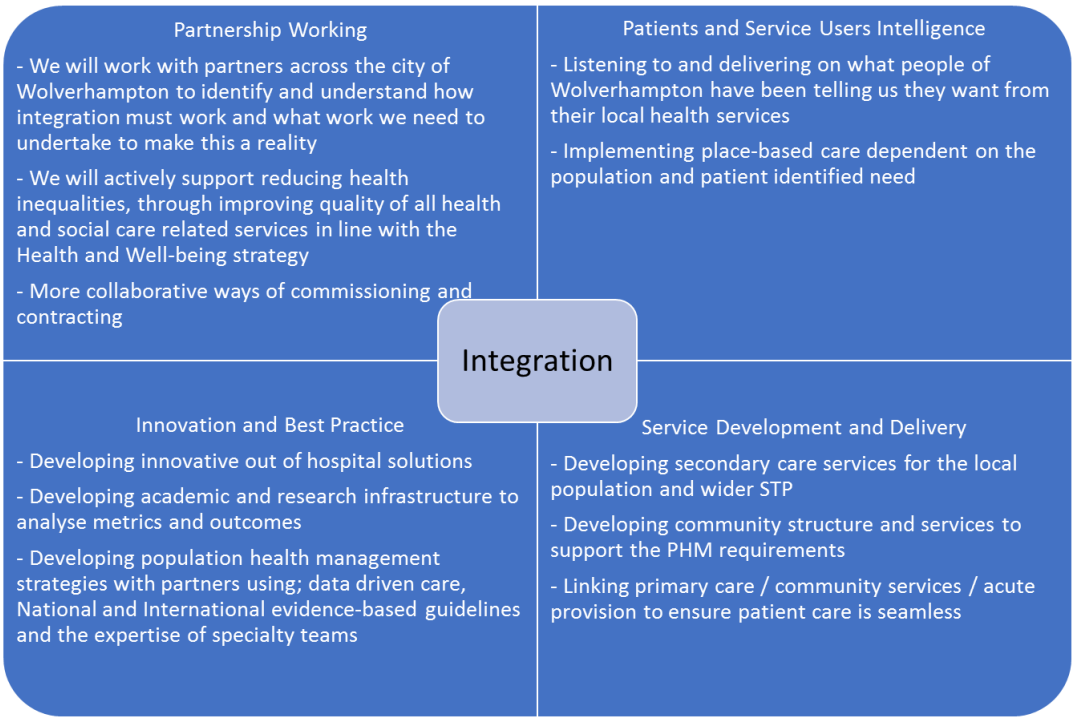
Nationally there has been the development of a new integration framework. We are a committed partner within the Black Country and are supporting the development and adoption of this new Integrated Care approach has been created to ensure that all associated organisations:

- 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.

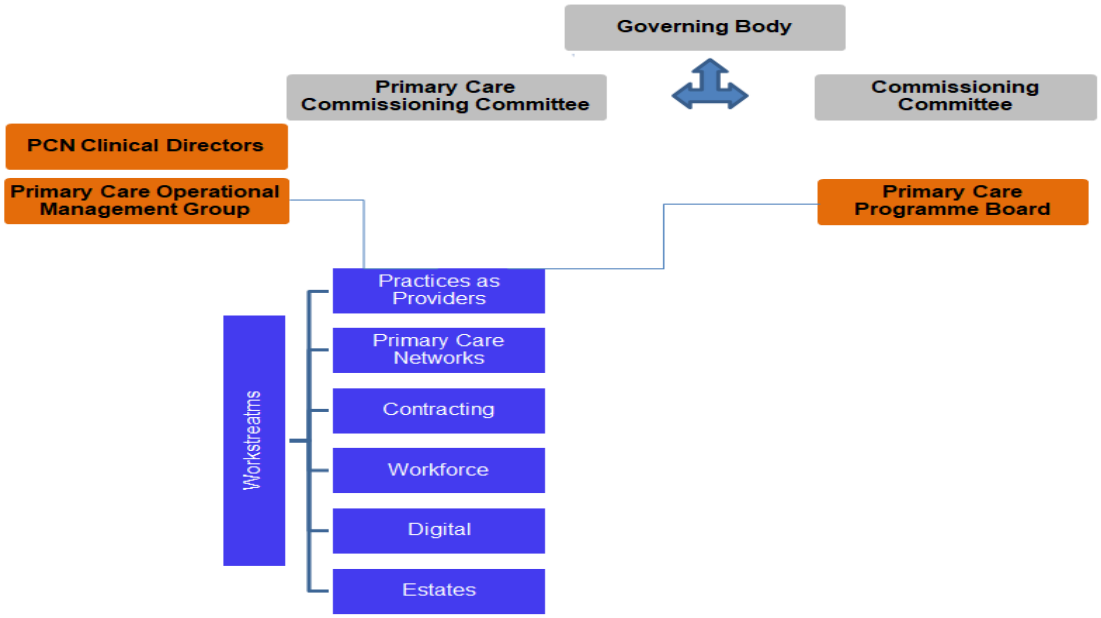
6.1 Our Delivery Programme

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.

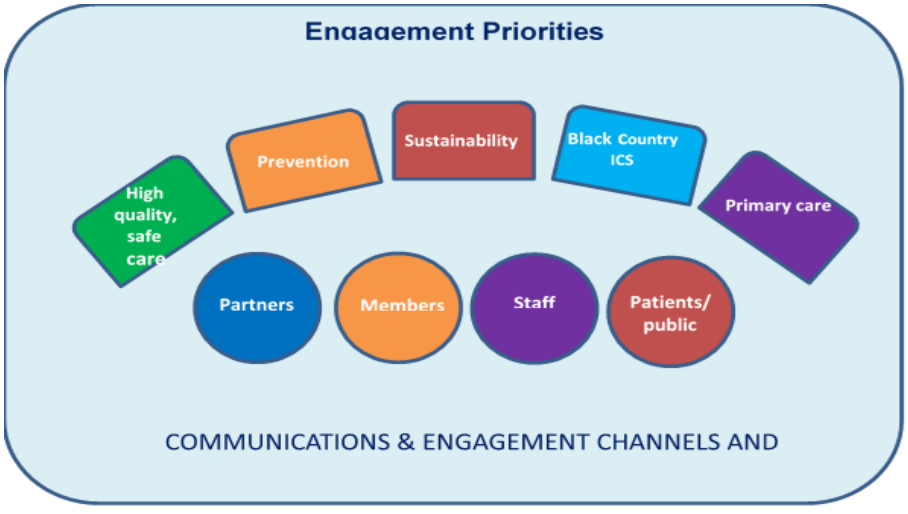
We will continue to draw on a range of two-way communication channels and engagement techniques to reach and listen to our target groups, including:

- 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

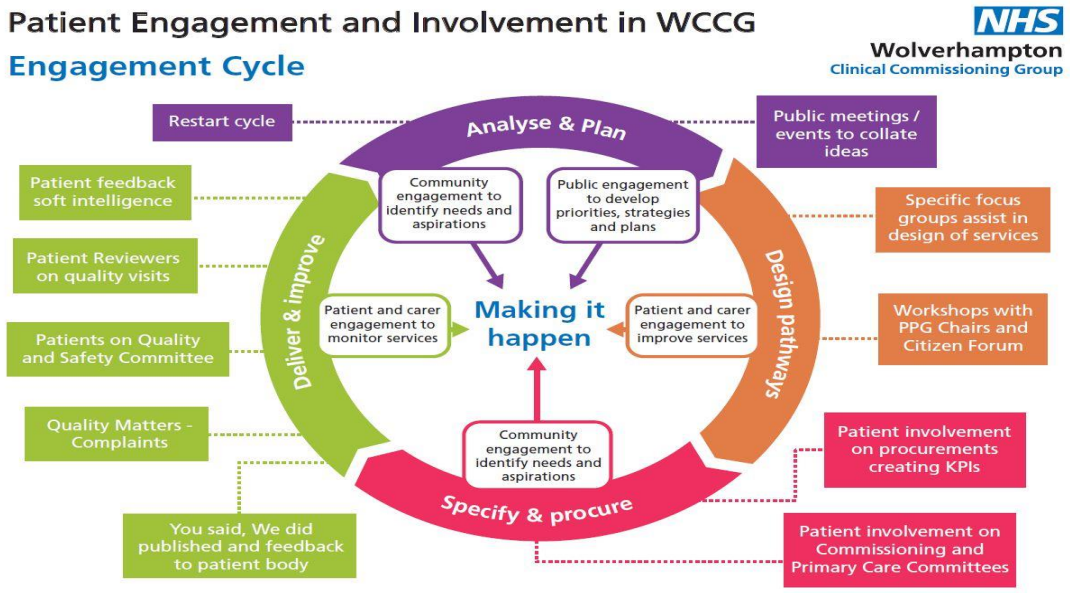
The Primary Care Team have a series of engagement activities scheduled for 2019 and also plan to extend 2021 these briefly comprise of the following areas of importance although this is not an exhaustive list:-

- Frailty & OTs in general practice
- End of Life Care
- Paediatric Pathways
- GP Home Visiting Service
- 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 the 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 the highest standards possible with the resource we have available to us.

Appendix 1
Primary Care - High Level Delivery Plan