NHS
Wolverhampton
Clinical Commissioning Group

General Practice Forward View Implementation Plan 2017-19

Your Health & Care Matter

Introduction

Our vision is to achieve universally accessible high quality out of hospital services that promote health & wellbeing for our local community. We seek to ensure that treatment is available in the right place, at the right time and to improve the quality of life for those living with long term conditions and reduce health inequalities.

In Wolverhampton we are supporting the development of new models of care delivery through emerging models that include a small Primary and Acute Care Model and three Multi-Speciality Care Providers. This is helping us to shape primary and community services for the future.

Our Sustainability & Transformation Plan is driven by improving access, care co-ordination leading to better continuity of patient care provided by a range of professionals across the city that requires transformation of primary care services;

- **Better health:** through reducing long term condition prevalence, reducing the number of deaths in hospital and social isolation but increasing the number of people feeling supported with long term conditions.
- **Better Care:** through improved access & co-ordination of care, patient experience of GP, community & other place based services such as maternity & end of life services. Clinical outcomes will be improved by multi-disciplinary team working for deliver of our care pathways that will lead to standardising access to care. Patient experience improves through co-production & patient activation; delivering more efficient care and preventative services will reduce the necessity for ongoing provision as time progresses. Safety and quality of service will be safeguarded through standardised access & pathways; improved community and reduction in variation.
- **Sustainability:** resource sustainability will be realised through a changing culture & improved staff retention, reductions in emergency bed days, admissions to hospital and use of acute beds, nursing and social care placements.

Our Primary Care Strategy (January 2016) is built on firm foundations as detailed in the General Practice Forward View and sets out how we will transform primary care in Wolverhampton. We have adopted a programme management office approach to ensuring the delivery of our primary care strategy and through close working with NHS England we are pro-actively prepared for and responsive to a range of projects being lead nationally that have an impact on primary care in Wolverhampton.

Operational Plan 2017-19

Our plans for Primary Care are set out in detail in the strategy approved by the Governing Body in January 2016 and the focus through 2017/18 and 2018/19 will be implementing the extensive programme of work that is now well underway. The implementation plans underpinning delivery of the strategy recognise and respond to the many influences of NHSE's General Practice Five Year Forward View to deliver improved access to primary medical services through practices working at scale to meet the needs of their patients.

We will continue to support practices to come together as groups to meet the needs of their patients on a shared basis. There are currently four collaborative groups made up of ca. 40 practices who are working together to provide care at scale for their local population based on National Association of Primary Care 'Primary Care Homes' and Medical Chambers models. We anticipate that, as they develop proposals for new ways of delivering care, this will rationalise into two formal MCP organisations, based on appropriate patient populations that will enable the delivery of sustainable services. We anticipate that these emerging MCPs will directly provide Community based services with a close and direct link to proactive and close population health support and health management. Their approach to providing care, with additional health care professionals on hand to respond to patient presentations is intended to prevent patients losing independence and/or deteriorating without the appropriate intervention from skilled health and social care professionals. Practices will be open longer, offering flexibility in appointment times into the evening and on Saturdays and where necessary a level of cover on Sundays that will be closely aligned with the out of hours service that is also strengthened to accommodate periods of increased demand. This will be a transformational change for Wolverhampton and we will utilise the financial support available to support practice groups – our emerging MCPs, to tackle the ten high impact actions advocated by NHSE and detailed in the Primary Care strategy. We will develop a menu of support for practices/groups to develop their skills and capability to work differently from 2017. Some examples of the types of support we are committed to:-

- Releasing time for care by accessing national resource and expertise to help practices adopt proven innovations quickly, safely and sustainably;
- Building capability for improvement through providing training and coaching for clinicians and managers to develop skills in leading change;
- Using funding to support the development of administrative staff to play a greater role in active signposting and managing more incoming correspondence;
- Actively enabling the use of technology for patient consultations, further strengthened by national funding that the CCG will direct towards helping GPs spend more time with those that need their attention most;
- Encouraging allegiances with community pharmacies, supporting practices to actively support patients accessing pharmacies for minor ailments and better medicines use by patients with long term conditions.
- Continuing to signpost practices towards national programmes such as the Practice Resilience Programme that will enable them to address issues and share learning.

A key milestone will be reached in April 2017, when the CCG embarks on a new approach to commissioning primary care in Wolverhampton, assuming fully delegated responsibility from NHSE. The CCG will purchase health care based on local population need, with particular emphasis placed on improving outcomes for patients with the most complex care needs by ensuring they receive support to meet their health needs as close to home as possible.

Primary Care Strategy

Delivery of the strategy spans a five year period that commenced in 2016 and is anticipated to conclude by 2021. The vision is reliant upon the transference of a range of services that have traditionally taken place in a hospital setting in order for us to reduce demand on secondary care and treat patients in the community. The strategy is underpinned by a programme of work that spans a number of enabling groups.

Each task & finish group was established in 2016 and they have embarked upon bringing the strategy to life with a defined and measurable programme of work to implement the strategy. Seven Task & Finish Groups specifically responsible for developing primary care: Practices as Provides; Localities/Practice Groups as Commissioners; Primary Care Contracting; Workforce; Clinical Pharmacist Role; Estates, Information Management & Technology.

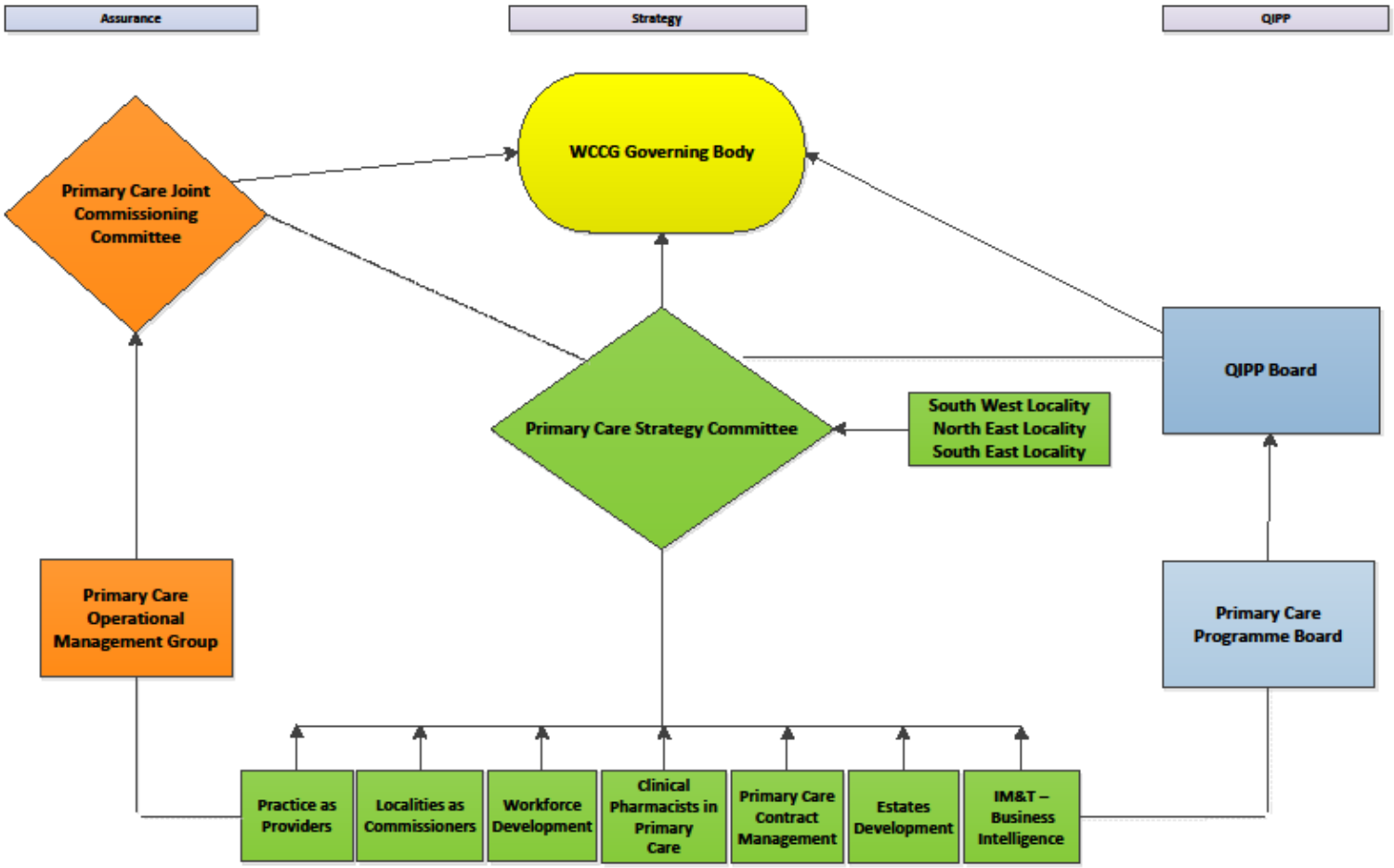
Governance arrangements have been established via the formation of a Primary Care Strategy Committee, a sub committee of the Governing Body. The following slides outline the governance arrangements. It is recognised that there are a number of development activities that will need to take place over the coming years. These are reflected in our organisational development plan & corresponding maturity model (see following slides).

Our governance framework includes the integration of GPFV projects at committee level. Additionally, GPFV is a standing item & this dovetails with the developments of the emerging new models of care (MCPs). This is also illustrated in subsequent pages.

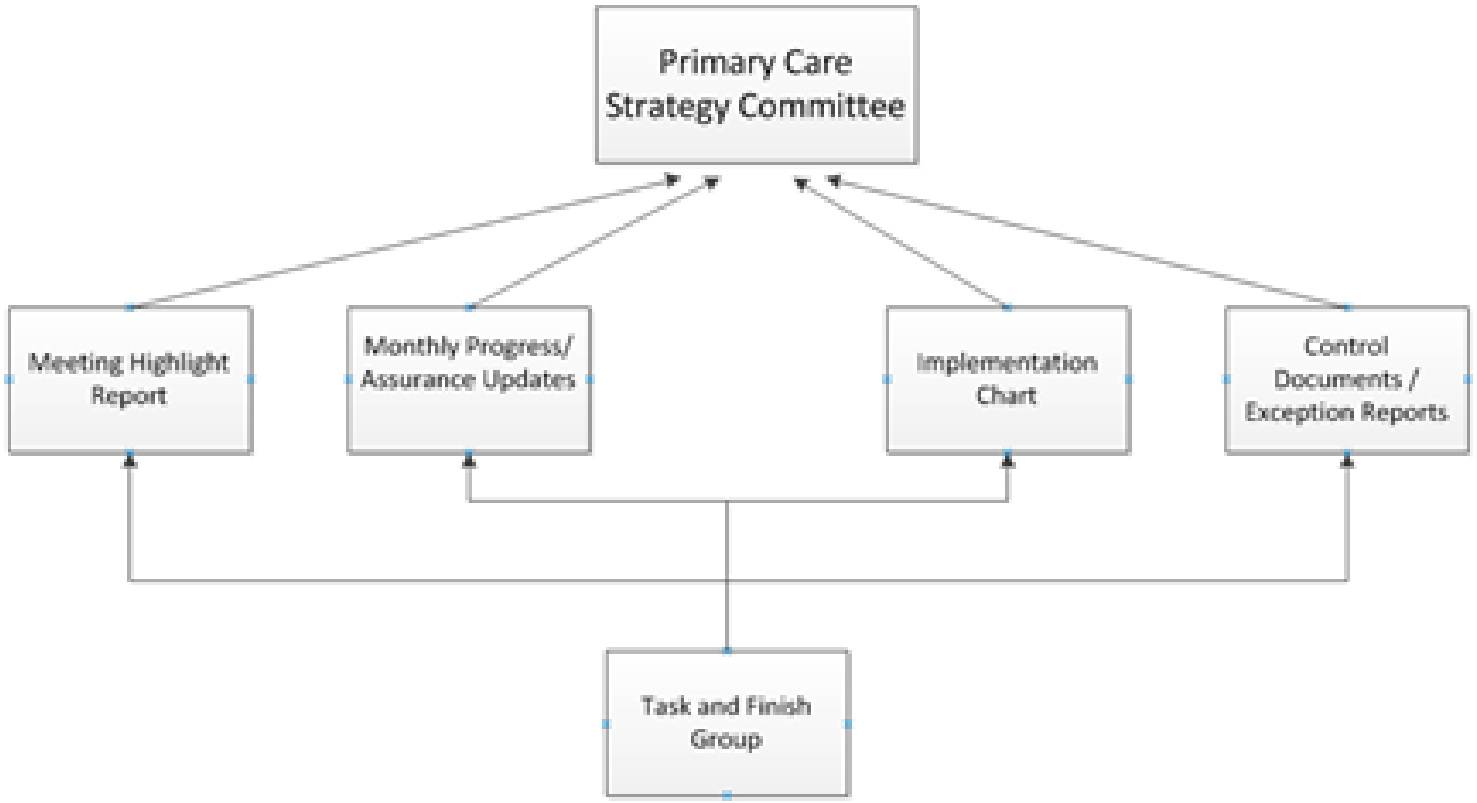
Practices are actively aligning themselves with their preferred model., This not only advocates working at scale but is very closely linked to care redesign. We anticipate that these new ways of working will aid us to identify the sustainable primary care organisation(s) we require for the future. Our demand management plan, introduced during 2016 comprises of a number of projects designed to manage the demand placed on secondary care and improve clinical effectiveness across each sector of the health economy.

Our strategy has been co-designed with member practices. As a membership organisation we are committed to collaborative working. Joint implementation of a very different way of working over the coming years continues to be undertaken in partnership with our group leaders. Our programme of work and accompanying documents demonstrate how this transformation will take place. We will also be launching in 2017/18 a series of locally defined quality indicators that build upon the National Quality Outcomes Framework as we strive for continuous improvement.

Primary Care Strategy Governance



PROGRAMME DELIVERY AND ASSURANCE



Transformational Support

Transformation funding made available from the CCGs allocation will be used to incentivise practices to improve access and champion each of the Ten High Impact Actions over a 2 year period (see investment). This is in addition to existing funding that has enabled practices to work at scale via dedicated Project Management Support provided by the CCG.

We are committed to continued development of sustainable practice groups. Our maturity model provides a roadmap for how we will achieve this - supporting the development of management structures, focusing on service delivery, contractual preparedness and a range of characteristics and financial models. Pivotal to the development of the MCP organisation(s) is collaborative working with the CCG.

Expected outcomes captured within our wider plans for primary care are end to end pathways provided on a citywide footprint. Priority areas are end of life, district nursing, musculo-skeletal service etc. This will be underpinned by MCP contracts that will replace existing standard contracts including DES's/LES's.

Transformational phasing is detailed in our organisational development model (see following slide) this coincides with our Primary Care Strategy implementation and includes GPFV influences as well, to ensure an inclusive approach.

Online GP consultation is a key priority for Wolverhampton. Practices are already working at scale to provide GP and nursing appointments on a shared basis across their group(s) via access to the electronic patient record. Further work is underway:

- Information sharing agreements completed to enable working at scale via clinical systems & interoperability where different clinical systems are in use, due to go live late February 2017
- From April 2017 online consultations will go live at group level, enabling practices to work at scale using a range of consultation types (telephone i.e. voice, text or video call, email as well as face to face) & improve access to appointments i.e. reducing waiting times and providing more evening & weekend appointments.
- Incentives attached to this project as part of the 2 year scheme (see investment) has been made available on a recurring basis & included within the baseline budget for Primary Care beyond 2019

All of the above activities will be overseen by our Primary Care Strategy Committee.

Furthermore, there are 9 PMS practices that remain in the city. We will ensure they are duly supported during the transition to alternative contract types (by 2022). As part of the collaborative contract review visits, attention will be given to the practices' business planning to ensure reductions in revenue are reflected. This will provide an opportunity to ensure these reductions in income does not result in a reduction the level of patient facing services already in place. Practices will be encouraged to hold discussions within the respective emerging MCPs to explore opportunities for collaboration & working at scale & will also benefit from participation in the Practice Resilience Programme to ensure a pro-active approach to manage change.

Links Across the STP - Your Health & Care Matter

Place based working across the Black Country STP has, since summer of 2016, focused on how each local Health Economy plans to integrate pathways to achieve the following objectives:-

- Improve the health and wellbeing of local people
- Improve the quality of local health and care services
- Deliver financial stability and efficiencies throughout the local health care system

Priorities from across the Black Country were reflected in the STP Plan ~~that was~~ developed in collaboration ~~among~~ with health & social care partners.

In Wolverhampton we have a small Primary and Acute Care Model and three emerging Multi-Speciality Care Providers. This is helping us to shape primary and community services for the future.

Our priority is to provide care that is easier to access, in the right place, at the right time and affords continuity throughout the patient journey. It follows our focus is to improve access, care continuity & care co-ordination among professionals.

Our Better Health & Care Plan was shared publicly at the end of 2016 & delivery of the plan across the STP is now underway:-

- Regular peer meetings among Primary Care professionals
- Collaborative approach to the provision of admin & reception training
- Black Country GPFV Event planned for 29 March 2017
- Commitment to transform mental health and learning disability services
- Improving maternity and infant health
- Creating a place where people want to work
- Providing the highest quality buildings to deliver health and care
- Improve patient outcomes & increase patient satisfaction
- Get patients and people who use services to the right place at the right time
- Support people to self-care to maximise independence reduce dependence on health & social care services
- Best Practice/Information Sharing workshops are due to commence in April 2017 for all health & social care stakeholders to showcase & develop service provision across the Black Country
- Local Workforce Advisory Board also meeting to ensure consistent approach to workforce challenges & development

GPFV Readiness Overview

There are many strands to the implementation of the GPFV that require support and input from a range of teams/personnel. Early in 2016 our Executive Team reviewed each of the chapters within the GPFV recognising the extent of work required. Each of strands defined within the chapters have been revisited with the Senior Management Team and scored to confirm their current and anticipated status i.e. already underway (score 1 or 2) and our organisational readiness is confirmed (score 3). This will lead to implementation of MCP contracts anticipated in 2018/19 (score 4).

The scores will be subject to regular monitoring and review to ensure timescales are indeed being achieved, these will be agreed with respective leads & managed as part of the Primary Care programme Management Office approach.

	GP Forward View Implementation	
	Key: Please indicate for each initiative (task) below whether (in the DCO view) that CCG is:	
	1) Already implementing	
	2) Ready to begin to implement this year (16/17)	
	3) Will be ready to implement next (i.e. 17/18)	
	4) Aims to implement later (18/19 or 19/20)	
GPFV chapter Ref	Task	Wolverhampton CCG
	Chapter 1 - Investment in General Practice	
5.2	CCG investment of £3 per head population in developing/supporting primary care provision: The CCG investment is designed to be used to: - stimulate development of at scale providers for extended access delivery: - stimulate implementation of the 10 HIC in order to free up GP time to care; - secure sustainability of general practice to improve in hours access	3
1.5	Will have achieved equitable funding of Practices across GMS/PMS and APMS	3
1.7	Development of single LA/CCG investment arrangements into General Practice through Better Care Fund	3

GPFV Readiness Overview

	Chapter 2. - Workforce	
2.1	Plans to increase training in General Practice	1
2.4	CCG supporting Practices to recruit	1
2.5	CCG seeking to recruit GPs from overseas	NA
2.7	CCG has initiatives in place to support GPs retention to return to work or delay leaving General Practice, such as developing portfolio posts, bursary for working in hard to recruit area or other local initiatives e.g. investment in leadership development, coaching and mentoring skills for experienced doctors	3
2.12	Investment in practice nurse measures, including return to work, improve training capacity, increase number of nursing pre-registration placements in primary care, improve retention	1
2.13	Extension of clinical pharmacy working in General Practice	1
2.21	General practice nurses access to mentorship training	1
2.26	CCG supporting practices to implement QNI Voluntary Education and Practice Standards for Practice Nurses	3
2.22	Working with GP Federation to create locum bank (or benefit for more commitment for locums to support General Practice within that CCG area)	3
2.23	Support for GP federations to better manage GP Locum rates	3
2.25	Support Practices to train/use Physicians Associates within General Practice	1
2.27	Practices in CCG have access to and support from Multi-disciplinary training hubs	1 & 2
	Chapter 2 - Workforce initiatives to help manage workload pressures in General Practice	
2.14	Propose use of Community Pharmacy to reduce workload pressures in General Practice	1
2.15	Use of Mental health therapists working directly in support of General Practice	3
2.16	Training of care navigators/medical assistants/reception and clerical staff	2
2.17	Propose to pilot new medical assistant roles to support General Practice	3
2.18	Development of direct patient access to physiotherapists to reduce workload in General Practice	2
2.19	Investment in development of practice managers	3
2.24	DCO to have commissioned support (Occupational Health service) for GPs facing burn out	2

GPFV Readiness Overview

Chapter 3. - Workload		
3.1	CCG accessing new national development programme	1
3.2	CCG supporting programme of self-care for patients	2
3.4	CCG plans to reform and integrate OOHs/111 service	2
3.5	CCG engaged and active participant in new DCO Practice resilience programme	1
3.8	CCG introduced GP access to hospital consultant hotline for advice and support	2
3.9	CCG to support GP Practices to implement New GPIT software to automate tasks	2
3.13	CCG proposes to amend national QOF, and AUA (or other National) Enhanced Services to ease GP workload	3
3.17	CCG developing IT strategy to accelerate moves to paper-free NHS	1
3.18	CCG supporting/encouraging greater GP Practice use of Electronic prescriptions	1
3.20	CCG support for GP Practices to use new (planned) Audit tool to help practices identify how they can reduce demand	1
3.21	CCG support to practices to adopt Automated appointment measuring interface	3
3.23	Promote social prescribing	2
Chapter 4: - Practice Infrastructure		
4.1	CCG submitted schemes and active participant in Estates and Technology transformation programme	1
4.4	CCG has an active NHS LIFT / public/private partnership to develop NHS Premises in local area	1
4.5	CCG/LDP proposals to support patients / practices to take up online patient consultation systems	3
4.6	CCGs are commissioning new core GP IT services	1
4.7	GP Federation / New Model of Care Organisations established across whole CCG which is supporting working / sharing across practices and IT interoperability	2
4.8	CCG has strategy in place to put WIFI services in all GP practices	1
4.9	CCG digital strategy supports delivery of Apps/digital self care	3
4.12	Roll out of pharmacy summary care record across CCG area	1
Chapter 5: Care Redesign		
5.1	Deliver the access commitment, including integration of extended access with out of hours and urgent care, enhanced urgent care services, learning from the GP Access Fund and Vanguard sites to support mainstreaming improvements	2
5.3	CCG propose use of New MCP contract to support 'bigger at scale' primary care provision	4
5.5	CCG funding and supporting protected learning time for practices	1

Chapter 1 : Investment in General Practice

The CCGs increased allocation to primary care in 2017/18 will be 4.9% this will be used to fund local initiatives including:-

- Quality Premium : Incident Investigation Training, Complaints Management Training, Peer Review, Risk Stratification
- Social Prescribing : Develop & improve the inclusion of health services in the city's Directory of Services, commission social prescribing advisors
- New Models of Care : Continued investment in workforce ie Project Management Support, Innovation Bids for working at scale
- Newly Commissioned Pathways : End of Life, District Nursing, MSK, Community Echocardiography, Counselling, Diabetes etc
- DES/LES & QoF Plus : Review of national indicators, development of locally defined quality indicators
- PMS Premium : Enhanced Health in Care Homes, General Practice Peer Review, Reduction in Avoidable Admissions – Asthma , Enhanced Review – COPD

The CCG will fund practice(s)/group(s) via a locally developed 2 year incentive scheme that seeks to build on existing investment to support our emerging MCPs to work at scale and will not **only improve access** but make primary care in Wolverhampton **sustainable for the future**. This will be achieved through a collaborative approach to providing improved access among practices, who will be encouraged to work at scale (within their groups) to offer a range of additional appointments for patients during the evening & weekend. Support staff in addition to GPs are planned: Clinical Pharmacists, Nurses, Counselling & Social Prescribers. The incentive scheme will be underpinned by the principles of the 10 high impact actions in 2017/18 & whilst improving access funds will not be available until 2018/19 we are keen to maintain momentum with work already underway in the city to improve access. Therefore, in 2017/18 we will strive to provide an additional 20 minutes consultation time per 1,000 population rising to 45 per 1,000 population in 2018/19 so that our practices achieve the 2019 milestone.

The **10 High Impact Actions** will be used as the basis for the local incentive coupled with improving access & new appointment systems patients will be actively encouraged to sign up for online services during a series of engagement roadshows planned through 2017 to maximise work in the following areas through working with our partners across health, social care and the private sector:-

- Active Signposting
- New Consultation Types
- Reduce DNAs
- Productive Workflows
- Personal Productivity
- Partnership Working
- Social Prescribing
- Support Self Care
- Develop QI Expertise

Financial Assumptions (based on 262,000 population)	2017/18	2018/19
CCG Recurrent Transformation Support £1.50 per head	£500,000	£500,000
NHS England Improving Access Funding	£0	£967,635
Scheme Value Year 1	£500,000	
Scheme Value Year 2		£1,467,635
Scheme Value Overall	**£1,967,635**	

Success will be overseen by our Primary Care Strategy Committee to ensure our practice groups/MCPs are developing as anticipated as MCPS in our maturity model & patients are not only satisfied with improvements we are making with access but also working with us to strive for continuous improvements that are reasonably achievable.

Investment in General Practice continued

Care Navigation Training

Training for administrative and reception staff will commence in March 2017, our plan has been co-produced with member practices, the Local Medical Committee (LMC) and co-ordinated by the CCG to ensure funds allocated to the CCG are spent in line with NHS England's specification to undertake active signposting and document management. Details of our 3 year plan are detailed below:-

Funding Allocations	programme Content	Allocation
2016/17 : Training for administrative & reception staff (Year 1)	• Review & update of Directory of Service ensuring one central citywide Director of Service is developed & owned by practice staff. • Introductory Training for practice admin staff defining the role of the administrator, care navigation & document management. • Monitoring & effectiveness of new skills acquired from this training will be undertaken in conjunction with our Practice Managers Forum & New Models of Care Leads	£23,000
2017/18 : Care Navigators & Medical Assistants (Year 2)	• Continuation of care navigation & promote every contact counts (MECC) with practice personnel & medical assistants • Relaunch of Directory of Services with stakeholders across the city including Social Prescribing & Promotion of Self Care & Signposting Patients to other sources of support including Pharmacies • Online training for all care navigators & medical assistants, including Practice Managers to demonstrate understanding of new skills & utilisation of the DOS • Provision of peer support & mentoring support for practice groups/MCPs • Patient awareness campaigns including diabetes, smoking cessation, sexual health & other local priorities through collaboration with Public Health and local pharmacies • Commence document management system project to improve administrative activities through a consistent approach to coding & managing patient correspondence	£46,385
2018/19 : Care Navigators & Medical Assistants (Year 3)	• Continuation of awareness & online training provisions, including MECC • Implementation of document management system to enable consistent coding & management of patient correspondence • Monitoring to determine benefits realisation, learning & improvements will continue to take place via our Practice Manager's Forum	£46,220

Oversight of Care Navigation Training plan will take place at the Primary Care Strategy Committee to ensure that each component is duly delivered. Discussions with fellow CCGs from across the Black Country STP continue to take place to explore how we may collaborate providers (announced mid December 2016) continue to take place. A fully worked up plan will be attached in the February 2017 iteration of this plan.

Investment in General Practice continued

Vulnerable Practice Programme

One Wolverhampton practice is already taking part in this programme (commencing January 2017).
The CCG recognises that the contract and content form the basis of a confidential agreement between the practice & provider. The practice has confirmed that it will be willing to share an overview of the findings from the programme to share their learning and outcomes plus any tips and techniques that may be relevant to other practices in the city.

The impact from this programme will be realised once the practice has implemented its new skills & actions to tackle individual difficulties. Ultimately the practice will transition from a CQC rating of "requires improvement" to "good" or "outstanding".

Practice Resilience programme

There are two practices due to commence this programme. Funding has been approved by NHS England.
Both practices will undergo an initial diagnostic interview based on the detail within their respective applications that will focus on resilience:-

- Practice 1 Workforce Planning & Sustainability
- Practice 2 Estate integration & rationalisation

Both practices are from different practice groups/MCPs, they have agreed to share the headline learning and any tips and techniques identified during their participation in the scheme *that can* be shared with other practices/groups in the city.

We will work with our practice groups/MCPs to determine future need as the groups mature with particular emphasis on organisational readiness, responding to demand, demand management appropriate to and reflective of prevalence in the registered population, importance of profile i.e. personal, organisational & collaborative, engaging effectively with stakeholders etc.
PMS practices may also benefit from participation in the Practice Resilience programme to ensure a pro-active approach to managing the foreseen change.

Bids will be submitted for 2017-18 & 2018-19 encompassing each new model of care in place in Wolverhampton. These will enable practices working at scale to strive for the highest standards for their employees and the care they deliver to their patients. They will demonstrate clinical effectiveness and achieve good or better ratings with the regulator as well as be recognised for their leadership & pro-active & reactive management of primary and community care.

Time for Care programme

Expressions of interest have been good from across the city, responses have been compiled and a bid for this programme to address each of the areas of interest is in train. This programme will further support the successful achievement of our 2 year scheme for improving access & working with patients to identify and co-produce solutions for improvement. There will be a number of focused programmes required for Wolverhampton practices. We anticipate approval from NHS England and the training programme(s) commencing ~~in~~ summer 2017.

Investment in General Practice continued

Online GP Consultation

Patient online services: Wolverhampton CCG is working with its practices to achieve 10% sign up for patient online as a minimum for each practice, although many are exceeding the 10% minimum standard. This will rise to 20% from 2017/18. A series of roadshows commenced in December 2016 and have continued to encourage as many patients as possible to sign up. This includes practices where uptake is almost at target and also cohorts of patients who are less likely to sign up. Locally this is encouraging Practice staff to: be competitive to sign up patients: add information to Practice websites; use technology where appropriate e.g. Jayex TV/scroll; deploy 'Pull up' posters around the patch.

Wolverhampton CCG will be working with NHS England GPFV Transformation Team and practices to implement online consultations. The funding for the project is detailed below:

17/18 - £69k
18/19 - £92k

The programme of work to compliment this investment has already begun, online consultations will be live from April 2017, staff training will be taking place in March and patients are already being encouraged to sign up for online services via dedicated roadshows & continued support from practice staff.

Summary Care Record (SCR): SCR has potential to be used by GPs in new models of care where patients are not registered to them. Wolverhampton CCG was awarded £716k for technology projects as part of the ETTF bid. The projects that the funding will support are:

Wolverhampton Shared Care Record - £320k
Wolverhampton Shared Care Record Infrastructure - £80k
All in One Patient Solution - £271K
EMIS Remote Consultation - £45k

Electronic Prescription Services (EPS) R2 and Phase 4: Wolverhampton GPs continue to use EPS very well, and will hopefully take to Phase 4 as easily as they have with EPS R2, thus participating to overall savings for the NHS.

Estate & Technology Transformation Fund

5 successful ETTF bids totally £1.7m
3 cohort 1 schemes have been signed off and to be delivered by NHSPS by March 2017
Remaining schemes in cohort 2 are scheduled for completion by 2019

Investment in General Practice continued

PMS Premium

We are committed to preserving the funds attached to the PMS Premium to enable the continuation of the following projects:-

- General Practice Peer Review
- Reduction in Avoidable Admissions – Asthma
- Enhanced Review – COPD
- Primary In Reach Team – Enhanced Health in Care Homes

These schemes also compliment our Demand Management Plan as we move through 2017-19 improving outcomes for patients and reductions in avoidable spend in the secondary care setting.

Public Health Services

Section 7A funding for public health services is intended to increase in 2017/18. We will continue to work collaboratively with Public Health, as a fellow commissioner, to ensure we are aligned and consistently commissioning primary care services. Recognition is given to the importance of collaborative commissioning both within the Primary Care Quality Outcomes Framework and Section 7A commissioning intentions for 2017/18 including:-

- Immunisation Programmes
- Screening Programmes – cancer & non-cancer
- Quality Improvement to the Child Health Information Services (CHIS)
- Public Health Services for people in prison & other places of detention (including Children & Young People's Secure Estate)
- Sexual Assault Referral Centres

Service specifications & national standards will be overseen as part of our collaborative contract review visit programme. However, should any difficulties or concerns be identified in year, our collaborative working communication and problem solving tool will be used for each eventuality to mitigate the risk of recurrence or continued non-adherance.

Mental Health Therapists

Fully funded practice based mental health therapists will be embedded within our Community Neighbourhood Teams during 2017-18 to support practice groups/MCPs with improved Primary Mental Health Care.

The Mental Health Strategy is currently under review to ensure Primary Mental Health Care is duly recognised & a Mental Health Project Worker is due to commence in post March 2017 to ensure effective shared care agreements are in place & clinically effective for both patients and clinicians (GPs & Consultant Psychiatrists).

In the meantime, there will be increased provision of mental health counselling for patients, accessible at group level on a shared basis, to prevent patients deteriorating in the community and requiring input from specialist mental health services.

Chapter 2 : Workforce

Governance

The Workforce Task & Finish Group cited in our governance structure & attached programme of work has a range of activities detailed within programme of work comprising:-

- Workforce Scoping & Planning
- “Wolverhampton - A Place to Work”
- Career Development for clinical & non clinical staff
- Pilot mapping skills for new primary care service provision models
- Piloting new roles/new ways of working
- Developing a leadership culture within primary care
- Improving & implementing standards of practice
- Increase training capacity in primary care
- Recruitment & retention
- Develop a primary care workforce development strategy

Local initiatives that have been developed in detail include:-

- A Recruitment Fair due to be held in March 2017 as part of our work to improve recruitment & retention in general practice & explore the feasibility of introducing a bank of suitable personnel to improve sustainability & planning across practice groups/MCPs.
- Practice nurse support provided by our Quality Team has enabled: improved links with Wolverhampton University; increase in the number of nurse training placements; provision of mandatory & clinical skills training; a programme of mentorship training for nurses has also been secured following a high level of interest.
- CEPN Project Manager recently appointed on a shared basis with Walsall CCG to focus on recruitment & retention and increasing student placements.

Working at Scale/New Models of Care

Our workforce task and finish group is working hand in glove with the new models of care/practice groups/MCPs in the city and also those practices not yet aligned. Each model of care is outlined in a previous slide confirming size and type of the models we are supporting. The programme of work seeks to ensure that each model is driven to adopt a series of workforce changes that will strengthen each profession in primary care.

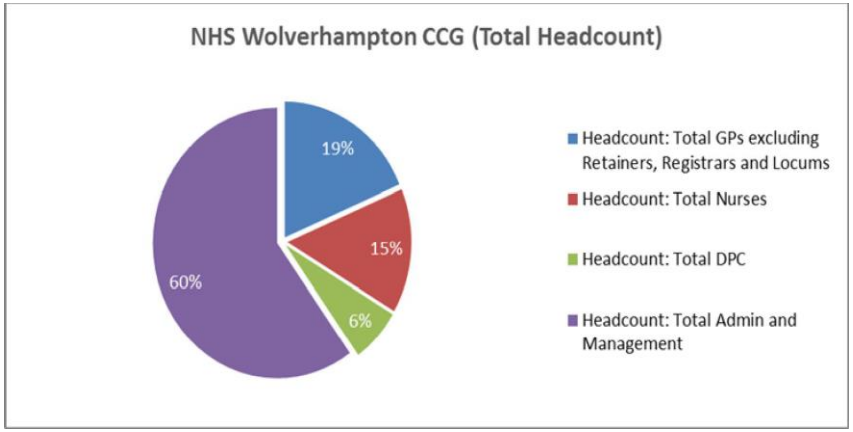
Workforce Risk(s)

Within our Workforce Task and Finish Group their programme of work spans a variety of strands of work pertaining to the development of our workforce, there are however recognised risks including:-

- The age profile of primary care professionals in Wolverhampton, particularly those aged over 54 is 21-31% for GPs, Nurse
- The largest cohort of our workforce are admin/non-clinical personnel which make up 60% of the workforce, 3% more full time equivalents than neighbouring CCGs. A review of back office functions will determine whether this figure is indeed based on need and sustainable for the future.
- Improved access to primary care will become a burden to individual practices if they do not work at scale
- Care navigation is in it's infancy in Wolverhampton, in 2017-19 greater impact in line with the 10 high impact actions will mitigate this risk further
- Continue to work with Wolverhampton University to secure General Practice placements for Physicians Associates (current cohort 20 trainees) across each of our new models of care (emerging MCPs and PACs)
- Loss of student placement sites in Wolverhampton will result in placement with out of area practices
- Risks pertaining to the role of clinical pharmacist were initially unattractive employment options for clinical pharmacists however this risk has been mitigated by a further round of bids to NHS England for 3 years support with funding. Also due to varying funding models and approaches to recruiting Clinical Pharmacists robust clinical networks are being established in the city
- There are 260,037 patients, Wolverhampton has 196 more patients per GP and 62 patients fewer per nurse compared to national benchmarks this is closely linked to the importance of exploration & development of other roles if we are to achieve a sustainable primary care for the future

The following slides provide more detailed information regarding our workforce detailing our headcount, full time equivalents, age profile and workforce compared with patient numbers.

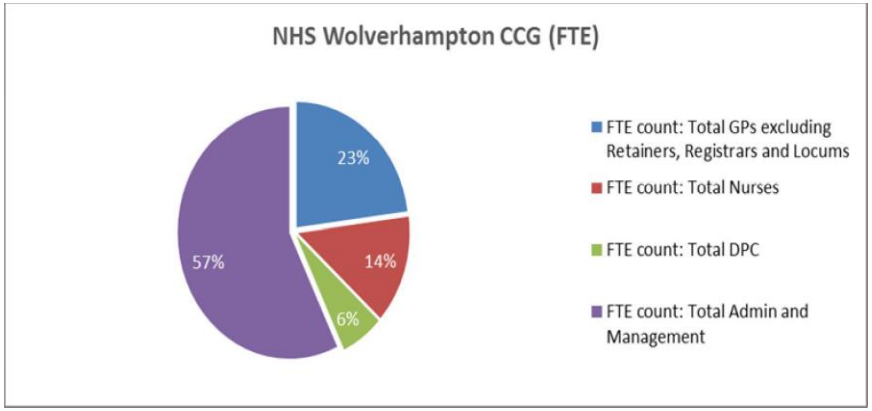
Headcount



Staff Group	Headcount
GPs (excluding Retainers, Registrars and Locums)	**139**
Nurses	**111**
of which Advanced, Specialist and Extended Nurse Roles	*29*
of which District Nurses	*0*
Total Direct Patient Care (DPC)	**49**
of which Therapists (DPC)	*0*
of which Pharmacists (DPC)	*2*
of which Physician Associates (DPC)	*0*
Admin/Non-Clinical	**447**

- In NHS Wolverhampton CCG, there are 139 GPs (excluding Retainers, Registrars and Locums), which make up 19% of the practice workforce
- The largest workforce group is admin/non-clinical, which make up 60% of the workforce, with a headcount of 447
- There are 4% more admin/non-clinical staff in NHS Wolverhampton CCG and 2% fewer GPs when compared with the national percentages (see appendix 5 for national analysis).

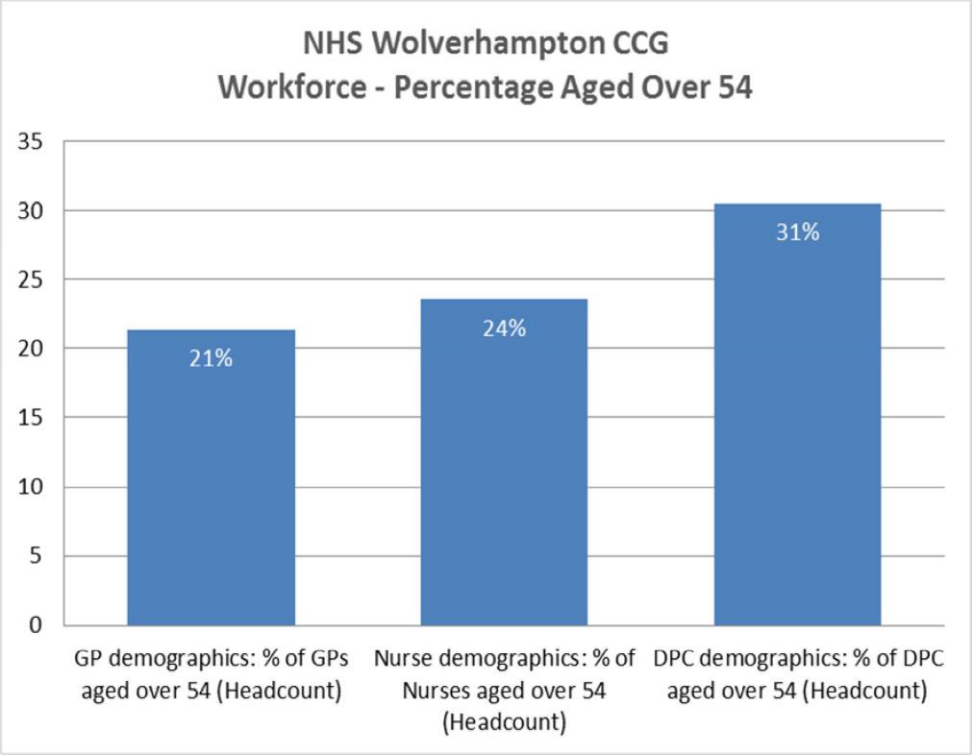
Full Time Equivalents (FTE)



Staff Group	FTE
GPs (excluding Retainers, Registrars and Locums)	**125**
Nurses	**75**
of which Advanced, Specialist and Extended Nurse Roles	*22*
of which District Nurses	*0*
Total DPC	**34**
of which Therapists (DPC)	*0*
of which Pharmacists (DPC)	*1*
of which Physician Associates (DPC)	*0*
Admin/Non-Clinical	**311**

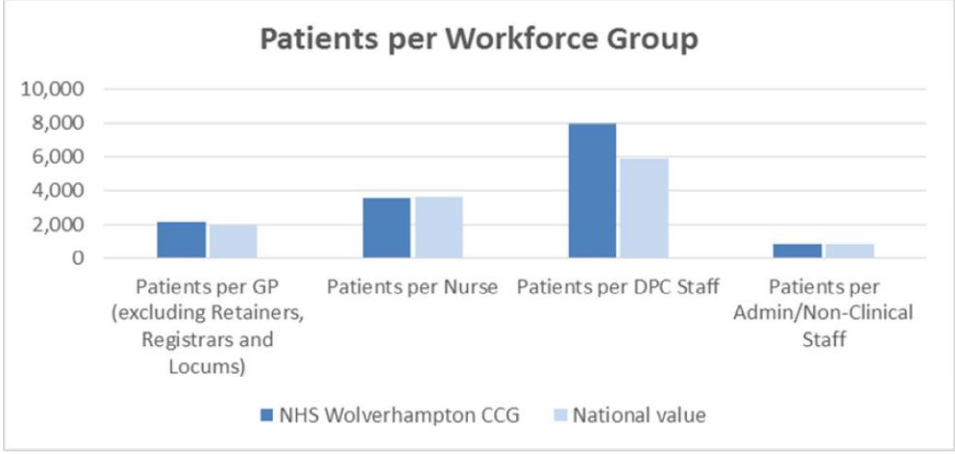
- In NHS Wolverhampton CCG, there are 125 FTE GPs (excluding Retainers, Registrars and Locums), which make up 23% of the practice workforce
- The largest workforce group is admin/non-clinical, which make up 57% of the workforce, with 311 FTEs
- There are 3% more admin/non-clinical FTEs in NHS Wolverhampton CCG when compared with the national percentage and 2% fewer GP FTEs (see appendix 5 for national analysis)
- In secondary care, the proportion of clinical staff to non-clinical staff is significantly higher than in general practice, with only 25% of staff being non-clinical (see appendix 5)

Age Profile of Workforce



- Over one fifth of GPs and nurses in NHS Wolverhampton CCG are aged over 54
- Almost one third of the DPC workforce are aged over 54

Workforce Compared with Patient Numbers



Staff Group	Numbers
FTE: Total GPs (excluding Retainers, Registrars and Locums)	125
FTE: Total Nurses	75
FTE: Total DPC	34
FTE: Total Admin/Non-Clinical	311
Total Patients	269,037
Patients per GP (excluding Retainers, Registrars and Locums) FTE	2,147.8
Patients per Nurse FTE	3,572.4
Patients per DPC FTE	7,971.5
Patients per Admin/Non-Clinical FTE	864.4
GP FTEs (excluding Retainers, Registrars and Locums) per 1,000 Patients	0.47
Nurse FTEs per 1,000 Patients	0.28
DPC FTEs per 1,000 Patients	0.13
Admin/Non-Clinical FTEs per 1,000 Patients	1.16

- There are 269,037 patients in NHS Wolverhampton CCG
- In relation to the workforce, this totals:
  - 2,148 patients per GP
  - 3,572 patients per Nurse
  - 7,972 patients per DCP
- When compared with the national analysis (see appendix 5), in NHS Wolverhampton, there are:
  - 196 more patients per GP
  - 62 fewer patients per Nurse
  - 2,065 more patients per DPC

Chapter 3 : Workload

Clinical Pharmacist(s) Working Practices

Investment has already begun from a variety of practices across the city - some are involved in the national pilot(s). Bids are currently being prepared by the emerging MCPs , with support from the CCG to enable them to not only introduce the role but also begin to experience the benefits of care redesign.

The role of clinical pharmacist has been promoted with GP colleagues it is recognised as an asset to the practice team. Our medicines optimisation team have oversight of the training and development of Clinical Pharmacists.

Development Programmes

A number of practices are participating in development programmes available via NHSE including:-

- Vulnerable Practice programme (1 Practice)
- Practice Resilience programme (2 Practices)
- Time for Care programme (1 group already commenced, 2 further groups anticipated in 2017/18)

Practice Manager Development

Practices attended a regional workshop held in December. Those unable to attend received a copy of the presentation & the topic will be discussed at our local Practice Manager Monthly Meeting. The launch of the Practice Manager Development Programme has been embraced locally, implementation is due to commence shortly. Attendance will be monitored via the General Practice Transformation Board & locally via our Primary Care Strategy Committee.

Selfcare for Patients

As one of the 10 High Impact Actions our local incentive scheme will maximise the opportunities to encourage self-care in all contacts. Practices will promote messages consistent with Choose Well, promoting healthy lifestyle messages (Making Every Contact Count) and proactive self- management of long term conditions through patient-held management plans or training courses & expert patient programmes. We are also exploring the introduction “The Sound Doctor”, a video and online resource to assist patients with condition specific self care.

Practice groups/MCPs are also working with Pharmacy Champions as part of the Healthy Living Pharmacy initiative to promote self care for patients will be delivering a series of campaigns together both in practices and pharmacies across the city.

Access to Consultant Hotline

In line with the national CQUIN for acute hospitals, there is a commitment to further improve advice & support for GPs from secondary care consultants. Consultant Connect is a conduit to enable joint working between primary and secondary care. The Consultant Connect model is a fully supported service and software platform that allows GPs to access immediate telephone advice and guidance from local hospital specialists during a patient consultation to discuss the presenting symptoms. In CCGs where the system has been implemented this has significantly reduced the number of referrals to secondary care. We anticipate implementation of Consultant Connect, in addition to existing support available via Advice & Guidance in 2017.

Ten High Impact Actions – Service & Care Delivery Improvement Map

High Impact Action	Benefits for practice	Benefits for patients	Short Term plan 6 months	Medium Term Plan 12-18 month	Longer Term Plan 24 months +	Measures of success and triggers for practices to receive payment
1 Active signposting Patients towards the most appropriate source of help to include Web and app-based portals which provide self-help resources	Frees GP time. Makes more appropriate use of each team member's skills. Reduces internal referrals.	Improves appointment availability. Reduces low-value consultations and onward referrals. Shorter wait to get to see the most appropriate person.	Reception staff training Social Prescribing Link Workers in post. Agree definitions of low value consultations Monitor the numbers of patients supported by Social Prescribing Link Workers Monitor the impact of SP on number patients supported by the service Enhanced Directory of Services available locally (WIN)	DOS embedded across health & social care sectors Online Care Navigation Training Medical Assistant(s) Role embedded		Number of patients supported by social prescribing Reduction in attendances at practice by patients supported by social prescribing Numbers of patients accessing online directory Reduction in the number of low value consultations
2 New consultation types, such as phone and email.	Shorter appointments (eg phone consultation average 50% shorter, 66% dealt with entirely on phone). More opportunities to support self care with e-consultations, text message follow-ups and group consultations.	Greater convenience, often no longer requiring time off work/caring duties. Improves availability of appointments. More opportunities to build knowledge, skills and confidence for self care.	Phone Consultation Set baseline of phone consultations by practice. Agree trajectory of increasing the % of all consultations undertaken by phone over 6 month, 12-18 month and 24+ months. Complete public awareness campaign on the benefits of telephone consultation and the clinical presentations where this would be appropriate.	E-Consultation improved uptake & availability to patients Simple Telehealth Group Consultations		Number of contacts using new consultation types Increase in number of consultations completed by phone Numbers of patients taking part in group consultations
3 Reduce DNAs	Free GP time. Easier to avoid queues developing, through more accurate matching of capacity with demand.	Improves appointment availability.	Set baseline of DNA rates by practice. Review of practice DNA policies. Agree trajectory of improving attendance rates over 6 month, 12-18 month and 24+ months. Text Messaging to confirm appointments Patients completing appointment cards Appointment Reminders by text Practices reporting attendances (e.g. number of appointments booked and attended)	Telephone follow up Primary Mental Health Strategy implementation		Reduction in practice DNA rates from baseline levels
4 Develop the team	Frees GP time. Makes more appropriate use of each team member's skills. Reduces internal referrals. Improved job satisfaction for administrative staff undertaking enhanced roles.	Improves appointment availability. Reduces low-value consultations and onward referrals. Shorter wait to get to see the most appropriate person.	Workforce training and development programme ie Time for Care, Practice Resilience & Practice Manager Programme	Physician Associates Mental health Support Workers Nursing Associates Admin & Reception Staff/Medical Assistants Practice Managers Practice Pharmacists Minor Illness Nurses		Number of contacts delivered by non medical practice staff Activities undertaken by Medical Assistants
5 Productive work flows Introduce new ways of working which enable staff to work smarter, not just harder.	Frees time for staff throughout the practice. Reduces errors and rework. Improves appointment availability and patient experience.	Improves appointment availability and customer service.	Better work flow for prescriptions, letters and queries	As above Consider ways to release GPs from administrative tasks		Number of additional appointments generated as a result Positive patient experience ie GP Survey/FFT etc
6 Personal productivity Support staff to work in an optimal fashion by reducing waste in routine processes	Frees clinicians to do more in each consultation, with fewer distractions and frustrations. Improves staff wellbeing and job satisfaction.	Improved quality of consultations, with more achieved. Reduced absence of staff.	Computer confidence & greater use of IT (patients/practice staff) Continued support for both individual & team resilience Less administrative work undertaken by clinicians Longer appointment slots for complex patients	Sustained improvement in use of clinicians time		
7 Partnership working Practices working at scale offers benefits in terms of improved organisational resilience and efficiency,	Frees GP time, makes best use of the specific expertise of staff in the practice. Creates economies of scale and opportunities for new services and organisational models.	Access to expanded range of services wrapped around the patient in the community. Reduces delays introduced by referrals to different providers.	Implementation of the Consultant Connect platform or the further development of the Advice and Guidance. Training and development required for both these systems.	Practices working at scale Direct Access to Therapists Work collaboratively with specialists Healthy Living Pharmacies		Number of additional appointments generated through collaborative working Number of direct access referrals to therapists Reduction in the number of referrals to secondary care Number of appointments for patients registered at another practice
8 Use social prescribing Refer or signpost patients to services which increase wellbeing and independence.	Frees GP time, makes best use of their specific medical expertise.	Improved quality of life. Improved ability to live an independent life.	Social Prescribing (12 month pilot intially with commitment to extend) Monitor the numbers of patients supported by Social Prescribing Link Workers Monitor the impact of SP on number of attendances at the practice by patients supported by the service	Reduction in patients who are socially isolated Improved physical/ mental wellbeing & independence GP time freed up for patients with complex needs		Number of patients supported by social prescribing Patient feedback positive experiences of care GP Survey & Complaints/Compliments Improved patient outcomes including reduced presentations within urgent care system
9. Self Care	Frees GP time, makes best use of their specific medical expertise.	Improved ability to live an independent life.	Number of staff in practice completing MECC training Numbers of patients with Long Term Conditions taking part in a LTC review – with a defined self care component Reduce dependance on community neighbourhood teams	Continued reduction in dependency on practice / community neighbourhood team		Number of patients taking part in a comprehensive long term conditions review Number of referrals to Stop Smoking Services Number of referrals to Drug and Alcohol services
10 Build QI expertise	Improved ability to achieve rapid, safe and sustainable improvements to any aspect of care. Increased staff morale and sense of control.	Assurance of continuous improvement in patient safety, efficiency and quality of care.	Timely care provided closer to home Continued co-production of improved service provision through working with PPGs & engaging with population Cohesive team working & commitment to continuously improve care & service quality	Reduction in negative care & service experiences Multi-disciplinary Team Work fully embedded at Practice/Group & Community Neighbourhood Team level		Practice undertaking 1 comprehensive QI project per year. Practice Group & Community Neighbourhood Team Service Quality Dashboard Performance

Workload continued

GP IT Automated Tasks

The IM & T team within the CCG actively review new opportunities to support GPs automation against set criteria to ensure they are viable, time saving and cost efficient.

Wolverhampton CCG are already working on a number of projects these include working in collaboration with GPs to support the development of automated tasks. The Integrated referral forms project was carried out with GPs to ensure that forms are easily accessible via the GP's clinical system. These forms auto populate to ensure that the GPs save time and forms are in the correct format.

The development of the Wolverhampton Shared Care Record project has an end of life module. This supports the auto population of the care plan with demographics and allows the easy transfer data from the clinical system into the plan. This plan will then be accessible across the whole of the Wolverhampton Health economy and can be updated by clinical staff throughout the health economy

Chapter 4 : Practice Infra-structure

Chapter 4 of the GPFV focusses on practice infra-structure. Our Estates and IT Task and Finish Groups have established work programmes detailing projects in place for each of the following areas:-

Project	Start	Completion	Funding Allocation(s)
ETTF Technical ETTF bids was awarded to Wolverhampton CCG to develop three areas • The Wolverhampton Shared Care Plan incorporating Primary care data, secondary care data (Acute, Community & Mental health) and Social care data. • EMIS Remote Consultation -The provision of access to GP clinical systems to view, book appointments and record consultation information on clinical systems within federated GP groups. • ALL in One Patient Solution - The provision of an advanced auto arrival solution that supports the delivery of Health information and the recording of friends and family through a questionnaire module.	01/11/16	31/03/17	£716k
Online Consultation & Interoperability Wolverhampton CCG will be working with NHS England GPFV Transformation Team and practices to implement online consultations.	01/04/2017	31/03/2020	Funding allocation based on National formula
WIFI in Practices Wolverhampton CCG is one of NHS Digital's Wi-Fi early adopters and will complete the roll out of Wi-Fi in GP Practices by 31st March 2017	01/09/16	31/03/17	£168K to include up front costs and two years running costs
Apps to Support Self Care The Wolverhampton Shared Care Record will provide a patient portal to the whole Wolverhampton Health Economy. This will support patients to view their own record and will develop to support the use of wearable's and monitoring devices.	01/04/17	31/03/19	

Chapter 5 : Care Redesign

During 2016 our new models of care have gained momentum in their development that has lead to their capacity and capability being strengthened. Each model of care is committed to tackling the challenges faced in primary care.

Practices took part in a range of Extended Access Schemes that commenced on 24 December:-

- 6 practices provided additional capacity during the Xmas & new year bank holiday(s)
- 7 practices providing additional capacity in hours
- 17 practices participating in group level cover within Primary Care Home (1&2) providing additional capacity for their patients on each Saturday morning from 24 December through until 4 March 2017 funded by the CCG, NHSE & A&E Delivery Board. Cover is provided from 3 sites across the city.

Schemes were designed to alleviate pressure on the urgent care system, initially during the Christmas and new year period, & some extended through until the end of February. We have worked closely with our urgent care lead to assess and manage demand, this has enabled stronger working relationships between 111 and our Urgent Care Centre and practices working together during what is anticipated to be a particularly challenge period. Improved access from 2017 onwards will be achieved by practices working together to provide further appointments during the evening & weekend providing not only GP appointments but also nursing and clinical pharmacists.

Enhanced Health in Care Homes Framework

In order to optimise the health of our population we will continue to build on measures already in place to improve health outcomes for patients in care home settings. Enhanced primary care support will continue based on work of the Primary In Reach Team (PITs) to ensure all homes have consistent GP & primary care cover.

Risk stratification will be undertaken at practice level in conjunction with their designated community matron to identify patients at high risk of admission in order to pro-actively review their care needs and develop a patient centred care plan designed to meet their individual needs. Working in this way enables a number of professionals to work together to develop a multi-disciplinary approach to managing the patients needs with holistic care yet encouraging the patient to own their plan and play a role in self management with support when needed. This approach seeks to reduce unplanned admissions to hospital and provides the patient with a named accountable individual who is responsible for their care co-ordination.

Sustained reduction in admissions to hospital, consistent care for residents in care homes are key outcomes that will demonstrate success. High quality end of life care and reduced length of stay as well as continued clinical quality improvement measures overseen by our Quality Nurse Team are examples of how we measure success Also attached are a series of supporting documents that further demonstrate how we will maximise care redesign including our Primary Care Strategy, Strategy Programme of Work, Operating Plan 2017-19 and STP Plan on a Page.

As we move away from locality level meetings & clinical networks and align with MCP/practice group working we are able to ensure that practices remain engaged in continued development of working at scale & implementation of CCG plans as they mature to be an MCP. Practices have long standing arrangements in place for back fill to enable participation in protected learning, this will continue in future years.

Primary Care - New Models of Care

NHS
Wolverhampton
Clinical Commissioning Group

Aim

Wolverhampton's Primary Care Strategy is underpinned primarily by delivery through a Multi Speciality Community Provider (MCP) contracting model, delivered by care hubs supported by integrated teams.
The introduction of care hubs enable the new care model to deliver improved access, improved care co-ordination and continuity of care in the community whereby care can be provided closer to home and in the community setting as far as reasonably practical.

Scope

- Primary Care Strategy implementation focussing on practice groupings, commissioning at scale provision, estate & IT developments, and clinical & non clinical workforce to cultivate group functionality with new roles to strengthen functionality.
- Community Neighbourhood Teams, wrapped around groups of practices including community matrons, specialist nurses (including paediatrics), social workers, mental health services and the voluntary sector who will oversee patient care.
- Patients will benefit from enhanced care navigation enabling greater choice and shared decision making, advice and support
- Practices working at scale and in close collaboration with out of hours services to enable 24 hour cover in the right place at the right time
- MCPs commissioning services from providers based on population need
- Sustainability of service review based on population need demographics

Partners

- Wolverhampton Care Collaborative, Wolverhampton Total Health and Unity Wolverhampton (MCPs)
- Royal Wolverhampton Trust
- Black Country Partnership Foundation Trust
- Healthwatch Wolverhampton
- Private & independent sector providers
- City of Wolverhampton Council
- NHS England

Status

- Year 1 of 4 year implementation plan
- Primary Care Home (ministerial visit to PCH site November 2017; Wolverhampton Total Health & Wolverhampton Care Collaborative)
- 2017/18 Shadow year (Alliance Agreements)
- 2018/19 MCP Contracts awarded (Partial Integration MCP)
- 2019/20 MCP Contracts awarded (Fully Integrated MCP)
- 2020/21 Business as usual (performance & contract monitoring)

STP Footprint

Black Country

V6.4 January 2017

New Models of Care (Wolverhampton)

NHS
Wolverhampton
Clinical Commissioning Group

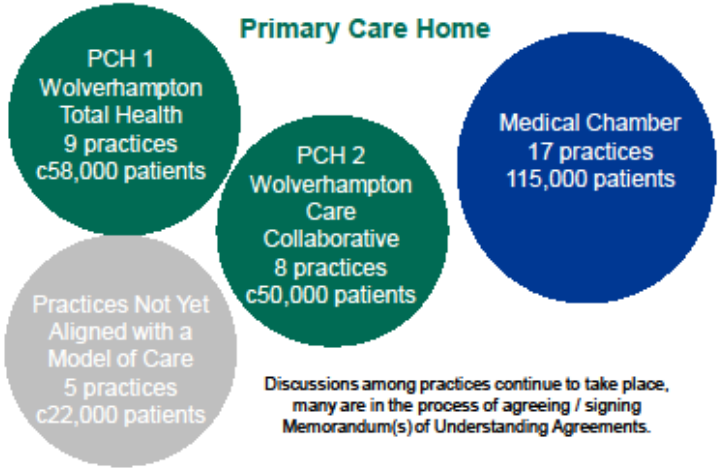
Multi-speciality Care Provider is a new deal for GP's as part of the 5 Year Forward View. This would take the shape of being a collaboration of a group practices i.e. federations, networks or single organisation(s). This is not only an opportunity to standardise back office functions and avoid replication but also a way of expanding leadership to include many healthcare professionals. Across the grouping there will be a collaborative approach to service provision whilst there will be a greater convenience for patients shifting the majority of outpatient consultations & ambulatory care out of hospital settings.

Primary & Acute Care Systems (PACs/VI) is a collaboration between NHS Trusts and GP Practices to meet the needs of registered list(s) of patients. This is an opportunities for trust's to kick-start primary care expansion but reinforce out of hospital care which could evolve into taking accountability for all health needs of a registered list of patients. Part of Vertical Integration is a greater level of back office support which is intended to improve the business element of General Practice.

Vertical Integration (VI)

Primary Care Home is a joint NAPC and NHS confederation programme. Primary Care Home Model is based on care hubs/neighbourhood approach. Supported by the new models programme featuring provision of care to a defined, registered population between 30-50,000 people, function with an integrated workforce with a strong focus on partnerships spanning primary/secondary/social care, a combined focus on the personalisation of care with improvements in population health outcomes, alignment of clinical & financial drivers with appropriate shared risks and rewards.

Primary Care Home



Discussions among practices continue to take place, many are in the process of agreeing / signing Memorandum(s) of Understanding Agreements.

Group Governance Arrangements

CCG Practice Group Governance Arrangements

PRIMARY CARE NEW MODELS OF CARE & MEMBERSHIP GOVERNANCE
Demonstrating clinical effectiveness through implementing the CCG's Primary Care Strategy, responding to the General Practice Five Year Forward View (GP5YFV) & making primary medical services fit for the future.

Priorities:-
Clinicians involved in & influencing care pathways & decision making
Peer Review focusing on Right Care Pathways & reducing variation, improving quality of care
Demand Management including patient choice, referral management and improved outcomes for patients
Risk Stratification (using Aristotle & other clinical data to ensure patient need is met through patient centered and co-ordinated care

Delivery Toolkit:-

Peer Review
Direct access for GPs to Consultant advice

NICE Quality Standards/ TAGs

Aristotle & EMIS

Quality Assurance (safety, experience & effectiveness)

Indicators of Success:-
Increased liaison with secondary care consultants, reduced referrals
Patient care provided closer to home as services transfer into community settings
Improved access ie online, telephone, text consultations, extended opening, 7 day services
Quality Outcomes Framework (National & Local) Monitoring

GENERAL PRACTICE GROUP MEETINGS (Quarterly)
Lead by Nominated Group Leaders:-
Primary Care Home 1
- 9 Practices
- c60,000 patients

Primary Care Home 2
- 8 Practices
- c53,000 patients

Medical Chambers
- 17 Practices
- c115,000 patients

Vertical Integration
- 4 Practices
- c25,000 patients
- Potentially further practices

Remaining Practices
- 5 Practices
- c21,000 patients

Priorities for discussion:-
- Principles of Good Governance
- Monitor Performance (demand, finance & contracts, risk assurance)
- Assisting in consistent commissioning of health services
- Demonstrating local ownership of the group's vision & values
- Demonstrating the furtherance of group working & provision of care closer to home

GROUP LEADER MEETINGS (Monthly)
Lead by the CCG Chairman:-
Primary Care Home : 1) Dr G Pickavance & 2) Dr P Mundlur
Medical Chambers : C Dr K Ahmed
Vertical Integration : Dr J Parkes
Director of Strategy & Transformation
CCG Head of Primary Care

Priorities for discussion:-
- Good Governance including GPs Vision, Values & Issues
- New Models of Care : Care Closer to Home, Information Sharing, Consistent Commissioning, Performance
- Practice development & educational requirements (ie Team W)

CCG MEMBERS MEETINGS (Quarterly)
Lead by the CCG Chairman:-
Attendance from Practices, Primary Care Groups & CCG personnel

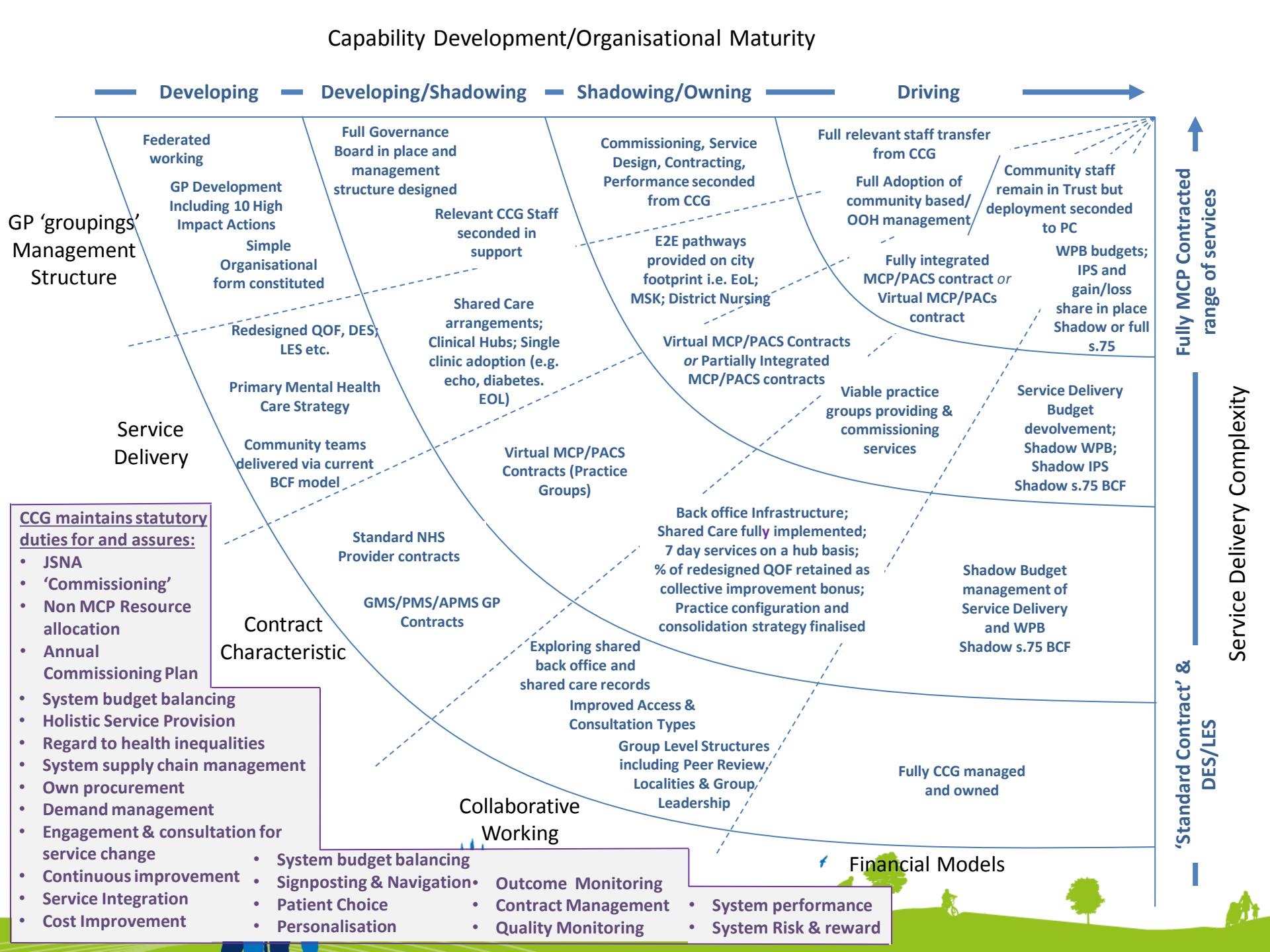
Priorities for discussion:-
- Practice Developments
- Primary Care Updates
- Opportunity for all practices to come together & exchange information/ receive updates

Other forums with an interest in Primary Care:-
- Clinical Reference Group
- Primary Care Commissioning Committee
- Primary Care Strategy Committee (delivery board)
- Governing Body

New Models of Care - Implementation Timeline

Organisational Development Plan

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
Primary Care Strategy Implementation	*Back office function review *Practice groups forming *MOUs signed & commenced new ways of working *Ten high impact actions scoped	*Launch 10 high impact action projects (IT etc) *Introduce new roles (Workforce ie Clinical Pharmacist, Mental Health Therapist, Nurse Associate, Physicians Associate & additional GPs) *Strengthen CNTs via our Better Care Programme (Specialist Nurses & Paediatrics) *Improved access (7DS) *Care Navigation; Active Patient Management; Social Prescribing all in place	*Sustain benefits from 10 high impact actions *Co-location of practices & services *Practice mergers - fewer/larger practices *Estate Strategy finalised *Estate Transformation Phase 1	*7 day primary & community services lead by practice groups via MCP contracting route *Estate Transformation Phase 2	*Business as usual for fully implemented model(s) of care including Contract Management, Risk Management, Finance & Performance & Clinical Effectiveness *Estate Transformation Phase 3
New Models of Care (MCP Framework) Primary Care Home 1&2	*Wolverhampton Care Collaborative & Wolverhampton Total Health (companies limited by share) *Priorities identified & responsive plans Launched	*Shadow Year NHS Contract practice/group *Strengthen infra-structure i.e. Business Management etc. *Development of risk adjusted capitated budgets	*MCP Partial Integration of primary & community services *Risk adjusted capitated budgets (shadow year) *Some services continue to be commissioned by CCG	*MCP Full Integration primary & community services (potential inclusion of out of hours strand of urgent care) *Full capability of acting as a lead integrator or as part of a lead integrator model and commissioning & sub-contracting service providers *Risk adjusted capitated budgets (fully integrated)	*Business as usual contracts monitored as all other providers *Provider Contract Review Meetings *Provider Clinical Quality Review Meetings
Medical Chambers	*Unity Wolverhampton (federation) *Alliance working without formalities of limited company *Priorities identified & responsive plans Launched	*Formation of limited company & associated Governance *Strengthen infra-structure ie Business Management etc.			
RWT PACs/VI	*Practices sub contract GMS to RWT *Practice staff employed by RWT	*Development of risk adjusted capitated budgets *See Checkpoint(s) below	*Risk adjusted capitated budgets (shadow year) * See Checkpoint(s) below	*Risk adjusted capitated budgets (fully integrated) *See Checkpoint(s) below	*Business as usual
Commissioned Services – Working at Scale MCPs Providing & Sub Contracting Services	*Enhanced Primary Care Schemes for delivery 2017/18 fully worked up (by Q4) *Consult on service specifications Q4 *Ten High Impact Actions launched *Peer Review of RightCare Pathways *Development of Local Quality Outcomes Framework/Incentive Scheme *Identify areas for priority investment based on population need	*Small scale service provision (EPCS) *Embed ten high impact actions (7DS , reduced DNAs etc) *Phase 1 services/pathways specified & commissioned from MCP; Frail Elderly, Diabetes, EOL, *Phase 2 services/pathways Community services planned *'RightCare' Pathways including LTC Management being addressed by MCPs *Commence transfer or services to community setting i.e. diagnostics (community ECG Reporting & Echo Clinics)	*MCPs & CCG both commissioning different aspects of community services *Including those carried forward from 2017/18 & new services defined in Commissioning Intentions *Roll out of Phase 2 Community Services commissioned from MCPs *Plan service requirements in preparation for full Community Service MCP delivery	*MCPs commissioning/ sub-contracting services i.e. EOL/Community Services, Out of Hours *Full MCP Community services procurement	*Business as usual of at scale delivery of MCP commissioned primary & community Services
Development Support Primary Care Home 1&2	*Project Manager & Gap Analysis (Q2) aligned with PCS Committee *Branding & patient engagement (Q4) *Scope extent of variation among practices & begin standardised approach (Q4)	*CCG based commissioning Support roles including contracting, redesign/ transformation, BI & finance aligned to each group to address business management requirements (secondment/ new posts) *Develop clinical leadership *Continue to reduce variation & improve care quality *Ownership & management of demand ie referrals management & reduce variation	*Continued ownership & management of Demand on services (all sectors) *Benefits realisation of primary care clinical leadership *Commissioning and provision roles confirmed & staff employed/seconded to MCP(s) *Functional business infra-structure Implemented	*Continued development of organisational form & functions	*Business as usual
Medical Chambers					
RWT PACs/VI	*Project Manager & Gap Analysis (Q3) aligned with PCS Committee *Branding & patient engagement (Q4) *Scope extent of variation among practices & begin standardised approach (Q4)				
	*Project support (Q1→) *First Wave June 2016 (x3 practices) *Second Wave Feb 2017 (2x practices) *Development of trust integration team	* See Checkpoint(s) below	* See Checkpoint(s) below	* See Checkpoint(s) below	*Business as usual
Measuring Success – Dashboard(s)	*Dashboard development & launch * Care Navigation; Active Patient Management; Social Prescribing *Demand Management *Risk stratification & co-ordinated care	*Quarterly monitoring of clinical outcomes *Clinical effectiveness/use of resources *Patient choice & shared decision making *Pro-active approach to population care needs	*Introduce contract & clinical quality review processes to monitor finance, performance & clinical outcomes & reduce variation *Clinical effectiveness/use of resources	*Continuous improvement in all aspects of successful models of care *Strive for consistent	*Business as usual contracts monitored as all other providers *Provider Contract Review Meetings *Provider Clinical Quality Review Meetings


Capability Development/Organisational Maturity
Developing
Developing/Shadowing
Shadowing/Owning
Driving
GP 'groupings' Management Structure
Service Delivery
Contract Characteristic
Collaborative Working
Financial Models
Federated working
GP Development Including 10 High Impact Actions
Simple Organisational form constituted
Full Governance Board in place and management structure designed
Relevant CCG Staff seconded in support
Commissioning, Service Design, Contracting, Performance seconded from CCG
Full relevant staff transfer from CCG
Full Adoption of community based/ OOH management
Community staff remain in Trust but deployment seconded to PC
E2E pathways provided on city footprint i.e. EoL; MSK; District Nursing
Fully integrated MCP/PACS contract or Virtual MCP/PACs contract
WPB budgets; IPS and gain/loss share in place Shadow or full s.75
Redesigned QOF, DES; LES etc.
Shared Care arrangements; Clinical Hubs; Single clinic adoption (e.g. echo, diabetes. EOL)
Virtual MCP/PACS Contracts or Partially Integrated MCP/PACS contracts
Primary Mental Health Care Strategy
Community teams delivered via current BCF model
Virtual MCP/PACS Contracts (Practice Groups)
Viable practice groups providing & commissioning services
Service Delivery Budget devolvement; Shadow WPB; Shadow IPS Shadow s.75 BCF
Standard NHS Provider contracts
Back office Infrastructure; Shared Care fully implemented; 7 day services on a hub basis; % of redesigned QOF retained as collective improvement bonus; Practice configuration and consolidation strategy finalised
Shadow Budget management of Service Delivery and WPB Shadow s.75 BCF
GMS/PMS/APMS GP Contracts
Exploring shared back office and shared care records
Improved Access & Consultation Types
Group Level Structures including Peer Review, Localities & Group Leadership
Fully CCG managed and owned
Fully MCP Contracted range of services
'Standard Contract' & DES/LES
Service Delivery Complexity
CCG maintains statutory duties for and assures:
JSNA
'Commissioning'
Non MCP Resource allocation
Annual Commissioning Plan
System budget balancing
Holistic Service Provision
Regard to health inequalities
System supply chain management
Own procurement
Demand management
Engagement & consultation for service change
Continuous improvement
Service Integration
Cost Improvement
System budget balancing
Signposting & Navigation
Patient Choice
Personalisation
Outcome Monitoring
Contract Management
Quality Monitoring
System performance
System Risk & reward

General Practice Forward View - Overview of Actions

Chapter	Requirement	Action(s)	Lead	Timescale(s)	Status
1	CCG Incentive Scheme (£1.50 per head 2017/18 & 2018/19	Finalise co-produced 2 year incentive scheme for practices underpinned by continuous improvement in each of the 10 High Impact Actions at practice/group level. Overseen by Primary Care Strategy Committee	Ranjit Khular	2-17-18	Scoping
1	Develop Community Neighbourhood Teams	Strengthen community neighbourhood teams to include paediatrics, mental health, social worker & wound care /specialist nurses & direct access to Physiotherapy	Andrea Smith	2017-18	Started
1	Achieve equitable funding across all contract types	Continue phase out PMS contracts offering planning support to practices involved & equitable funding as far as reasonably possible.	Vic Middlemiss	2017-18	Started
2	Increase Training in General Practice Recruitment & Retention including recruiting Physician's Associates Practice Nurse Development Multi Disciplinary Training Hub Training Care Navigators / Medical Assistants, Admin & Reception Staff Pilot new Medical Assistant Role Mental Health Therapists role Practice Manager Development	Workforce Task & Finish Group programme of Work	Manjeet Garcha	2016	Started
2	Community Pharmacy Workload/Utilisation Clinical Pharmacist Role	Clinical Pharmacist Task & Finish Group programme of Work	David Birch	2016	Started

General Practice - Overview of Actions continued

Chapter	Requirement	Action(s)	Lead	Timescale(s)	Status
3	Accessing new national development programme ie Practice Resilience Programme Time for Care programme	General Practice Transformation Board & CCG Training Tracker in place, monitored via Workforce Task & Finish Group, reported to Primary Care Strategy Committee. Events co-ordinated & overseen by CCG Primary Care Team. Learning from all training provision(s) are shared at high level with all practice groups/MCPs to ensure tips & techniques are available to non attenders.	Sarah Southall	2016	Started
3	Supporting programme of self care for patients & promote Social Prescribing	Practices as Providers Task & Finish Group Work programme	Ranjit Khular	2017-18	Started
3	CCG Plans to reform & integrate out of hours /111 Service	The Integration of OOH and NHS111 is in place. Access to the clinical hub and the wider skill mix is already in place. There will be continual monitoring and further development as the service embeds.	Dee Harris	2016→	Started
3	CCG introduced GP access to Hospital Consultant Hotline	In addition to Advice & Guidance, Consultant Access Service we will anticipate introducing Consultant Connect (4 acute specialities initially, will extend to Mental Health as well) Trust in support of the CQUIN for acute hospitals 2017-18	Ranjit Khular	2017-18	Started
3	CCG Review of National QoF plus DES & LES's to ease GP Workload	Local steering group due to be formed February 2017. Review QoF indicators, confirm suitability & introduce QoF Plus to include locally defined indicators underpinned for financial incentive(s) to improve quality of care and outcomes for patients and ease GP workload.	Ranjit Khular	2017-18	Started

General Practice - Overview of Actions continued

Chapter	Requirement	Action(s)	Lead	Timescale(s)	Status
3	CCG IT Strategy; Accelerate paper free NHS Support Electronic Prescriptions Audit Tool to help reduce demand Automated appointment measuring interface	The Wolverhampton locality have developed a delivery plan as part of the greater Black Country Local Digital Roadmap which outlines the steps and projects to support paper free at point of care, automated appointment measures and EPS	Steven Cook	2016-2020	Started
4	ETTF; Active participation & submission of schemes	Estates Task & Finish Group programme of Work	Mike Hastings	2016	Started
4	Active NHS Lift/Public/Private Partner to develop NHS Premises in local area	Estates Task & Finish Group programme of Work	Mike Hastings	2016	Started
4	Support practices/patients to take up online patient consultation Promote use of Apps/Digital Self Care WIFI (early implementor) availability in General Practice	Wolverhampton CCG are Wi-Fi early adopters and will have implemented Patient/Public and Staff Wi-Fi in all GP practices by 31st March 2017. AS part of the development of the Wolverhampton Shared Care Record a patient portal will be made available that will support patients view there records and record data from wearable devices. Wolverhampton CCG will be working with NHS England GPFV Transformation Team and practices to implement online consultations	Steven Cook	2017-18	Complete March 2017
4	Commission new Core IT Services for Federations/Groups	The CCG was awarded funding to support the integration of practices through a ETTF bid. They are working with EMIS to allow all of the federations view/book and hold consultations with patients within each federation	Steven Cook	2017-18	Started
4	Roll out Pharmacy Summary Care Record	The project was completed by Midlands and Lancashire CSU during 2016.	Steven Cook		

General Practice - Overview of Actions continued

Chapter	Requirement	Action(s)	Lead	Timescale(s)	Status
5	Deliver access commitment, including integration of extended access with Out of Hours & Urgent Care Commission new Core IT Services for Federations/Groups	The CCG in partnership with Royal Wolverhampton Hospital, The Black Country Partnership and Wolverhampton City Council have created a Wolverhampton Shared Care Record that currently contains Primary and Secondary Care data, which is accessible 24hrs a day. The Development of EMIS remote consultation will also support GPs accessing patients records within their federations.	Steven Cook	2017-18	Started
5	Deliver access commitment, including integration of extended access with Out of Hours & Urgent Care Commission new Core IT Services for Federations/Groups				
5	Introduce MCP Contracts to support 'bigger at scale' primary care provision	Primary Care Task & Finish Group Work Programme	Vic Middlemiss	2018-19	Not Started
5	Funding & Supporting Protected Learning Time	Workforce Task & Finish Group programme of Work	Manjeet Gracha	2016	Started

All components of this plan are overseen by the Primary Care Strategy Committee, each project is managed through to completion by the Task & Finish Group indicated.

Each task & finish group provides a highlight report on a monthly basis to the Primary Care Strategy Committee enabling progress to be closely monitored to ensure achievement.

The detail contained within this document should be read in conjunction with our Operational Plan 2017/19 and enclosed Primary Care Strategy Programme of Work.

This submission has been considered by the members of the Black Country STP Operational Group, who consider it to be consistent with the proposals within the current Sustainability and Transformation Plan.