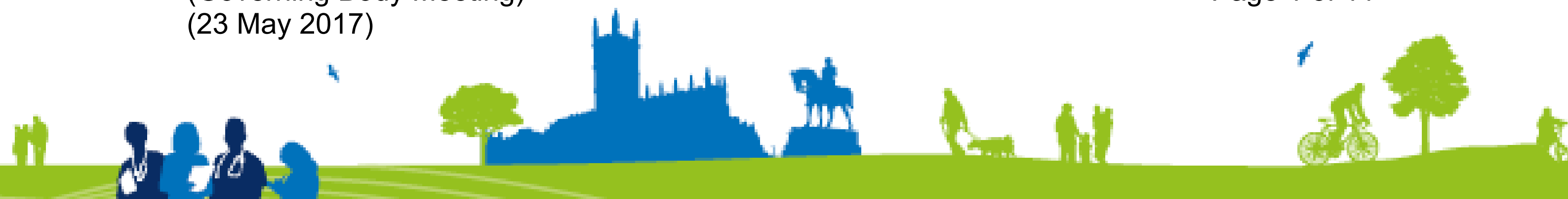
NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
Governing Body
23 May 2017

TITLE OF REPORT:	Report of the Primary Care Strategy Committee
AUTHOR(s) OF REPORT:	Sarah Southall
MANAGEMENT LEAD:	Sarah Southall
PURPOSE OF REPORT:	To update the governing body on continued progress that has been demonstrated to the Primary Care Strategy Committee, specifically the outcome of discussions at the April Meeting.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	• Provide assurance on progress made to date in relation to achievements that have been realised from the programme of work attached to the CCGs Primary Care Strategy and confirm what work is currently underway in the next phase implementation. • The report also confirms where assurance has been received from the committee in respect of new models of care demonstrating how practices have aligned with their preferred model & how working at scale is maturing. • The outcome of discussions at national level in respect of CCGs responsive plan that seeks to address the actions required to implement the GPFV is also confirmed.
RECOMMENDATION:	The recommendations made to governing body regarding the content of this report are as follows:- • Receive and discuss this report • Note the continued achievements being realised by the Committee
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1 Improving the quality and safety of the services we commission : Ensure on-going safety and performance in the system 2 Reducing Health Inequalities in Wolverhampton : Improve and develop primary care in Wolverhampton; Deliver new models of care that support care closer to home and improve management of Long Term Conditions. 3 System effectiveness delivered within our financial envelope : Deliver improvements in the infrastructure for health and care across Wolverhampton



1. BACKGROUND AND CURRENT SITUATION

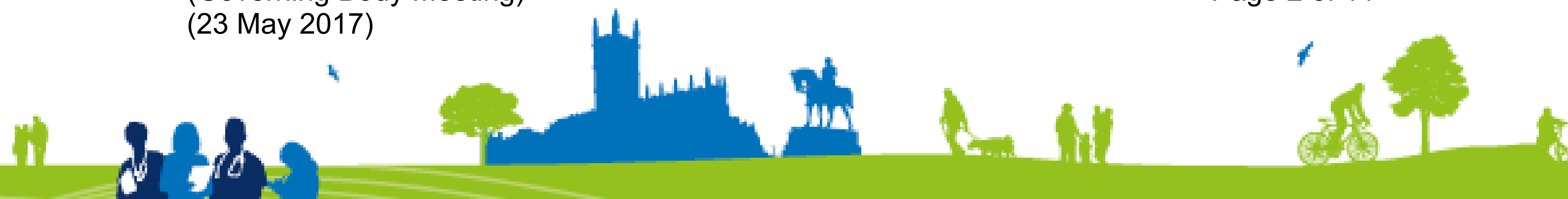
1.1. The CCGs Primary Care Strategy was ratified by the Governing Body in January 2016 in recognition of the changing demands in primary care. The programme of work was launched in the summer of 2016 and this report focuses on the achievements that have been realised since the programme of work commenced.

1.2. The CCGs vision is to achieve universally accessible high quality out of hospital services that promote the health and wellbeing of our local community, ensuring that the right treatment is available in the right place at the right time and to improve the quality of life of those living with long term conditions and also reduce health inequalities

2. PRIMARY CARE STRATEGY COMMITTEE

2.1. Since the programme of work was launched in the summer of 2016 a number of objectives have been achieved through the work of each task and finish group. The following section provides an overview of the milestones which have completed on the strategic higher level programme of work since the developed of the programme in August 2016 to May 2017:-

Primary Care Strategy Committee		
PCS001	Establish Primary Care Joint Commissioning Committee	**Completed**
PCS002	Establish Primary Care Operations Management Group	**Completed**
PCS003	Apply for authorisation for full delegation of Primary Care Commissioning	**Completed**
PCS004	Establish Primary Care Commissioning Committee following discussions refining remit and broader relationship to CCG Governance	**Completed**
PCS005	Hold Quarterly members engagement events.	**Completed**
PCS006	Establish Programme Management Governance , PMO Office and assemble Task and Finish Groups.	**Completed**
PCS007	Ensure alignment with CCG strategies and standard operations; QIPP, Operating Plan, BCW, H&WB, STPs	**Completed**
PCS008	Work with Practices/ Localities to submit proposals for 15/16 Primary Care Reserves Investment Plan	**Completed**
PCS009	Identify appropriate areas for development of extended services in line with population needs	**Completed**
PCS010	Project Management support to enable models of care i.e. PCH (WTH); Estates; LES forms	**Completed**
PCS011	Ensure practice indicative budget statements are rolled out	**Completed**

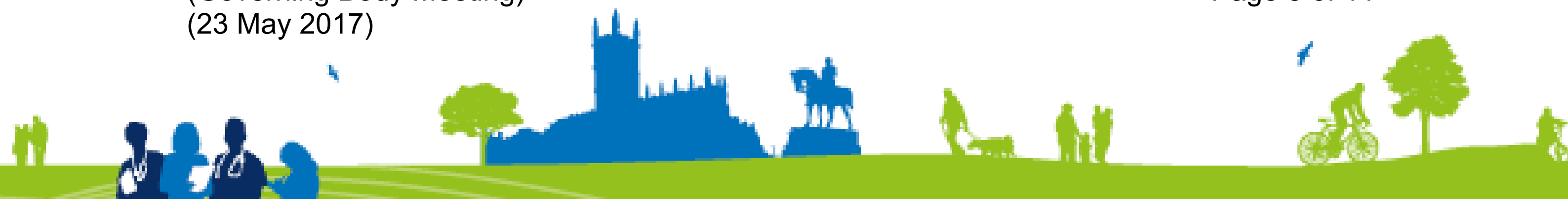


New Model of Care Objectives		
NMC002	Practice Group forming	Completed
NMC003	MOUs signed & Commenced new ways of working	Completed
NMC004	Ten high impact actions scoped	Completed
1. Practice as Providers		
1.5	Improving Access to Primary Care	Completed
1.8	Review COPD/ Asthma extended service	Completed
1.9	Continue to embed and evaluate the Primary Care In reach Team (PITs)/Resource Centres	Completed
5. Primary Care Contract Management		
5.1	Review MOU between NHS E/CCG to understand the future relationship between the hub and CCG and to scope future resource requirements for Primary Care contracting.	Completed
5.2	Develop a standardised collaborative approach to contract review and development support to enable a single contract monitoring visits	Completed
5.3	Develop an integrated management tool underpinned by a programme of prioritised contract review visits	Completed
5.4	Agree criteria, intervention modes, and processes for vulnerable/ practices with issues which require extraordinary support or practice visits.	Completed
6. Estate Development		
6.3	Estate Survey	Completed

Task and Finish Group Priorities

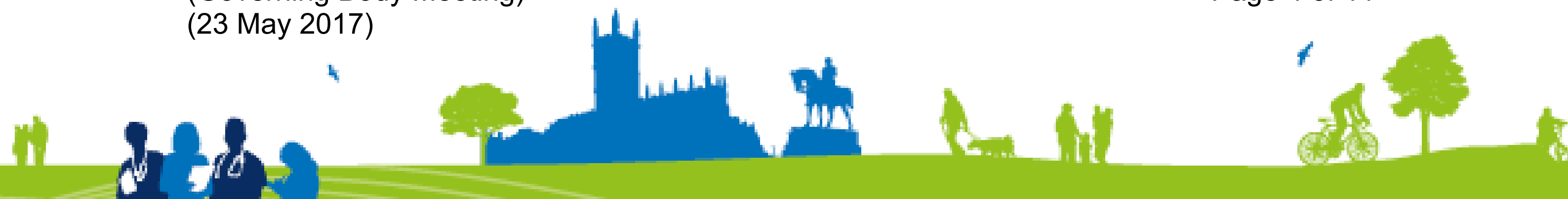
The following table highlights the individual Task and Finish Groups work programme priorities for the current quarter (April to June 2017). This only includes milestones which are due to commence or are due to be completed within this quarter. It does not include any existing programmes of work which are currently in progress and have a completion date after June 2017.

Project Implementation Plan - Practice as Providers v13	
4	**Work with New Models of Care i.e. PCH, Medical Chamber and VI to define and develop clinical pathways in scope of MCP model**
4.1	Organisation Structure and Governance arrangements
4.2	Identify clinical leads to lead the development of clinical pathways on themed areas (list)
4.3	Develop clinical pathways with the clinical leads that promote care within the primary care setting (list)



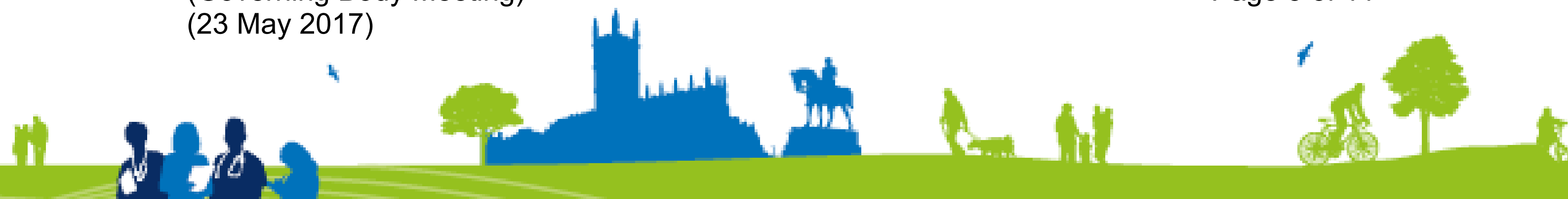
4.6	Develop a project plan for the implementation of new pathways/ delivery models
6	**Understand how the CCG should/ could respond to identified needs for Back office support functions for clinical networks/ MCPs**
6.2	Identify feasible options for the provision of non-clinical support functions as delivered by Vanguard sites
6.5	Ensure each Clinical Network has a plan for the provision of non-clinical services effective for 1st April 2018.
7	**Clearly defined Contract management processes through primary Care Issue Log to enable Practices to feedback there and their patient's experience of using the CCG commissioned services.**
7.2	Undertake a 6 monthly audit of all Practice Issue logs completed by all practices, to document learning and outcomes and make recommendations for optimal use of the log
7.4	Establish a process to ensure that matters reported through the Practice Issues log are escalated through Contract Management process
10	**Work with Community Matrons/CRG to streamline the proactive case finding via risk stratification tool.**
10.3	Practices to routinely use Aristotle Risk Stratification function to identify at risk patients.
10.4	Establish a system to ensure that Practices have access to current practice level locally available data & intelligence as published by PHE, HSCIC, NHS Digital.
10.5	CCG to have a high level plan for the use of Aristotle, which includes the role of the Practice/MDT.
10.6	Develop locally enhanced service to ensure practices undertake risk stratification and establish robust links with their respective community neighbourhood teams.
10.7	Ensure that there is on-going support from Aristotle to support new practitioners within primary care to utilise the system

Localities as Commissioners Task and Finish Group Plan V13	
1	**Practices to have insight of the needs of their practice population**
1.2	Establish a system to ensure that Practices to have access to current practice level intelligence as published by PHE, HSCIC, NHS Digital.
1.4	Develop locally enhanced service to ensure practices undertake risk start and establish robust links with their respective community neighbourhood teams.
2	**Practices utilise data/ intelligence to consider their utilisation of commissioned services**
2.1	Practices to engage in Peer Review at Group level
2.2	Practices to utilise the Right Care approach when undertaking Peer Review
2.3	Develop a reporting feedback mechanism to allow Peer Review Groups to report into CCG
2.6	Develop and introduce risk based capitated budgets.

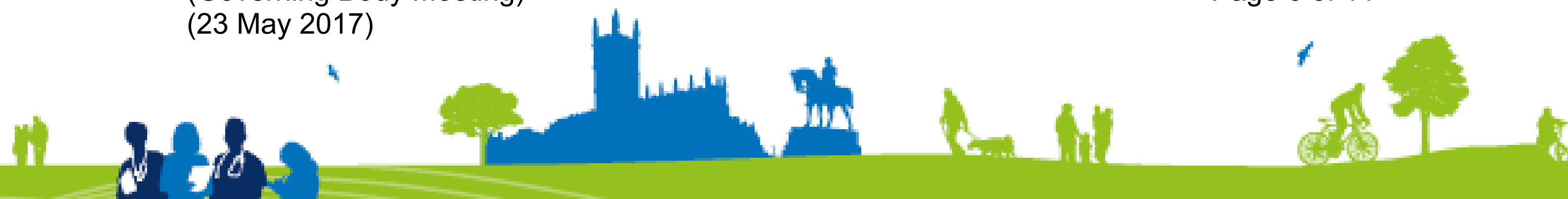


3	**Practices are informing the commissioning process**
3.2.1	Facilitate discussion at quarterly network meetings where practices are engaged in on-going service reviews and inform the service review process (Q1 April 2017)
3.3	Develop a planning template to incorporate clinical network priorities into Commissioning intentions
5	**Practices supported to develop and maintain intelligence of local services**
5.1.2	WIN directory of service to be developed to incorporate health services to enable social prescribing
5.4	Monitoring mechanism to determine launch and going effectiveness of social prescribing service to be defined and implemented.
6	**Ensure that new clinical networks/ practices working at scale have organisational and business requirements in place as commissioning entities**
6.1	Ensure MOUs are in place across all practices working at scale
6.2	Constitution and Articles of Association
6.3	Working capital
6.4	Organisation’s principal fields of activity, its values and main objectives.
6.5	Organisation and business structure
6.6	The organisation's insurance
6.7	Business plan and Strategy

Workforce and Development V2.6	
2	**Wolverhampton a place to work**
2.3	Work with HEWM re recruitment and retention of GP trainees
2.7	Develop a programme to recruit individuals from Wolverhampton where possible (i.e. those most likely to remain in Wolverhampton) via recruitment fair etc
3	**Career development for clinical and non-clinical staff**
3.3	Support implementation of career pathways in general practice and new models of care for: Advanced clinical practice (Masters)
3.4	Support implementation of career pathways in general practice and new models of care for: Non-academic development opportunities



4	**Pilot mapping Skills for new PC Service Provision model**
4.1	Identify locality
4.2	Map PH data – GP data – WF numbers
4.3	Workshops with identified teams
4.4	Secure resources and tools for scoping skills and workload
4.5	Scope skills for disease areas / teams
4.6	Monthly progress reports to group
6	**Developing a leadership culture within primary care**
6.1	Scope leadership skills within GP teams
6.2	Identify leadership courses and resources to support them
6.3	Increase uptake of leadership courses/programmes by teams
6.6	Develop and support the long term transformation of the primary and the community workforce
7	**Improving and improving standards of practice**
7.2	Standardise practice – for non-clinical workforce
8	**Increase training capacity in primary care**
8.2	Ensure clinical placement models in primary care are sustainable
8.3	Work with HEWM and Deanery to ensure GP trainees allocations are spread across all areas with WCCG footprint
8.4	Explore incentives for GP trainee recruitment in Wolverhampton
9	**Develop a Primary Care Workforce Development Strategy**
9.1	Amend and Implement the Primary Care Workforce Strategy
9.2	Monitor and evaluate the Primary Care Workforce Strategy
9.3	Develop a mechanism to record the primary health care workforce training requirements



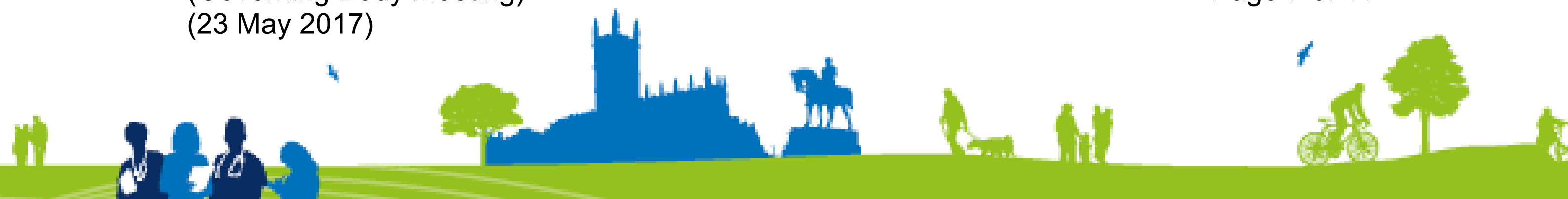
Primary Care Contract Management - Task and Finish Group V11	
5	Implementation of MCP/PACs emerging care model and contract framework, working in conjunction with NHS England
5.4	Identify appropriate contracting mechanisms for enhanced primary care services 2017/2018.
5.5	Prepare contracting plan for primary care in response to practice groupings i.e. limited company /alliance agreement based on local preference in line with national guidance.
5.6	Ensure practice groups are sufficiently prepared to sub contract services where deemed necessary.
5.7	Confirm state of readiness for contracting with practice groups for new models of care due to take affect April 2017. This involves development of a checklist to be used by practice groupings and also a CCG version for contracting/ commissioning purposes.
5.8	Develop an outline contract strategy for primary care based on MCP approach.

Project Implementation Plan - Task & Finish Group Estates V1.13	
2	**Primary Care Estates**
2.8	Estates Strategy to be Implemented.
4	**Estates Prioritisation**
4.2	Work with Practices who score highly on the prioritisation document to scope estates development.
4.3	Papers to be produced based on priority for relevant committees and governing body.

IM&T - Business Intelligence Implementation Plan V12	
5	**Improving Access - Lean**
5.2	Development of existing Text Messaging solution

2.4 All task and finish groups provide formal highlight reports to the committee at monthly intervals, in April the committee considered exception reports from two task and finish groups.

Task & Finish Group	Reason for Exception
Practices as Providers	The initial objective was to develop a project plan for the implementation of new pathways/ delivery models as defined by the new practice groups. The number of pathways was quite lengthy, 5 out of 12 have completed and the remainder will be complete by September 2017.
Localities as Commissioners	The availability of practice level intelligence and the introduction of an enhanced service for risk stratification had been delayed as a result of data final steps in completing these tasks had not been fully achieved. The revised implementation date was agreed as the end of June 2017.



2.5 Whilst there are risks attached to the delivery of this programme of work there are no red risks captured on the risk register at this stage, this was verified through discussions held at the committee meeting in April.

3. NEW MODELS OF CARE

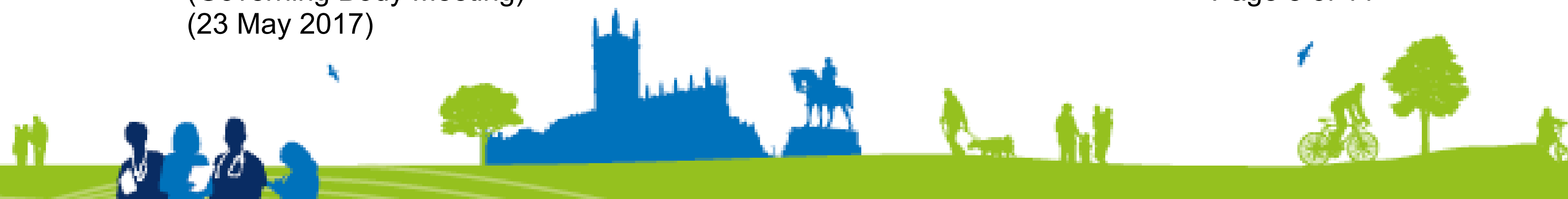
3.1 There are 45 practices within the membership of Wolverhampton CCG, almost all practices have aligned with like-minded practices to enable them to work together with a view to reviewing health care needs for their population(s) and where feasible exploring opportunities to share the workload through working at scale. Each group has identified the priorities they feel are most important for their population and comprise of some of the following:-

- Improving access for patients with diabetes
- Improving access for patients during the evening & weekends
- Adopting pro-active management of patients with frailty
- Using a risk based approach to managing patients with long term conditions

3.2 The current practice groupings are largely attached to the Primary Care Home Model where practices work together to serve a population of in the region of 30-50,000 patients to provide population based complete care in conjunction with health and social care partners and the voluntary sector. This enables patients to receive the right care, first time, personalised to their needs through a strong focus on partnership working. The primary care home model is owned and lead by our general practitioners within each practice who continue to engage with their clinical peers to ensure they achieve a consistency of approach in the way care is provided to their patients.

Practice Group	Number of Practices	Population Size
Primary Care Home 1	9	58,388
Primary Care Home 2	8	50,266
Medical Chambers	21	130,500
Vertical Integration	5	30,350
Not Yet Aligned	2	5,477

Discussions are taking place with practice group leads to identify how those groups can be aligned within the boundaries of the three localities, this will enable the Primary Care Home Model to be further developed by all practices within Primary Care Home 1, 2 and Medical Chambers. Further discussions with practices not yet aligned and vertical integration will also take place to ensure equity of delivery of patient care.



4 General Practice Forward View

As a result of feedback from NHS England in relation to the CCGs second stage implementation plan for the GPFV a range of supplementary information was provided to the regional team in a revised plan. The plan has since been confirmed as fully assured and a programme of work is well underway to implement each of the projects detailed within the plan. The committee will receive formal reports on all live GPFV projects from May 2017 onwards, this information will be reflected in future reports of the committee to Governing Body.

5 CLINICAL VIEW

5.1 There are a range of clinical and non-clinical professionals leading this process in order to ensure that the leadership decisions are clinically driven. Clinical representation at many Task and Finish Groups takes place on a regular basis.

6 PATIENT AND PUBLIC VIEW

6.1 Whilst patients and the public were engaged in the development of the strategy and a commissioning intentions event held in the summer specific to primary care the Governing Body should note that Practice based Patient Participation Groups are being encouraged to ensure their work with the practice(s) encompasses new models of care and the importance of patient and public engagement moving forward.

6.2 An update on Primary Care was provided to the Patient Participation Group Chairs in March, whilst this was welcomed they have requested further clarity regarding their involvement in the future in discussions with their respective models of care/practice groupings. Therefore, arrangements are being made for each group of PPG Chairs to meet with the CCG and the Group Lead(s) to discuss how this will be achieved and to ensure patients and the public are invited to share their suggestions on areas for improvement and take part in discussions about changes affecting patients.

7 RISKS AND IMPLICATIONS

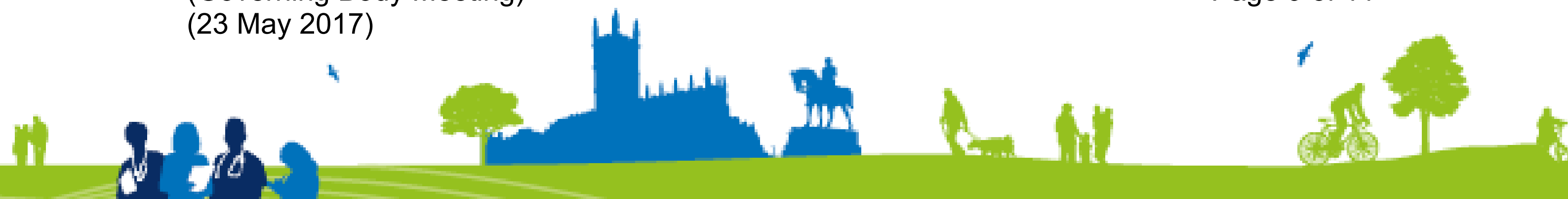
Key Risks

7.1 The Primary Care Strategy Committee has in place a risk register that has begun to capture the profile of risks associated with the program of work. Risks pertaining to the program are reviewed at each meeting and at this stage there are no red risks to raise with the Governing Body.

Financial and Resource Implications

7.2 At this stage there are no financial and resource implications for the Governing Body to consider, representation and involvement from finance colleagues at committee and tasks and finish group level will enable appropriate discussions to take place in a timely manner.

Quality and Safety Implications



7.3 Patient safety is first and foremost, the experience of patients accessing primary medical services as the programme becomes more established is anticipated to be met with positive experiences of care. The quality team will be engaged accordingly as service design takes place and evaluation of existing care delivery is undertaken.

Equality Implications

7.4 The Strategy has a full equality analysis in place. This will require periodic review during the implementation phase.

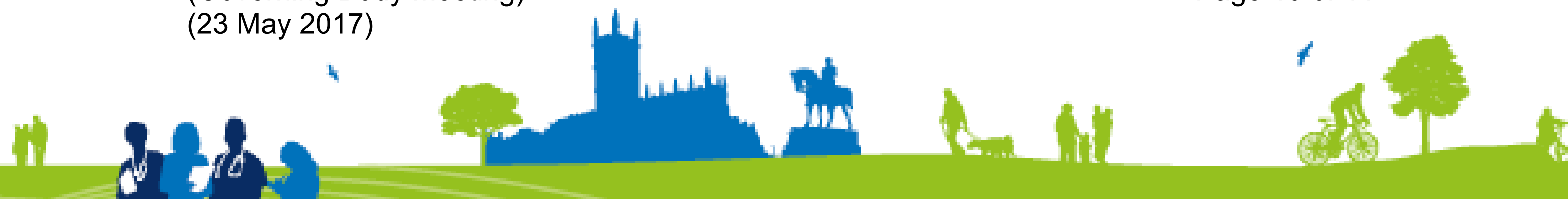
Medicines Management Implications

7.5 The role of clinical pharmacist is an area of specific attention within the programme of work. A task and finish group has been established to ensure this role is utilised with maximum impact in the future.

Legal and Policy Implications

7.6 The Primary Care Strategy demonstrates how the CCG seeks to satisfy its statutory duties and takes account of the key principles defined within the General Practice Five Year Forward View.

Name	**Sarah Southall**
Job Title	**Head of Primary Care**
Date	**12 May 2017**



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REPORT SIGN-OFF CHECKLIST

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

	Details/ Name	**Date**
Clinical View	**Salma Reehana**	**12.5.17**
Public/ Patient View	**Pat Roberts**	**12.5.17**
Finance Implications discussed with Finance Team	**NA**	
Quality Implications discussed with Quality and Risk Team	**NA**	
Equality Implications discussed with CSU Equality and Inclusion Service	**NA**	
Information Governance implications discussed with IG Support Officer	**NA**	
Legal/ Policy implications discussed with Corporate Operations Manager	**NA**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**NA**	
Any relevant data requirements discussed with CSU Business Intelligence	**NA**	
Signed off by Report Owner (Must be completed)	**Steven Marshall**	**12.5.17**