WOLVERHAMPTON CITY COUNCIL

HEALTH AND WELLBEING BOARD

Wolverhampton Clinical Commissioning Group **Integrated Commissioning Plan (ICP) 2013-2016**	
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Title of report:	Integrated Commissioning Plan (ICP) 2013-2016
Date of Meeting:	3 July 2013

1. Purpose of Report

Following the approval of the Executive Summary at the meeting on the 1 May 2013, the full Integrated Commissioning Plan is now submitted for information.

2. Recommendation

To receive the approved Integrated Commissioning Plan**.**

3. Detail

WCCG along with all other CCGs is required to develop an Integrated Commissioning Plan that describes:

- The strategic priorities that will be focused on in 2013/14
- The Case for change that drives those priorities
- Commissioning Intentions
- Contractual arrangements
- The Financial strategy and position of the WCCG
- Identify any risks associated with the Financial profile of WCCG
- Describes the methodology and structure that will deliver the WCCG's plans
- Describes the WCCG's approach to QIPP and its QIPP targets
- Details our stakeholder engagement intentions and methodology (including Patients, the wider general public, the local authority, Providers and member practices.
- Describes how we will work with and develop our Providers

- Requires us to describe how we will deliver against key areas of the NHS Outcomes Framework contained in the NHS England “Everyone Counts” planning guidance
- LAT – The ICP has been approved by the Local Area Team.
- The ICP was approved by the WCCG Governing Body on the 14 May 2013.

*Attached Integrated Commissioning Plan 2013-2016

Caring for our community

NHS
Wolverhampton
Clinical Commissioning Group

Integrated Commissioning Plan 2013 to 2016

*'**R**ight care in the **R**ight place at the **R**ight time'*

Version 1 - Published April 2013

Structure of this document

- Forward and Executive Summary
- Introduction
- Strategy
- Context
- The Case for Change
- Health and Wellbeing
- Quality and Performance
- Communications and Engagement
- Delivery methodology and QIPP
- Governance
- Commissioning
- Finance
- Risk
- Next steps & Conclusions

Distribution

Name	Title	Date of issue	Version
All members	The Governing Body	01/05/2013	Version 1
Dante DeRosa	Chair of WCCG	01/05/2013	Version 1
Helen Hibbs	Chief Clinical Officer	01/05/2013	Version 1
Claire Skidmore	Chief Financial Officer	01/05/2013	Version 1
Richard Young	Director of Strategy and Solutions	01/05/2013	Version 1
Wendy Saviour	CEO - NHS England (B,S&BC)	01/05/2013	Version 1
Alison Taylor	CEO - NHS England (B,S&BC)	01/05/2013	Version 1
Les Williams	Director of Operations and Delivery NHS England (B,S&BC)	01/05/2013	Version 1
All members	Wolverhampton Joint Health and Wellbeing Board	01/05/2013	Version 1
Cllr Roger Lawrence	Leader of the Council	01/05/2013	Version 1
Simon Warner	CEO Wolverhampton City Council (WCC)	01/05/2013	Version 1
Sarah Norman	Director of Community WCC	01/05/2013	Version 1
Viv Griffin	Assistant Director WCC	01/05/2013	Version 1
Ros Jervis	Director of Public Health	01/05/2013	Version 1
Peter Loughton	CEO Royal Wolverhampton Trust	01/05/2013	Version 1
Karen Dowman	CEO Black Country Partnership NHS FT	01/05/2013	Version 1

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Foreword

Wolverhampton Clinical commissioning group has been tasked with the job of driving forward the health agenda in Wolverhampton. As the commissioners we procure services on behalf of our population. We are acutely aware of the challenges that are before us. The population of Wolverhampton consists of a vibrant multicultural mix of people who add tremendous value to our society. Alongside this there are very high levels of people living with long term illness, significant deprivation and unemployment.

Wolverhampton Clinical Commissioning Group (WCCG) is committed to improving the health and wellbeing of our population reducing health inequalities both with regard to mortality rates but also with regard to quality of life of those living with long term conditions.

We will achieve this by commissioning the highest quality evidence based services, placing patients at the centre of our decision making and deliver this through the newly established model of clinically led commissioning. This model will bring about real differences for the health of our population and their experience of services.

This Integrated Commissioning Plan (ICP) describes the approach we will take to achieve our vision of meeting the health needs of the residents of Wolverhampton, whilst recognising that we are working with a number of challenges. These challenges include the high level of socio-economic deprivation, the elevated incidence of long-term illness and the extent of health inequalities within the City. In addition, the ICP acknowledges that services must be of the highest quality, sustainable and affordable in the context of increasing demand and in a period of financial restraint

We have to deliver transformational change in order to realise an efficient and effective health care system in Wolverhampton, which is both affordable and provides the highest service standards, which our population rightly expects and deserves.

Our programme of change will be led by clinicians who have a clear understanding of patient needs and of the challenges we are all facing. Operating in collaboration with our stakeholders (e.g. patients, practices, voluntary organisations, The Royal Wolverhampton Trust, The Black Country NHS Foundation Trust, Wolverhampton City Council etc.) our programme of change is deliberately flexible in order respond to emerging priorities.

WCCG will work with its providers to ensure that we have the best possible services for the local population This cannot be achieved without modernisation of

services and delivery of quality and productivity objectives which allow us to save resource in some areas and redirect it to other areas where it is needed for innovative new services. WCCG have a number of strong plans to ensure delivery of our objectives including robust financial management,an excellent communication and engagement plan and plans to improve the commissioned services including both hospital provided and primary care services. Our commissioning decisions will be shaped by the views of our patients and the public and effective engagement will be a central factor within our new ways of working.

This Integrated commissioning plan is a living document which will develop as our work develops .We look forward to the challenges ahead and to working with all our stakeholders and partners

Dr Helen Hibbs

CCG Chief Officer

Dr Dan DeRosa

CCG Chair

1.Executive Summary

1.1.About us

Wolverhampton Clinical Commissioning Group (WCCG) is a relatively new organisation formed in March 2012 from the amalgamation of two discrete clinical commissioning groups. Every practice, bar one[1], in the City is aligned with the clinical commissioning group and this provides us with the optimal environment to work with our patients to improve outcomes by commissioning high quality, evidence based services. This will be achieved by focussing on health needs, outcomes, sustainability and building effective care pathways. Our task is challenging, Wolverhampton ranks amongst the 25 most deprived areas in England. Wolverhampton has a:

1. Population of 249 470 (GP covered population 262 000)
2. 52 GP Practices (51 members of the CCG)
3. an 8% Unemployment rate
4. is 12th largest city outside London
5. is part of the West Midlands Urban area
6. which makes it part of the second largest urban area in the United Kingdom
7. an ethnically diverse community

Figure 1 - About Wolverhampton

Wolverhampton has a population of approximately 250 000 although our GP responsible population is believed to be higher this could be due to a transient element. Wolverhampton is a relatively compact geographical area so wards are in general quite densely populated. The CCG was authorised at the end of March with conditions, which we are currently addressing.

Although many of the staff at WCCG are new, the team is vibrant, dynamic and ambitious with a “can do” approach to commissioning good quality health care services for our residents.

[1] One practice is aligned with Wallsall CCG due to a retirement

As mentioned Wolverhampton has high levels of deprivation (source - the Index of Multiple Deprivation 2010 (IMD2010) and high levels of health inequalities. The following spine chart describes how Wolverhampton ranks against the cluster area and against the rest of England for some of the key outcome indicators:

NHS Wolverhampton CCG
Summary spine chart

The chart below shows the distribution of the CCGs on each indicator in terms of ranks. This CCG is shown as a red diamond. The yellow box shows the interquartile range and median of CCGs in the same ONS cluster as this CCG. The dotted blue line is the England median. Each indicator has been orientated so that better outcomes are towards the right (light blue).

This CCG is in the Cities & Services cluster

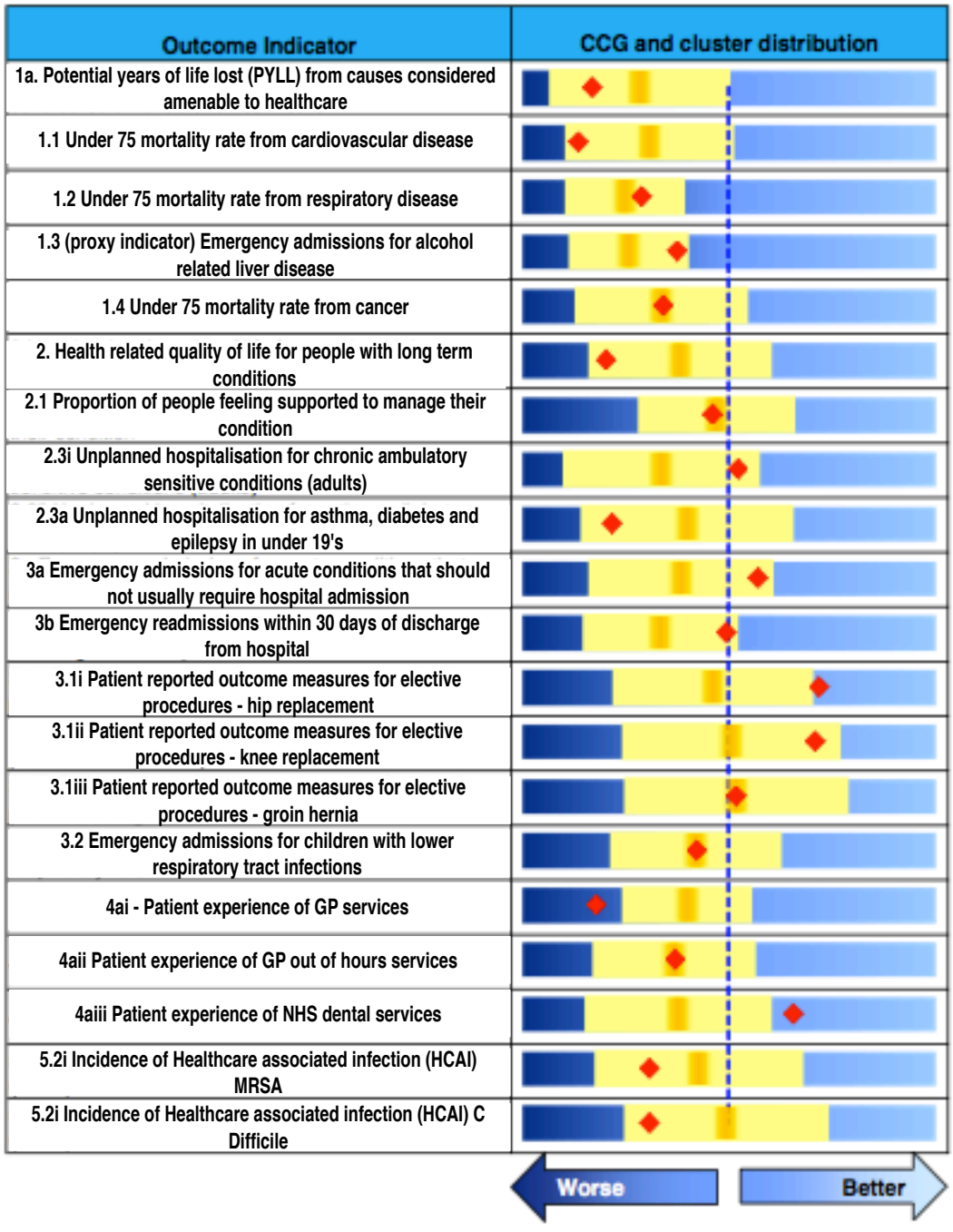

Fig 2 - Wolverhampton Health Profile

Wolverhampton also rates poorly in seven out of the twenty QOF disease prevalence indicators,including but not limited to : Hypertension, Heart failure, Diabetes, Epilepsy and Adult Obesity.

1.2.Strategic priorities

As part of our planning activities we have consulted widely and carefully examined the evidence documented in the JSNA and that supplied by NHS England, Public Health England and our GP's and providers. The results of that consultation and the analysis has identified three key health areas that the CCG needs to focus on during the 2013/14 financial year.

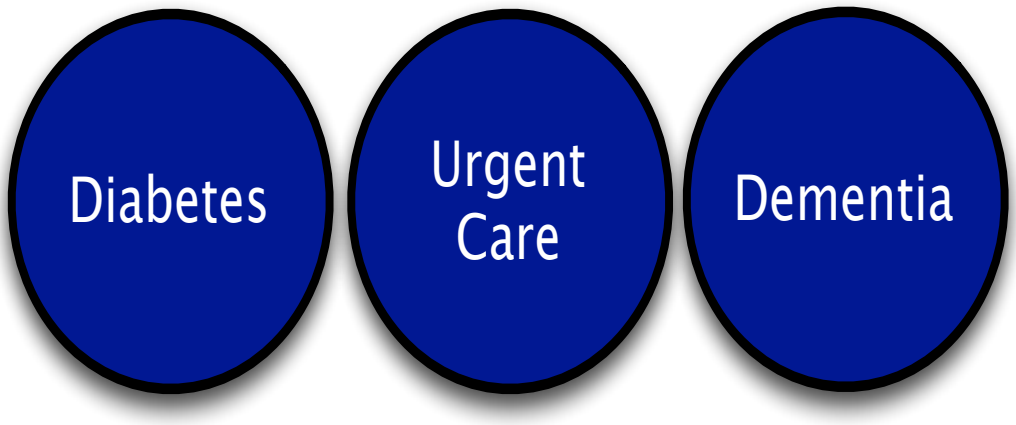

Figure 3 - Local priorities for 2013/14

WCCG will also focus resources in other areas that we have identified as being priorities for Wolverhampton such as COPD and alcohol abuse. We will work closely and collaboratively with our providers and the local authority to deliver the desired outcomes - which are **Right care** in the **Right place** at the **Right time**.

1.3.Communication and engagement - the patient voice

WCCG has developed a comprehensive communications and engagement framework and toolkit which we have implemented with the sole purpose of capturing, analysing and acting on what our patients, public, GP's and providers tell us is good, bad or indifferent about the health care services we are providing. Patients and the Public voice will be at the centre of all our commissioning activity in a tangible and visible way.

The framework and the way in which we have used it to date and some of the resultant feedback we have received so far is described in greater detail in the main body of this document in section 8.

We have worked very closely with our member practices to ensure that we get significant clinical engagement and input.We are determined to provide the **Right care** in the **Right place** at the **Right time.**

1.4.Quality and Safety

WCCG has carefully examined the Francis report and the recommendations made within it. As a commissioner we will ensure that we support our providers in the implementation of all the relevant recommendations. We will work closely with both our main providers, Wolverhampton City Council and the CQC to ensure that we provide safe and accessible health care provision across Wolverhampton - **Right care** in the **Right place** at the **Right time**. We will hold our providers to account for any lapses in acceptable quality standards.

1.5.Finance

WCCG has structured the organisation based on a “lean” model in order to meet the £25/head running cost guidance by which all CCG’s have to abide.

WCCG has a record of strong financial performance :

Year	Surplus £‘000
2009/2010	19,365
2010/2011	15,692
2011/2012	19,682

Figure 4 - Historical financial performance

2012/13 was the final year for the PCT and its strong financial position continued. A considerable amount of work was done in-year to identify the split of the PCT’s budgets to its successor organisations and monthly reporting has been arranged so that the emerging CCG can review its own financial position.

1.6.Providers and provider development

WCCG commissions the bulk of services from two key providers - Royal Wolverhampton Trust (RWT and The Black Country Partnership NHS Foundation Trust (BCP)

With our stated aim of **Right care** in the **Right place** at the **Right time** we will work with providers to ensure that we are able to deliver real transformational change to our health care system. Change that realises genuine benefits in terms of improved outcomes, improved patient experience, financial efficiencies and clinically led commissioning.

We are pro-actively supporting RWT's application for Foundation Trust status and we are confident that they will achieve FT status in a reasonable timescale.

1.7.Commissioning intentions

Although we commission the majority of services from RWT and BCP we also commission other providers. This is described in the table below (Fig 5), figures shown are gross before the allocation of specialised services to NHS England

Wolverhampton CCG LTFM Baseline Values 2013/14 LTFM	Recurrent £000s	Non-Recurrent	Total
Acute Non-Foundation Trust	151,286	631	151,917
Acute Non Foundation Trusts	10,538	0	10,538
Non Acute Foundation Trusts	25,977	750	26,727
Non Acute Non Foundation Trusts	35,507	0	35,507

Fig 5 - CCG Commissioning allocations (LTFM)

How we distribute our funding allocations and what we commission and where will support our ability to deliver the **Right care** in the **Right place** at the **Right time**.

1.8.Specialised commissioning

Funding for specialised services is held by NHS England who will directly commission those services. The CCG is liaising with the the Specialised Services Commissioning Team (SSCT) at NHS England, and its local provider The Royal Wolverhampton RWT to finalise the position and ensure integrated service provision

1.9. Health and Wellbeing Board

The Health and Social Care Act challenges local authorities and the local NHS to work collaboratively to address the "big picture" of health, this includes working together to reduce health inequalities by tackling the wider determinants of health. This will include looking at the root causes such as poor housing, high levels of unemployment, crime and disorder,alongside pure health commissioning.

WCCG has a strong presence on the Health and Wellbeing Board and is an active participant in the development and implementation of the strategy and initiatives emanating from the HWBB.

1.10.Quality Innovation Performance and Prevention (QIPP)

The QIPP agenda will be delivered using the programme management approach that we have described in greater detail in section 8.1 This allows for modernisation savings that can be reinvested in the health economy.

In September 2012, WCCG comprehensively risk assessed[2] its QIPP Programme and aligned it to its Development and Delivery Groups.

The CCG has some risk associated with its QIPP schemes. If schemes do not deliver the level of recurrent savings described above this will jeopardise the financial position of the organisation. If the target outturn position looks likely not to be achieved , the Governing Body would be required to seriously consider delaying or stopping planned work in order to avoid pressure on the financial position. This would not be a tenable position and therefore the organisation gives a significant importance to the QIPP programme as this is the vehicle through which service is transformed.

The CCG does not treat the management of QIPP savings as an annual event; rather, the DDGs are continuously looking for opportunities to deliver new projects. Therefore, if slippage occurs in the 13/14 schemes, there will be other schemes to bring forward from future plans to close the shortfall in the planned savings.

3 Year QIPP Forecast:

2013/14	2014/15	2015/16
£6.5M	£6M	£6M

[2] Risk reviews are now also carried out monthly at the DDG meetings

Introduction,Mission, Aims and Values

2.Introduction

This integrated commissioning plan (ICP) forms a key component of Wolverhampton Clinical Commissioning Group's (WCCG) commissioning process in Wolverhampton and informs our commissioning intentions for the future. The construction of the plan has been clinically led and developed in close collaboration with our key stakeholders. The plan represents the progress of our planning activities at the point of submission to NHS England's Area Team (the AT) and is a continuously evolving document, as such it will continue to require regular engagement and refreshed iterations of the document over the next 3 years.

2.1.Approach to the development of the plan

When we first engaged our clinical leaders on what we wanted our integrated commissioning plan (ICP) to achieve, we also started to outline the ongoing process that would deliver that plan. Our planning process is set out in Fig 6 below. We also set out our initial thoughts on how we will apply the process through a whole health economy approach or the Whole System Plan (WSP)

The case for change is a compelling one, one that has been developed in collaboration with our stakeholders as part of the longer term development of the plan for the health economy whilst maintaining an operational grip on the in-year position.

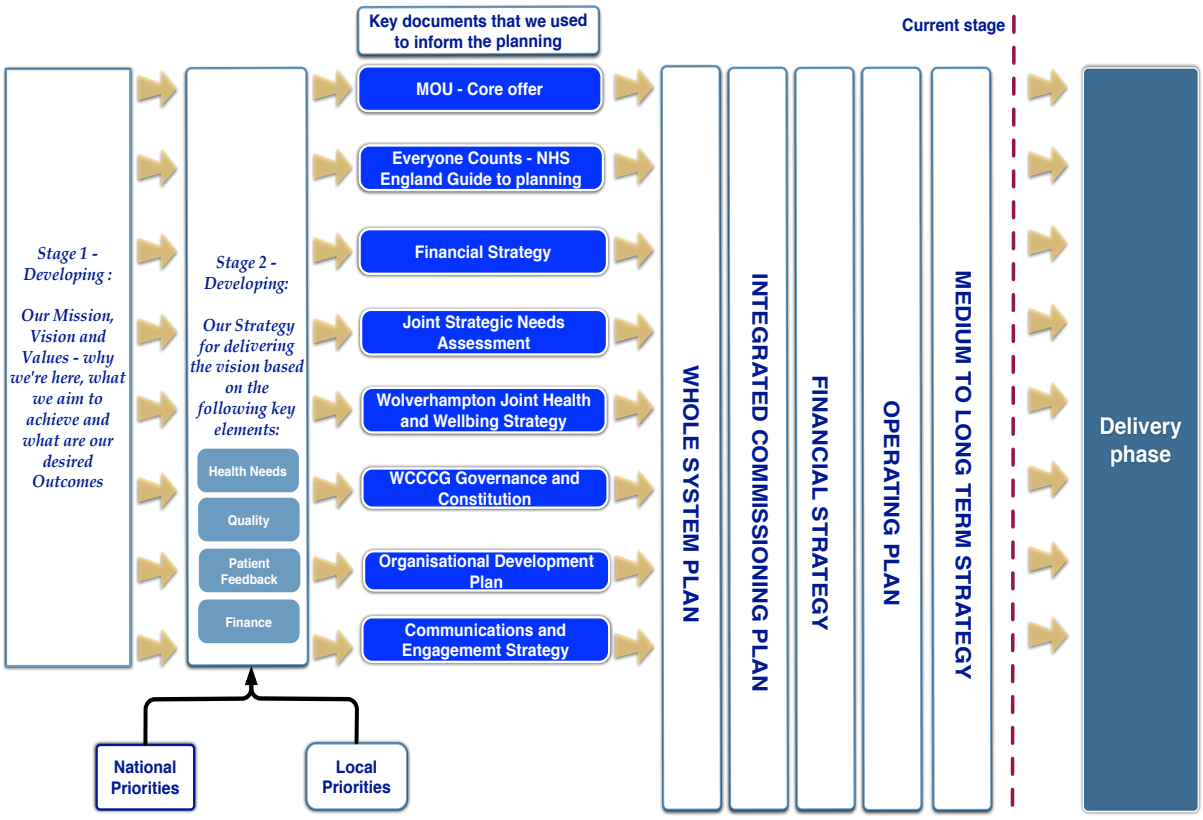

Fig 6 - Planning approach

The ICP is the recipient, along with the Whole System Plan (WSP), of information, intelligence, and plans from a suite of documents (see Fig 7 below) on which WCCG will rely to drive our strategic objectives and delivery.

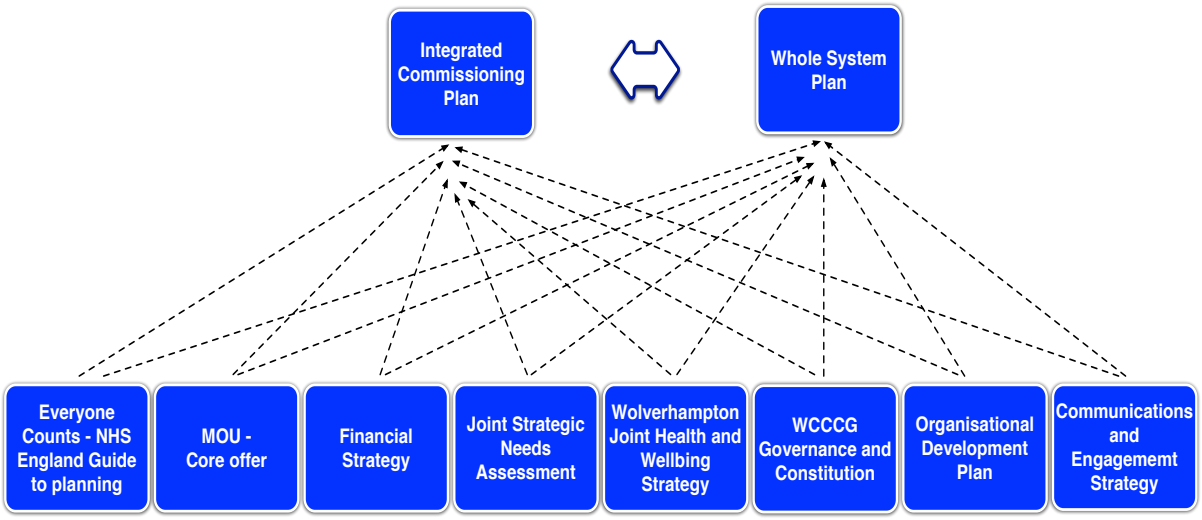

Fig 7 - "The Suite"

The ICP articulates our vision for the future of WCCG commissioning in Wolverhampton, reasons for the transformational change programmes to improve the health outcomes for the population of Wolverhampton and describes how we will operate in a way which is sustainable and delivers the '**Right care** in the **Right place** at the **Right time**'. The plan describes our governance arrangements to evidence that we have the required capacity and capability to undertake the commissioning functions and describes how we will manage risk, finance and performance (and especially quality). In order to support delivery of the ICP, we have constructed an Organisational Development (OD) Plan which will ensure that we have the necessary skills, capacity and effectiveness to undertake our roles and responsibilities.

The ICP is, deliberately, a live document and as such, it will be regularly updated to reflect progress on initiatives, national priorities/directives, the advancement of the organisation and horizon scanning. This submission, post authorisation, represents progress to date, describing a compelling case for change and helping us realise our intention to deliver the WSP subject to ongoing extensive engagement.

WCCG is a new organisation and was formed in March 2012 from the amalgamation of two discrete clinical commissioning groups. Every practice, bar one[3] in the City is aligned with the CCG and this provides us with the optimal environment to work with our patients to improve outcomes by commissioning high quality, evidence based services. We will achieve this by focussing on health needs, sustainability and building effective care pathways.

[3] One practice is migrating to Walsall and merging as a result of a GP retiring

Engagement with our stakeholders is key to our success. Resultantly, we will create a culture where engagement is inclusive, transparent and a central component of our ongoing commissioning decisions.

WCCG considers that the formation of the ICP confirms our intention to work collaboratively and continuously with all our stakeholders to produce plans which are functional, and robustly inform our organisational decision making.

The importance of providing clarity and credibility within our ICP is paramount in order to communicate with our practices, patients, partners, and the public what we are trying to achieve, by when and how we will go about it. In addition, the ICP provides assurances in regards to the feasibility of what we are planning to undertake and how this relates to the resource constraints we a operating within.

2.2.Aims, Vision, Values and Mission

The development of our mission, vision and values was led by our governing body, with the involvement of the public and patients through our regular community workshops. We have used the structure of the authorisation process as an opportunity to refine these fundamental guides for our internal and external planning processes such that we can live and breathe them as a CCG and that we can deliver the '**Right care** in the **Right place** at the **Right time**' These guiding principles are enshrined in our constitution. We shared the finished articles with our patient groups and delivery partners as part of the first ICP communication to our stakeholders.

2.3.Mission

Wolverhampton CCG will be an expert clinical commissioning organisation, working collaboratively with our patients, practices and partners across health and social care, to ensure evidence-based, equitable, high quality, and sustainable services for all of our population.

2.4.Our Aims

We have a range of challenging health issues in Wolverhampton with a diverse population. So we have used the evidence to inform our strategic aims, which are to:

- improve and simplify arrangements for urgent care;
- address variations in the quality of planned care;
- improve the care of those with chronic conditions;
- reduce health inequalities across the City;
- commission the highest quality of services within the available resources.

Only a collaborative and integrated approach with our key partners will enable us to achieve our aims and deliver '**Right care** in the **Right place** at the **Right time**'

2.5.Our Vision

Our vision is for the **Right care** in the **Right place** at the **Right time** for all of our population. Our patients will experience seamless care, integrated around their needs, and they will live longer with an improved quality of life.

2.6.Our Values

To be a dynamic, responsive and innovative organisation; to drive the commissioning agenda in the City; to be a trusted and valued partner contributing positively to the health and social care economy; to have a proactive, inclusive, equitable and professional approach that will secure best value for money and high quality in all that we do; to be open and responsive to the local population, patients and clinicians; to have ways of working that encourage people to want to work for us or with us as appropriate.

2.7.Equality and Diversity

Equality and Diversity are central to our strategy where everyone has the opportunity to fulfil their potential.Equality is about creating a fairer society and Diversity is about recognising and valuing difference in it's broadest sense

Wolverhampton Clinical Commissioning Group (WCCG) is fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity. We will ensure that we:

- commission accessible, high quality health services on the basis of clinical need, tailored appropriately to the different healthcare needs of the various groups in the community we serve;
- achieve equality and fairness in our employment practices.

The Equality and Diversity (E&D) policy document provides the equality and diversity framework within which WCCG will operate. We recognise that our aim is not to treat everyone as though they were the same, but to value the differences between individuals and deal with everyone fairly in that context.

2.7.1.Overview of the E&D Policy

As a minimum we will:

- observe principles of good governance, including the NHS Constitution and Equality Act 2010 (constitution paragraph 4.5(d) and (e));
- meet the public sector equality duty (paragraph 5.1.2(b));

- have regard to the need to reduce inequalities in patients' ability to access services and/or in the outcomes being delivered by the services they do use;
- eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act;
- advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it;
- foster good relations between people who share a relevant protected characteristic and those who do not share it;
- publish relevant information to demonstrate our compliance with the duty.

Strategy


STRATEGY
PLAN
THINK
MANAGE
NHS
New Cross Hospital
Neurology
Neurophysiology (EEG)
Staff Support Services
Wards 1, 9, 10,
City Council
Wolverhampton
WMAS

3.Strategy and Strategic Objectives

The following figure describes WCCG's strategy and objectives for the next 3 years in a snapshot. We will regularly review and validate the strategy to ensure that the strategic fit with Wolverhampton's health needs is still being met. To ensure that we deliver the '**Right care** in the **Right place** at the **Right time**'

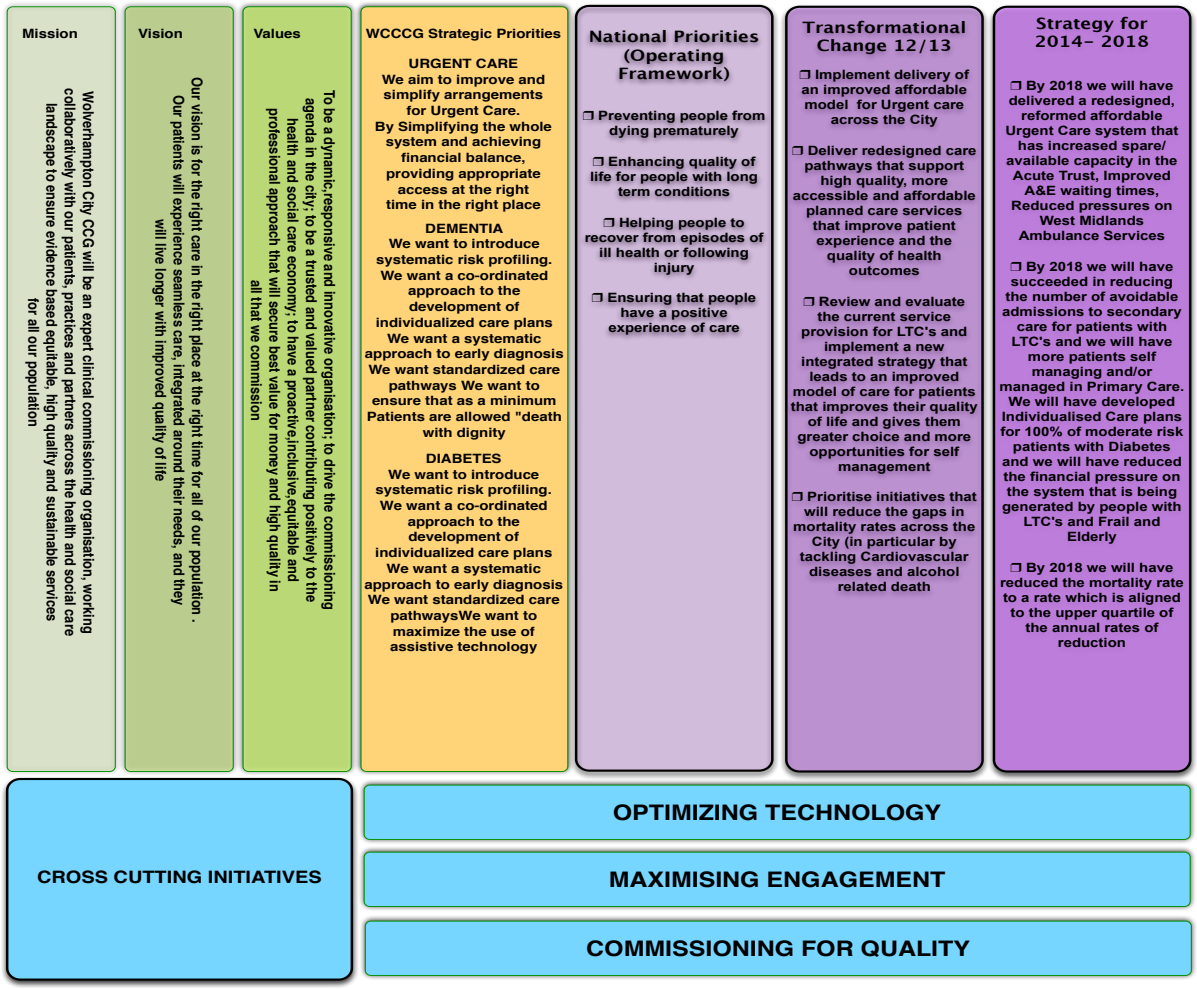

Fig 8- Medium to long term strategy

3.1.Wolverhampton Clinical Commissioning Group (WCCG)

Wolverhampton Clinical Commissioning Group is a relatively new organisation formed in March 2012 from the amalgamation of two discrete clinical commissioning groups and is the successor organisation to Wolverhampton City Primary Care Trust (the PCT). With the exception of one[4] every GP practice (52) in the City is aligned with the clinical commissioning group and this provides us with the optimal environment to work with our patients to improve outcomes by

[4] One practice is migrating to Walsall as a result of a retirement

commissioning high quality, evidence based services. This will be achieved by focussing on health needs, outcomes, sustainability and building effective care pathways

WCCG's funding allocation is based on a population of approximately 250 000 in a relatively compact geographical area. The incoming CCG is inheriting a healthcare economy which has in previous years been fortunate enough, and well managed to the extent that the PCT and their provider portfolio have enjoyed a reasonably healthy financial position.

We recognise that there will be a need to forge close links with other local CCGs and with the Health and Wellbeing Board in Wolverhampton (WHWBB), which we have, but we will also need links with neighbouring Health and Wellbeing Boards to share best practice, lessons learnt and potentially enter into risk sharing arrangements. To ensure that population health needs and priorities are clearly identified and met and that we deliver the '**Right care** in the **Right place** at the **Right time**'. By bringing to bear the potential economies of scale that can be realised by such collaboration.

Chaired by Dr Dante DeRosa with Dr Helen Hibbs as the Chief Clinical Officer, WCCG has significant clinical leadership with many years of experience in the delivery of effective healthcare services.

Dante and Helen have assembled a senior leadership team with impressive track records in the NHS, and with ambitious plans for future healthcare services in Wolverhampton which we expect to deliver sustainable changes in health outcomes, life expectancy, patient experience and a reduction in health inequalities for our residents.

3.2.Strategic transformation

The CCG will utilise strategic transformation (see Fig 9 below) based on a programatic methodology to construct the plans that will move us from the current state to the future state and thus deliver our strategic priorities.

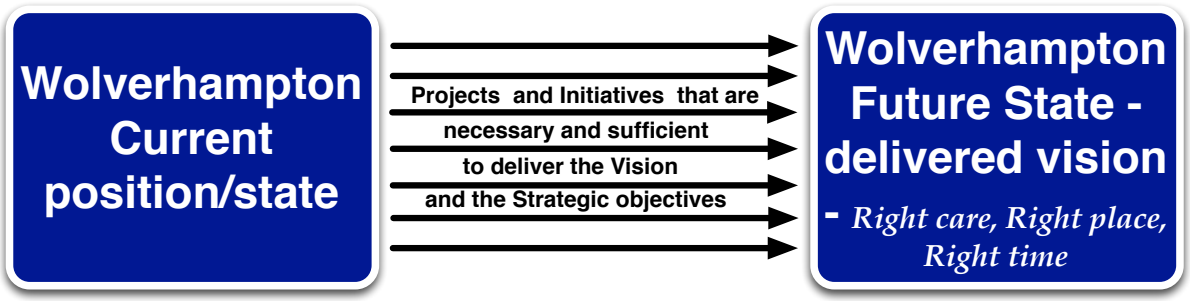

Fig 9- Anatomy of a Transformation Programme

Context


STRATEGY
PLAN
THINK
MANAGE
NHS
New Cross Hospital
Neurology
Neurophysiology (EEG)
Staff Support Services
City Council
Wolverhampton
WMAS

4.Context

4.1.National Context

The Health and Social Care Act 2012 initiated one of the most radical reforms to the NHS since its creation in 1946. The Act has major implications for the local health system and the relationship between that system and local government. In particular it provides for the:

- Abolition of Strategic Health Authorities (SHA's) and Primary Care Trusts (PCT's) and requires the establishment of Clinical Commissioning Groups (CCGs), led by GPs, to commission health services locally;
- Transfers responsibility for public health to local government; and
- Places a responsibility on Local Government to provide Public Health advice and intelligence back to CCGs and NHS England;
- Requires local authorities to establish Health and Wellbeing Boards that will set the agenda for a range of measures that influence and improve local peoples health;
- GPs will have responsibility for commissioning a wide range of healthcare services, with some exceptions. The Act allows GPs to join together in consortia (CCGs) , and to commission services in the ways that they judge will deliver the best outcomes for patients;
- NHS commissioners will be supported and held to account by a new body, NHS England, using the NHS Outcomes Framework;
- SHAs, PCTs or their replacements will no longer performance manage CCG's or providers;
- Ministers in the Department of Health will still be ultimately accountable for the NHS;
- Ministers will set objectives for the NHS through a mandate to NHS England.

Health and Social Care Bill and the new commissioning structure

The changes to the health and care system are intended to:

- Improve quality and choice of care for patients, and increase transparency for taxpayers;
- Give GPs and other clinicians primary responsibility for commissioning health care;

- Create a coherent system of regulation for providers, to drive quality and efficiency;
- Limit Ministers' ability to micromanage, while ensuring overall accountability - allowing CCG's to deliver the **Right care** in the **Right place** at the **Right time**.

Our view as a clinical commissioner:

- The role of the CCG is clear, as can be seen in Fig 10 - below. We will be responsible for the commissioning of healthcare services across a broad range of disciplines and care settings, with a strong need to meet the health needs of the local population within the envelope of the finite financial resources available.

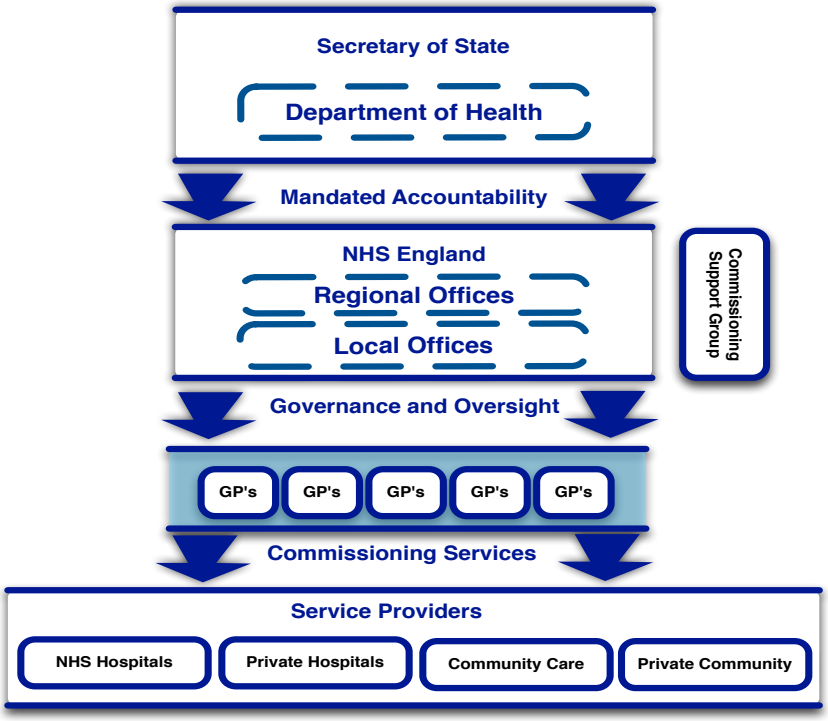

Fig 10 - Structure of the reformed NHS Commissioning Services

4.2. NHS Outcomes Framework

The outcomes framework has three core purposes:

- To provide a yardstick for measuring performance;
- To provide a mechanism for accountability between the Secretary of State for Health and NHS England;
- To act as a catalyst for driving quality improvement and outcome measurement;

The framework is structured around five outcomes that the NHS aims to address:

1. **Preventing people from dying prematurely;**
2. **Enhancing quality of life for people with long term conditions;**
3. **Helping people recover from illness or injury;**

4. **Ensuring people enjoy a positive experience of care;**

5. **Treating and caring for people in a safe environment and protecting them from avoidable harm.**

It is important to align NHS, Public Health and Adult Social Care outcomes to support integration. The NHS Outcomes framework must therefore be considered alongside the Public Health Outcomes Framework and the Adult Social Care Outcomes Framework.

The following tables overleaf describes the key indicators that NHS England will use to monitor the performance of CCG's and some of the actions that WCCG will take to meet the requirement.

Indicator	What WCCG will do
A seven day NHS	WCCG will be working with our GP's and our providers to develop a broader range of access times for services which, if available 24/7 will provide tangible benefits to patients. At this point in time it isn't clear if every service that the NHS provides, in all settings, would be beneficial if they were operated on a 24/7 cycle.
More transparency, more choice	WCCG will hold it's Board meetings in public, from the 1st of April 2013.
Listening to patients and increasing their participation	We will actively promote the development of existing patient forums and representation, where there are gaps we will proactively seek out patient champions who we can work with, to develop new forums/ groups to provide us with commentary on the services currently being provided and proposals for services changes and proposals for the commissioning of new services. This subject forms part of our wider programme for improving patient experience.
Better data, informed commissioning, driving improved outcomes	NHS England will take the lead in facilitating the collection of meaningful and accurate data - collected from the full range of providers and at various stages of the care process. WCCG will establish mechanisms and processes to ensure that we use and manipulate the data appropriately so that we realise the benefits of the data to inform our commissioning intentions, our performance management processes and outputs - which in turn will drive our service reviews, particularly if the data tells us that one or more services are not performing at the expected or agreed levels. WCCG will work closely and proactively with the Area Team to implement the guidance and recommendations that are expected in March 2013 from NHS England's National Director for Patients
Higher standards, safer care	Salutary lessons have emerged in recent years in the area of Health and Social Care, Winterbourne View Hospital, Mid Staffordshire NHS Foundation Trust, Alder Hey, Basildon Hospital. WCCG will work closely with providers and Wolverhampton Council and CQCto ensure that; the recommendations of the Winterbourne View report are fully considered and implemented; and the recommendations from the Francis Review at Mid Staffordshire NHS Foundation Trust are fully considered and implemented.
Joined up, local planning	WCCG has got strong historical working relationships with Wolverhampton City Council and all our service providers from whom we commission healthcare services. We have a joint commissioning unit established with the council which commissions a range of services for the council and WCCG

Indicator	What WCCG will do
Planning to meet responsibilities	CCG's have responsibilities to: reduce inequalities, obtain appropriate professional advice, ensure public involvement,meet financial duties, take account of the local JHWS. We will work with the Local Authority, specifically Public Health to measure the effectiveness of health interventions that will over a period of time reduce health inequalities. We will use the appropriate sources of expert advice when we need to and manage our finances in a professional and prudent manner
Addressing health inequalities	The Marmot report from 2010 provided clear links between public wellbeing and what are now commonly referred to as the wider determinants of health. We need to deliver a whole system integrated approach if we are to reduce health inequalities across the City. The Joint Health and Wellbeing Board (JHWBB) will provide the vehicle for the system to determine and agree the Joint Health and Wellbeing Strategy (JHWBS) which will drive the appropriate interventions that we will need to deliver.
Enhancing quality of life for people with long term conditions	Our Vision for Long Term Conditions Services: To create a sustainable and effective system to improve the quality of life for patients with Long Term Conditions, by reviewing and evaluating existing services, designing new care pathways where the evidence demonstrates that by doing so we will improves services for patients
Helping people to recover from episodes of ill-health or following injury	People enter hospital or sustain injury and suffer ill health for a variety of reasons but there are some recurring themes which can be seen to be on the increase in society at large. WCCG are working with all our provider organisations to reduce the time taken for people to recover and to provide the appropriate level of support in the right care setting
Ensuring people have a positive experience of care	WCCG is working to deliver a health economy where our customers experience is consistently in the upper quartile.We will work with patient groups to identify and rectify shortcomings in the model of care on which patients base their experience(s)
Treating and caring for people in a safe environment and protecting them from avoidable harm	There are a number of elements that need to come together to provide a consistently safe environment for patients and carers: - Respect - Compassion - Sensitivity - Diligence This subject is covered in more detail in the Section Safety and Quality later in the document
Eliminating long waiting times	We will closely monitor the consistent achievement of the 18 week target, striving to reduce the number of people waiting >26 weeks to as close to zero as possible and the number waiting > 52 weeks to zero.
	.

Indicator	What WCCG will do
More responsive care: urgent and emergency care	In line with the NHS England guidance WCCG will work closely with provider trusts to ensure that patients are not spending excessive amounts of time on trolleys awaiting transfer from Ambulance crew care to Hospital A&E care or left on trolleys in hospital A&E's for long periods of time.
Mental Health	WCCG will work closely with a range of organisations, voluntary and mainstream providers to ensure access to mental health provision. We will also be working closely with our Mental Health providers to develop and refine services for people with mental health problems. We will regularly review service provision and standards to ensure we are meeting the needs of service users.
Keeping our promises: reducing cancellations	WCCG will enforce the NHS England's pledge to patients cancelled at short notice i.e. on or after the day of admission, for non clinical reasons, they will be offered a new date that shall be binding within 28 days - or the patients treatment will be funded at the time and hospital of the patients choosing.
Finance	Wolverhampton PCT had a history of strong financial performance, having regularly delivered financial balance. WCCG has got a target of approximately £18.5 million cost reduction to be delivered over the next three years, as part of our QIPP and modernisation plans
QIPP	We have developed a QIPP plan, which has identified detailed proposals for 13/14 with future years still being refined. Specific details and values for QIPP schemes can be found later in the document. The delivery of QIPP is fully integrated within the day to day workings of the CCG's Development Delivery Groups (DDG's).A robust programme management approach will ensure rigorous performance management of the schemes.

The outcomes framework is the single most important tool for holding CCG's to account. We have therefore used it to inform our case for change, our future plans, and our emerging mechanisms to monitor our performance and that of our partners, so that we achieve our vision of delivering the **Right care** in the **Right place** at the **Right time**.

We have aligned the NHS Outcomes Framework, Public Health Outcomes Framework and Adult Social Care Outcomes Frameworks in our planning and work with our partners.

We have been actively monitoring the development of the Commissioning Outcomes Framework, which we have incorporated into our approach to planning specifying, procuring and performance managing services for Wolverhampton.

We commit to identifying at the earliest available opportunity any drift from the required outcomes in order to apply whatever corrective action is necessary to return to plan.

4.3.Local Context

4.3.1.Overview

The CCG will commission the **majority of services** from two NHS providers; the Royal Wolverhampton NHS Trust (RWT) and the Black County Partnership NHS Foundation Trust.

As lead commissioner for healthcare services across Wolverhampton, we also need to support the ambitions of the local council in respect of health and lifestyle initiatives, leading to tangible reductions in Health Inequalities.

It is therefore important and correct to appreciate the strategic intentions of those providers in order to ensure alignment and partnership.

In line with national policy, there is a heavy emphasis on delivering high quality, safe and effective services, **Right care** across all providers in the **Right place** at the **Right time**.

4.3.2.Wolverhampton City

The overarching aim of the council is to achieve 'Prosperity for all', which will be achieved by creating opportunities that encourage enterprise, empower people and re-invigorate the city.

The health specific issues are to create a city where people benefit from good health and live longer. Through empowering people and communities, it is hoped to tackle problems with alcohol, obesity, smoking and poor lifestyles.These issues are being led by the Health and Wellbeing Board (HWBB)

Mental health prevalence is particularly high – with 1 in 3 people in receipt of incapacity benefits due to poor mental health.

4.3.3.Our view as a clinical commissioner

As lead healthcare commissioner for Wolverhampton City, we will continue to actively engage and work in partnership to ensure the achievement of these healthcare targets and goals. We will commission services that will actively support and encourage our population to lead healthier lives, which will lead to a growth in life expectancy and reduce pressures across the entire health economy.

4.4.RWT

The Trust has an operating budget of £374m with 6,500 staff. It has a good track record of both strong financial and non-financial performance.

Through the TCS agenda, the Trust integrated with the Community Services from Wolverhampton City PCT, in recognition of the opportunities to realise transformational change through the vertical integration between acute and community care.

The Trust appreciates that the changing landscape has a bearing on their future and offers them an opportunity to work in collaboration with Commissioners in way which is patient focussed to deliver the **Right care** in the **Right place** at the **Right time**

4.4.1.Foundation Trust Status

The Trust's application was deferred by Monitor in September 2012 for up to 12 months. The Trust has agreed an action plan with Monitor and the Trust Development Authority (TDA) and is in regular contact with both parties. The Trust continues to report on its performance to the TDA via the Single Operating Model return and has submitted its Operating Plan which contains an overview of the actions through to reactivation of its application. The Trust Chief Executive has discussed the deferral with the Chief Clinical Officer of the CCG and with the Overview and Scrutiny Committee of the local authority.

A new Chair commenced on 6th March and the process has commenced to recruit Non –Executive directors that will return the Board to full complement by June. The Trust will agree with the TDA the elements of review required as described in Stage 3 of the Accountability Framework to enable the TDA to provide assurance to Monitor prior to reactivation of the Trust's application. The CQC conducted an unannounced inspection at the Trust in January 2013 and has published its final report which shows the Trust as being full compliant across all domains reviewed with no actions required. The Trust continues to work with its shadow Governors to ensure it is taking account of the role governors have in a foundation trust.

The CCG continues to support RWT's FT application, the CCG and the Trust have a productive relationship and there is a collaborative agreement between the Commissioner and the provider for the modernisation of Healthcare services across Wolverhampton - in which RWT will have a pivotal role. There is high level agreement between the organisations around the long term financial strategy for the health economy and also the major developments around the joint work for a new Urgent care centre.

The CCG will continue to work with RWT to achieve the best clinical outcomes, improve the patient experience and deliver a sustainable healthcare provision for the city.

4.5.Black Country Partnership (BCP)

Are a major provider of mental health, learning disability and community healthcare services for people of all ages in the Black Country. They provide:mental health and specialist health learning disabilities services to people of all ages in Sandwell and Wolverhampton, Specialist learning disability services in Walsall, Wolverhampton and Dudley and community healthcare services for children, young people and families in Dudley

There are over 2000 staff working in the Trust. Staff carry out a wide range of roles, working together to provide integrated care and support to all those using the services.

Frontline staff working in the trust include: mental health nurses,psychiatrists, social workers, healthcare support workers, health visitors, school nurses, allied health professionals (such as psychologists, occupational therapists, and speech and language therapists).

4.6.Wolverhampton City Council

Is the governing body of the City of Wolverhampton, England. The council offices are located in the Civic Centre, which is located in St. Peter's Square in the city centre.

The Labour party currently control the council and have been in majority on the council since 1974, with the exceptions of 1978–1979, 1987, 1992–1994 and 2008–2010.[2]

Councillor Mrs Christine Valerie Mills is Mayor of Wolverhampton for 2012/13.

Wolverhampton City Council was assessed in 2007 by the Audit Commission and judged to be "improving well" in providing services for local people; this rating was given to 59% of local authorities. Overall, the council was awarded "three star" status meaning it was "performing well" and "consistently above minimum requirements", similar to 46% of all local authorities. It was noted that it was rated as "good" for children's and young people's services.

The Vision Statement for the council is "Wolverhampton City Council, Leading, Supporting and Inspiring our City. Proud to be of service today and rising to the challenges of tomorrow”.

4.7.Primary Care

Primary Care commissioning is the responsibility of NHS England. The CCG is aware that delivery of primary care services is a key enabler to its strategy. The

current variability in quality in primary care leads to variable performance and variable patient satisfaction.

The CCG and NHS England's AT will need to work together to ensure practices are providing an acceptable minimum standard and are moving to becoming excellent health care providers.

Both clinical effectiveness and patient experience are key domains of health care quality.

If we are going to deliver '**Right care** in the **Right place** at the **Right time**' it is important to recognise the relationship between the two domains; considering them together is an effective way for general practices and the CCG to understand the quality of care that is being provided and to identify areas for improvement The two domains are:

- the Quality and Outcomes Framework (QOF), which was designed to improve quality by rewarding GP practices for meeting performance thresholds across a range of indicators of clinical quality
- patients' experiences of using their GP services, as measured by patient surveys on issues such as ease of making an appointment, information received from the practice, and consultations with staff.

Overall[5], patients are satisfied with their GP: 85 per cent reported being satisfied with the care they received at their practice, and said they would recommend it to others. However, mean GP Patient Survey (GPPS) scores showed considerable variation between the different domains of the patient experience. For example, only 50 per cent of patients were satisfied with the information they received from the practice , whereas 72 per cent were satisfied with access, 93 per cent expressed confidence and trust in practice staff, and 97 per cent said the practice premises were clean[6].

For patients, what matters is that their GP provides both a high quality of clinical care and a positive all-round experience of using GP services.

Using the QOF indicators and other available benchmarking data,WCCG will work closely with the AT to assure the delivery of high quality Primary Care consistently across all our member practices and develop a robust primary care strategy.

Where performance falls short of standards that we should reasonably expect we will, in collaboration with the AT, performance manage those practices that fall short until they attain and maintain an acceptable level of consistent performance.

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[5] These figures represent the picture nationally

[6] Source - The Kings Fund Data Briefing- Improving GP Services in England

What we must be absolutely attuned to is that if we want significant improvements in the capability and capacity of GP's to provide more services and interventions in Primary Care and if we want to deliver our vision of '**Right care** in the **Right place** at the **Right time**' we must provide the appropriate support to enable practices to do this.

4.7.1.Locally enhanced services

We currently hold contracts with GP practices for a number of Enhanced services – (most practices participate in many of these services) These agreements will continue for the next 6 months on the basis that they will continue to be commissioned by NHS England – after this period they will need to be re-commissioned by the CCG and contracts formalised on the Standard NHS Contract. They will then be contract managed in the same way as other WCCG health care contracts

4.7.2.AQP

The Any Qualified Provider (AQP) scheme means that, for some conditions, patients will be able to choose from a range of approved providers, such as hospitals or high street service providers.

Patients and GPs can choose a service based on what's important to them – perhaps one that is closer to home, has a shorter waiting list or is reporting better outcomes. WCCG will support GP's and Patients who feel that the AQP scheme offers them the opportunity of better outcomes.

These services will remain free for patients to use and access to them will be based on clinical need, in line with the NHS Constitution.

Current service provision in Wolverhampton via the AQP scheme are:

- Audiology;
- Podiatry.

The Case for Change

5.The case for change

This section by definition is the lengthiest part of the document, as would be expected. The Case for Change section contains the evidence base on which WCCG has relied to inform and drive our planning, our commissioning intentions, our consultations and ultimately our contracting proposals.

Within this section you will find significant amounts of evidence, data and informatics that describe what Wolverhampton's health profile looks like - and then compares it with the rest of England to provide a benchmark. This evidence provides the drivers for change, drivers that fuel our vision for **Right care** in the **Right place** at the **Right time.**

The format in which the information is presented is also consistent with how it is presented throughout England.

In this section you will find a mixture of narrative, data tables and graphs, it should be noted that because the tables and graphs are imported as images some of the information/data cells are empty, this is because the data is either not yet available or is not collected as a matter of course at this point in time. Therefore because the source tables has empty cells the image import also has empty cells and it has has not been possible to reconstruct the images so that the empty cells are not visible.

We will endeavour to update the tables as quickly as we can once we receive the relevant data. The data that is shown in this document is also available in the JSNA.

Each data table is located adjacent to the topic that it is associated with, for example Fig 13 relates to 5.3 Demographics and describes the population mix across Wolverhampton

5.1.Introduction

The case for change is fundamental in understanding the baseline assessment of the health profile in Wolverhampton, in order for us to commission the correct services in a sustainable manner. Four specific elements (see Fig 11) make up the case for change and ensure that a holistic appraisal is considered.

The case for change has been constructed in collaboration with our stakeholders and is congruent with the JHWBS. WCCG will continue to work with stakeholders in communicating and agreeing the case for change, in order that it forms a harmonious fixed point and assists the coordination of service developments and quality improvements across the Wolverhampton health economy.

Fig 11 - The case for change

5.2.Key Local Priorities

As part of our Authorisation process and the nationally mandated requirements for planning WCCG was required to identify three key local priorities that we are going to focus on for 2013/14, and possibly beyond.

We have used the evidence in the JSNA and have worked with the HWBB as well as using other key health indicators to determine the areas of focus for the CCG which are described in Fig 12 below and support and align with the principle of **Right care** in the **Right place** at the **Right time**. The following pages and tables describe the evidence base on which we have based the selection of the three Key Local Priorities for WCCG.

Urgent Care To reduce the number of avoidable admissions from Nursing Homes	Dementia - 75% of patients discharged from C22 are seen and reviewed by their own GP within two weeks of receipt of the discharge summary from C22. The underlying aim being to stabilise patients at home avoiding readmission. A further review will be carried out three months following the date of discharge	Diabetes - 75 % of moderate risk patients will have a care plan, helping patients to better manage their condition

Fig 12 - WCCG local priorities

5.3.Demographics

Wolverhampton's population is approximately 250 000[7]. It is one of the most densely populated places in the country, with nearly 9,000 residents per square mile.

About a third of the population is of black and minority ethnic (BME) origin. The biggest growth in the population is likely to be in this group with BME communities constituting around one third of the city's population by 2026.

Births have increased in the last 8 years leading to an increase in the 0-19 age group. 75% of these births are in the most deprived areas. This contributes to increased child poverty and intergenerational cycles of ill-health.

Wolverhampton is ranked 21st most deprived out of 354 local authorities. Deprivation is not concentrated in a few areas – almost half of the city's neighbourhoods are amongst the 20% most deprived in the country

Social marketing tools demonstrate distinct groups that will respond to services and health promotion in different ways.

Later pages go into more detail on the significantly different areas: ageing population, high BME population, high deprivation, high fertility rates, unemployment.

Demographic spine chart

Key:

- Significantly lower than England average
- Not significantly different from England average
- Significantly higher than England average
- No significance can be calculated

Spine chart explanation:

National average
Wton LA peers
Worst Best
25th Percentile 75th

Indicator	Local Number	Local Value	Nat Avg	Nat Min	National Range	Nat Max
% males 2010	118400	49.5	49.3	47.3		54.8
% population under 16 2010	46600	19.5	18.5	6.8		25.2
% population 65+ 2010	40500	16.9	17.5	6.8		29.9
% population white 2009	181700	76.2	90.8	44.7		98.0
% population asian 2009	32900	13.8	4.4	0.6		30.6
% population black 2009	12300	5.2	2.0	0.0		19.0
% population mixed 2009	7600	3.2	1.5	0.0		4.4
% population other 2009	4000	1.7	1.3	0.0		6.7
% population in poorest 20% from IMD 2010	82	51.9	20.0	83.7		0.0
% population in richest 20% from IMD 2010	3	1.9	20.0	0.0		84.9
Fertility rate 2010	n/a	2.1	2.0	0.7		3.1
Unemployment rate at November 2011	11584	7.6	3.8	8.0		0.5
Percentage change in projected number of children at 2033	51100	10.1	12.9	-14.2		42.7
Percentage change in projected number of working age at 2033	147100	1.2	7.5	-17.5		35.6
Percentage change in projected number of older people at 2033	61300	32.4	57.1	15.2		121.5
Percentage change in projected number of all ages at 2033	259500	9.0	18.0	-3.4		41.8

Fig 13 - Population demographic of Wolverhampton

[7] a recent census (2011) estimated the population at 249 000 and GP responsible population at 262 000

5.3.1.Wolverhampton Health Indictors

The following figure (Fig 14) describes the health profile of Wolverhampton, which we have used in conjunction with a number of other evidence based documents (see Figure 7) to inform the selection of our key local priorities (see Fig 12) and subsequently our commissioning intentions.

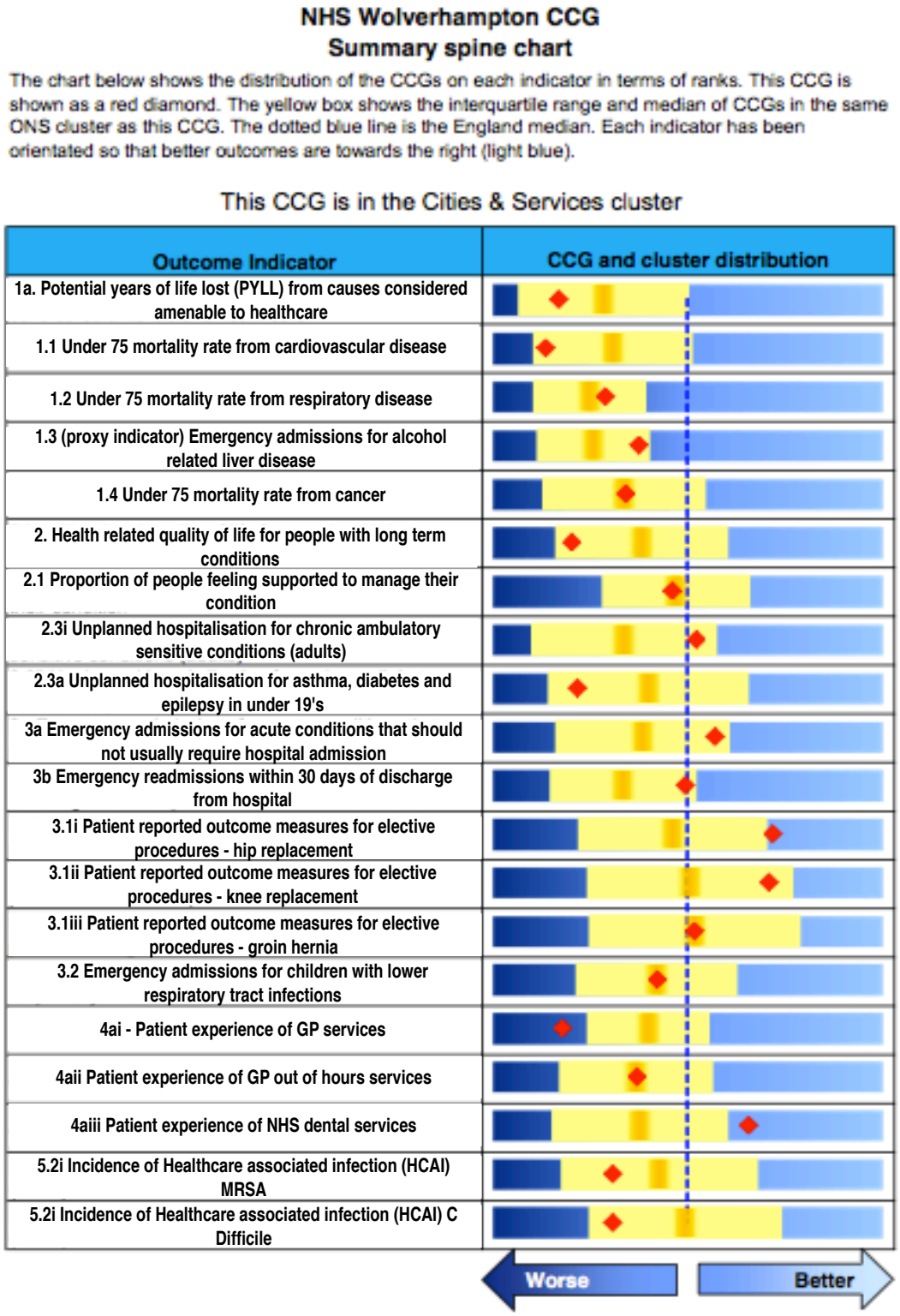


Fig 14- Wolverhampton Health Indictors

5.4. “The Big Six”

There are six conditions (“the Big 6” - see Figures 15,16 & 17 below) which account for over half of the difference in life expectancy that exists between Wolverhampton and England. When WCCG first started to examine Wolverhampton’s health profile the “Big Six” were coronary heart disease, stroke, infant mortality, lung cancer, suicide and alcohol-related liver disease (Director of Public Health, Wolverhampton City PCT, 2011) - since then the rankings have changed. This is seen disproportionally in the most disadvantaged communities. Deaths due to alcohol and those occurring in infancy are the major reasons why life expectancy has not improved. Wards which have seen improvements have only improved in line with the national average.

In 2001-2005 Wolverhampton public health department carried out research into the causes of death that accounted for the biggest share of the gap in life expectancy to the national average. From this work six conditions were identified as priority areas, these were; Infant mortality, CHD, stroke, lung cancer, alcohol related mortality, and suicide.The following re-examination of the data seeks to determine if these conditions still represent the most important causes of deaths that need to be addressed in order to close the gap in life expectancy to the national average. Further research was carried out in January of this year (2013) to determine if the original findings are still valid today.

Rank	Condition	Numbers	Rank	Condition	YLL
1	CHD	901	1	CHD	9465
2	Lung cancer	426	2	Infant deaths	9000
3	Disease of the respiratory system	390	3	Suicide and injury undetermined	5812
4	Stroke	329	4	Lung cancer	4295
5	Alcohol related Liver mortality	185	5	Alcohol related Liver mortality	4293
6	Suicide and injury undetermined	161	6	Disease of the respiratory system	4143
7	Colorectal cancer	149	7	Accidents	4125
8	Breast cancer	144	8	Stroke	3462
9	Diseases of the nervous system	137	9	Disease of the nervous system	2622
10	Infant deaths	120	10	Breast Cancer	2240

Fig 15 -Top 10 causes of death and top 10 sum of YLL 2001-2005

Rank	Condition	Numbers	Rank	Condition	YLL
1	CHD	594	1	Infants deaths	9000
2	Disease of the respiratory system	403	2	CHD	7006
3	Lung cancer	398	3	Alcohol related Liver mortality	5221
4	Alcohol related Liver mortality	236	4	Disease of the respiratory system	4461
5	Stroke	227	5	Accidents	4444
6	Colorectal cancer	150	6	Lung cancer	4078
7	Breast cancer	140	7	Suicide and injury undetermined	3231
8	Accidents	130	8	Stroke	2626
9	Diseases of the nervous system	121	9	Disease of the nervous system	2281
10	Infant deaths	120	10	Breast Cancer	2269

Fig 16- Top 10 causes of death and top 10 sum of YLL 2006-2010

The original big six conditions were based on the potential for improvement if Years Lost to Life (YLL) levels fell to those of the England and Wales average.

In 2006-2010 infant mortality tops the gap to the national average in terms of YLL; this was also the case in 2001-2005. If the rate of infant deaths in Wolverhampton had been equal to that of the national average in 2006-2010 then 736 YLL would have been avoided. The big change during this period has been the increase in the gap caused by alcohol related disease which has now replaced CHD in 2nd place, as well as the fall in the gap due to suicide, with suicide now lying outside the big 6 in terms of gap to the national average for YLL. In total the top six conditions account for 1,809 YLL out of a total gap to the national average of 2,708 (66.8%).

YLL annual potential improvement compared to England and Wales

Rank	Condition	2001 - 2005	2006 - 2010
1	Infant mortality	615	736
2	Alcohol related mortality <75	285	494
3	CHD Mortality <75	329	230
4	Respiratory disease mortality <75	98	184
5	Stroke <75 Mortality	259	161
6	Lung Cancer <75 Mortality	106	156
.....	.....	.....	.....
9	Suicide	279	33

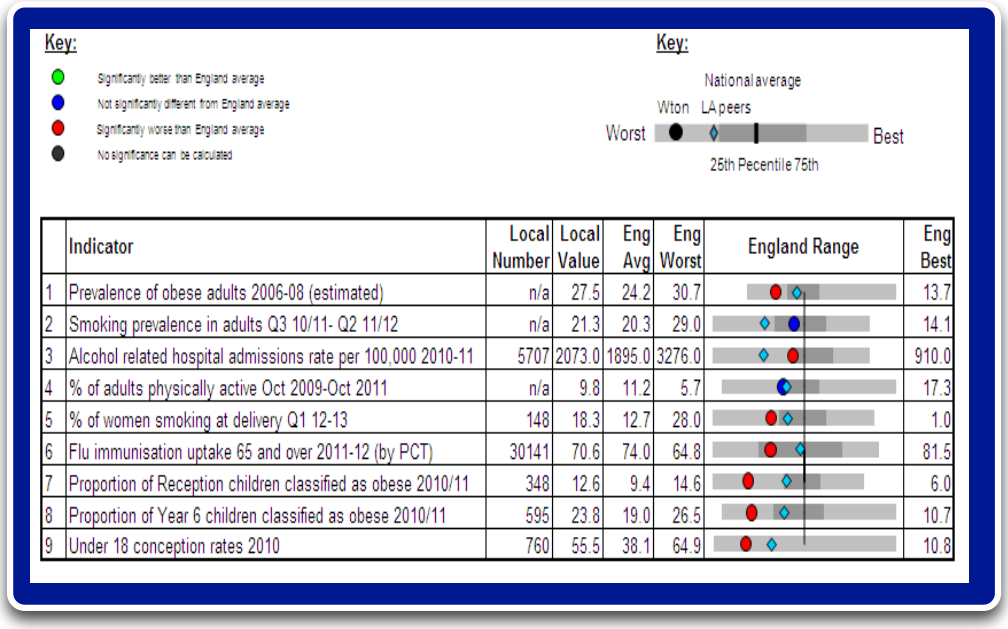
Fig 17 - YLL annual potential improvement compared to England and Wales

In summary the CCG can take advantage of the density of the population in a number of locations required to deliver services, services that have to be culturally appropriate.

Inequalities need to be considered in all service developments and delivery models. Service access and promotion development should take account of intelligence provided from social marketing tools.

5.4.1.Risk factors

- Obesity, smoking, physical inactivity and high alcohol consumption are all risk factors for circulatory disease mortality.
- Obesity, smoking, physical inactivity and high alcohol consumption are all risk factors for cancer mortality.
- High alcohol consumption is a precursor to alcohol related mortality.
- Smoking in pregnancy (see Fig 18) and high rates of teenage conceptions increases the risk of infant mortality.
- A bout of flu will reduce quality of life for people with long term conditions and increase unplanned hospitalisation for chronic ambulatory care sensitive conditions.
- Parental smoking are risk factors (see Fig 18) for emergency admissions for children (particularly around asthma and lower respiratory tract infections).
- Obesity and smoking impacts on effective recovery following any health event - Obesity can particularly effect recovery following hip or knee replacement.



	Indicator	Local Number	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
1	Prevalence of obese adults 2006-08 (estimated)	n/a	27.5	24.2	30.7		13.7
2	Smoking prevalence in adults Q3 10/11- Q2 11/12	n/a	21.3	20.3	29.0		14.1
3	Alcohol related hospital admissions rate per 100,000 2010-11	5707	2073.0	1895.0	3276.0		910.0
4	% of adults physically active Oct 2009-Oct 2011	n/a	9.8	11.2	5.7		17.3
5	% of women smoking at delivery Q1 12-13	148	18.3	12.7	28.0		1.0
6	Flu immunisation uptake 65 and over 2011-12 (by PCT)	30141	70.6	74.0	64.8		81.5
7	Proportion of Reception children classified as obese 2010/11	348	12.6	9.4	14.6		6.0
8	Proportion of Year 6 children classified as obese 2010/11	595	23.8	19.0	26.5		10.7
9	Under 18 conception rates 2010	760	55.5	38.1	64.9		10.8

Fig 18 - Key prevalence indicators

Encouraging uptake of public health commissioned services could reduce need for specific NHS commissioned services and improve recovery and quality of life, i.e. **high quality, safe** and effective services across all providers i.e **Right care** in the **Right place** at the **Right time.**

Targeting specific groups e.g. pregnant women, people waiting for elective surgery could lead to disproportionate returns on some NHS outcomes.

WCCG will work closely with providers and Public Health to ensure that we, as a health economy, are providing effective education programmes that will help to reduce the incidences of Smoking in pregnancy,Alcohol related hospital admissions, and with GP's to increase the uptake of the Flu jab by the over 65's.

5.5.Preventing ill- health and dying prematurely

Life expectancy in Wolverhampton is in the bottom 20%. The gap between Wolverhampton and the national average for men is two years and for women is 1.5 years. This is driven by "the big six" causes of death – infant mortality, coronary heart disease, alcohol related mortality, respiratory disease mortality, lung cancer and stroke.

There is currently little or no local data available for premature mortality for secondary mental health users or people with learning disabilities. However, national evidence suggests there is a 20 year mortality gap for men and a 15 year mortality gap for women. Circulatory disease is a major cause of death.

Wolverhampton has high prevalence of risk factors for the big six causes of death and therefore incidence of these diseases may grow causing either greater morbidity and/or mortality.

Key:

Significantly better than England average
Not significantly different from England average
Significantly worse than England average
No significance can be calculated

Wton
National average
LA peers
Worst
25th Pecentile 75th
Best

Regional Key:

No data
Still sourcing data
Needs source and discription

		Indicator	Local Number	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
1. Preventing people from dying prematurely	1a	Mortality from causes amenable to health care 2008-10	892	121.0	92.1	159.5		53.8
	1bi	Male Life expectancy at 75 2007-09	n/a	11.1	11.3	9.5		17.5
	1bii	Female life expectancy at 75 2007-09	n/a	12.4	13.1	11.3		19.3
	1.1	Circulatory disease mortality under 75 2007-09	639	85.2	70.5	122.1		37.9
	1.2	Mortality rate from Respiratory 2007-09	n/a	29.8	24.9	52.3		8.8
	1.3	Alcohol related mortality all ages 2007-09	164	22.3	10.4	33.6		2.2
	1.4i	Breast cancer survival at 1 year (Greater Midlands Network) 2001-03	4023	95.0	94.4	92.4		95.5
	1.4ii	Breast cancer survival at 5 years (Greater Midlands Network) 2001-03	4023	82.7	81.6	78.5		84.0
	1.4iii	Lung cancer survival at 1 year (Greater Midlands Network) 2001-03	3264	25.1	27.1	23.0		30.9
	1.4iv	Lung cancer survival at 5 years (Greater Midlands Network) 2001-03	3264	7.0	7.2	5.3		10.5
	1.4v	Colon cancer survival at 1 year (Greater Midlands Network) 2001-03	2058	68.6	68.6	61.6		73.1
	1.4vi	Colon cancer survival at 5 years (Greater Midlands Network) 2001-03	2058	50.3	49.8	42.2		56.3
	1.44vii	Cancer mortality under 75 2007-09	909	123.3	112.1	159.1		57.6
	1.5	*Premature mortality for secondary mental health services users*						
	1.6i	Infant mortality rates 2007-09	65	6.5	4.7	10.6		0.7
	1.6ii	Perinatal mortality rates 2007-09	123	12.1	7.6	14.7		2.0
	1.7	*Reduced premature mortality in people with learning disabilities*						

Fig 19 - Mortality indicators

As previously mentioned WCCG must focus on the big six causes of death. Giving consideration to the areas where Wolverhampton's outcomes are significantly worse than England in more detail (mortality from causes amenable to health care, life expectancy, circulatory disease mortality, alcohol related mortality, infant mortality, perinatal mortality and stillbirths) to develop interventions and initiatives that will improve the outcomes in these areas.

By working with our providers and the local authority we will review the provision of services that can have a direct impact on mortality rates and cancer survival rates by making sure that

- GP's refer early to increase the rates of early detection;
- Public health provides accessible and clearly understandable educational information to the citizens of Wolverhampton about cancer, respiratory health and other conditions that have a debilitating effect on people's health and how to improve it;
- Working with the secondary care providers to ensure that they facilitate "rapid access" for suspected cancer sufferers to increase early diagnosis and thus improve survival rates;
- We will constantly "horizon scan" to identify examples of new ways of working and new detection methodologies and treatments that can be brought to bear.

5.6.Enhancing quality of life for people with long term conditions

There is no data on health related quality of life for people with long term conditions – however disability free life expectancy would measure the opposite. Disability free life expectancy is low in Wolverhampton. The gap between Wolverhampton and the national average for men is 3.4 years and for women is 3.3 years. This is driven by some of the "big six" plus dementia, diabetes and depression.

Risk factors for emergency admissions for children include parental smoking, poor diet and physical inactivity (illustrated by childhood obesity) and wider social problems including poverty. Wolverhampton has significantly poorer outcomes for all these indicators compared to England.

Employment opportunities can support recovery for people with mental health problems. Wolverhampton currently provides less opportunities for employment compared to England.

2. Enhancing quality of life for people with long term conditions	2.0	*Health related quality of life for people with long term conditions*							
	2.1	*In last 6 months, had enough support from services to help manage long-term health condition*							
	2.2	*Employment of people with long term conditions*							
	2.3i	Unplanned hospital admissions for chronic ambulatory care sensitive conditions (adults)	n/a	256.1	240.2	426.8			34.9
	2.3ii	Emergency admissions for children with asthma under 18 April 2007 to March 2010	576	371.5	237.5	631.7			80.3
	2.3ii	Emergency admissions for children with epilepsy under 18 April 2007 to March 2010	215	140.3	76.9	181.2			19.1
	2.3ii	Emergency admissions for children with diabetes under 19 April 2009 to March 2010	52	93.1	67.4	123.1			14.9
	2.4	*Health related quality of life for carers*							
	2.5	% of secondary mental health services users in employment Q2 2010-11	42	5.1	8.8	0.0			16.0
	2.6	*Improved quality of life for those with dementia*							

Fig 20 - LTC's Indicators

We will support the commissioning of child and adult lifestyle services to improve parent and child lifestyle choices and support multi agency work on the wider determinants of health as identified by Marmot.

In addition to focussing on causes of reduced life expectancy we must also focus on those conditions which also contribute to quality of life, such as dementia, diabetes and depression.In line with our stated ethos of delivering **high quality, safe** and effective services across all providers i.e **Right care** in the **Right place** at the **Right time**.

There is no data for improved quality of life for those with dementia. However, we know dementia is a growing concern nationally and Wolverhampton is no exception to this.

The estimated number of people living with dementia in Wolverhampton is 2,940 people (POPPI 2010), which is approximately 7.3% of Wolverhampton's older persons population. The number of people with dementia is expected to increase by approximately 44%, over the next 20 years to 4,430 people. This represents an increase of approximately 75 people per year. (further detailed information can be found within the JSNA).

There is an issue with undiagnosed dementia.

- Working closely with Public Health we are proposing that NHS Health Checks, (delivered by our GP's) should "provide information designed to raise awareness of dementia and of the availability of memory services which offer further advice and assistance to people who may be experiencing memory difficulties, including making a diagnosis of dementia" to adults aged 65-74 years.

- This could include signposting to their GP anyone who shows any early symptoms or risk factors for dementia. WCCG will ensure there is an appropriate review of these people and ensure they are offered an appropriate pathway if diagnosed.
- We will also commission vocational support as part of mental health services.

Diabetes is another area where we have significant challenges in Wolverhampton-

The number of people with diabetes in the population at large is rising. Current data indicates there are approximately 15,500 known diabetic patients within the city. This will undoubtedly impact our referral rate, leading to more follow ups and increased emergency admissions with increased length of stay for patients.

The current situation is that there are also a lot of undiagnosed cases of diabetes in Wolverhampton, it is also the case that the complexity of the diabetic patient is not always taken into account and there are a mix of patients in acute and primary care. Not all patients have a clear care plan.

In 2011/12 there were 15,366 patients on the diabetes Quality Outcomes Framework (QOF) register, approximately 5.9% of the total GP population. The national prevalence for diabetes was 4.6%. Trend data suggests that the diabetes prevalence is increasing year on year, prevalence in Wolverhampton is consistently above the national comparators.

WCCG will:

- Identify patients who are at high risk from diabetes and ensure they are followed up in specialist care;
- Ensure patients who are at low risk are managed in primary care thus freeing up specialist capacity and reduce follow ups and referrals;
- Reduce the number of emergency admissions and average length of stay for these patients whom become part of this scheme;
- We will work towards every diabetic having an individual care plan, that has been developed with their contributions fully considered;
- Patients with complex conditions will be managed through the Acute specialist care team
- To improve the standards of care for patients with diabetes in Wolverhampton in line with current evidence base;
- We will be working with GP's to improve diabetic care.

5.7.Helping people to recover from episodes of ill-health or following injury

- The rates of emergency admissions from our most deprived populations are higher.
- The rates of emergency admissions from BME groups are higher specifically in the Black and Asian populations.

3. Helping people to recover from episopes of ill health or following injury								
	3a	Emergency hospital admissions: acute conditions usually managed in primary care 2008/09	2051	801.4	443.5	1042.9		88.7
	3b	Emergency readmissions within 28 days of discharge 2008-09	2295	9.1	11.2	15.4		7.0
	3.1i	Effective recovery following hip replacement Apr 2009 - Feb 2011	n/a	0.4	0.4	0.2		0.5
	3.1ii	Effective recovery following knee replacement Apr 2009 - Feb 2011	n/a	0.3	0.3	0.0		0.4
	3.1iii	Effective recovery following hernia Apr 2009 - Feb 2011	n/a	0.1	0.1	-0.1		0.1
	3.1iv	Effective recovery following varicose veins Apr 2009 - Feb 2011	n/a	0.1	0.1	-0.1		0.2
	3.2	Emergency admissions for children with lower respiratory tract infections 2008-09	n/a	107.7	93.8	238.6		32.1
	3.3	*An indicator on recovery from injuries & trauma*						
	3.4	*An indicator on recovery from stroke*						
	3.5i	*Proportion of patients with fragility recovering to previous levels of mobility at 30 days*						
	3.5ii	*Proportion of patients with fragility recovering to previous levels of mobility at 120 days*						
	3.6i	Percentage of 65+ still at home 91 days after discharge from hospital into rehab 2010-11	230	87.2	81.9	44.9		99.3
	3.6ii	*Proportion offered rehab following discharge from hospital*						

Fig 21 - Recovery indicators

We need to transfer care from emergency care settings to primary care by focusing on high need groups. Working closely with social care to support recovery following discharge from hospital - **high quality, safe** and effective services across all providers i.e **Right care** in the **Right place** at the **Right time**

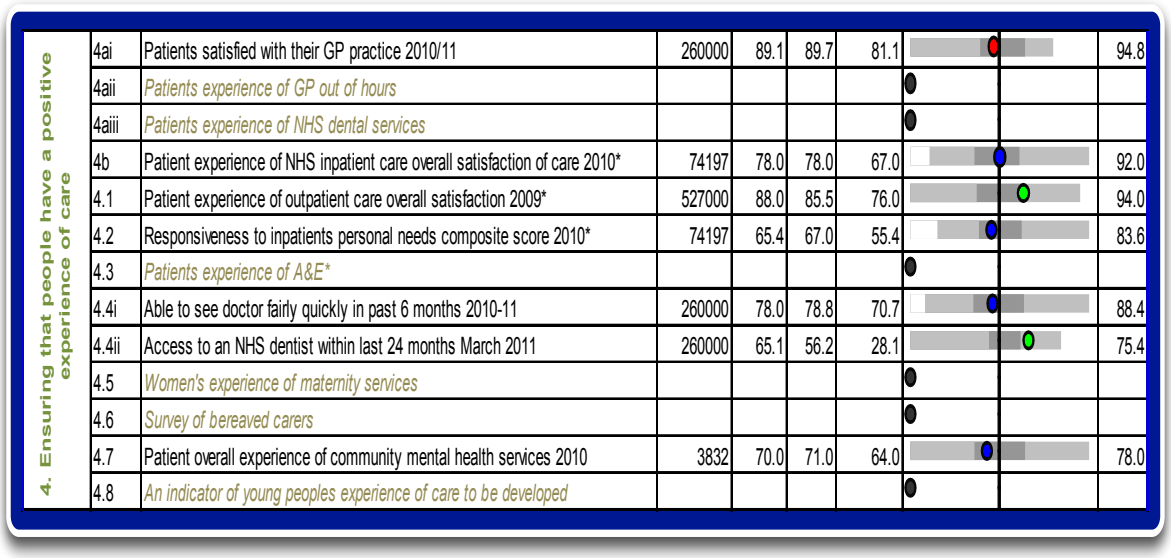
If we are going to be successful with this we must consistently have more detailed data on emergency hospital admissions.

5.8.Ensuring that people have a positive experience of care

Patient experience of care is positive in Wolverhampton, accepting that there are gaps in the data sources.

Key objectives for 2013/14 are:

- To improve the capture of patient experience information and to use it to inform and drive service improvement;
- Implement the recommendations in the Francis report that relate to patients having a positive experience of care

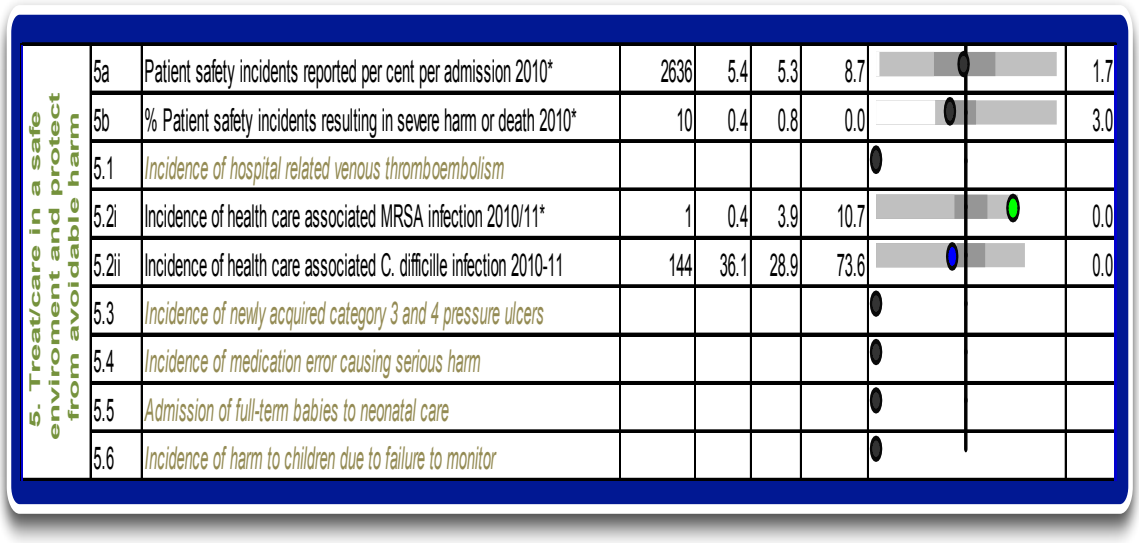


4. Ensuring that people have a positive experience of care								
	4ai	Patients satisfied with their GP practice 2010/11	260000	89.1	89.7	81.1		94.8
	4aii	*Patients experience of GP out of hours*						
	4aiii	*Patients experience of NHS dental services*						
	4b	Patient experience of NHS inpatient care overall satisfaction of care 2010*	74197	78.0	78.0	67.0		92.0
	4.1	Patient experience of outpatient care overall satisfaction 2009*	527000	88.0	85.5	76.0		94.0
	4.2	Responsiveness to inpatients personal needs composite score 2010*	74197	65.4	67.0	55.4		83.6
	4.3	*Patients experience of A&E**						
	4.4i	Able to see doctor fairly quickly in past 6 months 2010-11	260000	78.0	78.8	70.7		88.4
	4.4ii	Access to an NHS dentist within last 24 months March 2011	260000	65.1	56.2	28.1		75.4
	4.5	*Women's experience of maternity services*						
	4.6	*Survey of bereaved carers*						
	4.7	Patient overall experience of community mental health services 2010	3832	70.0	71.0	64.0		78.0
	4.8	*An indicator of young peoples experience of care to be developed*						

Fig 22 - Patient experience indicators

5.9.Treat/care in a safe environment and protection from avoidable harm

Patient care is provided in a safe environment for the areas we are currently able to measure.



5. Treat/care in a safe enviroment and protect from avoidable harm								
	5a	Patient safety incidents reported per cent per admission 2010*	2636	5.4	5.3	8.7		1.7
	5b	% Patient safety incidents resulting in severe harm or death 2010*	10	0.4	0.8	0.0		3.0
	5.1	*Incidence of hospital related venous thromboembolism*						
	5.2i	Incidence of health care associated MRSA infection 2010/11*	1	0.4	3.9	10.7		0.0
	5.2ii	Incidence of health care associated C. difficille infection 2010-11	144	36.1	28.9	73.6		0.0
	5.3	*Incidence of newly acquired category 3 and 4 pressure ulcers*						
	5.4	*Incidence of medication error causing serious harm*						
	5.5	*Admission of full-term babies to neonatal care*						
	5.6	*Incidence of harm to children due to failure to monitor*						

Fig 23 - Safety indicators

By continuing to monitor the environment and horizon scan for emerging themes, issues and new ways of working to improve patient safety we will go some way to achieving our stated aims which are **high quality, safe** and effective services across all providers - **Right care** in the **Right place** at the **Right time**.

5.10.Age profile and projections

Main expected growth will be in the older age groups 60+ especially in the long term up to 2035.

In the short term the increase in births in Wolverhampton will lead to more pressure on children's services.

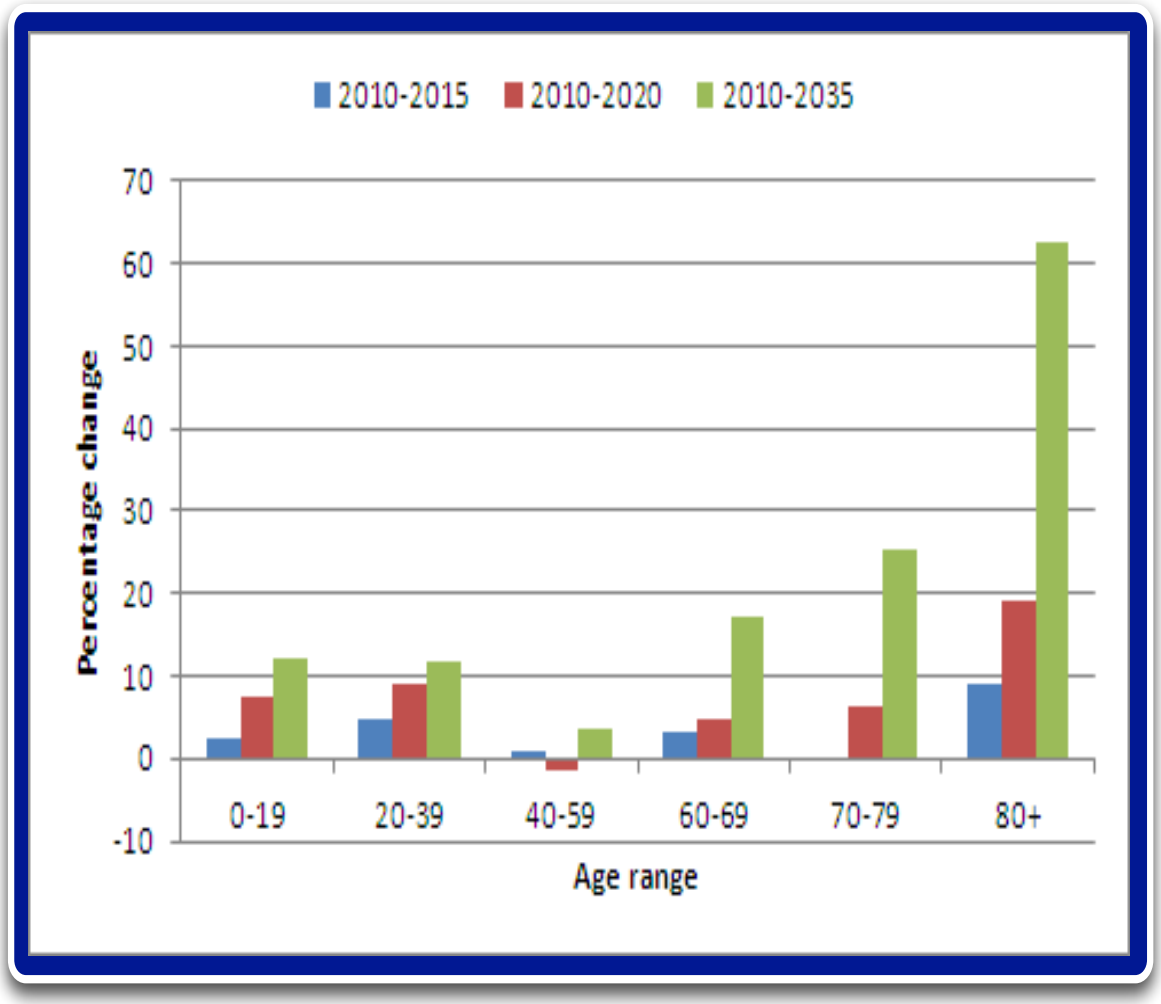


Fig 24 - WCCG Age profile

With the largest percentage growth expected in the 60+ age group WCCG will have to be mindful of the population profile when commissioning services, without focusing too much on one particular cohort at the expense of another.

We are in the process of reviewing and evaluating our Intermediate care services across Wolverhampton with a view to improving and streamlining the provision in order to reduce the number of avoidable admissions into secondary care and help the frail and elderly to have an improved quality of life and a better experience of health care services.

A number of initiatives have already been scoped around Nursing Homes and Care homes to prevent such admissions which will come online during 2013/14.

5.11.Ethnicity

- 32% of the population are from Black and Ethnic minority groups.

- The age profiles of ethnic groups differ significantly. With more younger people in the BME groups.

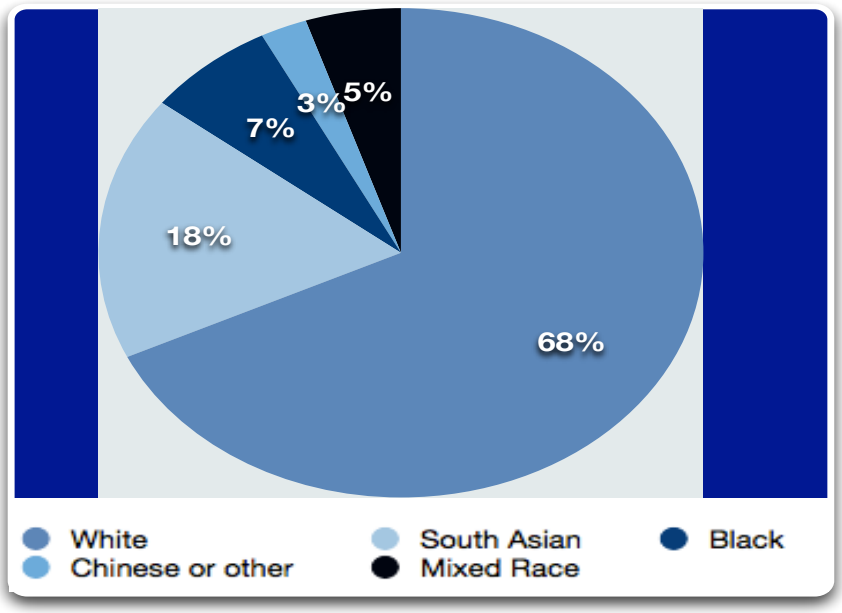


Fig 25 - Ethnicity indicators

The CCG will have to consider the ethnicity profile when commissioning services, to ensure that they are culturally accessible and appropriately structured to cater for the diversity of the City's population.

For example cancer screening services should be culturally sensitive, so that female patients feel that the service is accessible to them and sensitive to their diversity and religious needs

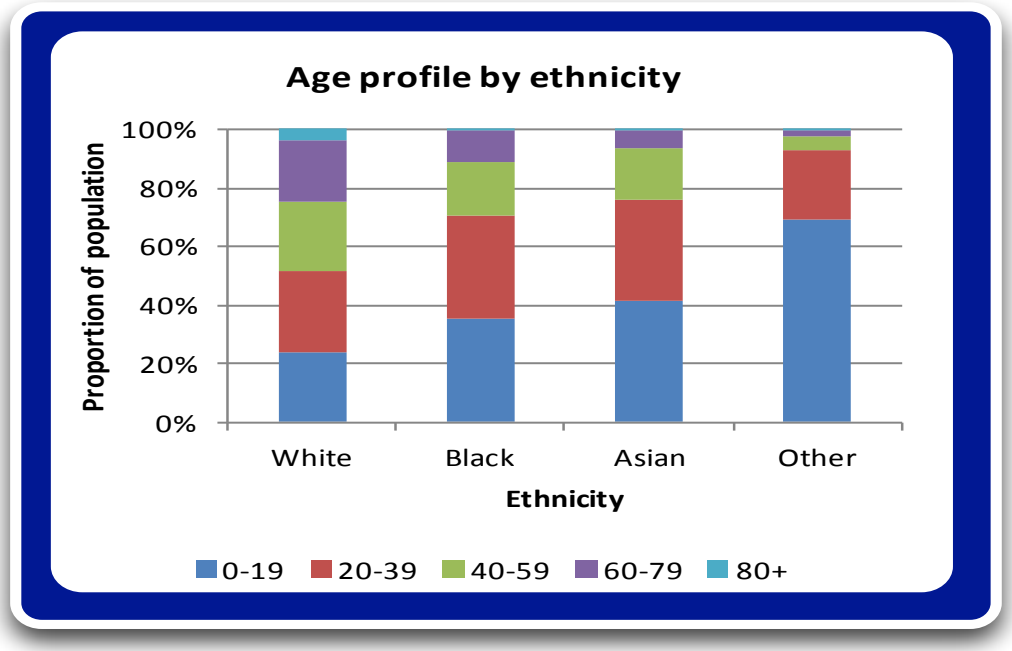


Fig 26 - Age and Ethnicity indicators

5.12.Deprivation

- Wolverhampton is ranked as 21st most deprived out of 354 local authorities.
- Deprivation is not concentrated in a few areas – almost half of the city's neighbourhoods are amongst the 20% most deprived in the country.
- Deprivation is focussed in the North East and South East wards of the City.
- Deprivation is correlated with poor lifestyles, high morbidity and high mortality.

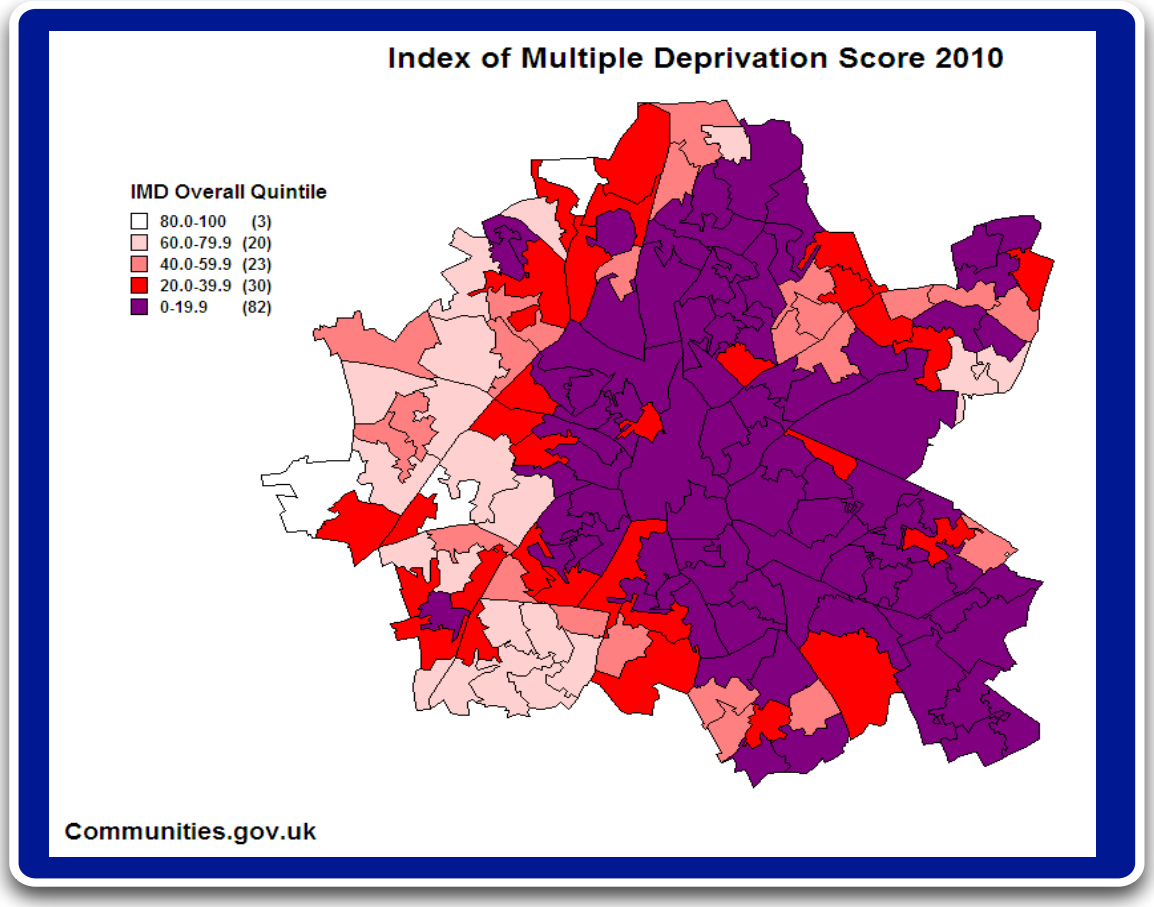


Fig 27 - WCCG Deprivation mapping

WCCG will have to consider the deprivation profile when commissioning services in order to drive down inequalities. Disproportionate access in deprived areas could be one way of helping to reduce health inequalities.WCCG will look closely at this methodology with WCC and member practices to determine the added value of increased access and develop effective interventions that will reduce inequalities

5.13.Fertility (birth rates)

In the last 10 years there has been a 30% increase in the number of births.

This is disproportionately in Wolverhampton's most deprived areas with a 36% increase in the two most deprived quintiles compared with a 17% increase in the three most affluent quintiles.

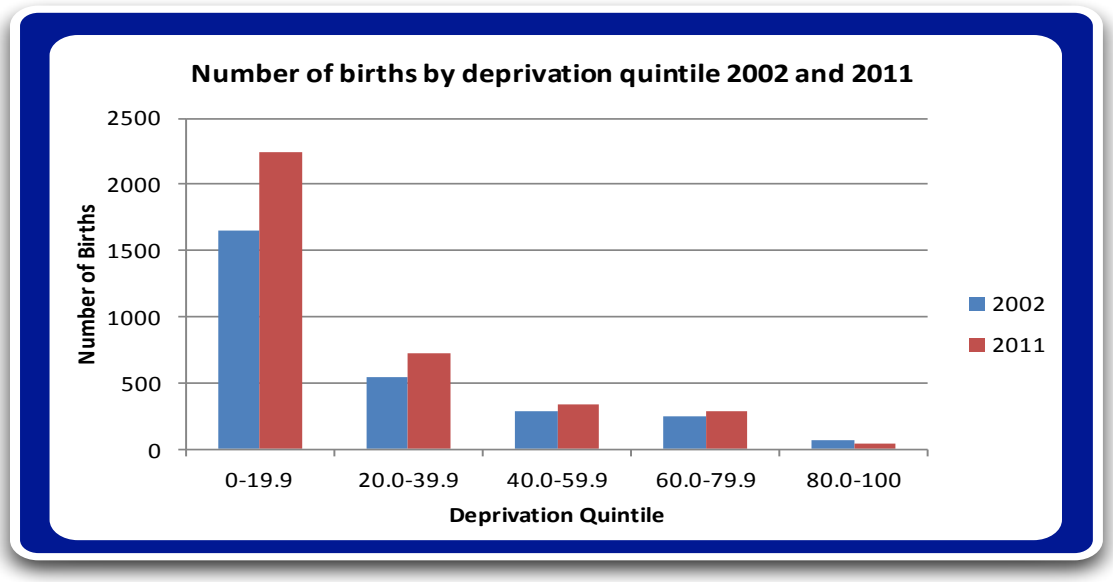


Fig 28 - Areas of deprivation Birth indicators

The CCG must consider births rates and the relationship with deprivation within its commissioning decisions, ensuring that we provide appropriate access to maternity services and sexual health services and advice.

5.14.Unemployment

After the spike in unemployment during the economic downturn, the position in Wolverhampton is worsening, while England as a whole and West Midlands are relatively stable.

Claimant count is only those who claim employment support allowance, true unemployment will most likely be higher than this, however data is not available at a Wolverhampton level and the claimant count is good indicator of the trend.

Unemployment is a risk factor for physical and mental health problem.

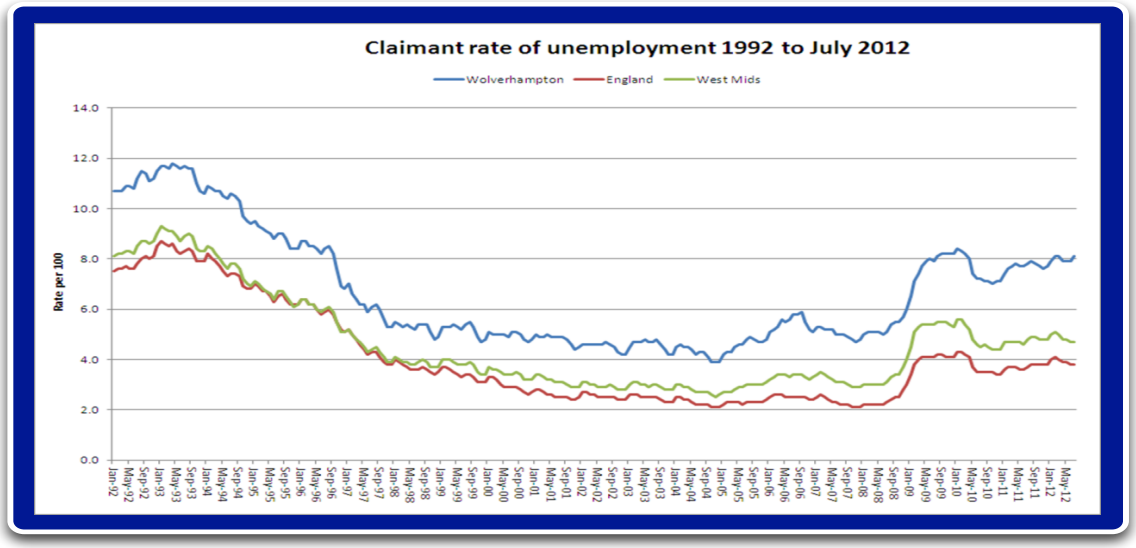


Fig 29 - Unemployment indicators

Unemployment is a highly emotive and political issue so rates of unemployment must be carefully considered when commissioning services, it is well known that as unemployment rises so demand on health services also rises, particularly in Mental Health .

WCCG will ensure that easy and timely access to health services across Wolverhampton is ever present so that people who are suffering from conditions that may have been worsened by their employment situation can be provided with the care they need, at the time they need it and in the appropriate setting- **Right care** in the **Right place** at the **Right time.**

5.15.Life expectancy at birth trend

- For both males and females Wolverhampton is close to the trend for LA peers groups.
- However, for women the gap to the England & Wales average has widened since 2000.
- For men the gap to the national average has remained constant over the last 10 years.

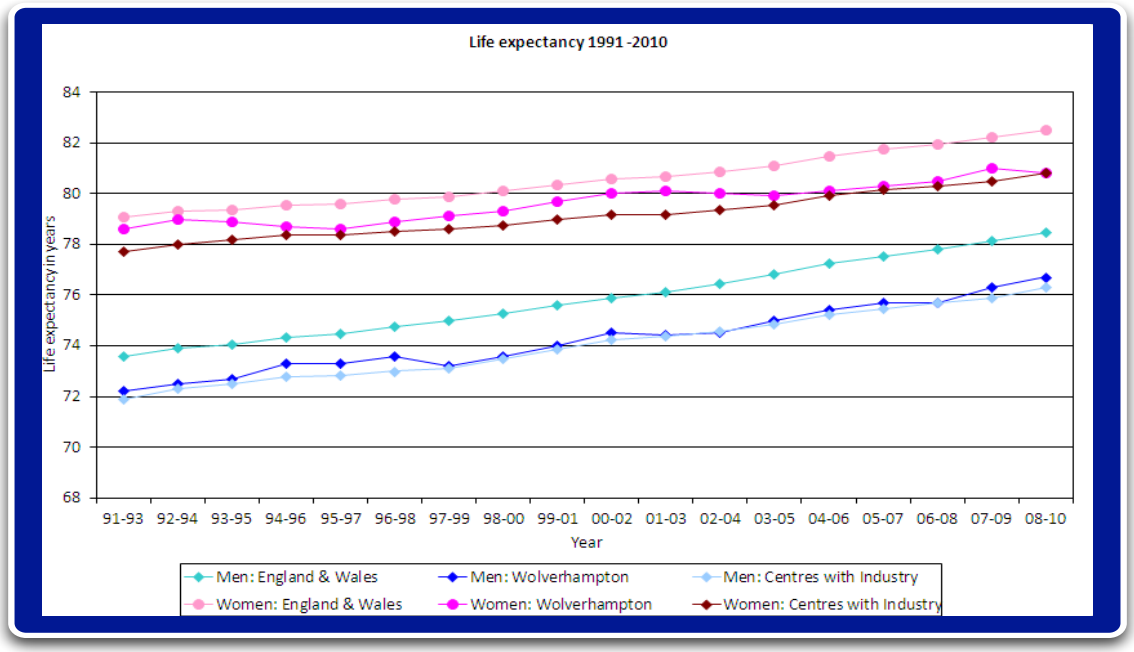


Fig 30 - Life expectancy indicators

WCCG will need to to work closely with the City Council to consider and understand what drives the life expectancy gap between Wolverhampton and England and Wales. Understanding what the drivers are in Wolverhampton will help to shape initiatives that will reduce the gap.

With Public Health support and collaboration we will introduce initiatives that are designed to improve peoples quality of life, such as more healthy environments,

healthy places and healthy eating advice, safer better quality housing that does not add to peoples health problems - and thus increases their life expectancy

5.16.Emergency hospital admissions: acute conditions usually managed in primary care

Wolverhampton is considerably above the trend for England in regards to conditions that could be managed in primary care.

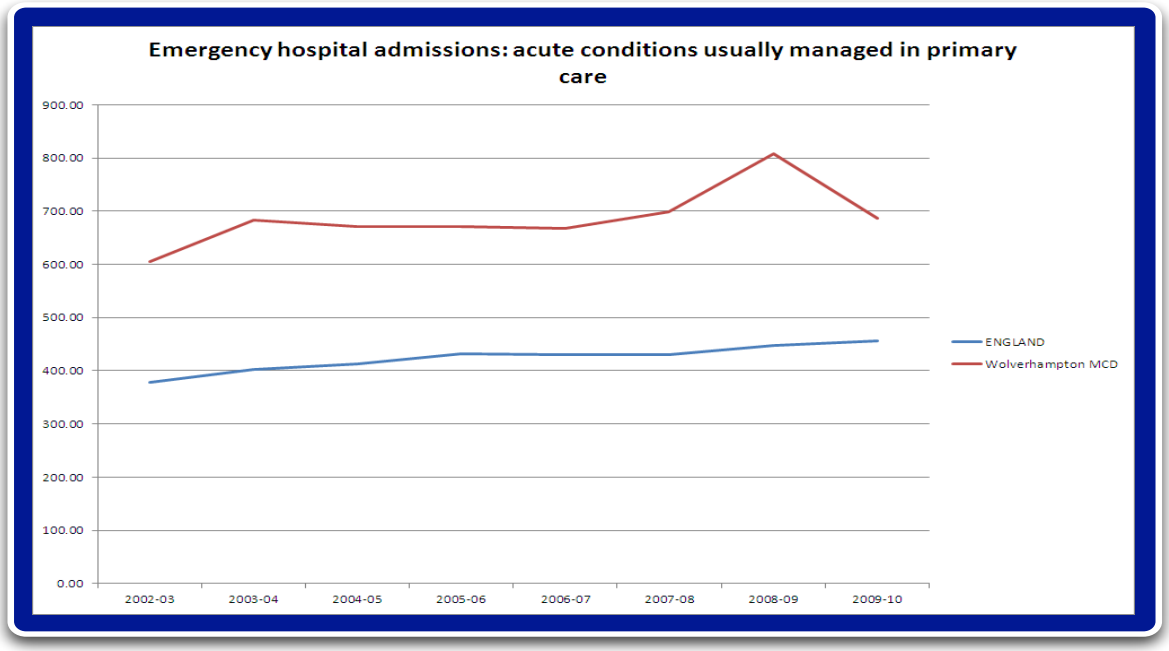


Fig 31 - Inappropriate A&E admission indicators

WCCG has opportunities to move clinically appropriately services from secondary to primary care, thus supporting “care closer to home”.We have to make sure we maximise these opportunities to improve patients experience and affordability - essentially providing **high quality, safe** and effective services across all providers - **Right care** in the **Right place** at the **Right time**

WCCG is in the process, and in collaboration with RWT, developing a comprehensive Urgent Care strategy which will provide an affordable, effective, efficient and accessible urgent care service for Wolverhampton. This is designed to provide the right care for the right patient in the right setting and to relieve the pressure on the Emergency Department at RWT. this will redress the over performance in Wolverhampton for acute conditions that can and should be managed in Primary Care.

5.17.Reconfiguration of Pathology services

WCCG is part of the consortium that is looking to reconfigure the delivery of pathology services across the North West, South West and East Midlands. The forecast benefits related to improvements in service provision coupled with the

anticipated financial efficiencies that will be realised make it an attractive collaboration.

The project is being led by the NHS Midlands and East Strategic Projects Team. The business cases have been fully developed and some modifications have been made following the decision by a small number of CCG's to withdraw from the consortium for locally focussed operational reasons.

The project is moving towards the formal procurement stage which is expected to take place in Quarter 3 of 2013[8].

WCCG will work collaboratively with local providers to ensure that the benefits of the proposed new service are complimentary to our Acute service providers.

The Carter Report[9] clearly identifies the optimum service delivery model for pathology services (community and secondary), through the formation of managed networks.

Both of the previous SHA regions have confirmed substantial savings can be achieved from creating provider networks and consolidating services. Savings of approximately £63 million have been identified across the previous regions in their respective pathology projects. West Midlands has identified £40 million and East Midlands has identified £23 million. Both of these estimates are conservative and below those envisaged in the Carter Report

5.18.Stroke Services

5.18.1.Current service provision

Stroke services are currently provided from the Acute Stroke unit at RWT with 23 beds, from this 3 beds are used as Hyper-acute and provide a hyper-acute service to patients from Wolverhampton Seisdon, Cannock and Stafford, in 11/12 they dealt with 693 confirmed strokes at RWT along with a number of stroke mimics. The hyper-acute service starts in A&E with agreed protocols for FAST with West Midlands Ambulance Service (WMAS).

They provide scans in A&E and a 24/7 thrombolysis service to patients who are appropriate and meet the thrombolysis criteria.

From A&E patients are transferred to the acute stroke unit (ASU) and are monitored in a hyper-acute bed initially for between 24 and 72 hours and then in an acute bed for up to 7 days on average.

[8] Correct at time this document was written

[9] The review of NHS Pathology Services in England

From the ASU patients are either discharged home during the first 7 days this is either home with follow up from a Community Stroke Co ordinator or home with daily support for up to 6 weeks from the early Supported Discharge (ESD) Team and then a Community Stroke coordinator for ongoing care and 6 month follow up.

Patients not suitable for discharge home are transferred for inpatient rehabilitation to The Stroke Rehab Unit at West Park Hospital for a period of rehabilitation they are discharged again with ESD if they meet the criteria or with CICT and Outpatient rehab if appropriate. All patients are seen within 72hrs of discharge by a Stroke Coordinator and again as required but as a minimum of 6 weeks, 3 months 6 months and 12 months.

A 7 day TIA service is provided with high risk TIAs seen within 24hours and low risk within 7 days.

5.18.2.Stroke Services Review

The review aims to work towards a step change in stroke care for people across the Midlands and East by improving the quality of life following stroke and the experience of patients. It covers the entire pathway of stroke care for adults, from pre-hospital care through to rehabilitation/social care and end of life. Stroke services have improved in the region and this review intends to, wherever possible, keep good practice and only make changes that will lead to improvements.

Birmingham and Black Country Networks submitted their position with the review to the EEAG last month. This indicated the need for further work to be done over the coming year to agree the confirmed configuration. A draft response from the EEAG has been received and a few points of accuracy have been raised – the final feedback document will be made available in due course.

Analysis of provider financial returns are being reviewed at present and a report will be prepared for the next joint CCG meeting. The two Networks have prepared a governance structure to take the review forward, and discussions are taking place to secure funds to support this work. The review process was handed over to the CCGs and the new Strategic Clinical Networks at the end of March.

The way forward

WCCG as Commissioners are continuing to develop our proposals including engagement/consultation requirements,following the 2013 Evaluation Project Advisory Group meeting took place on 16th March.

Midlands and East SHA Board received a report at their final board meeting at the end of March 2013 that informed them of where each system are with their plans, outlining next steps for moving forward.

NHS England (Area Team) and CCGs will receive a report advising of next steps for taking forward the review in each area.

Towards the end of 2012 the Birmingham and Black Country Cardiovascular Network wrote out to all CCGs requesting a Board level representative for the Strategic Clinical Network. WCCG is represented by a governing body member on this group which is being hosted by Sandwell and West Birmingham CCG.

Health and Wellbeing

6.Joint Health and Wellbeing Board and Strategy

Local Authorities are required under the Health and Social Care 2012 to formally constitute a JHWBB. This board must be multi agency and it must sit in Public. Central to the Governments vision is that decisions about services should be made as locally as possible, involving people and communities who use them to the maximum degree.

Strong local leadership is vital to this vision – local leaders and commissioners will need to identify what the needs of the local community are and then establish how those needs will be met, either through the services they commission, or through joint working and collective action.

With effective partnerships benefits can be achieved not just for local services, but more importantly to improve the health and wellbeing of the local community.

There is a clear expectation within the legislation that the JSNA and the JHWBS will provide the basis for all health and social care commissioning in the local area, and as stated above there will be a role for health and wellbeing boards to play in promoting integrated services. This begins with the duty of the CCGs, NHS England and the local authority to have regard to the relevant JSNA and JHWBS when carrying out their respective functions, including their commissioning functions. The bill also amends the NHS Act to make it clear that CCGS must involve health and wellbeing boards in preparing their commissioning plans or revising them in a way they consider significant.

6.1.Board structure and membership

The JHWBB is a City council statutory body which draws it membership from a broad cross section of the city economy and community. The following list describes the current standing membership of the Board and Fig 31 below describes the structure of the Board within WCC.

- Cabinet Member – Health and Wellbeing (Chair)
- Cabinet Member – Children and Families
- Cabinet Member – Adults
- Shadow Cabinet Member – Health and Wellbeing
- Director of Community
- Director of Education and Enterprise
- Director of Public Health

- Representative of Local Health Watch
- Wolverhampton Commissioning Consortia (3 representatives)
- West Midlands Police and Crime Commissioner (or representative)
- National Health Services Commissioning Board
- National Health Service Local Area Team
- University of Wolverhampton – School of Health + Wellbeing
- West Midlands Police – Wolverhampton Local Policing Unit

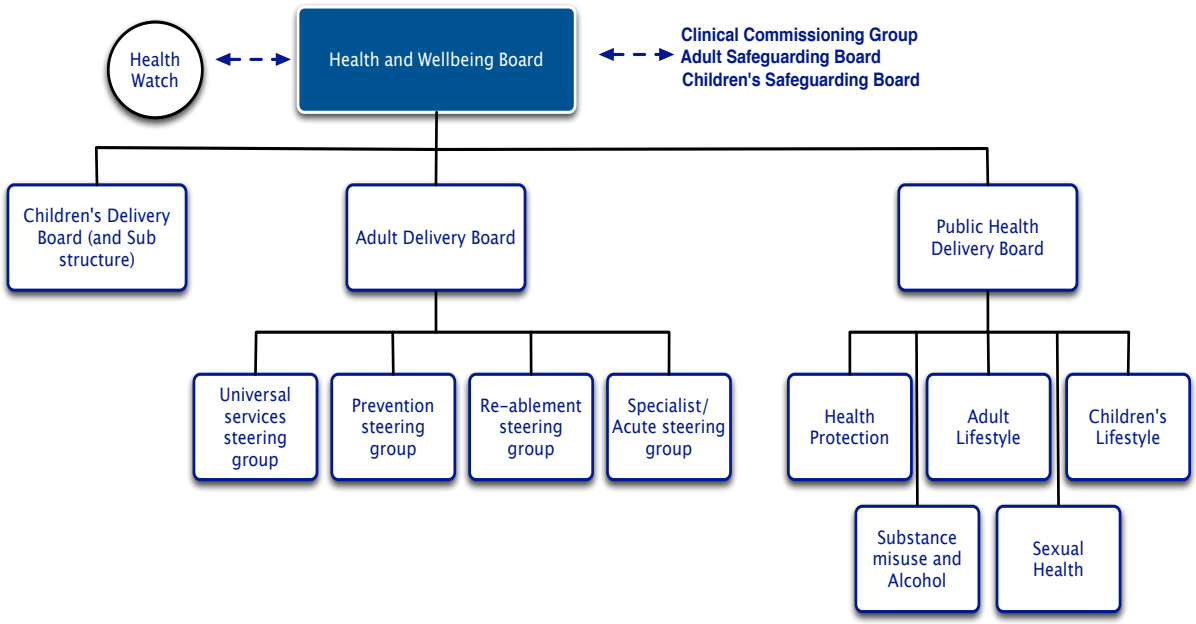


Fig 31 - Joint Health and Wellbeing Board Structures and sub-structures

6.2.Key principles that apply

There are a number of important principles that underpin the work of the JHWBB:

- They are a strategic body and must take account of the current and future health and social care needs;
- Significant gains will be made if the JHWBB looks beyond needs to examine how local assets, including how the local community itself can be used to meet identified needs.
- JSNAs and the JHWBS are key to understanding inequalities in the local area and the factors that influence them, including the wider determinants of health
- There should be a focus on the things that can be done collaboratively. These can be identified by health and wellbeing boards working with other local agencies, such as the Police, Fire service, Local business, Probation service, Local councilors, the NHS - and understanding the added value of pooling resources (including people) in order to achieve a greater impact across the local system

- Joint health and wellbeing strategies should prioritise the “big ticket” issues that require the greatest and most urgent attention, trying to fix everything at once will merely dilute the effect of of the interventions

WCCG has three representatives on the JHWBB and has worked in close collaboration with Wolverhampton’s JHWBB in the construction of the Joint Health and Wellbeing strategy and in the determining the key local priorities.

Like the CCG the Local Authorities have had to identify three key local priorities that they intend to address. WCC has identified:

- Alcohol;
- CVD;
- Reduce child poverty.

The case for change used for the two strategies is closely aligned and comparable the table below (Fig 32) indicates their close alignment.

This pronounced alignment will complement the work of the two bodies and further enhance the effectiveness of the strategies.

This collaboration will continue and will be reviewed in a timely manner to ensure duplication is avoided and gaps are addressed.

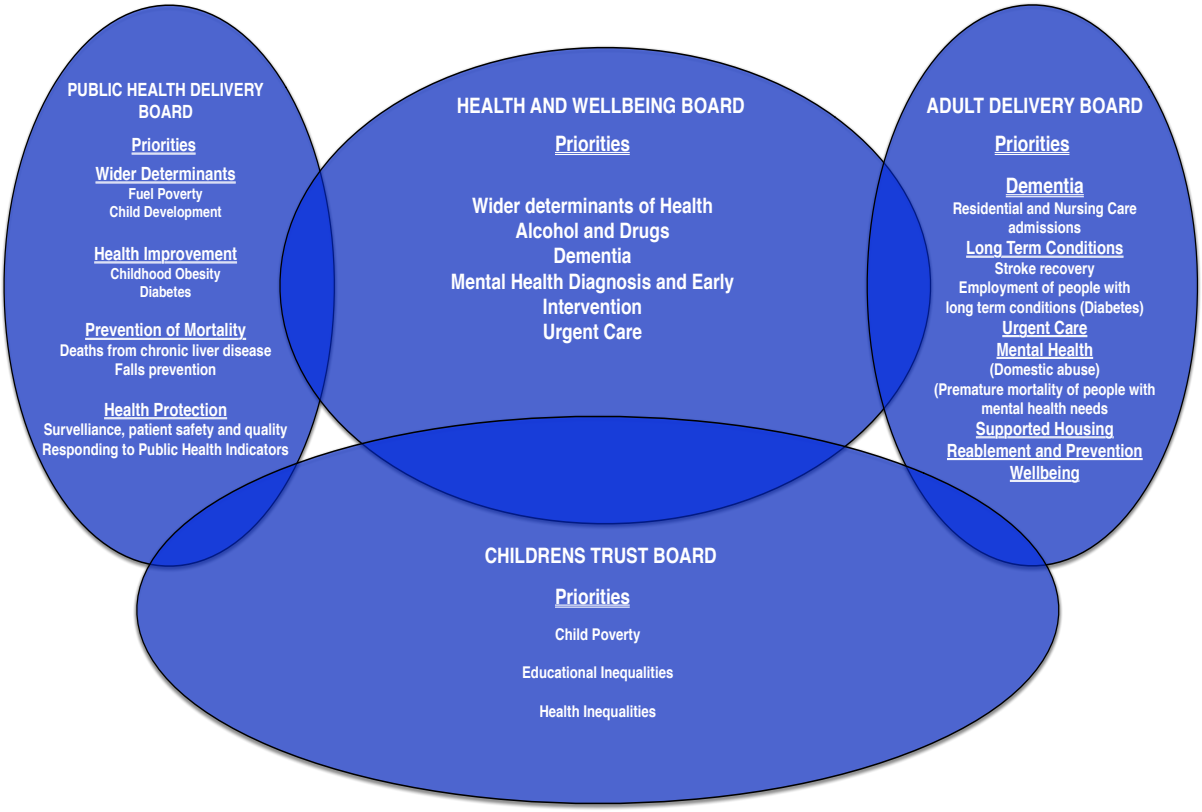


Fig 32 - Delivering the Health and Wellbeing Board priorities

Quality and Performance

7.Quality and performance

7.1.Treating and caring for people in a safe environment and protecting them from avoidable harm

Hospital and other care environments should, by definition, be places of safety. There have been far too many tragedies and serious untoward incidents reported in hospitals and care homes that have made headline news in the media. Recent public enquiries have identified numerous cases where the standard of care and safety afforded to patients has fell far short of what should reasonably be expected from the NHS, other healthcare providers and Social Service providers.

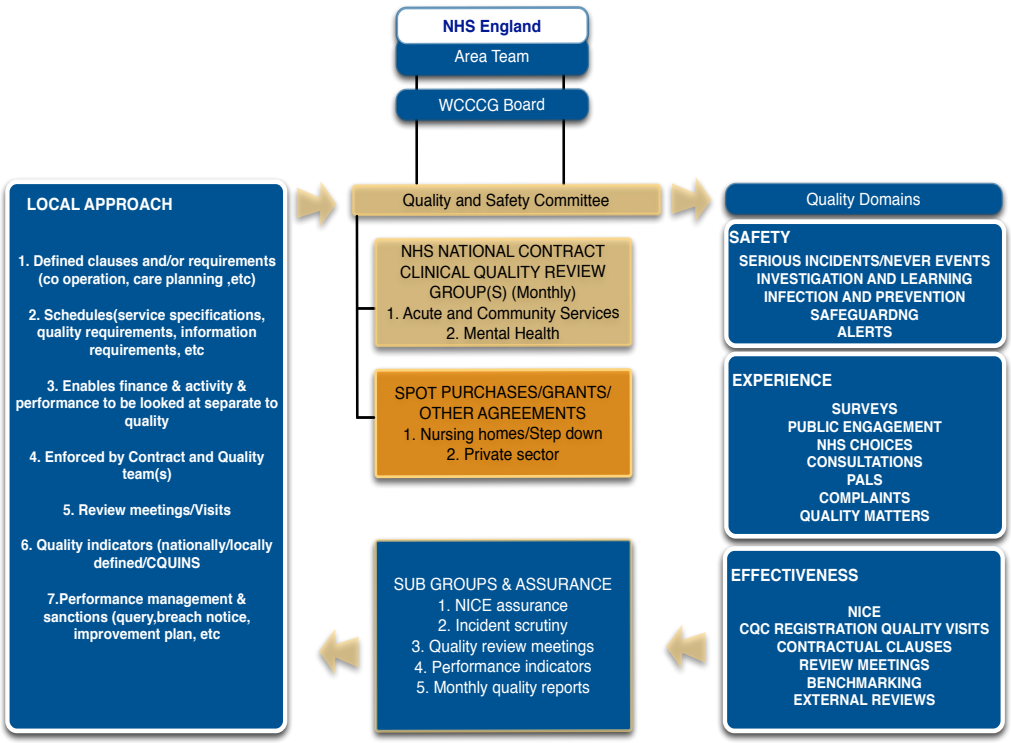


Fig 33- Quality framework

WCCG will be vigilant and we will act when required to do so, Fig 33 above describes WCCG's Quality framework which will be used to monitor performance and drive improvement.

There are a number of elements that need to come together to provide a consistently safe environment for patients and carers:

- **Respect** - having respect for our patients diversity and cultural needs; their privacy - including protecting it as much as possible in large, open-plan hospital wards; and for the decisions they make;
- **Compassion** - recognising when a patient and/or their relatives need emotional support, rather than just delivering technical medical and nursing care;

- **Sensitivity** - Demonstrating our sensitivity to patients' and clients' needs, ensuring their comfort;
- **Vigilance** - remaining vigilant at all times to make sure we are consistently delivering on the three previous points, holding organisations to account when standards slip and imposing appropriate penalties for failure.

7.2.Primary care

- Significantly improving quality & Safety in Primary Care
- Maintaining the position of low antimicrobial prescribing
- Continuous improvement in quality through the CCGs Quality Infrastructure including improving the reporting & learning from serious incidents
- Ensuring that people have a positive experience of care through plans to improve experience as a result of surveys & feedback
- Strengthen the resources & support available providers in all aspects of quality

7.3.Mental Health

- Overcome problems currently experienced relating to delayed transfers of care
- Improve standards for new referrals to EIS for psychosis
- Help people to recover from episodes of ill-health or following injury
- Strive for continuous improvement so that people have a positive experience of care
- Improve the proportion of patients assessed within 2 weeks of referral
- Improve the proportion of emergency referrals seen within 4 hours
- Improve partnership working between NHS & local government
- Actively engage with stakeholders during pathway & service redesign

7.4.Secondary care

- Continue to monitor & review mortality preventing people from dying prematurely
- Enhance quality of life for people with long term conditions
- Help people to recover from episodes of ill-health or following injury
- Strive for continuous improvement so that people have a positive experience of care
- Treat and care for people in a safe environment and protect them from avoidable harm

- Reduce A&E re-attendance rates and A&E time to assessment rates
- Collaboratively improve health visiting services across the city
- Improve 4 week smoking quitters targets and cessation rates
- Make every contact count using opportunity to deliver brief advice to improve health & wellbeing
- Improve partnership working between NHS and local government
- Actively engage with stakeholders during pathway & service redesign

7.5.Implementing the recommendations of the Francis Report

The Francis report is the result of the Public Enquiry carried out by Robert Francis QC into the failings at Mid Staffordshire NHS Foundation Trust. Concerns about mortality and the standard of care provided at the Mid Staffordshire NHS Foundation Trust resulted in an investigation by the Healthcare Commission (HCC) which published a highly critical report in March 2009. This was followed by two reviews commissioned by the Department of Health. These investigations gave rise to widespread public concern and a loss of confidence in the Trust, its services and management.

The resultant report by Robert Francis has widespread implications for the NHS and partner organisations, and further strengthens our determination to deliver the **Right care** in the **Right place** at the **Right time** . It makes a number of key recommendations all NHS Providers and Commissioners will have to take a very hard look at their service provision in light of these recommendations and ensure that they are fully implemented.

The recommendations contained in the Francis report are fully aligned to the requirements of the NHS Outcomes Framework(s) and the “five offers” set out by NHS England. There are in excess of 200 recommendations in the report, the key (18) recommendations for Mid Staffordshire NHS FT set out by Francis are listed in Appendix I, and whilst these are, in the main, specific to Mid Staffordshire NHS Foundation Trust as mentioned previously their impact and relevance are applicable to all providers and commissioners in the NHS

The Government published it’s response to the Francis report on Wednesday the 26th of March 2013 - the key points of which are summarised below and in more detail in the appendices:

- the introduction of new Ofsted-style ratings for hospitals and care homes overseen by an Independent Chief Inspector of Hospitals and Chief Inspector of Social Care;

- a statutory duty of candour for organisations which provide care and are registered with the Care Quality Commission;
- a review by the NHS Confederation on how to reduce the bureaucratic burden on frontline staff and NHS providers by a third;
- a pilot programme which will see nurses working for up to a year as a healthcare assistant as a prerequisite for receiving funding for their degree;
- nurses' skills being revalidated, as doctors' are now, and healthcare support workers and adult social care workers having a code of conduct and minimum training standards.
- WCCG commissioners have agreed a package of initiatives with RWT that will improve quality indicators and clinical outcomes in relation to the recommendations of the Francis report and the five NHS Offers

7.5.1.Position and proposed method of review for the Francis report

An internal review of the 290 recommendations has taken place within WCCG and the local health economy to understand where there are opportunities and requirements within the recommendations that will help to improve our care to ensure that we commission for the high quality safe care in our city.

The review looked at categories to define where the recommendations could have applications or implications. It is important to note that some of the recommendations may fall into more than one category.

- Improving the patient experience of compassionate care, including quality and satisfaction;
- Improving the health of our population;
- Reducing the per capita of health care;
- National applications;
- Organisational applications;
- Local Authority applications.

7.6.Care Quality Commission

WCCG will establish an integrated partnership approach to safety and quality, working with Wolverhampton Council, Providers and the Care Quality Commission (CQC) to develop and implement an inspection regime, both announced and unannounced. Working closely with the aforementioned partners failing providers will be held to account and a range of remedial actions and penalties will be imposed where appropriate..

The following two graphics below represent the latest assessment(s) published by CQC relating to two of our key providers : RWT and the Black Country Partnership and Penn Hospital specifically.

Fig 34 - CQC Assessment of RWT

Fig 35 - CQC Assessment of Penn Hospital

The Trust has submitted a detailed action plan with timescales, milestones and success criteria which has been agreed through the contract clinical quality review (CQR) process. The plan is rigorously monitored through CQR meetings and BCP FT has been able to demonstrate significant improvement and success against the plan.

The CCG will continue to work with BCP FT to improve the quality of care delivery, moreover the CCG is assured that the provider is taking the appropriate steps to ensure the delivery of high quality services.

Communications and Engagement

8.Communications and Engagement

Communications and engagement with patients, providers, the local authority and other partners will form the cornerstone on which WCCG's success will be built. The most common cause of failure in organisations worldwide is poor or ineffective communications and engagement.

WCCG intend to be an exception to this trait. We will engage closely and regularly right across the health and wellbeing landscape in Wolverhampton and (where appropriate) beyond.

8.1.The Patient Perspective

8.1.1.Involving patients and the Public

During our planning phase, WCCG engaged with numerous patient groups in order to obtain the perspectives of our population, to inform and influence our commissioning decisions and gauge support for our vision of delivering the **Right care** in the **Right place** at the **Right time**. The feedback has been grouped into the following themes and will be used to inform our case for change.

- Services are difficult to navigate;
- GP access is variable;
- There is significant variability in patient experience;
- Choice and the consistent delivery of high quality services are essential;
- Self management has a substantial part to play in healthcare;
- There is a recognition that services have to be sustainable;
- There is a strong appetite for patients to be involved in the commissioning of services.

Based on the outputs of the various engagement events we have developed a new culture of engagement at Wolverhampton CCG based on the premise of:

"No decision about you, without you"

We know that effective engagement with all stakeholders is essential to maintain practice and public confidence, good relationships and trust. We have defined engagement as a key characteristic of the way we work as a CCG. We have developed comprehensive and embedded engagement, where practices, patients and broader partners influence the decision-making process.

Our comprehensive framework for engagement ensures there are clear lines of sight between the feedback we receive, and the Governing Body. Between the two

are a range of engagement forums that both gather feedback and insights, and assess this feedback. These forums create systematic dialogue with all of the CCG's key stakeholders and audiences and promote a 'member culture' where our GPs and patients are not only just receiving information, but actively making decisions and steering the direction of our commissioning organisation. Two-way formal linkages exist between every tier and we believe this fosters a culture where ideas come from the bottom-up and that we work with everybody on the basis of equal partnerships, all within robust governance and accountability framework. This diagram shows how we engage at every level. See the descriptions of each layer below.

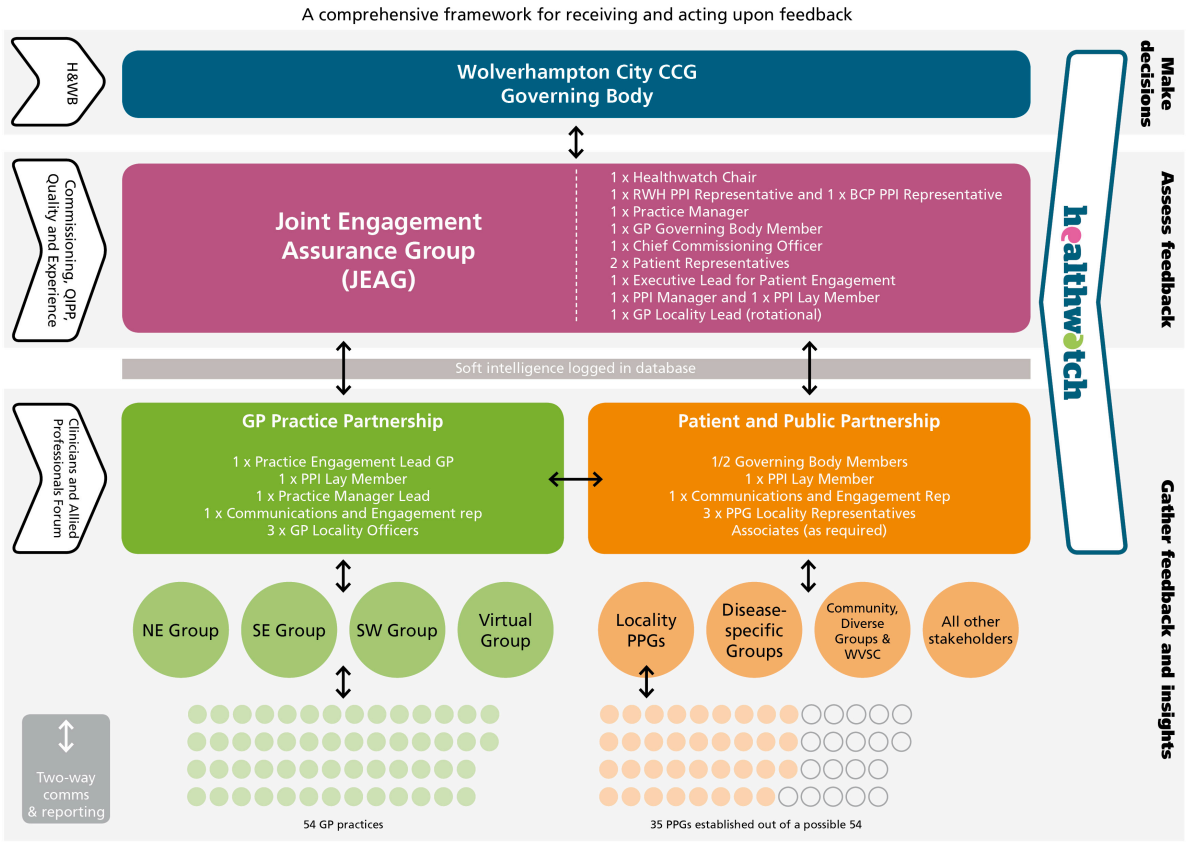


Fig 36 - Patient and Public Engagement Framework

8.1.2.The Joint Engagement Assurance Group (JEAG)

Meets quarterly

As a Governing Body sub-group, this brings together feedback and representatives from practices, patients, CCG staff, the public, community groups, stakeholders and Patient Participation Groups to inform the work and commissioning of WCCG. It will also signpost incoming intelligence to our partner organisations.

This group will be responsible for receiving strategy and proposals to endorse and scrutinise in order to ensure that the CCG takes a systematic approach to engagement in the commissioning cycle. It will set the CCG's overall strategic

engagement direction, advocate partner voice, ensure that the CCG meets its statutory obligations with regards to communication and engagement, and influence decision-making at the Governing Body and at every tier of the organisation.

The group will work in partnership with the CCG and be an advisory group to the Governing Body in matters related to engaging and communicating with patients and the public. It will be a decision-making body that will 'quality assure' the levels of patient and public engagement activities and have an overview of the day-to-day communications and engagement operation, reviewing and agreeing the communications and engagement team's priorities and work plan.

Members of the group will be consulted and outcomes shared with them. The group will also be able to provide advice on how to engage with a number of groups, including those groups considered to be marginalised.

In the engagement framework the group has two-way linkages with quality and commissioning committees. This will ensure patient experience feedback is considered, analysed and understood at decision-making level. The group will review patient experience reports, and sign off the patient and public engagement annual report or Duty to Report before they are presented at Board.

Members will be able to raise their service related issues within this forum and review impact against commissioning priorities and work streams.

8.1.3.GP Practice Partnership

Meets quarterly

As a member organisation, the CCG is made up of its constituent GPs, with stewardship of the organisation given to the Governing Body and Executive. The Governing Body is democratically elected, effectively representing the constituent practices. This is essential to ensure practice involvement in the working and development of the CCG and that members wishes and suggestions are taken into account and members are actively involved in the development and decision making processes. These decisions must be informed by a diverse range of views and the rationale and approach for decision making must be clear and transparent to all.

The GP Practice Partnership brings together clinical and non-clinical representatives from our three locality groups for the North East, South West and South East of the city with a combined membership of 52 member practices. The three locality groups form the basis of a structure to enable the whole process to culminate in governance and accountability. Bringing these groups together means that ideas can be shared, problems addressed and consensus achieved on the big

decisions – priorities, commissioning or otherwise, that the CCG needs to make. Business cases will be brought to this group so they may be clinically scrutinised and enriched. Quality issues, patient experience and other performance issues will be debated here.

The purpose of the GP Practice Partnership is to support the overall aims of the engagement strategy. The group will endeavour to develop together best practice and provide a forum for exchange of information and collaborative working on issues of clinical and patient concern.

8.1.4.GP Locality Groups

Meets quarterly

Practices are grouped into localities with protected time for regular quarterly meetings. These meetings are attended by GPs or their representatives, usually Practice Managers. The meetings are chaired by elected local chairs, usually GPs. The CCG Governing Body will be represented by three members who will be responsible to that locality and will be there as a conduit to and from the CCG. They will help facilitate the meeting. The aim of these groups will not only be to discuss CCG ideas and objectives and to decide on what needs to be progressed but also they are there to pass ideas to the CCG and also to voice any concerns or challenges. All meetings are minuted and these passed up to the CCG Practice Partnership, which will ensure the voice of each locality is passed to the appropriate committee of the CCG.

The Virtual Group ensures we can reach and engage with the city's single-handed practices. Mindful of the limited resources they have to spare on engaging with us, we survey, collaborate and share information virtually with these members using email, the intranet and special applications including Survey Monkey and scrolling news ticker to ensure all members large and small and work with us as equal members of our CCG.

8.1.5.Patient and Public Partnership

The Patient and Public Partnership comprises representatives from our PPGs, Healthwatch, residents and other patient, carer and health groups across the city. We call these our Patient Partners and membership comprises the broadest range of public, patient and community members who will receive regular communications from the CCG, but will also be actively engaged on issues important to them. Selected Patient Partners will be invited to attend one or more of the monthly Patient and Public Partnership meetings so the CCG can gain the broadest range of views from key stakeholders Fig 37 below illustrates this particular element of the framework.

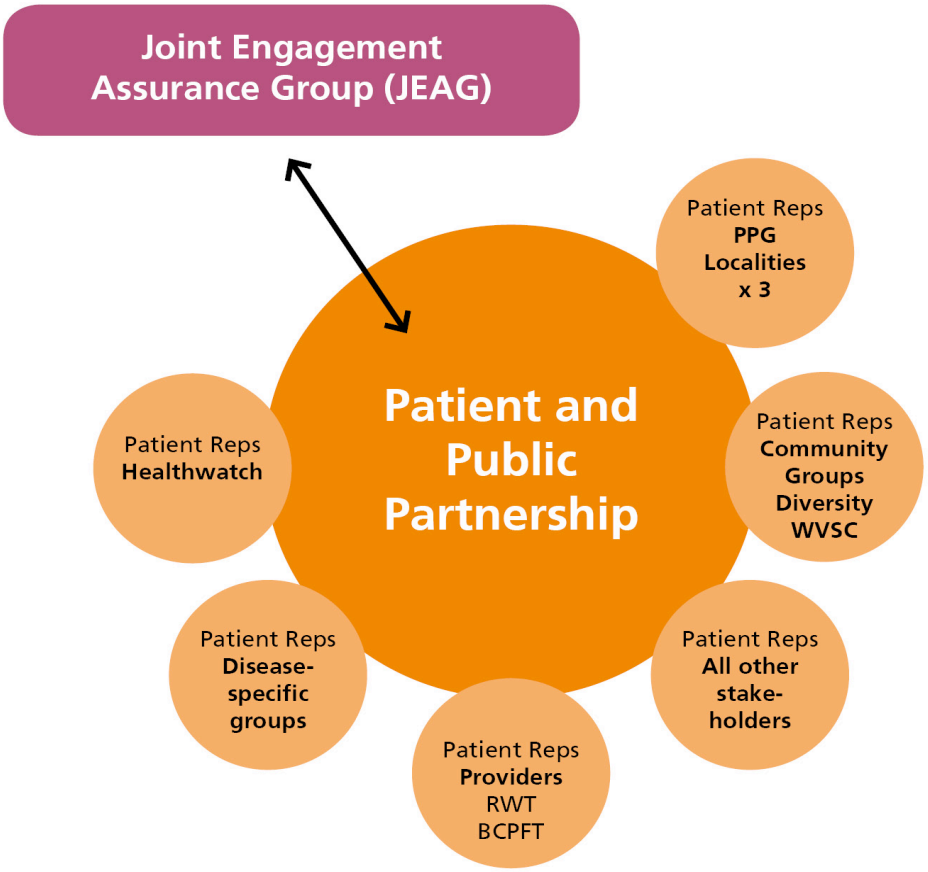


Fig 37 - Patient and public engagement model

Selected Patient Partners will be invited to attend meetings so that the CCG can gain the broadest range of views from key city stakeholders and interact. Patient Partners will be involved in the design and delivery of services from the beginning.

The Associate membership has actively been involved in the development of local services and continues to engage. The membership has been reviewed using the MOSAIC toolkit and has been found to be closely representative of the population profile of Wolverhampton.

Commissioning involvement opportunities will also be made available to all members. This will include procurement, evaluation and monitoring of services.

8.1.6.Patient Participation Group (PPG) Localities

The purpose of our three PPG Localities is to support the overall aims of constituent Patient Participation Groups (PPGs). The groups will work with PPGs and their members to develop best practice for their PPG locally. The group will provide a forum for exchange of information and collaborative working on issues of concern.

Priority issues will be taken forward to the Patient and Public Partnership by the locality representatives.

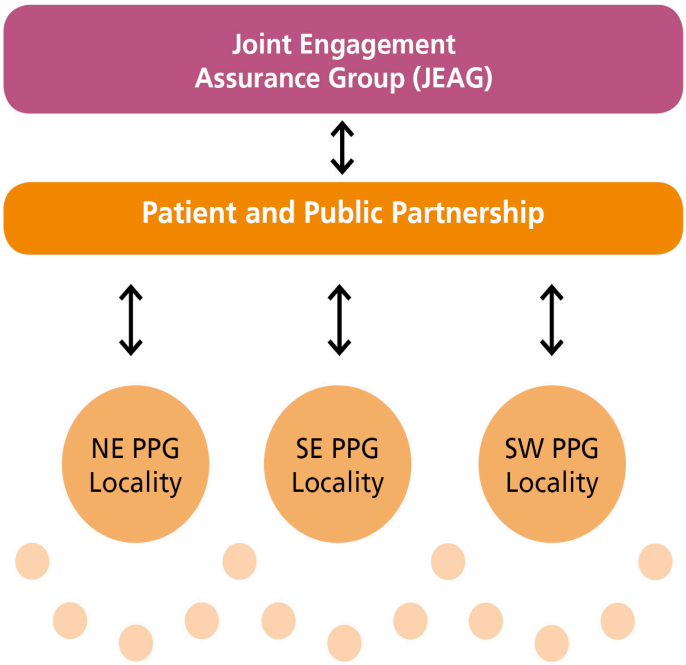


Fig 38- JEAG Locality model

All practices will be encouraged to develop PPGs and support will be available from the communications and engagement team, with actions including marketing to support recruitment, sharing information with the broader patient base via social media, etc. Patients will be able to use their experiences to develop and improve their local practice. They will be able to follow the DES format.

8.1.7.Case study - Working with patients to redesign urgent care

Reviewing and improving urgent care is a key priority for the CCG and an area we have already done much work in.

The CCG, working with South East Staffordshire and Seisdon Peninsula CCG, and RWT, are developing a joint urgent and emergency care strategy for the city. There have been seven options developed and we are currently engaging on these options, meaning we are asking for patient and public views on our proposals before we go to full consultation.

The engagement process started in December 2012 when we asked 180 people what their experiences of urgent care were. Themes that emerged included confusion, with people not knowing where to go, lack of consistency, and accessibility – especially with GP appointments.

The options were presented at a larger patient engagement event on 4 April, with over 30 people attending to hear two of WCCG's GP's, the CCG leads, two senior figures from RWT (one of which is an eminent clinician). Options ranged from no change to full system redesign, with the relocation or removal of two walk-in centres.

RWT's clinician explained that the current system was borne out of ad-hoc expansion of the system, with successive government policy responsible for uncoordinated expansion of services leading to a confusing service for patients. He then explained the way that people use services, it is partly because of this confusion, means we not make best use of the scarce resources we have.

Workgroups then examined the seven options in detail, feeding back on each. Finally, everybody was asked to choose their preferred option. The event provided the opportunity for us to test our thinking and we valued the feedback received. A couple of additional options were suggested and the Urgent Care Programme Board will examine these.

RWT's clinician and one of the CCG's GP's closed the event thanking attendees for the 'lively and robust' discussion. The future timescales were set out including the full 12 week consultation process to take place between June and September 2013.

8.1.8.Case study - Heralding the launch of our CCG

The CCG's launch event on 13 March provided a timely opportunity to explain the NHS changes to patients and answer questions on what they mean for them.

Chairman Dr Dante De Rosa, Chief Officer Helen Hibbs and the CCG's Lay Advisor for Patient and Public Involvement each presented on themes covering the local health context, our priorities and how people can get involved. Attendees numbering over 130 then broke-off into workgroups to share their thoughts on what our priorities should be. The event closed with a short film in which local patients, a prominent local councillor, the Chair of the Health & Wellbeing Board, and the incoming Chair of Healthwatch set out their hopes and aspirations for our CCG.

Through the session, the audience was quizzed on its understanding of the changes and the role of the new CCG through voting handsets bringing an interactive element to the event. To those who couldn't attend, the event was being live-tweeted through the CCG's twitter account so people at home could also join in.

Many people still have concerns and are unsure about the shake-up of the NHS. The event aimed to explain these simply, going some way to provide reassurance that the local NHS is safe in our hands.

8.1.9.Lay Advisor for Patient and Public Involvement

WCCG now has a Lay Advisor for Patient and Public Involvement, a new legal requirement. The Post holder has been employed specifically for their experience of promoting the patient voice. Having a seat on the Governing Body, this individual is WCCG's 'critical friend' ensuring our plans and priorities all build-in the views of patients

As might be expected, there's far more to WCCG's communications and engagement strategy than the framework above. An annual plan of activities including briefings, meetings, events and campaigns will help us to listen and respond to feedback, and keep important partners and the public informed about what we are doing. Everything from establishing the new WCCG website, holding events, designing leaflets, posters and documents, starting regular briefings to staff, members and stakeholders and working with the media all help us to build our profile and relationships.

With a population of approximately 250,000[10] and a high percentage of Black and Minority Ethnic residents (32%), ensuring everybody can have their say is no easy task. If we are going to deliver our vision, **Right care** in the **Right place** at the **Right time** we have to engage effectively with patients and their families. We are committed to engaging with people on their terms and ensuring we reach everybody, regardless of their ethnicity, disability, sexuality or area of interest. We know not everybody has a computer or has the time to attend meetings. We have created a range of ways for people to get involved that suit everyone.

8.2.Patient Partners

Our new membership scheme that allows patients to sign-up to receive information on issues of most interest to them. If they choose, members will be given the opportunity to take part in feeding back their views at local events in order to shape the decisions that we make. Whether it's identifying and setting priorities or buying a new service, the Patient Partners scheme allows us to bring in unique patient perspectives so every decision we make is in the very best interests of everyone we serve.Patients input and engagement will help the CCG to assess how we are progressing against our vision - **Right care** in the **Right place** at the **Right time**

To join the scheme:

Email: [insert]
Web: www.wolvescityccg.nhs.uk/patientpartner
Call us to be posted a leaflet: 01902 444 888

8.3.Patient Participation Groups

We have 35 PPGs across the city's 52[11] GP practices. These are groups of local patients who can help their GP make decisions but also look at larger plans affecting services in the wider local area. All are free to join by contacting the local practice receptions to find out more.

[10] The GP responsible population is estimated at closer to 262 000

[11] It should be noted as mentioned previously that one practice is migrating to Walsall due to a GP retiring

8.4.Community Partners

Our ethos is to engage with communities on their terms. We will identify and reach out to the city's diverse communities, attending their meetings and the places they convene. Twice yearly we will host a city-wide Community Partners' meeting to test our plans and priorities and work through areas of consensus and disagreement.

Our Lay Advisor, Chairman and CCG representatives also attends selected Patient Participation Groups and Local Neighbourhood Partnerships, reaching local people in discrete areas of the city.

8.5.Surveys, web and social media

We use a range of surveys, twitter, Facebook and the website to gain people's views and promote other ways that people can have their say. So that amongst other things they can tell us if we are delivering the **Right care** in the **Right place** at the **Right time**.

If you want to join us please contact us:

Web: www.wolvescityccg.nhs.uk/
Twitter @NHSinWolves
Facebook: NHS in Wolverhampton

8.6.Stakeholder engagement

We have talked in some detail about how we interact and engage with our GP's, our Patients and the Public at large. Obviously as an operational commissioning organisation we will need to carry out a range and variety of stakeholder engagement and management activities, which will have their own unique features and profiles.These will include our relationships,communications and collaboration which includes (but is not limited to) the following :

- Healthcare providers;
- The local authority;
- NHS England (specifically the AT);
- GP practices (operationally, for quality, for performance and feedback);
- AQP's;
- Other CCG's.

The relationship between our engagement activities and our operational and governance structures are set out below and overleaf (Figures 39 & 40) and are set out in detail in our Communications and Engagement Strategy.

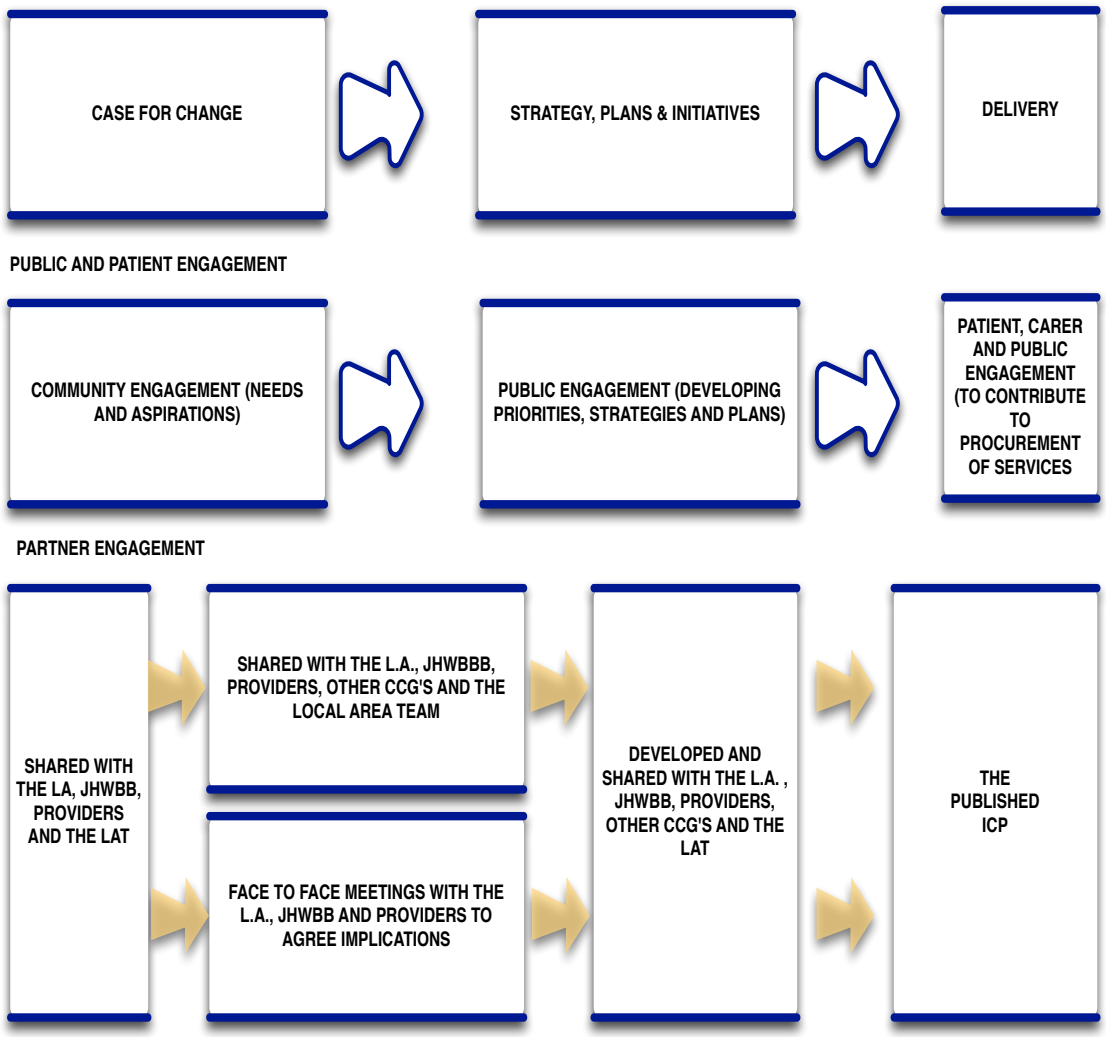


Fig 39- Approach to engagement

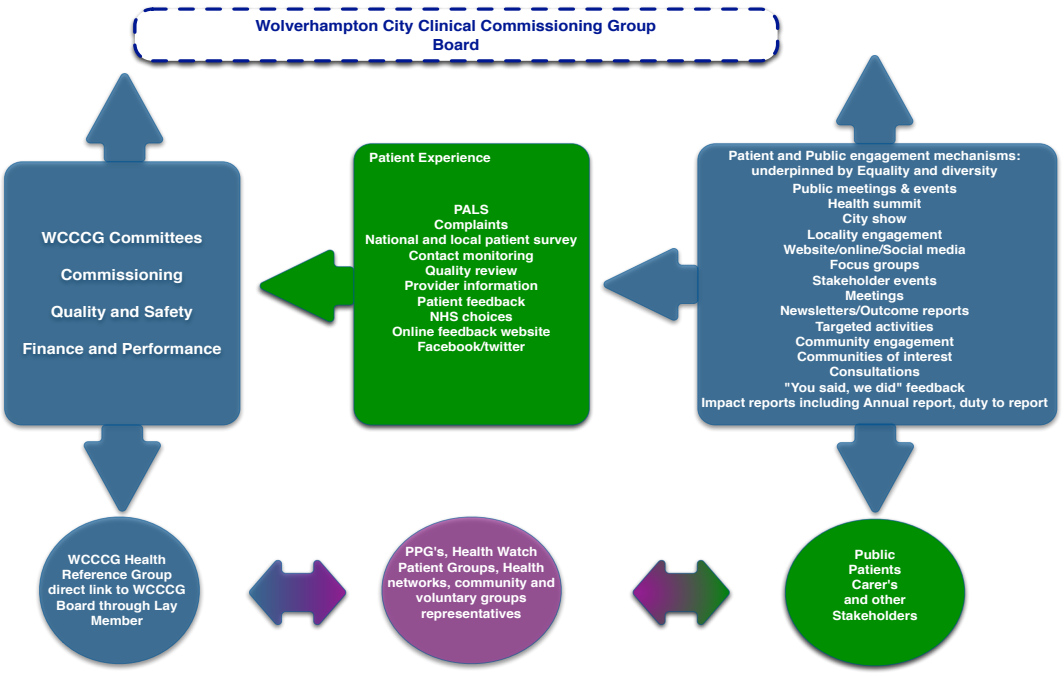


Fig 40- Engagement delivery mechanisms

Additionally for all major projects and initiatives we will refresh our stakeholder map(s) as stakeholders will move up and down the scale in terms of interest and influence depending on the specific situation and circumstances Fig 41 below is representative of what a stakeholder mapping exercise might look like at any given point in time.

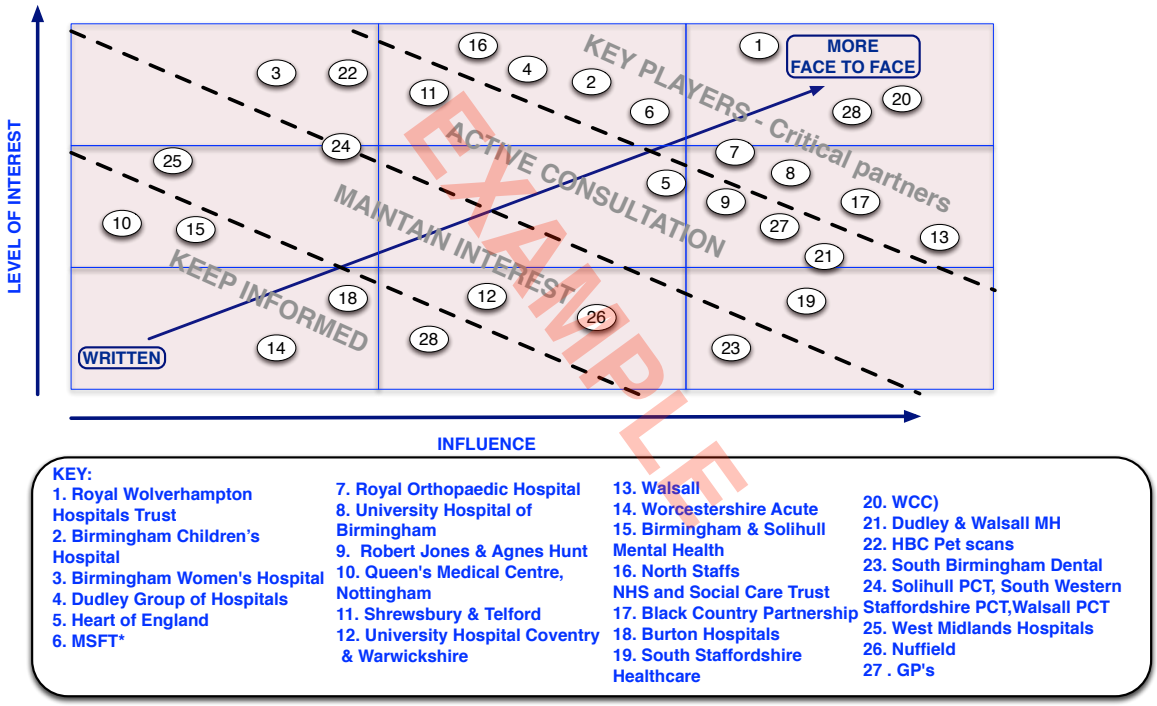


Fig 41 - Typical stakeholder mapping

Delivery Methodology and QIPP

9.Delivery Methodology and QIPP

WCCG will work differently to the former PCT. Its decision making and direction will be firmly led by clinical commissioners. To enable this, WCCG has developed commissioning communities – i.e. where clinicians, managers and other interested stakeholders from commissioning come together to strategically lead commissioning work streams and appropriately deal with key management issues. A structured and disciplined approach to delivery enhances our chances of delivering **Right care** in the **Right place** at the **Right time**. This will be particularly important for collaborative commissioning and as a minimum will include:

- WCCG clinicians and managers.
- CSU managers.
- JCU managers and social care professionals.

9.1.Programatic approach

WCCG has adopted a programatic approach to the delivery of programmes and projects based on the Prince2 and Managing Successful Programmes (MSP) approach. The majority of the commissioning team have undergone Prince2 and MSP training and are now accredited. The MSP approach to programme management structures programmes into three distinct phases with an assurance oversight running across all three phases. Fig 42 below describes the programme phases.

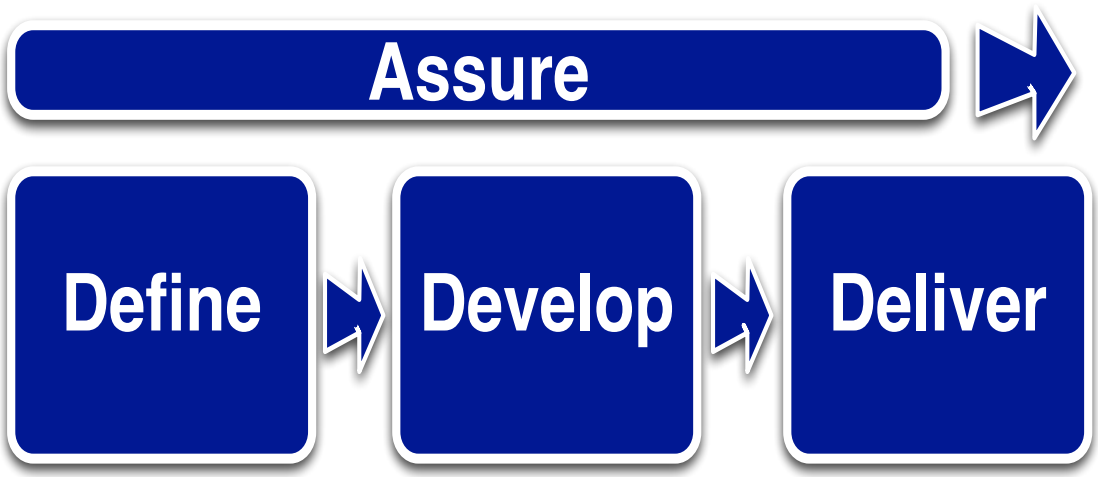


Fig 42 - Programme phases

The commissioning of healthcare services will be led by a designated clinical lead from the CCG Governing Body. They will have funded time to lead this service area and our leadership development programme will support them to be fully equipped

with the requisite commissioning and leadership skills to fulfil their clinical leadership function.

- They will oversee the delivery of commissioning through a combination of 'functional' and 'project' work streams, utilising our programme approach.
- The clinical lead will be supported by an executive member of the CCG management team who will be responsible for the strategic development, resource management and delivery of the programme portfolio.
- The day to day business of commissioning will be delivered by the CCG commissioning and redesign team – in collaboration with the Joint Commissioning Unit (JCU) for collaborative commissioning issues and functions – and supported by the contracting, procurement and business intelligence functions from the Commissioning Support Unit CSU).

The commissioning community concept will be supported in part by the adoption of a form of matrix working within the CCG. One of the key features of this will be to adopt a programme approach to generic areas of commissioning (e.g., Planned care, Urgent care, Long Term Conditions, Mental Health, etc). At the heart of each programme will be a workstream group or Programme Board (see Fig 43 below) managing the delivery of strategic goals.

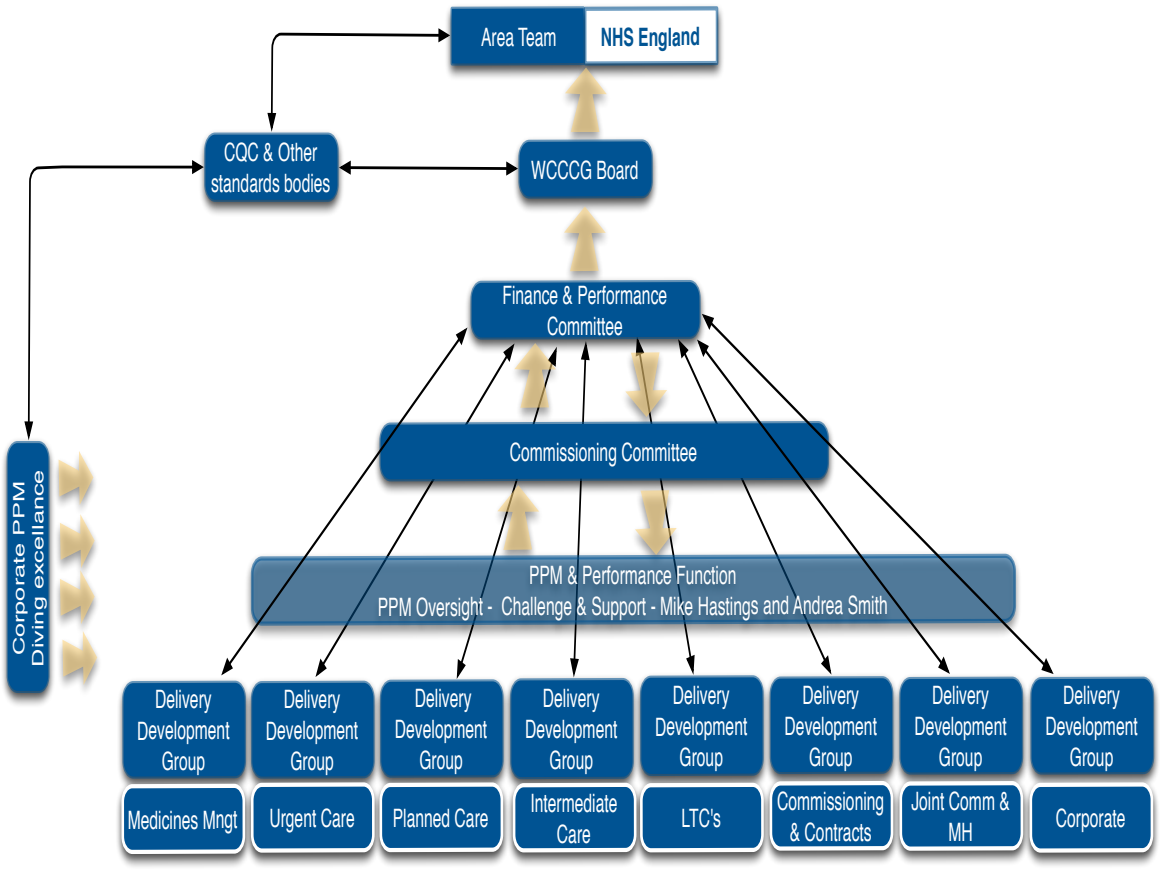


Fig 43- Programme Governance structure

Within the CCG, this will have the following key features:

- Everyone has a work portfolio split between ‘functional’ work and ‘workstreams’ or projects.
- Workers are line managed for functional work.
- Workers report to a programme lead for workstreams.
- Workstreams are led by the appropriate CCG Clinical lead, an executive sponsor and a programme manager.
- Each workstream will be fed by a limited number of task & finish groups and standing committees.

There will be a need to establish appropriate work gateways to manage demand more effectively against limited staff resources. Workstream groups will need to prioritise within their strategic areas.

The Programme lead function works closely with all aspects of other Commissioning Support Teams including quality assurance and risk, finance, contracting, performance monitoring, and clinical governance and itself needs support from ICT and Human Resources.

This model could also be adopted for areas where the JCU undertake the strategic commissioning in areas such as mental health and where a JCU senior staff member could be the programme manager. In addition, with a slight shift in emphasis, existing fora could be utilised to become the strategic programme group.

9.2.Virtual teams

One of the ways in which each strategic programme group could operate is through the extensive use of small virtual teams set up to deal with a specific project, task or set of issues.

In an environment where resources such as skilled and experienced staff are likely to be at a premium and capacity is scarce, a flexible operating model will be required.

CCG, CSU and JCU staff will need to work as part of project groups or task & finish groups using a multi-disciplinary approach to managing and resolving issues.

These essentially are the teams that will deliver the work stream projects described in the programme approach, managed by the day-to-day lead.

Project teams will be identified and resourced from the flexible resource pool at initiation based on skills and availability using an estimate of time required to deliver the project.

The same principles for the core skills and competencies section apply to the JCU as well.

Fig 44 -WCCG Competency Areas

9.3.Core Skills and Competencies

The core skills and competencies required of the commissioning teams will cover:

- Management and delivery of functional and project activities to meet time-limited quality and financial objectives;
- Adopt a programme approach to co-ordinate all aspects of the service area/ commissioning portfolio;
- Management of interpersonal relationships including occasional conflict resolution, strong opposition or reluctance to change;
- Produce formal reports and deliver presentations to formal and informal groups or committees and large groups of stakeholders / members of the public in a variety of settings;
- Analyse performance and financial data;
- Develop clear commissioning strategies and service specifications, and review business plans;
- Effective internal and external communication using a variety of media;
- Hold providers of services to account against agreed finance/ activity and quality plans whilst maintaining positive working relationships;
- To act as the expert monitor to ensure VFM and delivery of the services;
- To deliver at best practice models for commissioning or service improvement;
- Provide partnership representation for the CCG on multiple working groups;

- Provide expertise to the CCG requiring service re-specification (redesign);
- Assigns staff roles & responsibilities on behalf of the CCG;
- To support commissioning governance arrangements across the local health & social care economy;
- Be the main resource and identified management lead for commissioning (with technical support from CSU Contract Management and Informatics Teams);
- Be responsible for Relationship Management with care providers;
- Contribute to Financial Efficiencies and Improved Quality (QIPP);
- Development of Project Initiation Documents (PIDS)/Business Plans;
- Develop, implement and manage recovery plans, action plans or remedial action plans as required;
- Lead any Procurement Exercises (with technical support from CSU Contract Management, Procurement and Informatics Teams);
- Respond to workstreams emanating from government departments or their regional / local offices, the strategic health authority or NHS Commissioning Board;
- Market Shaping.

9.4.QIPP

The QIPP agenda will be delivered using the programme management approach that we have described in 8.1

In September 2012, WCCG comprehensively risk assessed its QIPP Programme and aligned it to its Development and Delivery Groups (DDG's)as described in Fig 45 below;

❒ Planned Care	Clinical lead,Exec Lead,Programme Mngr
❒ Urgent Care	Clinical lead,Exec Lead, Programme Mngr
❒ Long term conditions	Clinical lead,Exec Lead,Programme Mngr
❒ Intermediate care and Community Services	Clinical lead, Exec Lead,Programme Mngr
❒ Medicines management	Clinical lead, Exec Lead, Programme Mngr
❒ Joint commissioning and mental health	Clinical lead, Exec Lead, Programme Mngr
❒ Contracts and Commissioning	Clinical lead,Exec Lead, Programme Mngr
❒ Corporate	Clinical lead,Exec Lead,Programme Mngr

Fig 45- The DDG's

The table below summarises the QIPP targets currently incorporated in the CCG's Finance Strategy:

2013/14	2014/15	2015/16
£6.5M	£6M	£6M

Fig 46 - QIPP Targets 2013-16

The CCG has significant risk associated with its QIPP schemes. If schemes do not deliver the level of recurrent savings described above this will jeopardise the financial position of the organisation. If the target outturn position looks likely not to be achieved , the Governing Body would be required to seriously consider delaying or stopping planned work in order to avoid pressure on the financial position. This is not a tenable position and therefore the organisation gives a significant importance to the QIPP programme as this is the vehicle through which service is transformed.

The table below (Fig 47) describes the programme of work developed by the DDGs to deliver the 2013/14 target of £6.5m. Some schemes pose a low risk to the organisation as they have been incorporated into contracts for the new year whilst others are not so far advanced and it is recognised that they may not deliver the level of savings originally envisaged.

The CCG does not treat the management of QIPP savings as an annual event; rather, the DDGs are continuously looking for opportunities to deliver new projects. Therefore, if slippage occurs in the 13/14 schemes, there will be other schemes to bring forward from future plans to close the shortfall in the planned savings.

QIPP SCHEMES	Original plan	Plan as at May 2013
	£'000	£'000
Urgent Care	1,068	1,739
Planned Care	1,900	1,550
Medicines management	750	752
Mental Health	1,000	1,000
Long term conditions	609	612
Intermediate care	800	417
Plans under development	403	460
Total	6,530	6,530

Fig 47 - QIPP schemes

9.4.1.Hot clinic

As part of the QIPP Programme at Wolverhampton City CCG, the Urgent Care Delivery and Development Group have identified efficiency savings across a range of areas.

The primary purpose of this project is to develop a Paediatric Hot Clinic for specific clinical areas generating efficiency savings as well as an improvement in patient experience.

In line with its QIPP Programme, the CCG must generate efficiency savings to ensure financial sustainability.

Based on data from RWT 2012/13 activity, Paediatric activity is increasing especially in specialty code 420 – non elective paediatrics

The justification for this project is to reduce avoidable costs as well as ensuring patient's safety and treated in accordance with their needs. Lower Respiratory Tract Infection in Paediatrics is a priority for the CCG as documented in *"Supporting Planning 2013/14 For Clinical Commissioning Groups"* Dec 2012, NHS England

9.4.2.Frequent Flyers

Pre-defined criteria will be set for each GP practice on the amount of patients they are to target using data from MiCS Portal based on practice list size. It is estimated that the 52[12] practices across the city will target the top 200 frequent service users.

Each patient will be clinically reviewed by their registered GP and where necessary a multidisciplinary review will take place. The individual patient will be referred to alternative services as appropriate with the aim of reducing inappropriate use of urgent care services.

9.4.3.GP alongside A&E

Aims to reduce pressure on the current A&E department (Consultant led service) by diverting appropriate low risk activity to a Primary Care/GP led service. Patients will continue to be triaged in A&E and where appropriate, patients will be diverted to the alternative service based within the A&E setting. This service will run 7 days per week and cover the core hours when activity in A&E is high.

9.4.4.Rapid falls assessment

Working with West Midlands Ambulance Service (WMAS), the CCG has developed a scheme to reduce conveyance rates to the acute trust for patients who fall and call 999. The scheme will see WMAS respond with a rapid response vehicle

[12] One practice is aligned with Walsall CCG as mentioned earlier in this document

equipped with hoists. The patient will be clinical assessment by the paramedic, and only conveyed to the acute trust where necessary.

9.4.5.POLCV

The Procedures of Limited Clinical Value policy was developed by the Black Country Cluster to identify procedures of limited clinical priority that the CCG will not fund unless specific criteria are met; the policy incorporates evidence relating to clinical and cost-effectiveness. The implementation of the policy will reduce outpatient and inpatient activity and will provide assurance that: patients are receiving appropriate health treatments in the ***right place*** and at the ***right time***, treatments with no or a very limited evidence base are not being used and treatments with minimal health gain are being restricted. Therefore, implementation of the policy has been reflected in the modelling for the 2012/13 activity plan.

9.4.6.Modernisation O/P

Wolverhampton City Clinical Commissioning Group (WCCG) has commenced a new project with The Royal Wolverhampton NHS Trust. The project will see the two organisations work together in a bid to ensure continued improvement to patient experience and outcomes across a range of services which are increasingly in demand. The aim is to maximise the patient's appointment experience by making sure they are seen in the most suitable clinical setting and that unnecessary attendances are avoided by ensuring referral pathways are clearly defined.

The primary objective of this project is to reduce the number of avoidable outpatient appointments at RWT by 3,000 per year, worth approximately £400k p.a. to RWT's commissioners and enabling approximately £200k per annum cost avoidance for RWT. This programme will also deliver significant benefits to patients and staff, and support on-going operational and financial performance improvement

9.4.7.Pathology

Community Pathology is defined as pathology services that are commissioned by PCTs and CCGs, directly from existing pathology providers for their primary care users that are within the disciplines of Biochemistry, Haematology, Microbiology and Immunology. It includes GP direct access requests and Out Of Hours GP services. It excludes Cytology, Histology and Acute Pathology services and Pathology provided as part of block arrangements from community, mental health providers, Independent Sector Treatment Services and prison services.

In March 2012, and in response to the Independent Review of NHS Pathology Services in England (the Carter Report), PCT Commissioners across the East and West Midlands Strategic Health Authorities (SHA) agreed to commission an Outline Business Case (OBC) to review the options to deliver the Carter Report. All ten PCT

Clusters were involved in the discussions and had input into the Outline Business Case.

9.4.8.C2C

The nature of this project is for full implementation and appropriate contract variation with regard to the Consultant to Consultant (C2C) Referral Policy. Implementation of the policy will improve the patient experience and reduce activity/ costs resulting from inappropriate C2C referrals. Confirmation has been received through Contracting and Commissioning that the Consultant to Consultant Referral Policy has been implemented across the Trust. Therefore, full implementation of the policy has been reflected in the modelling for the 2013/14 activity plan

9.4.9.High cost drugs in secondary care

Background

- Allowing for a substantial reduction in growth in spend from 2011 onwards.
- Requirement to fund new specialised drugs and devices as recommended by NICE.
- Requirement to improve information systems for performance management from the acute sector post 2012
- Reduce the rate of growth to implement and manage high cost drugs in secondary care.

Patient Access Schemes (PAS) were developed by pharmaceutical companies as a way of reducing the cost of expensive new medicines to the NHS (also known as risk-share schemes). These schemes involve offering a rebate to trusts and are seen as a way of improving access to new medicines, by improving their cost-effectiveness and thereby enabling NICE approval. PAS' are often complicated and are patient specific which means they need to be tracked back through the system to identify which PCT receives the rebate.

Project objectives

- Original projection was to deliver cost savings of 500K over 3 years
- Deliver cost savings of £218k for 2013/14 from PBRe (as many PBRe drugs will be commissioned directly from NHS England.
- Improve the quality of information in order to benchmark levels of high cost drugs prescribing
- Reduce the rate of growth in PBR-excluded drugs
- Ensure prescribing is consistent with NICE approved drugs

- Improve the primary and secondary care interface and the quality of information for the purposes of performance management
- Reduce the number of inappropriate / unnecessary Individual Funding Requests (IFRs) and the cost of resources used to process them
- Produce pre-approval proformas for the use of all PBRe medicines
- Improve the management of Patient Access Schemes
- Projected target of £275K savings for 2012/13 revised to 330K

9.4.10.Prescribing efficiencies

Wolverhampton is performing well in relation to Better Care Better Value (BCBV) indicators and scope for making savings on low cost drugs is limited. However on-going monitoring and challenging of prescribing practice by prescribing advisers could see significant potential savings over three years

Background

- Allowing for a substantial reduction in growth in spend from 2011 onwards;
- Requirement to fund new specialised drugs and devices as recommended by NICE;
- Requirement to improve information systems for performance management from the acute sector post 2012;
- Reduce the rate of growth to implement and manage high cost drugs in secondary care.
- Project Objectives-
- Promoting & implementing procurement & medicines optimisation prescribing efficiencies;
- Deliver cost savings of £134k for 2013/14 from vial optimisation projects.

9.4.11.Integrated respiratory

Respiratory Action Network for the benefit of Wolverhampton (RAINBOW), the Lung Improvement Programme is already established within RWT based on a pilot scheme further developed and accepted as an NHS Improvement Programme.

COPD exacerbations have a significant impact on urgent care services. Initial data from the pilot project indicates that emergency admissions have been avoided through the availability of urgent appointments through the Hot Clinic, therefore by embedding the programme within healthcare services this should reduce the number of emergency acute admissions and reduce the length of stay of those patients that are admitted.

9.4.12.Diabetes

A bespoke Diabetes Dashboard will be used to support the management of diabetics and identify those at the most risk of moving towards the need for secondary acute care.

The Dashboard will R/A/G rate known diabetic patients, Secondary care consultants will liaise with Primary Care to ensure Green patients that are currently being followed up in Acute, and transferred to primary care. Individual care plans will be developed to improve the outcomes of patients.

9.4.13.Anti-coag /Stroke reduction

The review of the Anticoagulation Service will deliver:

- Improved Service specifications;
- Change of treatment for appropriate patients from Warfarin to new treatments. Clinical outcomes would improve and would become more cost effective for these patients. This will free up capacity within the service with frequent attenders moving to new treatment. This will reduce the requirement for frequent monitoring by the service and enable the service to support additional patients without additional resource;
- Additional capacity within the service will meet identified unmet need within the city. This will enable proactive optimal management of patients on AF registers by GP practices. Patients identified of being at risk of AF will be proactively screened.

In conjunction with this, the introduction of the Risk Stratification process and Optimal Management index across all long term conditions, patients will identify those patients that are not currently being managed within optimal clinical parameters for their condition, therefore enabling clinicians to improve the overall risk factors of patients, and reducing the risk of stroke.

9.4.14.Tele-health

Simple Telehealth and Flo (Advice & Interactive Messages (AIM) for health) will allow patients with long term conditions to self-manage and monitor their condition and symptoms, reducing the need to attend for routine appointments in primary care. In addition, other improvements, such as improved concordance with medication should contribute to reducing deterioration of long term conditions and prevention of avoidable hospital admissions

9.4.15.Risk stratification

The principle of the risk stratification model is that people with LTC's should not be admitted to hospital unless the exacerbation exceeds the capacity of what can be

provided in the community. The systematic process of Risk Stratification will identify those high risk/ complex cases/ high intensity users which will then receive further intervention from a facilitated MDT (by Community Matrons) to agree an individual care plan.

The Optimal Management Index will identify those patients that are not currently being managed within optimal clinical parameters for their condition, therefore enabling clinicians to reduce the patients overall risk factors of patients,

The model will support outcomes based improvements in standards and quality of care making services proactive rather than reactive. It is anticipated that by utilising either individual or both elements of Risk Stratification and Optimal Management Index that these components will support the following improvements:

- People with LTC's:
    - Improvement in the quality of care by proactively identifying patients;
    - Personalisation/Self-management/Choice for people and carers;
    - Increased independence/well-being and quality of life;
    - Patients being Optimally Managed for their condition.
- The system:
    - Assessment of physical/mental/social need and prioritising risk (at the **right place** and at the **right time**);
    - Improved system enablers (e.g. Data sharing and linked information systems, access to services etc.);
    - Prevention of hospital attendances & emergency admissions;
    - Reduction in readmissions;
    - Reduction in A&E attendances;
    - Increased Value for Money.

9.4.16.Nursing homes support

The purpose of the programme is to create a co-ordinated approach across the health and social care economy to support nursing homes. The overall objective of the project is to improve service delivery and safety in nursing homes through co-ordinated support. A joint approach to the work will result in reduced duplication, better use of resources and a more focussed methodology.

The CCG is aware that work is being undertaken across the health and social care economy to support nursing homes to better meet the needs of their residents. The identified areas of work include:

- Training and education opportunities;
- Admissions avoidance initiatives;
- End of life care initiatives;
- Stop the pressure initiatives;
- Improving quality in nursing homes initiatives.

The key milestones identified for the review are:

- Projects for inclusion identified;
- Project plans created for all projects;
- Project monitoring implemented.

Each project will work to its own clearly identified milestones.

The co-ordinated approach should improve the quality of care residents receive whilst in nursing homes, reduce the number of emergency callouts, reduce the number of A&E attendances from nursing homes and reduce the number of avoidable acute admissions from nursing homes.

9.4.17.Falls

The purpose of the review is to improve the falls service across the health and social care economy for the local population. Falls have a significant impact on physical health, confidence and quality of life. Early identification and intervention can prevent those at risk from falling and reduce the number of subsequent falls in patients who have experienced a first fall.

A retrospective analysis of clients attending the falls service indicated that approximately 35-45% of clients referred would be classed as low to moderate risk and community based postural stability classes would be appropriate. The current falls service will triage cases and refer on to the community based classes which will be funded using social care for health re-ablement funding. Due to an increasing frail and elderly population the number of falls that result in an admission for hip fracture is expected to rise by approximately 20 per 100,000 each year. Data relating to hip fracture admissions show that Wolverhampton is above the England average. The review aims to identify changes to the service that will increase early identification and intervention to prevent falls and hip fractures.

The key milestones for this project are:

- Research of best practice completed
- Community based stability classes implemented
- · Review of current service completed

- Proposal for changed developed

The changes to the falls service should reduce the number of A&E attendances the resulting from a fall, reduce the number of acute admissions as a result of falls and reduce the number of hip fracture admissions to acute care. Preventing falls and hip fractures should also reduce the number of admissions to long term residential nursing care.

Governance


STRATEGY
PLAN
THINK
NHS
New Cross Hospital
Neurology
Neurophysiology (EEG)
Staff Support Services
City Council
Wolverhampton
WMAS

10.Governance

WCCG has established transparent and effective governance arrangements in order to commission high quality, effective and sustainable services. This is underpinned with well-defined accountability and reporting mechanisms. These mechanisms provide the matrix that supports the formation and further development of our plans.

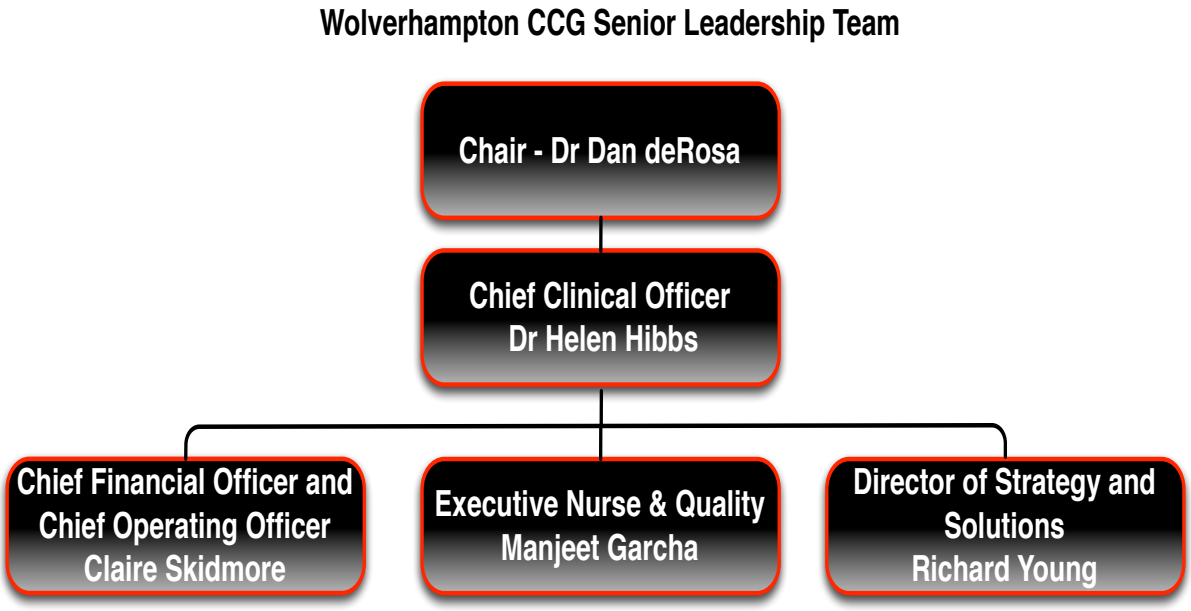


Fig 48 WCCG Leadership team

The governance arrangements are detailed within our Constitution and in summary:

- Accountability for quality lies with the Accountable Officer and is delegated to the Executive Nurse
- Financial oversight is delegated to the Finance and Performance Committee
- The corporate governance mechanisms will ensure that the Chair, Chief Clinical Officer, Chief Financial Officer and all other Governing Body members have a clear brief
- The objectives of all WCCG officers and Clinical Leads are well defined through the Terms of Reference of our Committees and other documents.
- The CCG will work with third parties including the local authority and other statutory bodies in developing and implementing appropriate agreements in order to improve and develop local services.
- The CCG will also work with NHS England to ensure that the services commissioned by them are an effective and cost-effective part of the overall range of services available to the people of Wolverhampton.

The CCG has a framework (see Fig 33)which assures that the CCG implements its responsibility for ensuring the quality and safety of patients.

10.1.Provider development

Close collaboration is the key to success for both commissioner and provider - one cannot succeed at the expense of the other. So it is critically important that commissioners and providers establish working arrangements that are productive and that deliver a “patient first” approach that delivers improved clinical outcomes as well as improving the efficiency of the service.

WCCG has three specific initiatives in train at the point of publication:

- The Joint Modernisation programme;
- The Joint Urgent Care Strategy;
- WCCG have also agreed a package of initiatives with RWT that will improve quality indicators and clinical outcomes

Commissioning

11.Commissioning

11.1.Commissioning intentions

The distinction between what have often been thought of as 'primary', 'community' and 'acute' health services has become less useful and the requirement to integrate care across pathways based on patients and their needs is increasingly the focus for clinical commissioners i.e. **Right care** in the **Right place** at the **Right time**

WCCG recognises that previously the construction of commissioning intentions has been a reactive, confined and unscheduled procedure which has often resulted in an inadequate platform for future planning. In response to this the CCG will implement a proactive, systematic and dynamic process which will utilise the Commissioning Cycle effectively and efficiently, be patient centric, apply and adhere to an established timetable/schedule and engage with stakeholders.

The six overarching commissioning intentions which WCCG will enact in 2013/2014 are:

- The Commissioner will work with the Provider(s) in order to enact the PBR guidance 13/14 (Gateway 17973);
- The Commissioner will work with the Provider(s) in order to implement schemes to continuously improve quality;
- The Commissioner will work with the Provider(s) in order to implement system wide service improvement;
- The Commissioner will work with the Provider(s) in order to agree revised mechanisms for contracting, payments and activity;
- The Commissioner will collaborate with regional bodies in order to shape the configuration of services;
- The Commissioner will work with the Provider(s) in order to realise efficiencies from the use of medicines and technology.

11.2.Commissioning strategy

Recognising the pressures that the health economy faces, WCCG is developing an overarching Commissioning Strategy based on the key drivers that have been identified in the JSNA, by the Providers themselves, by the commissioning team, by GP's and the patients and the public themselves.

Strategic development work within the CCG is at an advanced stage and progressing well. We are focussing our strategic development on the following key areas:

- Urgent care;
- Long term conditions;
- Intermediate care;
- Modernisation;
- Mental Health.

11.2.1.Commissioning principles

WCCG aspires to be a “best in class” commissioner of healthcare services (**Right care** in the **Right place** at the **Right time**), perceived as such not just in the locality but across England as well. If we are to achieve this status we must adopt and implement a range of key principles that will govern our approach to commissioning on a consistent basis. The following list, although not totally exhaustive, describes some of those principles:

- We will contract with and performance manage using the levers of, the national standard NHS contract in its entirety;
- We will review service specifications to ensure that they meet local needs and make the best use of up to date evidence and innovations in health care;
- We will apply rigorous and measurable quality requirements;
- We will apply rigorous performance reporting regimes requiring adherence to national standards such as SUS and non SUS NHS number requirements;
- We will create realistic and seasonably adjusted activity plans for each service line using currencies that enable benchmarking;
- We will promote innovation by entering into CQUINS which are truly innovation focussed.

11.2.2.Urgent care

WCCG is working closely with RWT to jointly develop a sustainable and affordable urgent care system for Wolverhampton. Like many other Acute trusts the emergency department at RWT is under almost constant unsustainable pressure. WCCG’s strategy for commissioning acute provision is to ensure that acute care is still provided by acute providers, in an acute setting, but that non-acute elements of each care pathway are provided in more appropriate settings, at a lower cost. This will increase efficiency by aligning the care setting to effectively meet patient needs.

We are mindful that the CCG's strategy will not only impact on acute provision, but also requires improved primary and community care to enable the shift in care provision, so that patients can be appropriately managed in non-acute settings. Likewise outpatient care will need to be delivered in an integrated way across the health economy, supported by co-ordinated and communicated care plans.

The following figure (Fig 49) describes the current status and progress of the work;

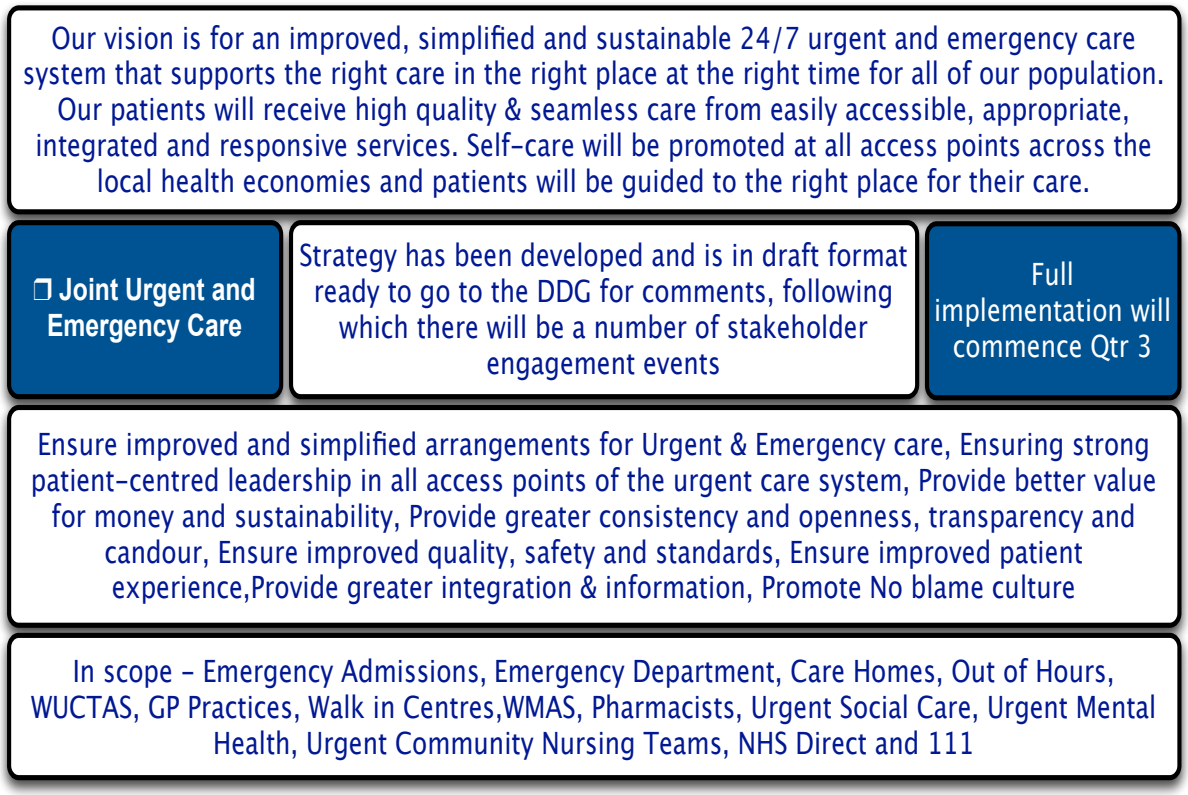


Fig 49 - Joint Urgent and Emergency Care progress status

11.2.3.Long Term Conditions (LTC's)

The impact on patients themselves and the health economy of LTC's cannot be underestimated. Often those suffering with LTC's struggle to lead a life that has a quality that could be measured as comparable to other members of society.

There are a number of key contributors to the impact that LTC's are having on the health economy not just in Wolverhampton but nationwide:

- An aging population with increasing numbers of people living with dementia;
- Increasing numbers of people being diagnosed with Diabetes as a result of lifestyle choices;
- Low physical activity levels;
- Smoking;
- Alcohol abuse.

WCCG members have agreed that the current service provision is not economically sustainable and does not align to the vision of **Right care** in the **Right place** at the **Right time**.

To this end WCCG have determined the need to develop and implement a comprehensive LTC strategy that will then be a key driver for the commissioning agenda, ultimately informing the commissioning plan. The following diagrams (Figs 50-52) describe the current progress by the commissioning team around LTC's, Intermediate care and the Modernisation programme.

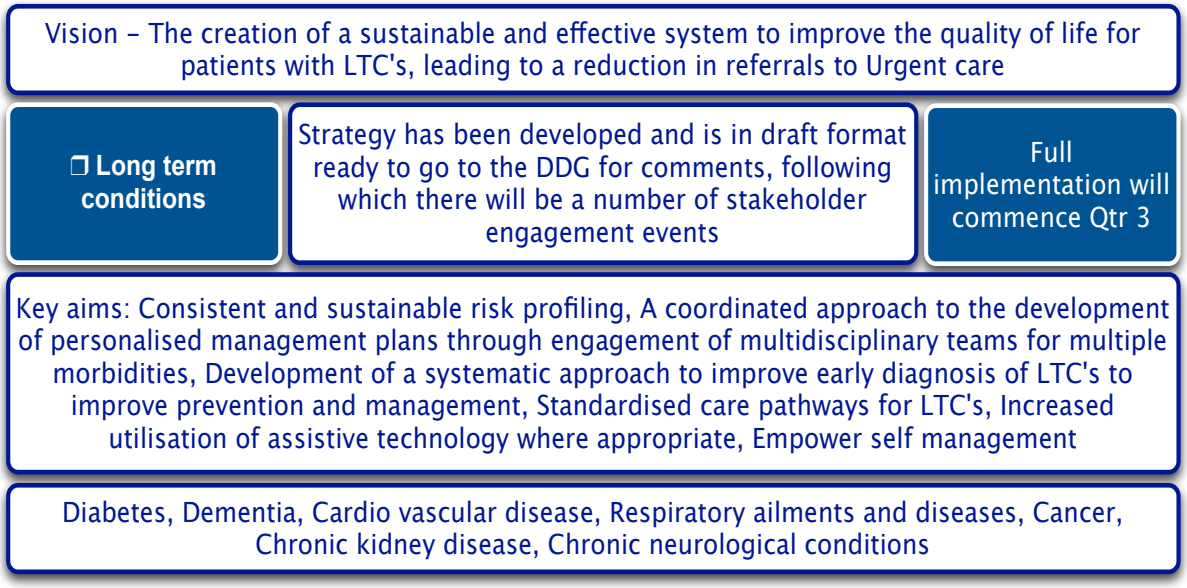


Fig 50 - LTC's Strategy development

11.2.4.Intermediate care

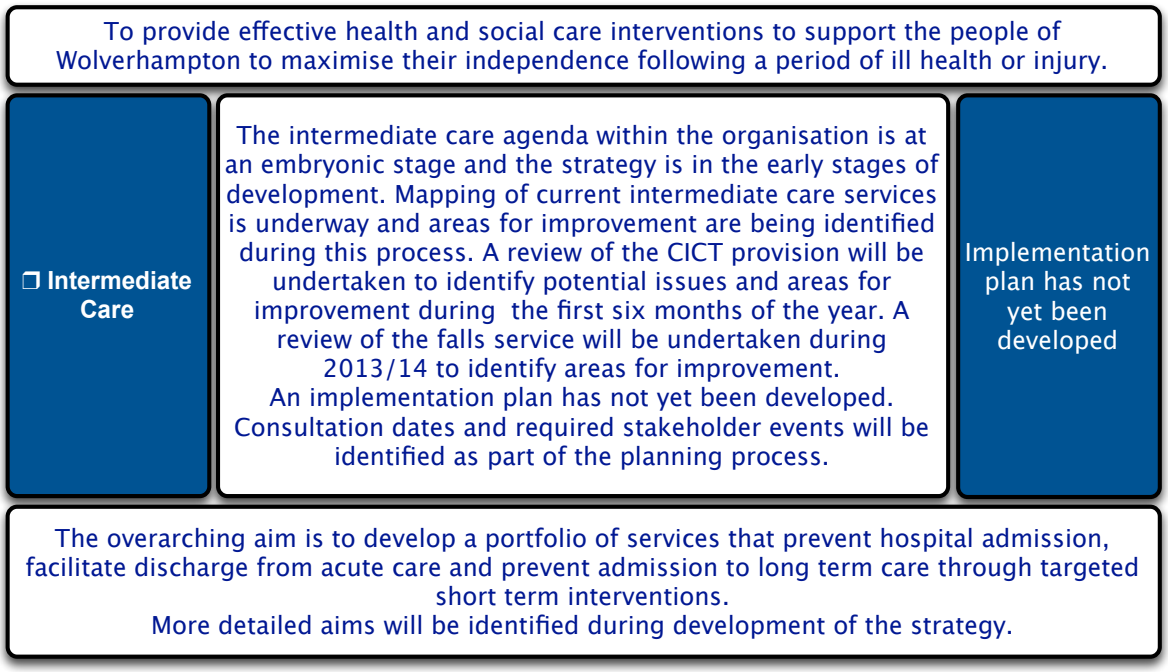


Fig 51 - Intermediate care strategy development progress

11.2.5.Modernisation

Vision – To review current outpatient pathways and to reduce outpatient attendances within the Hospital setting. Ensuring patients are given the most appropriate treatment at he right place at he right time		
❒ Modernisation	Status of the strategy – ie. When will it be published, when will it go to consultation, what stakeholder events will be held – The programme started in January 2013. Each individual workstream/pathway will engage with appropriate stakeholders i.e. Gastroenterology pathway – stakeholders inlcude GPs, Gastroenterologists, directorate managers, Outpatient Booking team, IT. Consultation / engagement with patients and public will be managed by individual workstream/pathway. For example with Gastroentereolgy we are seeking advice regarding how GPs will manage patient expectations within the new pathway.	
The key aims are – reduction in outpatient appointments within the hospital setting, improved patient experience, simplified pathways for GPs, secondary care clinicians and patients		
In scope – Outpatient appointments, all specialties, excluding 2WW/Fasttrack		

Fig 52 - Modernisation strategy development progress

11.3.Commissioning intentions/allocations

The CCG has finalised it's commissioning plan based on the a structured process as described below in Figure 53, and where necessary and appropriate we have included a service design element to ensure that we commission services that provide a high standard of care and are affordable within the available financial envelope.

Fig 53 - Commissioning process

The following table in Figure 54 is a summary of the CCG's commissioning allocation proposals.

Wolverhampton CCG LTFM Baseline Values 2013/14 LTFM	Recurrent £000s	Non-Recurrent	Total
Acute Non-Foundation Trust	151,286	631	151,917
Acute Non Foundation Trusts	10,538	0	10,538
Non Acute Foundation Trusts	25,977	750	26,727
Non Acute Non Foundation Trusts	35,507	0	35,507

Fig 54 - Proposed Contracting allocations

11.4.Specialised commissioning

From April 2013, the NHS England will have responsibility for directly commissioning all prescribed specialised services. 'Prescribed' specialised services are those services which have been 'tested' against the four factors in the Health and Social Care Act 2012 as suitable for commissioning by NHS England.

Funding for specialised services is held by NHS England who will directly commission those services. Commissioning portfolio. The CCG is liaising with the the Specialised Services Commissioning Team (SSCT) at NHS England, and its local provider The Royal Wolverhampton Trust (RWT) to finalise the position and ensure integrated service provision.

11.5.Collaborative Commissioning Arrangement

From 1st April 2013, WCCG will formally take on a significant proportion of the commissioning responsibilities of the former Wolverhampton City PCT.

Among these commissioning responsibilities will be those services that have been traditionally "jointly commissioned" between the PCT and the Local Authority (Wolverhampton City Council).

The CCG document, "***Collaborative Commissioning in Wolverhampton***", sets out a high-level specification for the services, working methodologies / relationships, governance arrangements and outputs/ outcomes that the CCG would wish to achieve by contracting with WCC for the Council to provide the commissioning functions for these services on behalf of the local health and social care economy.

WCCG have set out their business proposals for undertaking the specified services, these arrangements will be governed by a service level agreement (SLA) which will be reviewed annually.

"Collaborative Commissioning in Wolverhampton" sets out WCCG's arrangements for commissioning services for :

- Mental health;
- Learning Disabilities;
- Community Equipment and the Independent Living Service.

The document also sets out Wolverhampton City CCG's intention to commission the following Jointly Commissioned services:

- Intermediate Care (in part);
- Carers Support Services (including information / sign posting / respite care / short breaks);
- Autism services;
- Dementia;
- Child Health Mental Services (CAMHS);
- Child Health services.

11.6.Governance and Accountability for Collaborative Commissioning

The commissioning of collaboratively commissioned services will be will be led by the relevant designated clinical lead from the CCG Governing Body.

Collaboratively commissioned services will be supported by the Director of Strategy and Solutions within the CCG who will be responsible for the strategic development, resource planning and delivery of the programme area and will be held to account by the Governing Body.

The CCG will remain the accountable body for the agreement and operation of such contracts; however the day to day commissioning arrangements arising from the management and operation of those contracts will be managed by the JCU on behalf of WCCG.

This will require 3-way or tripartite working across the CCG, the CSU and the JCU where:

- WCCG will 'hold' the contract, but

- The strategic development of services and commissioning / financial management is undertaken by the JCU, and
- The contract monitoring, management, and the annual contract arrangements are handled by the CSU.

11.7.The Joint Commissioning Unit

The Joint Commissioning Unit will be hosted by the Council. The joint commissioning unit will:

- Maintain appropriate expertise to enable the production and implementation of commissioning strategies and plans;
- Gather relevant intelligence about individual and community needs, market conditions and community capacity;
- Prepare drafts of any planning or commissioning documents relevant to services which are necessary to enable the Partners to fulfill their responsibilities or are required by the Government;
- Prepare bids for funding from Government or other sources;
- Through the offices of the Joint Commissioning Unit, the CCG and WCC may commission services from any suitable third party source to fulfill their responsibilities under a section 75 Agreement or it's replacement , as an alternative to providing them themselves.

11.8.RWT

The Trust has identified three priority delivery areas for 2013/14:

- **Urgent Care**: Promoting self care; Treatment in the **Right place** (ambulance arrivals at A&E will be assessed within 15 minutes and doctors will aim to see patients within an hour); Working with GPs; Reducing paediatric A&E and PAU attends – with closer to home alternatives.
- **Care of the Elderly**: with a focus on Falls; Pressure Ulcers; Nutrition; Infections.
- **End of Life Care**: Choosing where to die; Improving Access; Supporting families and carers.

The financial stability of RWT creates a stable platform and starting position across the entire health economy.

The integration of acute and community care provides a great opportunity for Wolverhampton, but national studies have shown the benefits are far from easy to achieve and require a genuine 'whole-system' approach to planning and delivery.

The approach to urgent care in respect of right place, right time is absolutely the right direction of travel. The challenge for the health system will continue to be educating and changing the attitudes of patients who see A&E as the first port of call and transforming provision accordingly.

The focus of elderly care has rightly been on quality and getting it right first time: these aspects of care are rightly now seen as the norm. However, the elderly population is growing fast and this is an area of care that will require transformational change in the future.

11.9.Black Country Partnership NHS Foundation Trust (BCP)

The Trust has a turnover in excess of £100m, a third of which is delivered across Wolverhampton. It has a positive cash position, returning a surplus in 2011/12.

Through the TCS programme, the Trust has doubled in size, employing approximately 2,000 people.

The Trust has identified four key goals it wishes to achieve:

- Reducing inequality across its geographic area;
- Improving and promoting the health and well being of local communities;
- Providing high quality care in the right place at the right time;
- Putting people and their families at the heart of care.

The financial stability of the Trust presents the opportunity to start from a solid base across the entire health economy.

Reducing inequality aligns with the ambitions of the City and is generally accepted as being the norm rather than the exception.

This needs to be viewed as a longer term strategy, but one that that presents huge benefits for our population and the entire health economy.

Providing the **Right care** in the **Right place** at the **Right time** is absolutely the right approach and is well recognised as the way to drive out efficiencies and improve the safety and quality of care. We will need to work together to understand in more detail what the implications of this is for our patient population.

Putting people and their families at the heart of care in a real sense is critical, and has to start with a patient centred approach to planning for the health economy – it's only from the patient's perspective that the politics and incentives of individual organisations can be transcended. Mental health provision is undergoing a lot of change and is coming under increasing business pressures. We will be working closely with BCP and the Local Authority to jointly develop sustainable plans for the next five years.

Finance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12.Finance - Local and National background

WCCG has developed a stand alone Financial Strategy document and this document (the ICP) should be read in conjunction with the ***Financial Strategy 13/14 - 15/16*** , this section describes the headlines emerging from the Financial Strategy document.

We have not sought to duplicate the Financial Strategy document within the ICP but we have included the key components of the strategy in order to make sure that the two documents are aligned.

12.1.WCCG

Whilst it is true that the NHS, so far in the life of this Parliament, has been protected from the main raft of public sector budget cuts, with a settlement that provides for an annual inflation uplift on existing budgets for the next two years. The service will still need to deliver improvements in its financial performance - reduction in the cost base and improvements in value added activities. We do know, that there are a number of factors that make for a very challenging environment for the NHS some of which include:

- Rising demand from an aging population , from increased “lifestyle” disease and from increasing technological capability...estimated at as much as 2% pa;
- The actual cost of NHS inflation (driven by technological advance) running ahead of general inflation;
- VAT and National Insurance increases;
- Pay bill increase resulting from increments and Excellence Awards;
- Transfer of NHS resources to Local Government (e.g. Public Health);
- Challenges to Local Government and other public sector partners resulting from real budget cuts which may require actions that in turn have consequences for the efficiency and effectiveness of NHS operations or indeed for demand for services.

12.2.Financial background - Local context

The following table (Fig 55) below illustrates the underspend reported in the PCT’s annual accounts for the last three years.

Year	Surplus £'000
2009/2010	19,365
2010/2011	15,692
2011/2012	19,682

Fig 55- WPCT Historical financial performance

2012/13 is the final year for the PCT and its strong financial position continues. Current forecasts indicate that the PCT will close with a surplus in the region of £15.3m. Much work has been done in-year to identify the split of the PCT's budgets to its successor organisations and monthly reporting has been arranged so that the emerging CCG can review its own financial position.

In 2012/13, WCCG has budgets delegated to it of £358m. WCCG is on track to support the PCT in achieving its target underspend position. It plans to meet its share of the PCT's QIPP target for the year and is also able to offset some of its reserve underspends to support overspends within other PCT budgets.

The historic position of the PCT has meant that in previous years, the organisation has been fortunate that it has had access to non recurring underspends brought forward and has not had to rely on large scale efficiency programmes to ensure financial balance. This position will not continue in the future however as the CCG will have to make provision for its expenditure at a time when growth in NHS allocations is slowing and cost pressures are increasing. The impact of these factors is considered in the CCG's financial plans and is factored into the CCG's assessment of risk within its financial position.

12.3.Overarching strategy

The CCG's Financial Strategy is to make available the resource required to transform the local healthcare system; improve the quality of life for the people of Wolverhampton and contribute to reducing health inequalities across the City.

The commissioning of high quality services will be underpinned by a prudent approach to financial management that provides assurance to the public that value for money is delivered through the CCG's actions.

Hence a successful strategy will serve the CCG's vision for Wolverhampton whilst also delivering the organisation's statutory financial obligations and having strong regard for risk.

12.3.1.Objectives

The CCG's Finance Strategy sets out 8 financial objectives for the organisation:

- To ensure expenditure within a financial year does not exceed the allocated budget;
- To ensure that revenue resource use and capital resource use do not exceed the separate limits set for each;
- To ensure that the CCG's revenue resource use on prescribed matters relating to administrative costs (ie costs not relating to healthcare services) does not exceed an amount specified by NHS England (ie the 'running costs' allowance);
- To ensure that the CCG adheres to any further limits set by NHS England in relation to capital or revenue resource to reflect limits set by the Secretary of State on NHS England;
- To provide financial information to NHS England as required to allow in-year monitoring against budgetary and Parliamentary controls;
- To keep proper accounts and proper records in relation to the accounts, prepare annual accounts and have these audited, and comply with any directions of NHS England as regards accounts;
- To use a specified banking system (i.e. the Government Banking Service);
- To ensure adherence with Public Sector Payment Policy.

Delivery against the eight objectives will be reported regularly in the form of finance reports that are presented to Finance and Performance (F&P) committee. The objectives themselves will also be reviewed regularly to ensure that they continue to meet WCCG's requirements. The CCG's financial plan for 2013/14 to 2015/16 has been constructed on a 'most likely' basis. In addition to this, two further scenarios[13] have been mapped to consider the impact of both best and worst case assumptions. In these scenarios, growth and inflation assumptions are flexed and risks are altered to demonstrate the impact on the CCG's position.

WCCG has been awarded funds for two different streams of expenditure;

- A 'Programme budget' is the CCG's main source of funding and it is allocated to pay for commissioning activities;

[13] Included in the Finance Strategy but not the ICP

• The 'Admin budget' is earmarked to fund the running costs of WCCG

The admin budget is capped and whilst admin underspends can be consumed within programme areas, programme funds cannot underpin admin overspends.

The CCG's budget over the next three years is set out in the table below. This illustrates the 'most likely' position alongside best and worst case scenarios.

	Most likely			Worst case			Best case		
	13/14	14/15	15/16	13/14	14/15	15/16	13/14	14/15	15/16
Income	£M	£M	£M	£M	£M	£M	£M	£M	£M
Allocation forecast	309.5	316.4	323.7	309.5	316.4	319.6	309.5	316.4	324.3
Previous year carry forward	10.7	9.3	9.0	10.7	0.7	-9.4	10.7	11.4	16.7
Growth	7.0	7.3	7.4	7.0	3.2	3.2	7.0	7.9	6.5
	327.1	332.7	340.2	327.1	320.3	313.4	327.1	336.8	347.5
Expenditure									
Forecast expenditure (LTFM)	316.3	318.7	324.5	320.6	319.5	329.7	314.6	314.8	319.1
Inflation	8.0	8.0	8.1	8.0	9.5	9.8	8.1	8.0	8.1
Efficiencies	-11.5	-10.6	-10.7	-11.5	-10.7	-10.8	-11.6	-10.8	-10.6
QIPP Savings	6.5	6.0	6.0	3.3	3.0	3.0	6.5	6.0	6.0
Growth (Demographic plus other factors	6.6	6.6	7.3	7.3	7.3	7.8	5.8	5.9	6.3
CCG Developments	5.2	7.0	7.9	5.2	7.0	7.9	5.2	7.0	7.9
	318.1	323.7	331.2	326.4	329.7	341.3	316.7	319.1	324.7
In year surplus/(Deficit)	1.7	0.0	0.0	-10.0	-10.1	-18.5	0.8	5.3	6.1
Cummulative surplus/(Deficit)	9.0	9.0	9.0	0.7	-8.4	-27.9	11.4	16.7	22.8

Fig 56 - Income and Expenditure[14]

In the 'most likely' scenario, a realistic position is achieved along with a control total that exceeds the current requirement to deliver a 1% surplus. Plans assume that this level of underspend will be maintained and returned to the CCG in future years. A contingency reserve is held in all years.

The CCG is able to accommodate a level of growth beyond its control ('demographic and other factors') whilst setting aside additional funds for schemes that will support its strategic priorities and other areas it highlights to receive investment ('CCG Developments').

[14] Finance and Activity schedules relating to the key contracts within the CCG's expenditure are available in the Appendices

The key information and assumptions included in the 'most likely' model are detailed below:

2013/14 - Category	Key Information/Assumptions
Resource Allocation , (income)	Programme baseline £310.1m, Admin baseline £5.9m, 2.3% uplift to CCG programme baseline (confirmed by NHS CB),
Programme Spend	0.58% demographic growth (based on ONS statistics) 2.5% additional growth in prescribing spend 12% additional growth in continuing care spend 1% additional contract growth 2.7% inflation across all programme areas except for continuing care 4% inflation continuing care 4% tariff efficiency on secondary care contracts 3% efficiency in prescribing 2% efficiency in continuing care
Admin Spend	Assumes all costs of pay awards, incremental drift and inflation are managed within the target figure
Other	2% recurrent funds lodged centrally, cases constructed for non recurring application of these funds, 1% contingency held (requirement for at least 0.5%), Control total of £9m; as agreed with the Area Team

Fig 57 Key assumptions 2013/14

12.4.WCCG Financial Risk

The main challenges for WCCG to remain within budget are to manage activity to contracted levels and to develop the Modernisation Agenda in order to deliver cash releasing efficiencies to support modernising services.

WCCG will be operating in a challenging environment. The magnitude alone of the QIPP scheme inherently holds risks. WCCG has identified risks which are contained on the Risk Register but risks specifically related to finance can be summarised as follows:

- Uncertainty and Government Policy changes may lead to stagnation in delivering schemes;
- Loss of key staff, key knowledge, and insufficient resource to deliver WCCG's strategic agenda including QIPP;
- The magnitude and complexity of the change agenda may lead to WCCG taking their eye off the day to day running of the CCG and thereby eroding into the solid foundations laid by WCPCT;
- Lack of clarity regarding the future funding streams in terms of growth etc. may lead to the erosion of the underlying financial position;
- All QIPP savings will be negotiated out of contracts. The ability to do so is dependent to a large extent on real partnership working, the desire to improve health services and the desire to share risks to maintain a stable health economy.

Deviations from planned levels of activity can have a significant impact on the CCG's financial position.

In constructing its finance plans, consideration has been given to what risks the CCG has and the following schedule identifies these risks for 2013/14 and describes how they would be mitigated:

Risk	Full Value £'000	Probability of risk being realised	Potential value of risk £'000
Contract overspend	5,000	50%	2,500
(particular concern regarding Acute emergency activity and mental health reconfiguration)			
Continuing care increase in costs due to more complex cases	1,000	50%	500
QIPP- slippage on schemes	1,000	50%	500
NHS 111 - True cost of roll out not yet known			
Mitigation	Full value	Probability of success of Mitigation	Expected value of mitigation
Contingency	£3,100.00	£1.00	£3,100.00
Extend QIPP	1,000	50%	500
			3,600

Fig 59 - Finance risks (QIPP)

There is also a further risk to the CCG that it may not have the 2% recurring funds available to spend non recurrently. The CCG is expecting to have these monies (£6.2m) top sliced and it is not yet known whether they will be returned.

Current plans to spend these monies in 2013/14 are detailed below

			£'000
Already committed	Specific schemes have been commsssioned and cannot be ceased without incurring costs e.g. Newtons, Pathology. These schemes will result in delivery of significant QIPP savings and knowledge transfer into the CCG		2,203
Can be stopped/not started	Funds to pump prime projects these would have to be delayed and delivery of QIPP would be impacted		3,000
May be Winter pressures if not available	Flexibility to agree schemes to manage surges in activity with providers will be seriously compromised		1,000
			6,203

Fig 60 - Spending plans

If the worst case happens and the CCG does not receive these funds back, mitigations are as follows:

	£'000
Further QIPP Extensions	1,703
Non-recurrent measures	1,500
Delay/reduce investment plans	3,000
	6,203

Fig 61- Risk mitigation plans

Source: LTFM Submission Mar 8th 2013

Since the production of the 8th March LTFM, a further risk to the CCG has been identified. When the CCG budgets were allocated in December 2012, approximately £20m was top sliced from the PCT's budget to reflect the loss of responsibility for those specialised services that would transfer to NHS England. Calculations to date suggest that the actual value of activity to be removed from contracts could be less than £20m hence, there could be a significant cost pressure to the CCG if this problem is not addressed.

This is a national issue, shared by all CCGs and the local finance and information teams are currently working with specialised services colleagues and providers to understand the budget transfers that are required and the corresponding impact to CCG budgets. Any associated hit to the CCG's budget in 2013/14 once budget transfers are complete will need to be funded. This adds additional pressure to the CCG's finance position and, in particular the recurrent resource base.

Risk


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13.Risk

Datix is the CCG NHS system for reporting incidents and Risks. Once Risks are reported on Datix the handler will manage the Risk and update it on a regular basis until the Risk is closed. At this stage the relevant WCCG Director will view the Risk and if satisfied that the final risk score is correct and completed, will give final approval for Risk closure.

13.1.Identification of risk

Risk to CCG programmes and initiatives are generally identified by the DDG's where there is consistent clinical presence and engagement. Each risk is discussed and a preliminary score allocated. This scoring is later validated and assessed by the CCG Risk manager and the Head of Performance.

When each new risk is identified the relevant DDG will agree the response approach to the specific risk on the following response criteria:

Fig 62 - Risk response criteria

13.2.Recording risks

When new Risks are added, a Director is always notified as this field is mandatory when completing a Risk and a manager has to be selected. If the Risk score is high (12 or above and Red), this appears on the monthly Board Assurance Framework report where the score is monitored, Red Risks are also reported on at a number of CCG Meetings being the most severe type of Risk on the register.

The Risk scoring matrix is made up of a likelihood x impact rating (see Fig 63 below).

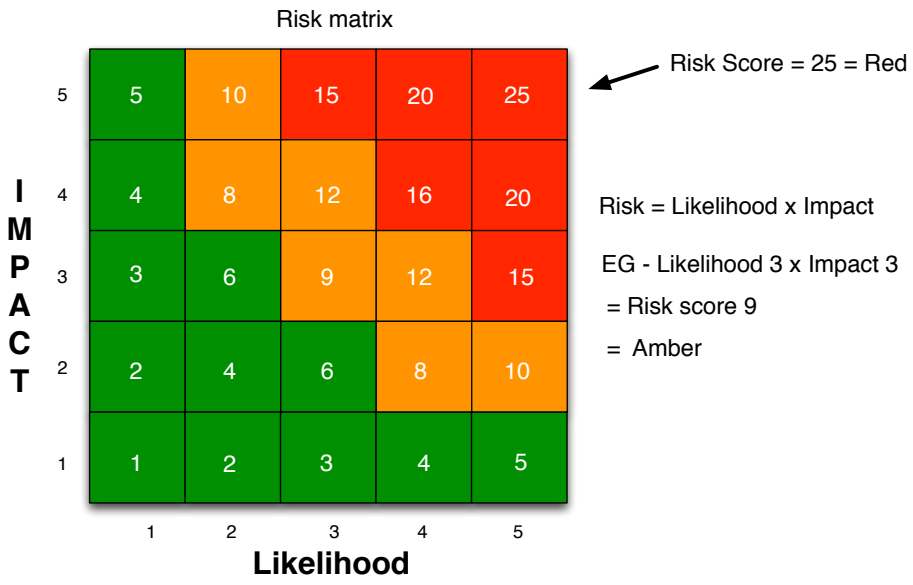

Fig 63- Risk scoring matrix

There are a number of low scoring risks on the CCG Risk Register which are also included on the Quality themed CCG Senior Management Team (SMT) meeting so all open risks are always discussed at some point on a quarterly basis.

13.3.Risks to the delivery of this plan

13.3.1.Strategic

- That we fail to provide a genuinely transformational vision for the health economy;
- That we fail to change the model of care across the whole system and services become unaffordable;
- That we fail to gain support for the change required through genuine collaborative working with our stakeholders.

13.3.2.Operational

- That demand and activity grows faster than we have forecast and therefore our response will be insufficient;
- That integrated models of care are not planned appropriately and do not deliver the intended clinical outcomes;
- That demand management schemes are unsuccessful and increase pressures on acute services;
- That we fail to deliver our OD plan and as a result staff do not have the capacity, capability, or motivation to deliver significant change within the health economy.

13.3.3.Financial

- That our QIPP programme does not deliver as forecast;
- That price efficiency is not matched by genuine cost reductions by our providers;

- That our providers over-perform in response to rising demand and it is unaffordable.

Conclusions

14.Conclusion

14.1.Purpose and Challenges

14.1.1.Our Purpose

Wolverhampton City Clinical Commissioning Group is wholly committed to improving the health and wellbeing of our population. We will achieve this by placing patients at the centre of our decision making and deliver this through the newly established model of clinically led commissioning. This ICP sets out the vision and mechanisms for achieving our vision of meeting the health needs of the residents of Wolverhampton.

14.1.2.Our Challenges

Our population is complex and requires us to be sensitive to the cultural as well as the many health needs of the rich diversity of our communities. Deprivation remains a stubborn issue with almost half of the city's neighbourhoods amongst the 20% most deprived in the country. Meanwhile, Life expectancy in Wolverhampton is in the bottom 20%. The gap between Wolverhampton and the national average for men is two years and for women is 1.5 years. This is driven by "the big six" causes of death - as described earlier in the document. The causes of short life expectancy also contribute to quality of life. WCCG will focus on improving the care for people with long term conditions and – more importantly – develop strategies and initiatives targeted at identifying and treating people with life-limiting conditions at an earlier stage to help lengthen life and improve the quality of life.

WCCG will be operating in a financially challenging environment. The CCG will remain within budget by managing activity to contracted levels and by developing the Modernisation Agenda to deliver cash releasing efficiencies and promote better clinical outcomes. As a PCT Wolverhampton has performed well financially over recent years. There has been significant growth in spend over recent years but this is unlikely to continue. Whilst the most likely case in WCCG's LTFM shows it breaking even, QIPP savings are necessary for ensuring that this is delivered and service developments can take place.

The magnitude of the QIPP challenge inherently holds risks – we will need to retain key staff knowledge and skills to deliver WCCG's strategic agenda for QIPP. We need to ensure that the scope and complexity of the change agenda does not lead to WCCG taking their eye off the day to day running of the CCG and thereby eroding into the solid foundations laid by WCPCT.

14.2.Our Future

WCCG developed this ICP through an extensive and on-going process of engagement with partners, stakeholders and staff. The strategy that underpins the ICP reflects commitments to transformational change driven by our demographic, financial and health needs case for change. It is also underpinned by a finance plan that demonstrates a sustainable financial position for the next three years and shows how resources will be used to meet patients' needs and show value for money for the people of Wolverhampton.

WCCG's priorities represent some of the most challenging areas for health improvement in the city. Nevertheless they are key to the achievement of the overall vision of ensure the **Right care** in the **Right place** at the **Right time** for all our patients and progress has been made in each of the priority areas. A clear performance management process is in place to ensure that our initiatives are delivered and reviewed against planned improvement trajectories.

An OD plan (which is also a live and developing document) is in place to support improved performance in each of the commissioning competency areas. This plan addresses individual skills and training but also covers organisational behaviours and process to ensure that WCCG systematically demonstrates high level competency in all its activities.

Whilst recognising that we are working with many challenges, we are committed to delivering transformational change in order to realise an efficient and effective health care system in Wolverhampton, which is both affordable and provides the highest service standards, which our population rightly expects and deserves. Our programme of change will be led by clinicians and will operate in collaboration with our stakeholders.

WCCG is committed to its vision and values. Reducing health inequalities and creating a sustainable health economy particularly during recession remains a significant challenge. This plan demonstrates how WCCG, working with others, will meet this challenge.

Next steps


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15.Next Steps

15.1.The WSP

The WSP for 2013-2016 , describes the strategic and operational intentions of Wolverhampton City Clinical Commissioning Group (WCCG). It also seeks to describe and demonstrate our understanding of the links between the local issues and priorities for healthcare services that need to be commissioned for the population of Wolverhampton and the key indicators in the NHS Outcome Framework.

15.2. A different approach to planning, to achieve a different result

We have developed the WSP and the ICP through a number of internal workshops involving our clinical and non-clinical leaders. They were run in parallel with three organisational development workshops, ensuring our development as an organisation is focused on the capability and capacity we need to meet the requirements of the health economy as a clinical commissioning organisation.

When we first assembled our clinical and managerial leads, we identified a number of principles we wanted to characterise our approach to planning and our role within the health economy in the future. They included:

- Meaningful involvement of stakeholders;
- Using leadership skills to lead the Health Economy not be led;
- Building robust sustainable relationships;
- To be proactive not reactive;
- Place quality at the top of our agenda and the patient at the top of the hierarchy.

Whilst remaining focused on delivery for 12/13, we have approached the development of this plan with the express intention of achieving these principles by developing a robust case for change for the health economy over the next five years. Our discussions at our strategic planning workshops have repeatedly led to the conclusion that a sustainable health system can only be built through a whole system approach. This document represents one step in this process and defines the development required for the CCG to ensure we are successful at it.

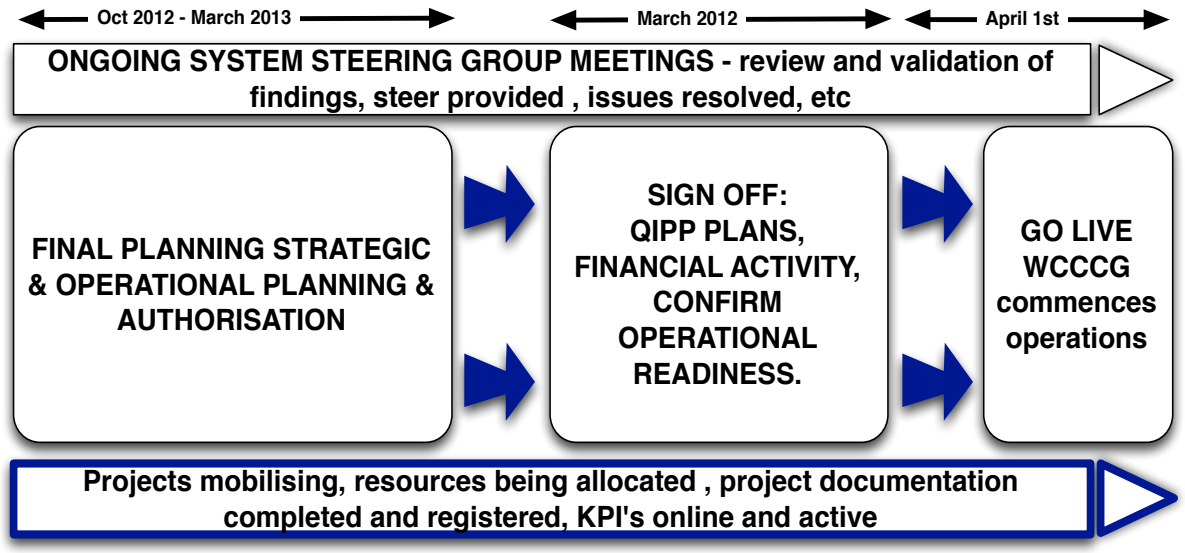

Fig 64 - Current WCCG Status

15.3.Outcomes

It is critical that the conclusions, recommendations and supporting analysis/ modelling for this work are fully owned by system leaders:

- We must continue to engage our stakeholders to develop our understanding of current plans and shape our conclusions around further opportunity and potential impact;
- We must develop our quantitative analysis, working alongside our stakeholders' finance and performance teams;
- We must test the plan to ensure that it delivers "right sized" and complementary services across the health economy that will assist both us as a new CCG and our providers to confront the medium and long-term financial challenge in an effective way.

15.4.Our Next Steps

Collaborating on plans is much more challenging than building them in relative isolation. We recognise this challenge in our OD plan and consider our needs and the development required for WCCG to ensure we are successful at it. We have developed our strategic planning approach with our stakeholders – set out earlier in this document.

- At the point of submission for Authorisation assessment, this plan represented our progress at that point in time, since then we have been successful in constructing that compelling case for change that informs our Whole System Plan (WSP);
- This plan was the final consultation document prior to April 1st with which we engaged with our practices, partners, providers, patients and public.

The ICP is deliberately a live document and, as such, it will be regularly updated over the next three years to reflect progress on initiatives, national priorities/ directives, the advancement of the organisation and horizon scanning.

During this period, WCCG will also commence some of the strategic reviews highlighted earlier within the plan which, together with the outcomes from the continuing engagement activities will combine to provide our short to medium term commissioning intentions.

Working in collaboration with all our partners we will further develop and refine our financial planning and our medium to long terms QIPP programme to deliver the service improvements and quality outcomes aspired to by the local health and social care economy - and demanded by the patients and public of Wolverhampton.

Appendices


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16.Appendices

16.1.Appendix I - The Francis recommendations

Recommendation 1: The Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard.

Recommendation 2: The Secretary of State for Health should consider whether he ought to request that Monitor – under the provisions of the Health Act 2009 – exercise its power of de-authorisation over the Mid Staffordshire NHS Foundation Trust. In the event of his deciding that continuation of foundation trust status is appropriate, the Secretary of State should keep that decision under review.

Recommendation 3: The Trust, together with the Primary Care Trust, should promote the development of links with other NHS trusts and foundation trusts to enhance its ability to deliver up-to-date and high-class standards of service provision and professional leadership.

Recommendation 4: The Trust, in conjunction with the Royal Colleges, the Deanery and the nursing school at Staffordshire University, should review its training programmes for all staff to ensure that high-quality professional training and development is provided at all levels to and that high-quality service is recognised and valued.

Recommendation 5: The Board should institute a programme of improving the arrangements for audit in all clinical departments and make participation in audit processes in accordance with contemporary standards of practice a requirement for all relevant staff. The Board should review audit processes and outcomes on a regular basis.

Recommendation 6: The Board should review the Trust's arrangements for the management of complaints and incident reporting in the light of the findings of this report and ensure that it:

- provides responses and resolutions to complaints which satisfy complainants;
- ensures that staff are engaged in the process from the investigation of a complaint or an incident to the implementation of any lessons to be learned all part of the recommendation
- minimises the risk of deficiencies exposed by the problems recurring; and
- makes available full information on the matters reported, and the action to resolve deficiencies, to the Board, the governors and the public.

Recommendation 7: Trust policies, procedures and practice regarding professional oversight and discipline should be reviewed in the light of the principles described in this report.

Recommendation 8: The Board should give priority to ensuring that any member of staff who raises an honestly held concern about the standard or safety of the provision of services to patients is supported and protected from any adverse consequences, and should foster a culture of openness and insight.

Recommendation 9: In the light of the findings of this report, the Secretary of State and Monitor should review the arrangements for the training, appointment, support and accountability of executive and non-executive directors of NHS trusts and NHS foundation trusts, with a view to creating and enforcing uniform professional standards for such posts by means of standards formulated and overseen by an independent body given powers of disciplinary sanction.

Recommendation 10: The Board should review the management and leadership of the nursing staff to ensure that the principles described are complied with.

Recommendation 11: The Board should review the management structure to ensure that clinical staff and their views are fully represented at all levels of the Trust and that they are aware of concerns raised by clinicians on matters relating to the standard and safety of the service provided to patients.

Recommendation 12: The Trust should review its record-keeping procedures in consultation with the clinical and nursing staff and regularly audit the standards of performance.

Recommendation 13: All wards admitting elderly, acutely ill patients in significant numbers should have multidisciplinary meetings, with consultant medical input, on a weekly basis. The level of specialist elderly care medical input should also be reviewed, and all nursing staff (including healthcare assistants) should have training in the diagnosis and management of acute confusion.

Recommendation 14: The Trust should ensure that its nurses work to a published set of principles, focusing on safe patient care.

Recommendation 15: In view of the uncertainties surrounding the use of comparative mortality statistics in assessing hospital performance and the understanding of the term ‘excess’ deaths, an independent working group should be set up by the Department of Health to examine and report on the methodologies in use. It should make recommendations as to how such mortality statistics should be collected, analysed and published, both to promote public confidence and understanding of the process, and to assist hospitals in using such statistics as a prompt to examine particular areas of patient care.

Recommendation 16: The Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford hospital with the objective of learning lessons about how failing hospitals are identified.

Recommendation 17: The Trust and the Primary Care Trust should consider steps to enhance the rebuilding of public confidence in the Trust.

Recommendation 18: All NHS trusts and foundation trusts responsible for the provision of hospital services should review their standards, governance and performance in the light of this report.

16.2.Appendix II - Government response to the Francis report

The following is a transcript of the Secretary of State for Health the Rt Honourable Jeremy Hunt MP:

With permission Mr Speaker, I would like to make a statement on the Government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry.

I congratulate my Rt Hon Friend and predecessor for setting up the Public Inquiry, and for the many changes that he made foreseeing its likely recommendations.

I would also like to pay tribute to Robert Francis QC for his work in producing a seminal report that I believe will mark a turning point in the history of the NHS.

Many terrible things happened at Mid Staffs, in what has rightly been described as the NHS's darkest hour. Both the current and former Prime Minister have apologised. But when people have suffered on this scale, and died unnecessarily, our greatest responsibility lies not in our words but in our actions.

Actions that must ensure the NHS is what every health professional and patient wants – a service that is true to the NHS values, that puts patients first, and treats people with dignity, respect and compassion.

The Government accepts the essence of the Inquiry's recommendations and we will respond to them in full in due course. But given the urgency of the need for change, I am today announcing the key elements of our response so we can proceed to implementation as quickly as possible.

I have divided our response into 5 areas:

- Preventing problems arising by putting the needs of patients first;
- Detecting problems early;
- Taking action promptly;
- Ensuring robust accountability; and
- Leadership.

16.2.1.Let me take each in turn.

- Preventing problems arising by putting the needs of patients first

To prevent problems arising in the first place, we need to embed a culture of zero harm and compassionate care throughout our NHS. A culture in which the needs of patients are central, whatever the pressures of a busy, modern health service.

As Robert Francis said,

The system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment that should never be tolerated in any hospital.

At the heart of this problem, the current definitions of success for hospitals fail to prioritise the needs of patients. Too often the focus has been on compliance with regulation rather than on what those regulations aim to achieve. Furthermore, the way hospitals are inspected is fundamentally flawed, with the same generalist inspectors looking at slimming clinics, care homes and major teaching hospitals – sometimes in the same month.

So we will set up a new regulatory model under a strong, **independent Chief Inspector of Hospitals, working for the CQC**. Inspections will move to a new specialist model based on rigorous and challenging peer-review. Assessments will include judgements about hospitals' overall performance, including whether patients are listened to and treated with dignity and respect, the safety of services, responsiveness, clinical standards and governance.

The Nuffield Trust has reported on the feasibility of assessments and Ofsted-style ratings, and I am very grateful for their thorough work. I agree with their conclusion that there is a serious gap in the provision of clear, comprehensive and trusted information on the quality of care.

So in order to expose failure, recognise excellence and incentivise improvement, the Chief Inspector will produce **a single aggregated rating for every NHS Trust**. Because the patient experience will be central to the inspection, it will not be possible for hospitals to get a good inspection result without the highest standards of patient care.

However, the Nuffield rightly say that in organisations as large and complex as hospitals, a single rating on its own would be misleading. So the Chief Inspector will **also assess hospital performance at speciality or department-level**. This will mean that cancer patients will be told of the quality of cancer services, and prospective mothers the quality of maternity services.

We will also introduce a **Chief Inspector of Social Care** and look into the merits of a Chief Inspector of Primary Care in order to ensure that the same rigour is applied across the health and care system.

We must also build a culture of zero-harm throughout the NHS. This does not mean there will never be mistakes, just as a safety-first culture in the airline industry does not mean there are no plane crashes. But it does mean an attitude to harm which treats it as totally unacceptable and takes enormous trouble to learn from mistakes. We await the report on how to achieve this in the NHS from Professor Don Berwick.

Zero-harm means listening to and acting on complaints. So I will ask **the Chief Inspector to assess hospital complaints procedures**, drawing on the work being done by the Rt Hon Member for Cynon Valley and Professor Tricia Hart to look at best practice.

Given that one of the central complaints of nurses is that they are required to do too much paperwork and thus spend less time with patients, I have asked **the NHS Confederation to review how we can reduce the bureaucratic burden on frontline staff and NHS providers by a third**. I will also be requiring the new Health and Social Care Information Centre to use its statutory powers to eliminate duplication and reduce bureaucratic burdens.

16.3.2. Detecting problems quickly

Secondly, we must have a clear picture of what is happening within the NHS and social care system so that, where problems exist, they are detected more quickly.

As Francis recognised, the disjointed system of regulation and inspection smothered the NHS, collecting too much information but producing too little intelligence.

We will therefore introduce **a new statutory duty of candour for providers**, to ensure that honesty and transparency are the norm in every organisation. And the new Chief Inspector of Hospitals will be the nation's whistleblower in chief.

To ensure there is no conflict in that role, the CQC will no longer be responsible for putting right any problems identified in hospitals: their **enforcement powers will be delegated to Monitor and the Trust Development Authority**, whom they will be able to ask to act when necessary.

We know that **publishing survival results improves standards**, as has been shown in heart surgery. So I am very pleased that we will be **doing the same for a further 10 disciplines**: cardiology, vascular, upper gastro intestinal, colorectal, orthopaedic, bariatric, urological, head and neck, and thyroid and endocrine surgery.

16.4.3. Dealing with problems quickly

The third part of our response is to ensure that any concerns are followed by swift action.The problem with Mid Staffs was not that the problems were unknown; it was that nothing was done.

The Francis report sets out a timeline of around 50 warning signs between 2001 and 2009.

Ministers and managers in the wider system failed to act on these warnings. Some were not aware of them, others dodged responsibility. This must change.

No hospital will be rated as good or outstanding if fundamental standards are breached. And Trusts will be **given a strictly limited period of time to rectify any such breaches**. If they fail to do this, they will be put into a failure regime which could ultimately **lead to special administration and the automatic suspension of the board.**

16.5.4. Accountability for wrongdoers

The fourth part of our response concerns accountability for wrongdoers. It is important to say that what went wrong at Mid Staffs was not typical of our NHS, and that the vast majority of doctors and nurses give excellent care day-in day-out. We must make sure the system does not crush the innate sense of decency and compassion that drives people to give their lives to the NHS.

Francis said that primary responsibility for what went wrong at Mid Staffs lies with the board. So we will look at **new legal sanctions at a corporate level for organisations who wilfully generate misleading information or withold information they are required to provide**.

We will also consult on **a barring scheme to prevent managers found guilty of gross misconduct finding a job in another part of the system**. In addition, we intend to **change the practices around severance payments**, which have caused great public disquiet.

In addition, the General Medical Council, the Nursing and Midwifery Council and the other **professional regulators have been asked to tighten their procedures for breaches of professional standards**. I will wait to hear how they intend to do this, and for Don Berwick's conclusions on zero harm, before deciding whether it is necessary to take further action.

The Chief Inspector will also ensure that hospitals are meeting their existing legal obligations to **ensure that unsuitable healthcare support workers are barred**.

16.6.5. Leadership and motivation of NHS staff

The final part of our response will be to ensure that NHS staff are properly led and motivated.

As Francis said,

All who work in the system, regardless of their qualifications or role, must recognise that they are part of a very large team who all have but one objective, the proper care and treatment of their patients.

Today I am announcing some important changes in training for nurses. I want **NHS-funded student nurses to spend up to a year working on the frontline as support workers or healthcare assistants, as a prerequisite for receiving**

funding for their degree. This will ensure that people who become nurses have the right values and understand their role.

Healthcare support workers and adult social care workers will now have a Code of Conduct and minimum training standards, both of which are being published today.

I will also ask **the Chief Inspector to ensure that hospitals are properly recruiting, training and supporting healthcare assistants**, drawing on the recommendations being produced by Camilla Cavendish.

And the Department of Health will learn from the criticisms of its own role by becoming the first department where every civil servant will have real and extensive experience of the frontline.

16.7.Conclusion

Mr Speaker, the events at Stafford Hospital were a betrayal of the worst kind. A betrayal of the patients, of the families, and of the vast majority of NHS staff who do everything in their power to give their patients the high-quality, compassionate care they deserve.

But I want Mid Staffs not to be a byword for failure, but a catalyst for change.

To create **an NHS where everyone can be confident of safe, high quality, compassionate care.**

Where best practice becomes common practice.

And where the way a person is made to feel as a human being is every bit as important as the treatment they receive.

That must be our mission and I commend this statement to the House.

16.8.Appendix III - Activity

UNDER DEVELOPMENT - STEVE PHILIPS/LESLEY SAWREY