Appendix 1

NHS
Wolverhampton
Clinical Commissioning Group

Wolverhampton Clinical Commissioning Group

Operational Plan 2019/20

Contents

1. Introduction

> *'2019/20 will be the foundation year which will see significant changes proposed to the architecture of the NHS, laying the groundwork for implementation of the Long Term Plan'*.[1]

For Wolverhampton CCG, this means focusing on maintaining work currently underway in key priority areas, both locally and regionally, as well as supporting planned transitions to an Integrated Care System (ICS) and integrated care provision for the four 'places' of the Black County and West Birmingham Sustainability and Transformation Partnership (BCWB STP) – Wolverhampton, Walsall, Dudley and Sandwell and West Birmingham. This focus will enable us to align the CCG with the ICS as it develops, transitioning to the local, regional and national healthcare system set out in the NHS's Long-Term Plan (LTP).[2]

This Operational Plan for 2019/20 is a response to the context outlined above; to make the appropriate decisions as to our operations to be fit-for-the-future, whilst maintaining our eye on existing responsibilities to our population.

Our vision for the future **is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources.** In order to achieve this, we have five priorities for the coming year:

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

The detail provided in the reminder of this planning document outlines how we will achieve these priorities.

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[1] NHSE, NHSI. *NHS Operational Planning and Contracting Guidance 2019/20.* 2019. Available at https://www.england.nhs.uk/wp-content/uploads/2018/12/NHS-Operational-Planning-and-Contracting-Guidance-201920-FULL-VERSION.pdf

[2] NHSE, NHSI. *NHS Long Term Plan.* 2019. Available at https://www.longtermplan.nhs.uk/

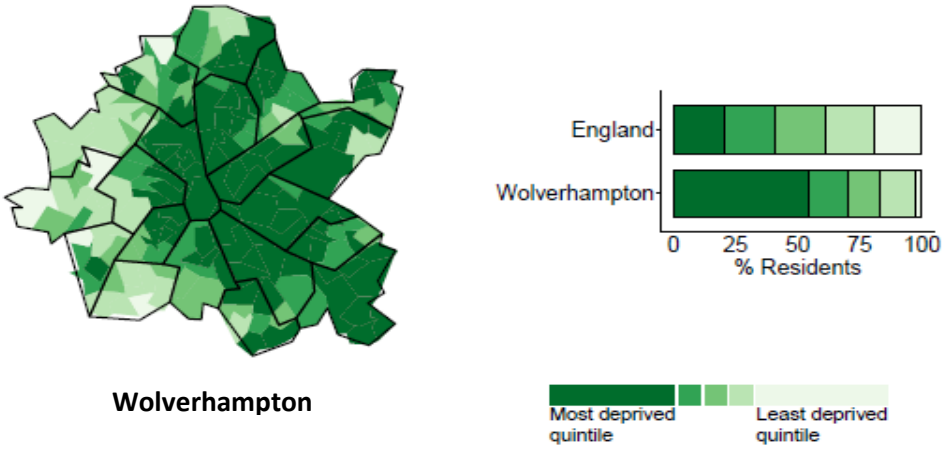
2. Local challenges

Wolverhampton has a population of 258,100 (2016) which is estimated to grow to 264,000 by 2020 and 275,900 by 2030. Wolverhampton is a diverse city and 32 per cent of our population belongs to black minority ethnic (BME) communities compared to 15 per cent for England.[3] Table 1 provides some of the key demographic detail for Wolverhampton, compared to the national picture:

	Wolverhampton (persons)	England (persons)
Population (2016)*	258	55,268
Projected population (2020)*	264	56,705
% population aged under 18	23.0%	21.3%
% population aged 65+	16.7%	17.9%
% people from an ethnic minority group	27.6%	13.6%

Table 1: Sociodemographic profile of Wolverhampton and England. Taken from Public Health England. Wolverhampton Local Authority health profile (2018).

Wolverhampton is one of the most densely populated local authority areas in England and is amongst the most deprived areas within the country ranking as the 11th most deprived local authority area in England. In recent years unemployment has fallen in the city but it remains the sixth highest unemployment rate per local authority in England. Figure 1 demonstrates Wolverhampton's deprivation and its distribution across the city:



Wolverhampton

[3] WCCG, *Annual Report 2017/18.* (2018). Available at https://wolverhamptonccg.nhs.uk/about-us/10-about-us/660-annual-report-2017-18

Figure 1: Deprivation profile of Wolverhampton and England. Taken from Public Health England. Wolverhampton Local Authority health profile (2018).

The previous trend of increasing life expectancy for men and women in Wolverhampton has begun to level off in recent years and the gap to England is not increasing. Healthy life expectancy data shows that in Wolverhampton, men and women live 7.0 and 4.6 years respectively in poorer health than the England average. In Wolverhampton the average man and woman can expect to live the last 21 years and 21.9 years of their lives respectively in poor health. It is these years lived in poor health that leads to higher demand on our health and social care services in Wolverhampton.

There are six conditions which account for over half of the difference in life expectancy that exists between Wolverhampton and England. These are heart disease, stroke, infant mortality, lung cancer, respiratory illness and alcohol mis-use. The impact of these conditions is seen disproportionally in the most disadvantaged communities. We are committed to reducing unwarranted variation where possible, drawing on RightCare[4] analysis.

Cancer, in particular, is a low performance area for the city and plans are being realised in 2019/20 to mitigate against this (see section 5.3).

It is recognised that there will always be variation in clinical care and this is at the heart of place-based systems. Some variation is based on clinical need and appropriate decision-making; on early adoption of innovation and of new technology, for example. However, unwarranted variation is not acceptable and can often lead to poorer outcomes. We understand that the healthcare needs of our population will be different across localities. Whereas we are committed to reducing unwarranted variation, some intended variation will be necessary across localities to reflect the fact that each patient is different, and interventions should be assessed according to the needs of the population served.

3. National context

3.1 The Long Term Plan

In January 2019 NHS England (NHSE) published its LTP, setting out a vision for the NHS over the next ten years, supported by the £20.5 billion additional investment in

[4] The NHS RightCare teams work locally with systems to present a diagnosis of data and evidence across that population.

real terms by 2023/24 and building on the new models of care tested and refreshed as part of the *NHS Five Year Forward View*[5] *and Next Steps on the NHS Five Year Forward View*[6] respectively. The key service priorities set out in the LTP are:

- **Boosting 'out-of-hospital' care and dissolving boundaries between primary and community care;**
- **Reducing pressure on emergency hospital services;**
- **Giving people more control over their health and providing more personalised care where appropriate;**
- **Mainstreaming digitally-enabled primary and outpatient care across the NHS;**
- **A nationwide shift to ICSs with a focus on population health.**

These priorities will be enabled locally and nationally by:

1. **Doing things differently –** giving people more control over their own health and care, encourage collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities;
2. **Preventing illness and tackling health inequalities –** increasing NHS contributions to tackling causes of ill health;
3. **Backing our workforce –** increasing the NHS workforce, training and recruiting more professionals, including clinicians, providing more routes into the NHS and improving retention by making the NHS a better place to work;
4. **Making better use of data and digital technology –** providing more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data; and
5. **Getting the most out of taxpayers' investment in the NHS –** working with clinicians to reduce duplication and make better use of the NHS's combined buying power to reduce costs.

[5] NHSE. *Five Year Forward View.* (NHSE, 2014). Available at https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[6] NHSE. *Next steps on the NHS Five Year Forward View.* 2017. Available at https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/

This Operational Plan details how Wolverhampton CCG is already planning on delivering against these priorities locally, laying the ground work for their realisation at the system level.

3.2 National Strategies

Various national strategies have informed the plans detailed here for 2019/20: These include (but are not restricted to):

- *Five Year Forward View* (2014) and *Next Steps on the NHS Five Year Forward View* (2017)
- *Achieving World Class Cancer Outcomes* (2015)
- *Building the right support* (2015)
- *General Practice Forward View* (2016)
- *The Five Year Forward View for Mental Health* (2016)
- *Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care* (2016)

The work we have carried out in delivering against these strategies to date has laid the foundations for us to transition to the health system set out in the LTP. More specifically, they support the emergence of PCNs and other local infrastructure to deliver care in the right place, at the right time, making best use of local resources.

4. Transitioning to the Long Term Plan

As highlighted above, Wolverhampton is part of the BCWB STP consisting of 18 partners including NHS commissioners, providers and local authorities. The STP set out a five-year plan[7] in 2016 to transform the local health and care system around the following priorities:

- Implementing local place-based models of care that deliver improved access to better coordinated community and primary care that provides greater continuity for patients who can and should receive integrated services in an out of hospital setting;
- Extending collaboration between acute service providers to create a coordinated system of care across the Black Country to reduce variation, improve quality and deliver organisational efficiencies;

[7] Available at http://www.dudleyccg.nhs.uk/wp-content/uploads/2016/11/Black-Country-STP-Full-Plan.pdf

- Building on existing plans to transform mental health and learning disability services;
- Addressing the significant challenges faced in maternal and infant health through the development of a single maternity plan;
- Working together on key enablers such as digital infrastructure, public sector estate utilisation and workforce transformation to deliver modern patient centred services and commissioning functions; and
- Acting in partnership with the West Midlands Combined Authority (WMCA) and other partners to address the wider determinants of health including employment, education and housing.

It is likely that these priorities will be reviewed in 2019/20 as part of the development of the STP five-year plan in response to the LTP. **The challenge for 2019/20 is to continue to integrate patient pathways at the local level, whilst working towards strategic and operational alignment as described in the LTP.**

4.1 Delivering system alignment

Black Country ICS Transition

By 2021, NHSE have stipulated that all STPs will have transitioned into ICSs, bringing together local organisations to redesign care and improve population health. In 2019/20, therefore, significant progress is required in the Black Country in realising this transition. This will be overseen by a Transition Board, made up of Accountable Officers (AOs) and Chairs.

Our vision for the Black Country ICS is **working together to improve the health, wellbeing and prosperity of our local population.**

The four CCGs in the Black Country: Sandwell and West Birmingham, Dudley, Walsall and ourselves, have formed a Joint Commissioning Committee (JCC) to enable us to commission some services at scale for people across the Black Country. This committee is complemented by the work of a Clinical Leadership Group (CLG) which has been integral to the development of the STP's clinical strategy. It is planned for the JCC to be delegated greater responsibility in 2019/20 for spending in mental health, learning disabilities, community services delivered by the Black Country Partnership Foundation Trust (BCPFT) and acute services. Furthermore, in 2020/21, an options appraisal will be carried out to determine the organising framework for a 'single commissioning voice' in the Black Country and

planning for this will commence in 2019/20. Figure 2 shows the transition timeline for the system:

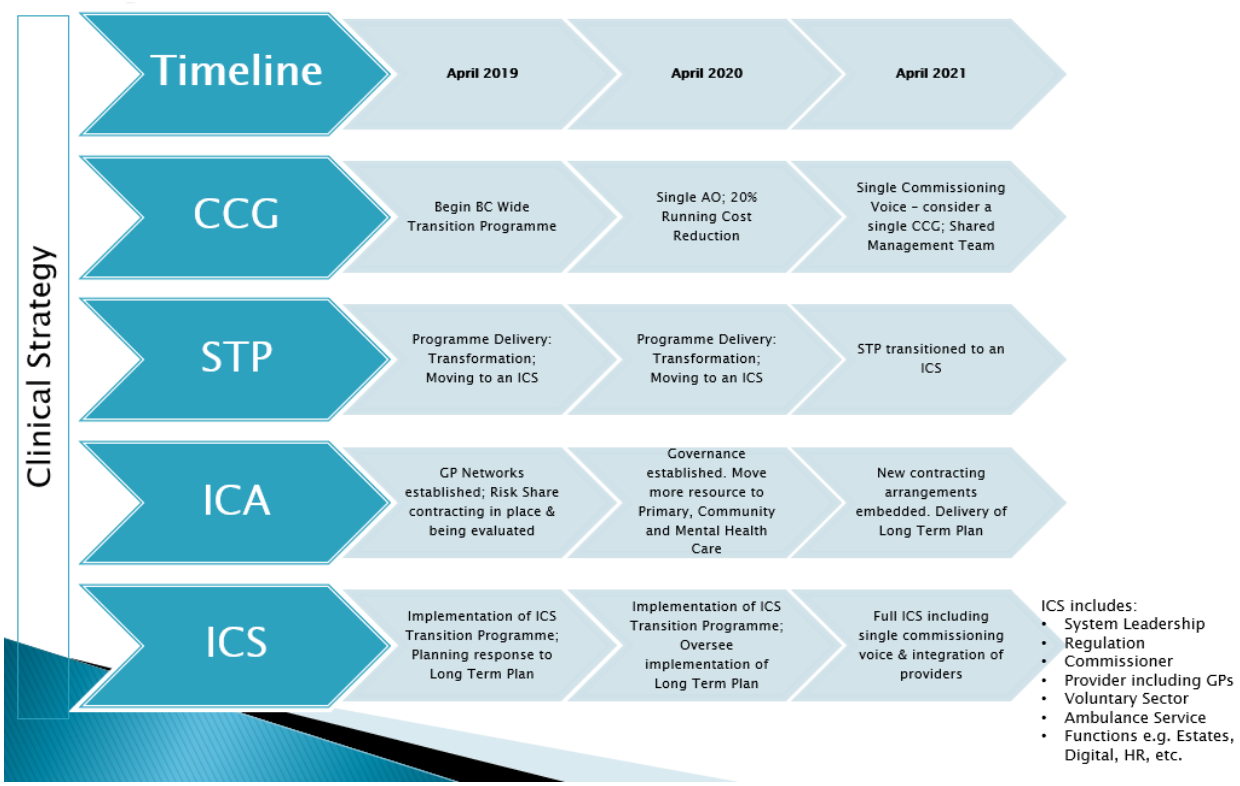


Figure 2: System transition timeline for BCWB

STP Clinical Strategy

As we align our strategic planning to the STP, we must review our local commissioning priorities against the STP clinical strategy. This strategy will shape system transformation in terms of the 'triple aim': the triple aim is part of the NHS *Five Year Forward View*. This sets out areas where action must be taken to ensure that people in England receive **Better Health; Better Care; Better Value.**

This strategy will inform the phasing of the transformation work required, providing focus for the areas where immediate attention and action is required. **For the CCG, it enables the shift towards an Integrated Care Alliance (ICA) and closer system working for Wolverhampton and sets out a pathway which informs our operating requirements for 2019/20.**

Consistent with the *Five Year Forward View*, the clinical strategy will support delivery of national priorities:

- 7-day services – right care, right time, right quality;
- Integrated mental health and physical health;

- The promotion of good mental health and prevention of poor mental health;
- Driving up early cancer diagnosis as well as treatment times.

In addition to describing our local commissioning priorities therefore, the sections below will also discuss relevant clinical priorities at the STP level to demonstrate how alignment will take place between the STP clinical strategy and the CCG plans. Underpinning this alignment are a number of system enablers which will we will support the delivery of in 2019/20 (figure 3).

Figure 3: Drivers for integrated care in BCWB STP

As an introduction, Table 2 includes the clinical priorities for the STP which have been based on the *Five Year Forward View,* 2018/19 NHSE Planning Guidance and opportunities identified via RightCare.

Proposed Priority Area	Scope includes
Primary Care*	Primary Care Networks – sustainability of General Practice and the integration of care at the 'locality' level (30-50k population) working towards the involvement other providers of primary care (dental, pharmacy and optometry).
Cancer*	RTT, Urology, Upper GI, Haematology, screening, radiotherapy, services requiring 1m+ population
Mental Health*	Access for children and young people, IAPT, crisis care, dementia, suicide prevention, integrating mental/physical health
Learning Disability Services*	Transforming Care programme, including shift towards greater community provision
Maternity & Neonates*	Better Births, infant mortality, maternity capacity (incl. consultant-led vs MLU, antenatal and newborn screening and maternal and neonatal immunisation programmes).
Children and Young People	It is our ambition that the Black Country is a place where children and young people thrive: that all children in the Black Country get a good start in life and are healthy; that all families are supported to be independent, responsible and successful; where the most vulnerable children are protected; and where our children are supported to become function and productive members of our communities We want to move the Marmot curve for our CYP population. Services work towards this ambition including specialist 24/7 care, TCP, CAMHS, Community services, prevention (e.g. oral health, screening and immunisations, Healthy Child Programme safeguarding etc.
Urgent & Emergency Care*	Reducing attendance/admission, UTC specification, emergency general surgery, trauma/ITU provision, emergency/elective split
Cardiovascular Disease	Prevention
Clinical Support Services	Pathology, interventional radiology
Musculoskeletal Conditions	Standardising elective orthopaedics
Respiratory Disease	Smoking cessation, COPD pathway
Frailty	UTIs, falls, dementia

Table 2: BCWB STP Clinical Priorities taken from BCWB Clinical Strategy

*NHSE *Five Year Forward View* priorities

Local Integrated Care Provision

Local place-based models of care are being developed and implemented for each of the four STP places in support of the clinical strategy. These models are emerging vehicles for bringing together health and care services for defined populations in a more integrated way. They aim to deliver improved access to local services for their whole population, greater continuity of care for those with ongoing conditions and more coordinated care for those with the most complex needs.

This work is consistent with the process of transitioning to an ICS, built on accountable care organisations providing more effective services to defined populations for the long term.

Each 'place' has its own plan, but each plan is drawn from the same central principle. This will bring health, social care and voluntary sector organisations together, to achieve improved health and wellbeing. This will deliver models of care that are tailored to their populations, but which also benefit from working alongside each other as part of a system as described in figure 4. In Wolverhampton, this has been defined as an Integrated Care Alliance (ICA).

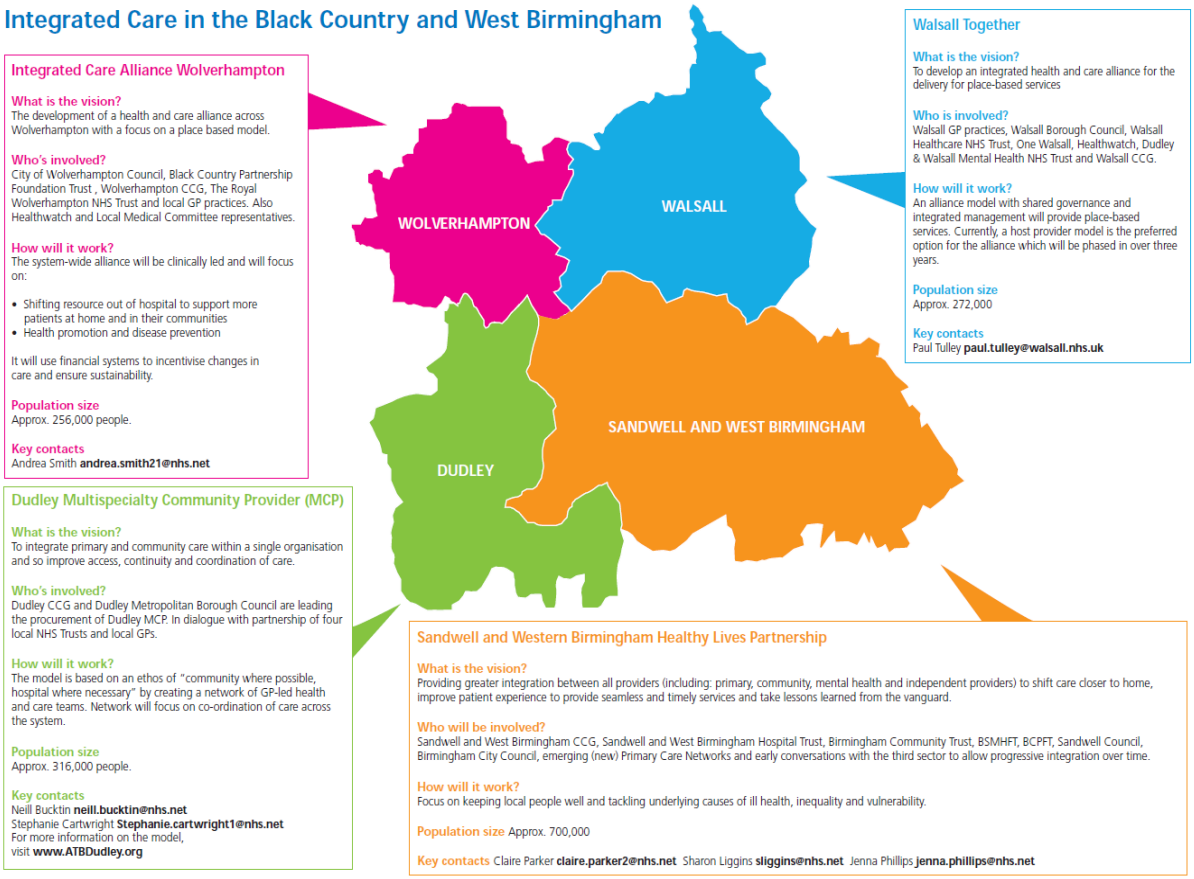


Figure 4: Place-based care in the BCWB STP

Wolverhampton Integrated Care Provision

The Wolverhampton ICA focuses on Wolverhampton working as a system rather than through independent processes. The strategy is clinically led, managerially supported and patient centred. There is a shared governance system across the alliance stakeholders which provides system leadership and who are mutually accountable for delivery.

The ICA will shift resources from hospital to out-of-hospital services so that more people are supported proactively in their home and communities. It will focus on health, developing our approach to health promotion and disease prevention to support the wellbeing of our communities alongside the care that we already provide.

A key feature of the ICA is an integrated data system where all parties can access data to support the patient's pathway. This reduces delay, encourages cooperation and supports integrated working.

The ICA must be financially sustainable, making the best use of the resources that we have collectively. This will mean amending the current funding flows as they do not always incentivise best practice.

The ICA has a number of key aims that are guiding its programme:

- To modernise and support ALL primary care to improve care quality and financial sustainability;
- To redesign our local NHS system by removing barriers that act against integrated care, to support strategic commissioning;
- To redistribute risk in a better a way across the system;
- Improve population health outcomes in partnership with the commissioner's mental health services, social care services, public health and the voluntary sector;
- To improve co-ordination of services and move care out of hospital where appropriate- Integrated user focussed care delivery;
- Facilitate networked solutions for hospital services where there is opportunity to improve care quality and financial sustainability.

Four clinical priorities have been identified for the ICA for 2019/20. For each of these clinicians from across local providers have determined areas of focus:

Children and Young People's Services

- Development of the Wolverhampton 'Big 6' (six most common conditions/symptoms that can cause children and young people to present for emergency and urgent care);
- Implementation of the standards in 'Facing the Future – Together for Child Health';
- Shift in activity from secondary care to community (care closer to home)
- Joint specialist and generalist clinics;

- Targeted care for vulnerable groups (CAMHS, SEND, etc.);
- Co-design of services with parents/carers.

Mental Health

- IAPT;
- Long Term Condition IAPT;
- Dementia;
- Mental health and the cross over with physical health;
- Implementation of the Wolverhampton Mental Health Strategy (see section 5.4).

End-of-life

- Care coordination;
- Advance care planning;
- Targeted engagement with the public;
- Raising awareness of death and dying;
- Community model of palliative and end of life care;
- Developing a workforce fit for purpose;
- Targeted care for vulnerable groups (learning disability, dementia, etc).

Frailty

- Designing targeted services for the different cohorts of patients classified as living with frailty;
- Standardising identification and assessment across the pathways;
- Integrating pathways of care to improve patient experience and care;
- Developing a workforce fit for purpose;

ICA working groups have also been established to consider:

- Information governance
- Contracting and finance
- Outcomes development

Primary Care networks

Within the ICA are four PCNs – a central feature of health systems as set out in the LTP. These are formally recognised networks of GPs, each serving between c. 55,000-95,000 patients in Wolverhampton. PCNs represent the building blocks of

place-based models of care and are the key to preserving the integrity of NHS service provision going forward.

For our service users, patients and carers, PCNs will bring:

- Access to a wider range of professionals than may have been available in individual practices enabled by a shared patient record;
- Improved/shorter waiting times that are focused around the access needs of those using services including extended GP hours;
- Improved access to a wider range of services and support through use of the resources and partners within the PCN;
- Using the wider access to professionals and services, provide a focus on increasing access to care locally (place-based care) and avoiding admission avoidance and hospital attendance where possible.

In 2019/20 service and pathway integration will reach beyond primary care to include other health and care services, **building on work carried out during the previous year.** This will include district nursing, pharmacy, social workers, community psychiatric nursing, social prescribing, housing and a range of other roles to support patients' care in their own communities, organised in Integrated Community Teams (see section 5.6). Figure 5 describes some of the services that will be wrapped-around PCNs.

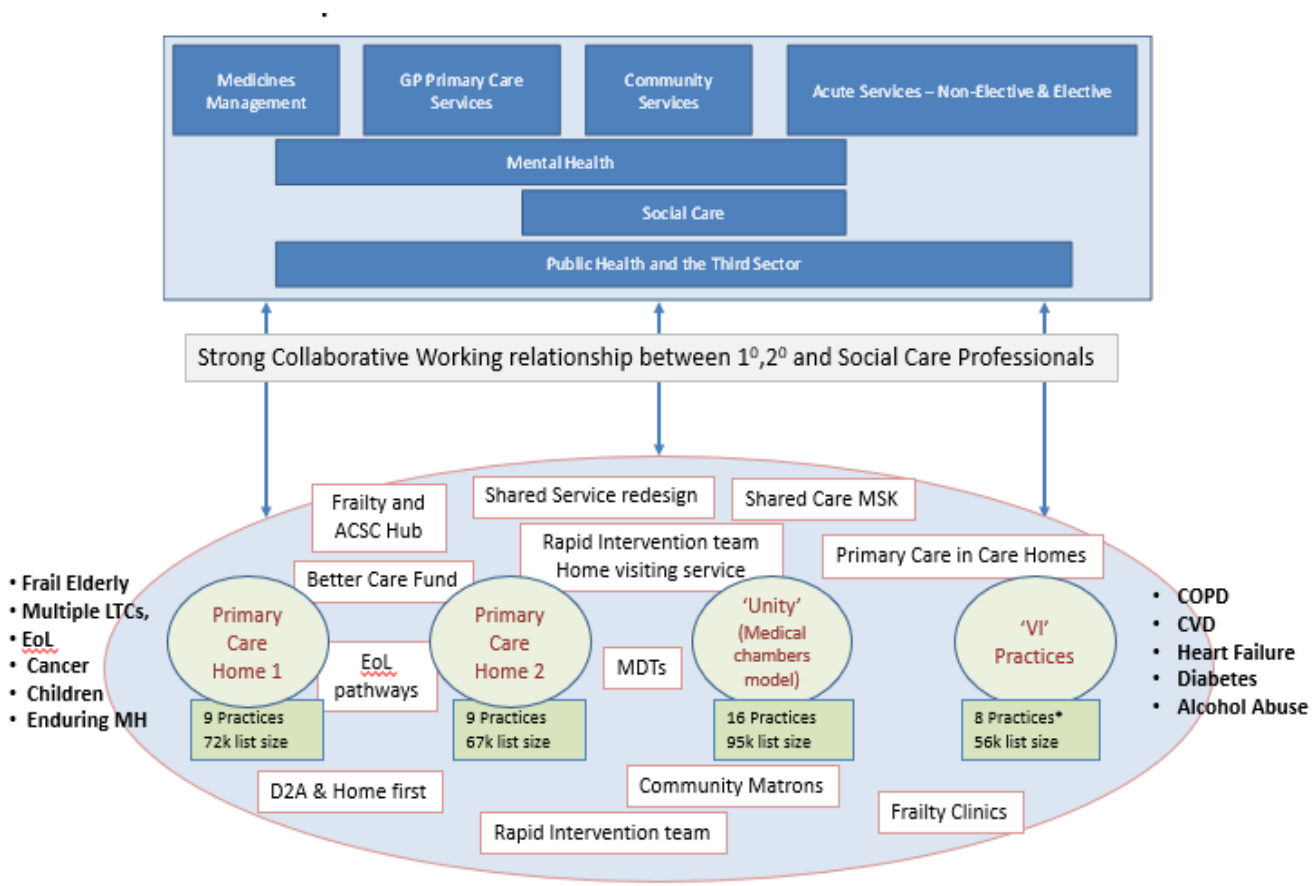


Figure 5: High level mode for PCNs in Wolverhampton STP/ICA

The PCN model is being developed across the STP as per the requirements in the LTP.

4.2 Financial sustainability

Several priorities and actions have been defined for the CCG in 2019/20 in order to ensure financial sustainability and contribute to delivering financial balance across the NHS. These refer directly to our stated priorities to:

- continue to commission high quality, safe healthcare services within our budget; and
- ensure our services are cost effective and sustainable.

1. Deliver CCG organisational control total to support local system financial control totals.

- Long term financial model in place to deliver control totals during lifetime of plan;
- Contracts in place from March 2019 with providers based on financial plans;

- QIPP plans in place and agreed in contracts with providers;
- Ensure CCG does not exceed management cost allowance and plan to achieve 20% real terms reduction by 2020/21;
- Deliver efficiency ask of 1.1% per year.

2. Implement local STP plans to moderate demand growth and increase provider efficiencies

- Financial plans aligned with STP plans and assumptions;
- Local delivery plans aligned with STP priorities;
- Work to simplified CQUIN scheme indicators as defined in upcoming guidance.

3. Implementing demand reduction measures to support financial sustainability.

- Reduce variation in spend and outcomes, utilising RightCare opportunities;
- Develop options for elective care redesign;
- Urgent and emergency care reform;
- Implementation of 'Place' strategy;
- New pathways and services that support self-care and prevention;
- Medicines optimisation;
- Improving the management of continuing healthcare processes.

4. Enhanced investment in out-of-hospital care

- Increase investment in mental health services in-line with MHIS, including Children and Young People (CYP) mental health services;
- Commit recurrent funding to developing and maintaining primary care networks;
- Shift funding from acute to community services in support of the ICA.

5. Meeting our 2019/20 Operating Plan Requirements

We are developing a commissioning for outcomes framework that will be implemented during 2019/20. The following sections detail the clinical priorities in key service areas for the STP and then locally for the CCG to demonstrate where they are most closely aligned. Local commissioning priorities will also form part of the activity happening at the ICA level described above. The purpose is to

demonstrate how plans for 2019/20 respond to local need, whilst also transitioning to the healthcare systems laid out in the LTP.

5.1 Urgent and Emergency Care

Summary

Patients in the Black Country will benefit from both localised and system-wide approaches to Urgent and Emergency Care (UEC). The CCG, during 2019/20, is focused on working in partnership across the STP to avoid unnecessary hospital admissions and ensure care is provided in the right place, at the right time, particularly with regards to frailty. The CCG is developing an Urgent and Emergency Care Strategy during 2019/20 which will identify and address both identified local need and opportunities for commissioning services at a STP level, supporting the system priorities outlined below.

Urgent and emergency care at the STP level

At the STP level, the scope of the clinical priorities has been informed by the *Five Year Forward View* and includes:

- Reducing attendance/admission
- Urgent Treatment Centre (UTC) specification
- Emergency general surgery
- Trauma/ITU provision
- Emergency elective split

The vision for UEC at the STP level is **to sustainability meet the urgent and emergency care needs of local people through the development and delivery of a comprehensive and integrated care services.** The triple aim opportunities for UEC have been identified as:

- **Better Health -** Addressing societal and lifestyle issues that drive poor health outcomes;
- **Better Care -** Increase access to primary care to free up the time of specialist UEC clinicians to service serious or life-threatening cases; and
- **Better Value -** Stem the growth of people using UEC, providing a more joined up and consistent service.

Two early priorities have been defined to deliver against these opportunities in 2019/20:

- The development of primary care to offer 7-day access and multidisciplinary care through PCNs;
- Place-based integration with local authorities to further reduce delayed transfers of care.

We will continue to work in partnership with CCGs across the STP and Urgent and Emergency Care Network to identify how the Clinical Assessment Service (CAS) could be enhanced to support admissions avoidance.

Urgent and emergency care services in Wolverhampton

The CCG is working in collaboration with Royal Wolverhampton Trust (RWT) clinicians to ensure the reduction of avoidable admissions through the establishment of an acute frailty service, which is one of the key components of the frail elderly pathway which entails cross-boundary and multi-agency working to support:

- healthy living/ageing well
- proactive care
- assess to admit
- frail elderly Emergency Department team
- acute admission under geriatrician
- discharge to assess
- comprehensive reablement.

Further work will take place during 2019/20 to ensure that clinical pathways are well developed and that the appropriate workforce is in place to ensure that patients are being assessed, treated and supported by skilled multidisciplinary teams.

Other key priorities for 2019/20 include:

- The CCG will develop its Urgent and Emergency Care Strategy during 2019/20 which will identify and address both identified local need and opportunities for commissioning services at a STP level and will help inform the future model of care we wish to commission;
- The CCG will continue to work towards delivering Delayed Transfer of Care (DToC) targets and will continue to reduce bed occupancy by long stay patients;
- The CCG will continue to review the Directory of Services (DOS) to ensure that information and profiling reflects locally commissioned services and supports the ‘right place, first time’ approach;

- The CCG will ensure that the accreditation of UTCs is in place by December 2019;
- We will continue to build links with key partners such as West Midlands Ambulance Service (WMAS) to identify how activity could be diverted into existing admission avoidance commissioned services in the community such as the Rapid Response Team and identify where there may be gaps in provision;
- We will work with the integrated Urgent Care Alliance and WMAS to pilot 'intelligent conveyance' across the West Midland including the Black Country. The intended outcomes are to improve integration across systems, collaborative working, that would support improved 4 hour performance, better patient flow, better management of capacity and improved hospital handover through immediate identification of pressures;
- Improve GP access in primary care for urgent appointments and continue work between RWT and our GP-led UTC to build on the work already in place with the joint integrated triage. This will deliver a consistent reduction in conveyance rates to bring Wolverhampton health economy in line with the rest of the Black Country and see increased numbers diverted to the UTC, see and treat and discharge at triage. A working group has been established to review ambulance conveyances and consider methods for reduction;
- Improve A&E Access Standards by playing a key leadership role in the local A&E Board to support delivery of a programme of work to address locally identified areas of pressure. Key nationally mandated deliverables for this work include:
    - streaming at A&E to ensure patients are seen by the appropriate clinician
    - transfer of NHS 111 calls to clinicians
    - ambulance response times
    - improving patient flow and discharge

- The CCG will review its High Intensity User (HIU) support offer for demand management in UEC. This has a CQUIN place and a mental health nurse in support.

Each of these activities will contribute towards the triple aims for UEC identified by the STP.

5.2 Referral to Treatment Times and Elective Care

Summary

Patients in the Black Country will benefit from both localised and system-wide approaches to RTT and elective care. The CCG, during 2019/20, is focused on ensuring access to elective care is within national targets, opportunities for delivering care closer to home are utilised and unnecessary referrals are reduced. Working with partners across Wolverhampton will be integral to this and this activity will support the clinical priorities set by the STP outlined below.

Referral to treatment times and elective care at the STP level

The STP have determined the following clinical priorities around elective care:

Interventional Radiology: Patients will have access to a service that will deliver high quality clinical outcomes. Early intervention and quicker access to services will improve outcomes and offer better value.

Pathology: Delivering prompt diagnostic and clinical intelligence in cost effective and efficient organisations. Provide earlier intervention to prevent disease progression and promote lifestyle changes and deliver more standardisation and efficiency across the service.

Musculoskeletal (MSK) Conditions: Patients will have good outcomes, high quality of care and experience efficiency in service delivery. Referral processes will be streamlined and waiting times reduced through reduction in unnecessary referrals and avoiding secondary care follow ups where unwarranted.

Respiratory: Mortality rates will be reduced below the England average and patients will be able to access consultants through outreach in the community. Detection and prevention through lifestyles interventions will improve outcomes and reduce spend on respiratory related conditions.

Maternity and Neonates: Maternity pathway will involve women and those close to them in making the right choices for them to give birth in a safe and caring environment. Reducing rates of stillbirths, neonatal death, maternal death and brain injury during birth and engaged with the Maternity and Neonatal Health Safety Collaborative.

Referral to treatment times and elective care in Wolverhampton

In Wolverhampton, we will deliver services in 2019/20 to ensure delivery against the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment. To do this we will streamline elective care pathways and, where required, robustly performance manage our providers using contractual levers where necessary to achieve performance standards. The CCG will continue active monitoring of very long waits (over 52 weeks) to ensure each case is investigated with the Trust responsible and resolution plans agreed. In addition to managing contracts as 'lead commissioner' the CCG also actively works collaboratively with other lead commissioners where we are associates, to understand any waiting time challenges, the core issues and remedial actions.

Also during 2019/20 the CCG will implement our demand management plan aimed at reducing avoidable hospital referrals and ensuring patients receive the right care, at the right time, in the right setting. Schemes continuing into 2019/20 include:

- Targeted peer review of referrals by GP practices;
- Access to expert advice and guidance in primary care;
- Out-of-hospital care for the most common conditions (MSK, and Ophthalmology);
- A GP Education and Training Programme;
- Implementation of commissioning policy to restrict procedures of limited clinical value.

During 2019/20 work will continue to embed MSK best practice pathways and improve surgical conversion rates, redesign dermatology services, enhance primary care eye care services and continue clinical evidence reviews of procedures of limited clinical value. The CCG will be seeking to establish a Joint Elective Care Programme Board with our local Trust, to transform and redesign elective care services in partnership.

5.3 Cancer Treatment

Summary

Patients in the Black Country will benefit from both localised and system-wide approaches to cancer. The CCG, during 2019/20, is focused on improving early diagnosis, compliance with national waiting targets and patient experience. Working

with partners across Wolverhampton will be integral to this and will support the clinical priorities set by the STP outlined below.

Cancer services at the STP level

The STP has described a vision for cancer services that are in **the top quartile for prevention, early diagnosis and treatment.** This has informed the triple aim opportunities of:

- **Better Health**: Taking concerted action to address some of the environmental, societal and lifestyle issues that drive poor health outcomes;
- **Better Care**: Our key opportunities are targeted interventions to improve the uptake of cancer screening; implement the national faster [28 day] diagnosis pathways; deliver Living With and Beyond Cancer; and
- **Better Value:** Taking actions to increase screening uptake and earlier diagnosis should not only save lives but reduce costs for unplanned cancer care.

Early priorities to deliver this work are to:

- Achieve the 62-day waiting time standard
- Implement early diagnosis
- Improve the patient experience
- Review opportunities for collaboration between Walsall and Wolverhampton cancer units.

Cancer services in Wolverhampton

The number of people diagnosed and living with cancer each year will continue to grow rapidly. The primary reasons for this are our ageing population and our success in increasing survival rates. This will place significant additional demand on our health and social care services.

Together with City of Wolverhampton Council (CWC), we have drafted a five-year Wolverhampton Cancer Strategy to be initiated in 2019. This strategy sets out our local ambition to improve cancer outcomes in Wolverhampton so that by 2024:

- fewer people are being diagnosed with preventable cancer;
- more people survive for longer after a diagnosis;
- more people have a positive experience of care and support; and
- More people enjoy a better long-term quality of life.

We will achieve this by a greater focus on prevention, earlier detection and improved treatment. Critically, we will focus on improving health and wellbeing across all the areas but also significantly reducing inequalities and variations in outcomes between local areas and between different population groups. Local cancer incidence data indicates that here is a correlation between deprivation, age, lifestyle and cancer incidence. Screening data also highlights that in areas of low deprivation and a high BME population there is a low take up of screening services.

Part of our commitment to early detection is to improve our performance in terms of emergency diagnoses. Table 3 shows Wolverhampton's performance in this area compared to the national picture.

	Emergency diagnoses of invasive malignant tumours The data shows the proportion of tumours diagnosed in A&E, by CCG, expressed as a percentage.						National position based on 2017 Data
CCG	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	
NHS Wolverhampton CCG	23.41%	22.95%	21.18%	23.25%	23.89%	20.75%	158/194
England	20.94%	20.25%	20.04%	19.84%	19.49%	18.75%	

Table 3: Emergency presentation data

Cancer screening provides an opportunity to diagnose cancer at an earlier stage before signs and symptoms have developed and when treatment may be less complex and outcomes better. There are three cancer national screening programmes (Breast, Bowel and Cervical) and Wolverhampton has a lower take-up than the national average in all three. Increasing take-up of screening programmes will therefore be an important part of our activity in 2019/20 through:

- Working collaboratively with Public Health England, Bowel Cancer Screening Hub, Breast Screening Service and Cancer Research UK (CRUK) to develop robust plans to support GP Practices, Healthy Living Pharmacies and the wider community to increase cancer screening uptake;
- Working collaboratively with other primary care staff including Healthy Living pharmacy staff care navigators and practice cancer champions; and
- Delivering targeted education events.

Three priorities have been defined for cancer services in Wolverhampton which will be achieved through eight key actions (figure 6). These support the delivery of National Cancer Standards and West Midlands Cancer Alliance

priorities and are aligned with the STP and national cancer priorities (appendix B).

Priority 1: Reduce the growth in the number of new cancers

Key Action:

- Promote, encourage and empower people to adopt healthier lifestyles

Priority 2: Improve survival of people diagnosed with cancer in Wolverhampton

Key Actions:

- Increase diagnosis through screening programmes before signs and symptoms appear
- Empower patients to present early with cancer signs and symptom
- Support primary care to manage patients in accordance with best practice
- Ensure prompt access to diagnostic tests and referral pathways

Priority 3: Improve the quality of life of patients after treatment (access to the Recovery Package and other support)

Key Actions:

- Provide individualised care and support to cancer patients
- Reduce risks and improve long term outcomes amongst those diagnosed with cancer
- Monitor progress and performance of the strategic aims

Figure 6: Wolverhampton Cancer Strategy priorities and actions

Year one priorities:

This is a five-year strategy so it will be necessary to focus on improving identified areas in 19/20 to support the delivery of future years. These priorities for year one will be:

- Develop robust QOF+ to support the increase in screening uptake and early diagnosis / develop robust communication and promotion plan;
- Improve cancer waiting time standard 62-day RTT and review root cause analysis;

- Support the implementation of nationally agreed rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers; Cancer Alliance priority to include Upper Gastrointestinal cancers;
- Improve patient experience and quality of life outcomes / continue with patient engagement ;
- Further develop and implement Risk Stratified follow-up pathways for breast cancer;
- Continue 104-day harm review to identify any physical or psychological harm to patients;
- Continue to deliver 28-day target;
- Monitor performance and capacity;
- Continue dialogue across cancer teams.

5.4 Mental Health

Summary

Patients in the Black Country will benefit from both localised and system-wide approaches to mental health services. The CCG, during 2019/20, is focused on delivering against its mental health commissioning strategy which has a stated intention to deliver a Mental Health Integrated Care System and close gaps in service provision across our footprint, working with partners to support the clinical priorities set by the STP outlined below.

Mental health services at the STP level

The STP has described a vision for mental health services that provide patients with **access to universal and specialist mental health and mental wellbeing initiatives that improve the quality of life chances and opportunities.** This has informed the triple aim opportunities of:

- **Better Health**: Improved access to universal and specialist mental health and mental wellbeing initiatives, with increased focus upon prevention and early intervention at key moments in life, reducing levels of complexity and chronicity including physical health and improving the quality of life chances and opportunities;
- **Better Care**: Improved access to integrated health and social care initiatives including focus on primary care mental wellbeing and the wider determinants of mental ill health in individuals, families and communities;

- **Better Value**: Transformed outcomes, experience and reduced demand on mental and physical health secondary and tertiary services. Releasing savings through reductions in inappropriate out of area placements.

Early priorities to deliver this vision have been defined as:

- Identify services that will benefit from being jointly commissioned at the STP level;
- Deliver against the STP Mental Health 'One Commissioner' project on a page.

Mental health services in Wolverhampton

The table below shows the number of people affected by mental health problems based on Wolverhampton's 2011 census total population of 248,470, of whom adults are 186,508.

	Prevalence	Wolverhampton
Number of people at risk of mental health problem	250/1,000	46,627
Of those at risk attending GP	230/1,000	42, 897
Subsequently diagnosed as having mental health problem	130/1,000	24,246
Referred to Specialist Mental Health Service	20-30/1,000	5,595
Admitted to Mental Health Hospital	<10/1,000	1865

Table 4: Prevalence of mental health problems in Wolverhampton

We have worked with services users and carers to develop an outcomes-based system of care with an agreed and cohesive set of values which includes:

- Responsiveness kindness and compassion – being helpful, making every contact count;
- Professionalism, effectiveness and accountability, seamlessness;
- Self-efficacy, learning, growth, self-expansion and recovery;
- Supporting personal aspirations, hopes, dreams, goals and purpose including a focus on practical things – housing benefits employability.

We have recently developed a new Mental Health Commissioning Strategy (MHCS) that outlines our **seven priorities**:

Priority	Detail
1. Closing the treatment gap	Improving access to evidence-based quality services and improving access to and responsiveness of services including referral to treatment and waiting times
2. Closing the data quality gap	Improving Data Quality
3. Closing the mortality gap	Integration of mental and physical health
4. Closing the parity of esteem / funding gap	Maintaining the CCG's commitment to Mental Health Investment Standard
5. Closing the early intervention and prevention gap	Improving the Wider Determinants of Mental Health
6. Closing the information gap.	Delivering an information revolution - working with all key stakeholders to ensure that together we have a joined-up approach to information sharing, advice and guidance, navigation, communication, marketing and engagement
7. Closing the workforce gap.	Delivering a workforce plan in line with Stepping Forward to 2020 to develop capacity and capability across our services

Table 5: WCCG Mental Health Priorities

The **15 goals of our MHCS** outline our implementation plan of service re-design across universal, primary, secondary and tertiary services, including commissioning of a new service model for mental health and dementia community and in-patient services across mental health urgent and planned care. This includes our work with local authority and provider colleagues as part of the Better Care Fund (BCF: see section 5.6) to ensure we deliver early intervention and prevention across the life span, pro-active support at times of crisis and ill health and on-going support to deliver admission avoidance, helping people to stay well and achieve and maintain personalised recovery.

This MHCS describes our plans to develop our Mental Health Integrated Care System and close gaps in service provision across our footprint, working with partners across our STP to deliver evidence-based services of critical mass and at scale and pace delivering value for money and avoiding unnecessary duplication of costs. **Further evidence of alignment between national, STP and local planning around mental health is described in appendix C.**

5.5 Adult Learning Disabilities and Autism

Summary

People with LD and/or autism in the Black Country will benefit from both localised and system-wide approaches to LD and autism services. The CCG, during 2019/20, is focused on providing support and services that increase the opportunities for people to live valued lives in their communities, as well as sharing best practice and learning across health and care as to working with patients with LD and/or autism. Working with partners across Wolverhampton is integral to this and this activity will support the clinical priorities set by the STP outlined below.

Learning disability and autism services at the STP level

The vision for services in the STP is for **those with learning disability and/or autism to be seen as citizens with rights, who should expect to lead active lives in the community.** The triple aim opportunities to support this include:

- **Better Health:** The Transforming Care Partnerships (TCP) programme will result in people with a learning disability and/or autism seen as citizens with rights, who should expect to lead active lives in the community;
- **Better Care:** The TCP programme will improve the quality of life for people with a learning disability and/or autism. The right specialist community services will be in place to allow service users to benefit from maintaining links with their local support network and family;
- **Better Value:** The reduced reliance on bed-based care, reduced A&E attendances, fewer inpatient admissions and fewer delayed discharges of care will release costs; expensive out of area placements can be reduced.

Early priorities to deliver this vision have been defined as:

- Reduce premature mortality by improving emergency department education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism;
- Share learning across emergency departments and maximise the use of out-of-hospital interventions to provide alternatives to emergency attendance.

Learning disability and autism services in Wolverhampton

Our vision remains to support citizens with learning disabilities to be equal citizens, leading valued, healthy lives as contributing members of their local communities.

We will continue to implement our ambitious plans to transform care and support for people with learning disabilities by delivering our Transforming Care Delivery Plan, developed across the Black Country, and in response to the national plan: *Building the Right Support.*

Building on learning from Wolverhampton's Intensive Support Service (ISS), in 2018/19 **we have commissioned Intensive Support across the Black Country, with extended hours of operation, and planned weekend working**. We have also commissioned a specialist health forensic learning disability team across the Black Country, and this new service is working in partnership with Wolverhampton's dedicated learning disability forensic social work team to ensure that care and treatment delivers good outcomes and works to clear timescales.

We have also developed a forensic Supported Living Framework (SLF) **to support the timely discharge of citizens with forensic needs into highly specialist community placements.** These new services will be reviewed in 2019/20 in order to further develop them and ensure that they are meeting needs effectively.

We will continue to develop our Transforming Care Quality Dashboard (TCQD) by rolling out recently developed citizen questionnaires, a quarterly self-assessment tool for both community and inpatient providers, and by **using data and system intelligence to support us to improve the quality, safety and effectiveness of services, and improve both citizen experience and outcomes**. The principles of stopping the over medication of people with a learning disability, autism or both (STOMP) will be fully embedded and reflected in this dashboard, with careful monitoring of medication, a clear emphasis on reducing restrictive practices and developing a workforce which has positive behaviour support as its ethos.

We will review and re-specify the specialist health community learning disability teams in 2019, with a revised agreed specification across the Black Country in order to deliver consistent, evidence-based care and support.

We will use the recently developed risk registers and enhanced multi-disciplinary working **to plan robust care and support with people with learning disabilities who are at risk of coming into hospital**, **or coming into contact with the**

criminal justice system, with strong Care and Treatment Reviews supporting decision-making and planning.

We will continue to place emphasis on designing individual solutions, and creatively meeting needs, and will enable more people to take control of their care through using personal health budgets in order to achieve this (see section 8). Increasing the number of annual health checks completed, and reviewing their quality and effectiveness are key actions in 2019, in addition to continuing to embed and learn from the Learning Disabilities Mortality Review (LeDeR) programme through membership of the steering group and quality and consistent planning around LeDeR reviews.

We will work with our NHS providers to ensure that they have robust plans in place to deliver awareness raising with their workforce, agree how the impact of this will be evaluated, and how such awareness raising could be shared more widely. We will continue to support work between our acute provider, primary care and specialist health to ensure that people with learning disabilities have the opportunity to have a digital flag in their patient record to alert clinicians to high risk clinical or behavioural issues to help them to support their care through reasonable adjustments.

Further evidence of alignment between national, system and local planning for learning disability and autism services can be found in appendix D.

5.6 Primary Care and Community Health Services

Summary

Patients in the Black Country will benefit from both localised and system-wide approaches to primary care and community services. The CCG, during 2019/20, is focused on developing our PCNs, wrapping community services, mental health services and social care around them to provide the populations they serve with a holistic model of care to ensure they receive the right care quickly and help them stay closer to home. Working with partners across Wolverhampton is integral to this and this activity will support the clinical priorities set by the STP outlined below.

Primary and community care at the STP level

The vision for primary care in the STP is for **patients to have access to resilient, accessible primary care.** The triple aim opportunities for primary care identified in the STP clinical strategy are:

- **Better Health:** Involving GPs in commissioning discussions and decision making enables new approaches to prevention and management of ill health for our population;
- **Better Care:** Networks supporting local populations will allow the provision of personal care. Move from disease management alone, towards prevention, wellbeing and self-care, optimising patient outcomes;
- **Better Value:** Rebalancing the investment between primary and secondary care providers makes sense as optimising the use of out of hospital services averts the current waste.

Early priorities to deliver this vision have been identified as:

- Develop and deliver a collective STP programme of work that fulfils the requirements of the *GP Forward View*;
- Have dedicated resource to implement the programme;
- Work with national bodies to ensure available funding is accessed and deployed across the STP;
- Continued engagement with general practice;
- Continue to implement the STP workforce strategy to support sustainability within primary care;

Primary and community care in Wolverhampton

The LTP confirmed a £4.5 million uplift to primary medical and community health services, placing key responsibilities on PCNs to improve out-of-hospital care.

As a CCG, we want to design and commission primary and community care services that:

- Reduce hospital admissions and provide more care closer to home through community-based services, improving coordination and access;
- Give us more responsibility for GP services;
- Focus on preventing illnesses, working with public health to look at lifestyle factors that increase the risk of ill-health;
- Give patients better access to GPs as well and innovate to reduce pressures on GPs; and
- Deliver seamless health and social care through closer collaboration with the City of Wolverhampton Council.

Primary Care Strategy

We implemented a five-year primary health care strategy in 2016 that stated as its vision to **achieve high quality out of hospital care which is accessible to everyone.[8] This will, in turn, promote the health and wellbeing of our local community. We want to ensure that the right treatment is available in the right place at the right time and to improve the quality of life of those living with long term conditions and reduce health inequalities.**

This strategy will be refreshed in 2019/20 to reflect the activity described in this section.

Governance arrangements

In Wolverhampton our GP Practices have split into four different groups to help us shape primary and community services for the future. A group of eight practices have joined with our local NHS Trust, RWT, as part of a vertical integration programme. Part of vertical integration is a greater level of back office support which will take care of the business element of general practice. All staff, including the GPs of these practices, have become employees of RWT. All other practices in Wolverhampton are aligned to three further groups. These groups are Unity Limited, Wolverhampton Total Health and Wolverhampton Care Collaborative. Each group is a limited company and are working towards the principles of the Primary Care Home Model (NAPC).[9]

This approach enables access to services to improve whilst practices work together to share their workforce and become more resilient in the services they deliver. This means that patients may access services through practice group hubs and shared teams across practices. The introduction of care hubs will help to increase access as well as co-ordinate care so that, where possible, care can be given closer to home and in a community setting.

The CCG is committed to supporting each model of care to help streamline patient pathways, deliver more care in the community and aid the development of the ICA.

Primary Care Investment

[8] WCCG, *Annual Report 2017/18.*
[9] http://napc.co.uk/primary-care-home/

In addition to the £3 per head invested during 2017/18 and 2018/19, the CCG has committed £500,000 each year into the support, mentoring and training of practices, as well as engagement and development of our PCNs. Support and development of at-scale working and provision of services and other funding from both local budgets and national funding streams have enabled leadership and development training to be made available to practice teams and staff groups to allow their skills and competence to be further developed and strengthened.

In 2019/20 and 2020/21 the CCG will fund £1.50 per patient in line with the national Directed Enhanced Services (DES) to enable PCNs to flourish.

Primary Care Network Development

The integration of out-of-hospital services is central to our ambitions for 2019/20, reflected by the co-dependency of primary and community care in this operating plan. The main priorities for community services for the coming year are highlighted in figure 7.

Priority 1 – Wrapping community services around PCNs

There is currently one co-located community team in Wolverhampton with social care, community and district nursing, mental health, social prescribing and housing. We will be looking to deliver two more in 19/20 to address wider determinants of health. These teams will become more closely aligned with PCNs.

Priority 2 - Delivering an appropriate Multi-disciplinary Team (MDT) model for Wolverhampton

We are presently running pilot schemes for MDTs at selected sites in Wolverhampton. Based on the learning from these pilots, a model for MDT working will be rolled out across the PCNs. QOF+ funding will be used to support this.

Priority 3 – Shifting services out of hospital into community settings

During 19/20, services that can be appropriately shifted from hospitals into community settings will be identified and business cases for the change developed with a view to first significant shifts in 2020/21.

Priority 4 – Support delivery of ICA priority clinical pathways

Four pathways have been prioritised for 2019/20: frailty, end-of-life, children and young people and mental health.

Figure 7: Community Care priorities for WCCG 2019/20

As part of our activities around integration of services we will be reviewing which CCG activities might be better delivered at the STP level. During 19/20 the following areas of work will be considered as opportunities for working at scale:

- QOF
- Digital technology
- Progress against the 10 High Impact Actions[10]
- Supporting people living with long-term conditions to self-care
- Accessibility of primary care including:
    - Extended access
    - GP capacity
    - Communications
    - Inequalities

Further evidence of alignment between national, system and local planning for primary care and community services can be found in appendix E with the note that the local strategy is being refreshed in 2019/20.

Better Care Fund

The BCF provides an opportunity to develop a single pooled budget to allow health and social care services to work together more closely. Wolverhampton's Better Care Plans are an integral and important component of our vision for services in Wolverhampton.

The CCG will continue to work together with partners in an integrated way, aiming to improve pathways and services for patients, moving care closer to home where appropriate.

The BCF's vision statement is to:

> '*Provide individuals and families in Wolverhampton with the services, methods and knowledge to help them to live longer, healthier and more independent lives no matter where they live in the city. Health & Social Care colleagues will work better together, alongside local community organisations to deliver support closer to where individuals and families live and in line with their needs.'*

There are five workstreams within the programme:

- Adult Community Care

[10] https://www.england.nhs.uk/gp/gpfv/redesign/gpdp/

- Mental Health
- Dementia
- CAMHS
- Integration

Within these workstreams are a number of projects that will be delivered during 2019/20:

Adult Community Care

- Continued implementation of People Living with Frailty Programme;
- Continued review and redesign of community services programme;
- Managing transfers of care and reducing length of stay;
- Development of community neighbourhood teams including co-location of remaining two localities and expansion of MDT working;
- Admission avoidance programme.

Mental Health

- Implement new community pathways/services based on gap analysis of existing services (including prevention);
- Implement integrated models for mental health.

Dementia

- Review and refresh of joint dementia strategy;
- Implementation of dementia strategy.

CAMHS

- Workforce development to be continued;
- Mapping of all services available to CYP for emotional mental health and wellbeing, giving consideration to all commissioned services by both NHS and Local Authority;
- Introduction of a pilot for self-referrals for parents of all CYP and those aged 14+ to begin in Oct 2019.

Integration

- Continued delivery of integrated health and social care record;
- Continued review and development of Data Sharing Agreements across BCF;
- Joint communications and engagement activity;
- Manage any estates requirements of the programme;
- Oversight of finance and performance of the programme.

5.7 Children and Young People's Services

Summary

Patients in the Black Country will benefit from both localised and system-wide approaches to CYP services. The CCG, during 2019/20, is focused on developing services for CYP specifically relating to maternity and neonatal, mental health, learning disability and/or autism services, as well as avoiding unnecessary hospital admissions and keeping care closer to home. Working with partners across Wolverhampton is integral to this and this activity will support the clinical priorities set by the STP outlined below.

Children and young people's services at the STP level

The STP has set out a vision for CYP services **that they are in good physical and mental health, enabling them to become independent and productive members of our society.** The triple aim opportunities have been identified as:

- **Better Health**: To ensure that CYP in the Black Country are in good physical and mental health;
- **Better Care**: CYP receive care as close to home and their social networks as possible; and
- **Better Value**: Maximise opportunities for high value interventions such as prevention and proactive care and disinvest in low value interventions such as reactive care in an emergency.

Early priorities to deliver this vision have been identified as:

- Invest in services for CYP;
- Identify good practice across the STP and nationally in relation to CYP services with positive outcomes;
- Expand scope of safeguarding across STP.

Children and young people's services in Wolverhampton

The LTP has set a clear ambition to improve the mental and physical health of CYP. Specifically, the LTP has defined health priorities that require CCG response as:

Maternity and neonatal

- Improve continuity of care
- Expand roll-out of maternity digital care records

- Improve access to perinatal mental health
- Improving access to postnatal physiotherapy
- Redesigning and expanding neonatal critical care services

Mental Health

- Expanding mental health services for CYP
- Improving access to mental health services
- Embedding mental health support in schools and colleges
- Developing support around the transition to adulthood

Learning disability and autism

- Tackling the causes of morbidity and preventable deaths
- Better understanding of the needs of people with learning disabilities or autism
- Increasing investment in intensive, crisis and community support
- Improving the quality of inpatient care

CYP with cancer

- Providing children with cancer whole genome sequencing
- Supporting CYP to take part in clinical trials
- Offering boys aged 12 and 13 HPV vaccination

Redesigning other health services for CYP

- Improving childhood immunisation
- Reduce A&E attendance of CYP
- Improving quality of care for children with long-term conditions
- Providing more paediatric critical care and surgical services as close to home as possible

We have already set in train services to support CYP and will continue to develop our interventions during 2019/20. In particular:

Maternity and Neonatal

- Deliver Better Births: tackle infant mortality, identify foetal growth restriction, address reduced foetal movements, collaborative cross boundary working, women-centred clinical pathways as directed by NICE;
- Saving Babies' Lives Care Bundle: objective to halve stillbirth rates, neonatal and maternal deaths and brain injuries by 2030, reduce premature mortality

rates, support breast feeding, reduce obesity and diabetes, reduce smoking in pregnancy;
- Personalised Care Planning: early contact, improved patient choice, continuity of carer, single point of access, single digital patient health record, enhanced community engagement;
- Reduce health inequalities: improve experiences and outcomes for groups such as migrants, asylum seekers and refugees, deprived communities, seldom heard communities.

Mental Health

- Continue to expand mental health services for CYP, resulting in easier access with young people over the age of 14 and their parents/carers being able to self-refer into services by October 2019;
- Continue to embed the new emotional mental health and wellbeing service as well as the digital online counselling offer across the city;
- The workforce development offer will enable staff working with CYP in schools and colleges to have more confidence when supporting them with their mental health needs;
- Continue to ensure that the transition process for CYP from CAMHS to adult mental health services is a smooth process and one where they are aware of what the expectations of the service will be going forward.

Learning Disabilities and Autism

- We will participate fully in the LeDeR process to ensure that we understand the causes of morbidity and preventable deaths for CYP with learning disability and/or autism;
- Our young people will be supported to ensure that they grow to live as equal citizens, leading valued, healthy lives as contributing members of their local communities;
- We will use the recently developed risk registers and enhanced multi-disciplinary working to plan robust care and support with CYP with learning disabilities and /or autism who are at risk of coming into hospital, or coming into contact with the criminal justice system, with strong care, education and treatment reviews supporting decision-making and planning;
- A pilot project is currently being run to establish what an intensive support service for CYP with autism and/or learning disability may look like which on evaluation will help us to develop our long term intensive support services offer in the community for this vulnerable group of young people and look to

prevent admission to a Tier 4 mental health hospital or the criminal justice system.

Avoiding hospital admissions and delivering care closer to home

- We will increase the number of immunisations to CYP who have missed or were not offered the BCG vaccine at birth, particularly in line with the immunisation against infectious diseases guidance;
- We are keen to ensure that CYP are seen in the right place, at the right time and by the right people so work is being undertaken to establish what service could be commissioned to support reducing the number of CYP who attend A&E.
- Develop work around the 'Big Six' which refers to the six most common conditions/symptoms that can cause CYP to present for emergency and urgent care. This guide will promote evidence-based assessment and management of unwell CYP for the most common conditions when accessing local NHS services in an emergency or urgent scenario. There will be a development of joint clinics between primary care staff and secondary care staff to support care closer to home.

5.8 Longer term deliverables

The preceding sections have outlined our commissioning plans for 2019/20 across a number of areas and themes. **In addition to these, reducing health inequalities forms part of a long-term objective for the CCG.** To this end, we have, with CWC, developed a Joint Health and Wellbeing Strategy 2018-2023[11] that sets out the following priorities:

- Early Years
- CYP mental wellbeing and resilience
- Workforce
- City Centre
- Embedding prevention across the system
- Integrated Care; Frailty and End of Life
- Dementia friendly city

[11] WCCG and CWC. *Wolverhampton Joint Health and Wellbeing Strategy 2018-2023.* 2018.

The strategy highlights the importance of collaborative working in making a positive impact in these areas, and also aligns this work with the Wolverhampton Public Health vision for 2030.[12]

6. Workforce

There are several workforce strategies being implemented by WCCG during the course of 2019/20.

Primary care workforce strategy

Our shared vision across the STP is to develop and sustain a workforce built around the needs of our population, which has the skills, knowledge and values to transform at scale and deliver high quality care within Wolverhampton. **Primary Care will be delivered across primary care networks, across multidisciplinary integrated teams, 7 days per week offering prevention and treatment services to reduce demand, integrated with partners and Local Authorities.** This vision is supported by a primary care workforce strategy that is itself informed by the *General Practice Forward View.*

Central to the STP programme of work is to introduce the new roles that will lead to delivering our PCNs that are central to our own ICA in Wolverhampton, as well as provide for additional investment in current staff. Figure 8 provides an example of the transformed workforce described by the STP primary care workforce strategy:

[12] CWC. *The vision for Public Health 2030. Longer, healthier lives.* Undated. Available at http://www.wolverhampton.gov.uk/CHttpHandler.ashx?id=15370&p=0

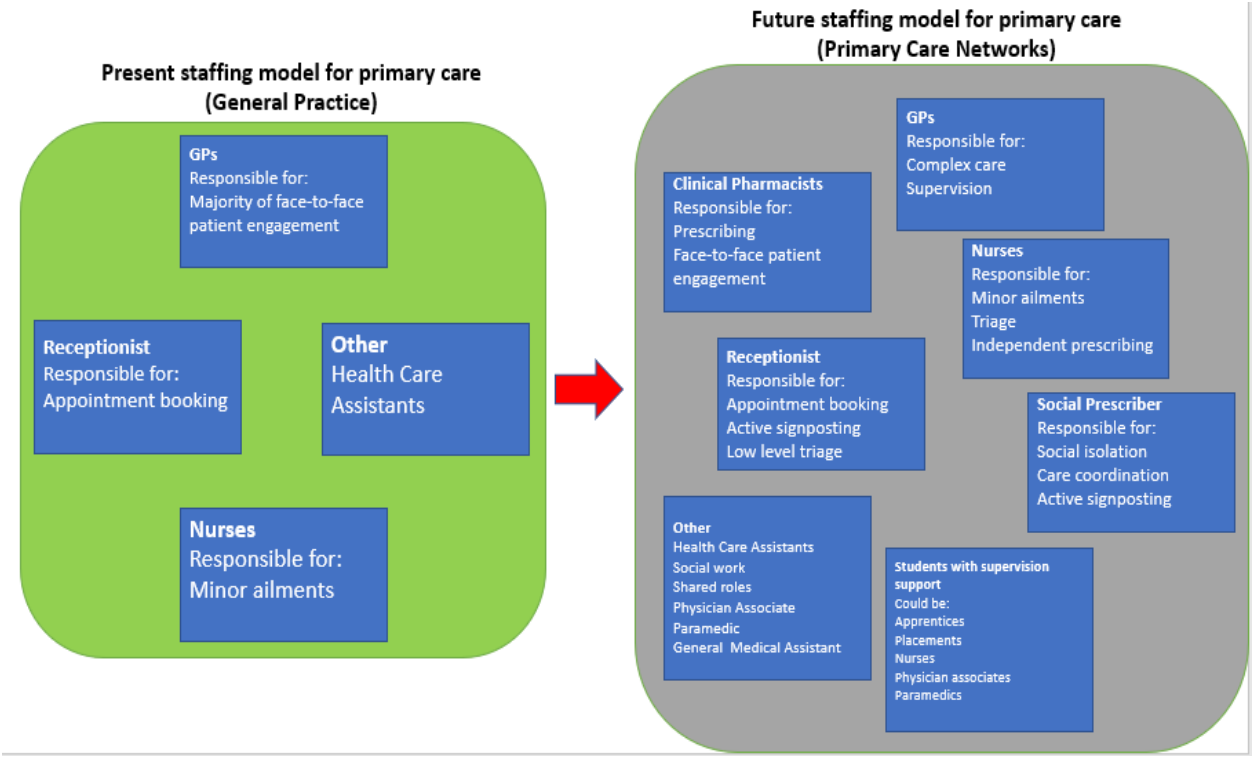


Figure 8: Primary Care workforce transformation

As a CCG our mission is to lead workforce planning locally, and during 2019/20 we will make decisions with our partners as to which funding and service delivery decisions will be best made at the STP level, and which should stay with the CCG. Wolverhampton CCG will continue to support and enable primary care workforce development through new ways of working. Access to innovation funding, commissioning and piloting of new roles and building relationships with other partners to ensure workforce development are key enablers for transformation. **We have developed a retention plan and are learning from intensive support to recruit and retain GPs and nurses.**

Mental health workforce strategy

Delivering the required workforce to respond to the national mental health workforce plan[13] is a core component of our MHCS. At a national level, this should include an expansion in the capacity and capability of the CYP workforce, building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence-based interventions by 2020/21.

[13] HEE. *Stepping forward to 2020/21: The mental health workforce plan for England.* 2017. Available at https://www.basw.co.uk/system/files/resources/basw_62959-3_0.pdf

We will also support the development of the next generation of practitioners and leaders through continued participation in the Think Ahead programme for social workers working in mental health and other areas across the NHS.

Child and adolescent mental health services workforce

Consideration of the workforce required in future CAMHS services forms part of the discussion in the Wolverhampton *CAMHS Transformation Plan Refresh 2018-2020*.[14]

The main focus is to contribute to the national plan through the creation of new roles which will increase access to services at a much lower level rather than waiting for the child/young person to become so ill that they require significant specialist intervention.

Staff increases for 2019/20 are planned in the Emotional Mental Health and Wellbeing service and Neurodevelopmental service.

STP Workforce Strategy

The STP are developing a system-wide workforce strategy with the objective of recruiting and retaining a workforce that contributes to achieving a sustainable health economy. This will continue to be developed and implemented during 2019/20.

7. Data and Technology

We have pursued a strategy to identify and adopt new technologies that can benefit patients and staff in the Wolverhampton health economy. **We were one of the first CCGs to implement GP Remote Consultation for GP Practice groups**, which supports extended opening hours and the ability of clinicians to hold and record consultations with patients from any of the practices within the federated GP Groups. The development of online consultation follows the trend of the CCG implementing new technologies for patients and builds on the CCG being the first to fully implement free NHS patient Wi-Fi .

For the coming year we have a large portfolio of work. This includes:

- The provision of a texting solution that increases the range of texts that we can send to patients while allowing patients to cancel appointments by text;

[14] Available at https://wolverhampton.moderngov.co.uk/documents/s87953/Wolverhampton%20CAMHS%20Transformation%20Plan%20Refresh%202018%20v6.pdf

- An ambitious project to migrate to Windows 10 from Windows 7; we aim to migrate to the new operating system over the next 18 months, ensuring that the migration is complete before Windows 7 goes end of life on 14 January 2020;
- We have secured additional funds though the Estates and Technology Transformation Fund (ETTF) scheme to continue the development of the insight shared care record. This will support the CCG working closely with Walsall and the use of EPaCC's (End of Life Care Plans) across all care settings;
- Working with the STP we have successfully bid and received funding to upgrade our electronic document management solution (Docman) to the latest cloud-based solution;
- Continue to register patients for online services at each GP practice (current target 30% coverage);
- The CCG continues to support GP practices through the provision of servers, switches, printers, scanners, monitors, laptops and PCs. This is done on a rolling 5-year replacement scheme that ensures that the IT infrastructure within the CCG is current and fit for purpose;
- The CCG is embarking on a new network redesign to improve on the old N3 broadband lines and installing ultra-fast 100mb leased lines to connect the GP practices to the network. This will improve access speeds for clinical systems but will also support the development of online triage and video consultations through provision increased bandwidth. The ultra-fast network backbone will also support practice work across sites in federated groups and support hub working; and
- Updated patient auto-arrival solution: the CCG will be looking to improve the existing solution to update the software from local isolated media players and windows touch screen to hosted central managed cloud estate using Jayex Connect.

Local Digital Roadmap

The digital priorities for the CCG are aligned closely with those of the STP, which has a stated vision of a **digitally connected Black Country Health and Social Care System that enables self-care and promotes wellbeing**. This vision is focused on the following digital themes:

- **Empowerment:** Through the use of technology there will be patient and citizen access and contribution to their health and care records;

- **Infrastructure**: A resilient infrastructure across the Black Country health and social care economy enabling access to required information to support decisions from anywhere, aiding place-based working;
- **Integration:** Creating opportunities for systems to be interlinked across the STP, with the potential for further integration in the future; and
- **Intelligence**: Development of robust business intelligence across the Black Country to support decision making and identification of best practice models leading to improved patient care.

One of the key aims underpinning these themes is interoperability. This allows for variation in delivery mechanisms for digital technologies across the STP whilst ensuring the ability to exchange information; to provide a single consolidated view of the patient in the context in which the patient is being viewed, supporting operational excellence within our new models of care.

The CCG have been a key driver in the development of the STP SharePoint solution that is already used by the STP PMO team, Transferring Care Partnership, Joint Commissioning Committee and Local Maternity System team. Plans are in place to expand this to the Local Digital Roadmap and other groups in the coming year. The development has been made possible by the support of the ETTF funds that have supported the online solution for a further 3 years.

NHS App

In 2018, we were one of the private beta testers for the NHS App and will continue to support its uptake amongst patients.

8. Personal Health Budgets

Personal health budgets (PHBs) are part of a wider drive to personalise health, social care and education set out clearly in the LTP:

> *'Within five years over 2.5 million more people will benefit from "social prescribing", a personal health budget, and new support for managing their own health in partnership with patients' groups and the voluntary sector'.*

We are committed to meeting the increased targets for PHBs, as set out for us by NHSE.

We are currently developing plans and a work programme to help us address some of the challenges experienced to date and reaching these additional numbers. In line

with the NHSE directive to make PHBs the default position for continuing healthcare (CHC) we will have a standard PHB offer for all new and existing CHC cases from February 2019.

Other priority areas we will be focussing on during 2019/20 are Education, Health and Care (EHC) plans, wheelchairs, Section 117 aftercare[15] and joint packages of care that involve a health element.

The programme will bring focus and momentum identifying and engaging with key staff leads with local knowledge and experience who will be responsible for having ongoing ownership and oversight of PHBs in their work area. Additional training and awareness of PHBs for staff that require this will be provided.

We will be working closely with providers and the wider market to help shape additional options for budget holders that will promote greater choice and control.

Personalised Care

The Black Country STP is a Demonstrator Site for personalised care. Wolverhampton CCG is committed to this programme of work which includes:-

- Personalised Care Plans
- Health Coaching
- Social Prescribing
- Peer Support
- Structured Self-Management / Education Sessions
- Patient Choice
- Co-production
- Workforce Development

The work already underway with Care Closer to Home, community neighbourhood teams, MDT and integrated working all supports this national and local drive for personalised care.

9. Medicines Optimisation

The CCG has a medicines optimisation strategy for 2019-2021 that sets out the following aims:

- Ensure opportunity for patients to be involved in ‘shared decision making’ about their medicines i.e. a collaborative process through which a clinician supports a patient to reach a decision about their treatment;

[15] See https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/section-117-aftercare/#.XFxe-Vz7SUk

- Evidence based cost effective prescribing;
- Medicines optimisation is considered in all commissioning arrangements;
- Medicines optimisation Quality, Innovation, Productivity, Prevention (QIPP) delivery;
- Work with stakeholders to ensure medicines optimisation is part of routine practice; and
- All medication is used safely.

For 2019/20, these aims have been distilled into the following priorities for the CCG to maximise value from medicines:

- Reviewing repeat prescription management systems;
- QIPP delivery;
- Continuing to maximise uptake of biosimilars;
- Continued implementation of over the counter medicines guidance and the drugs of limited clinical value;
- Expanding our current provision for medicines reviews in care homes;
- Continued focus on appropriate prescribing of antibiotics in line with AMR;
- Support and facilitate nutrition reviews.

These objectives align with the medicines optimisation and pharmacy agendas for the STP and LTP in that they:

- Promote evidence-based cost-effective prescribing;
- Improve safety;
- Encourage shared decision-making; and
- Continually implement polypharmacy reviews.

10. Quality

We will maintain a strong emphasis on a system-wide approach to quality assurance and safety improvement through our quality and safety strategy which will be reviewed on the basis of the LTP in 2019/20. Our work focuses on avoiding and reducing avoidable harm in health and care and where harm has occurred, ensuring timely, transparent reporting and robust processes to ensure local and system-wide learning is critical. Learning from local and national incidents and inquiries is key to ensuring safer services for our population.

Contracts with provider organisations provide a basis to drive improvement and we have revised our contract schedules for 19/20. Scrutiny of the quality of care is undertaken in a consistent way by the CCG and includes a number of quality

assurance arrangements, which are used to collate and triangulate information gathered. These include formal meeting arrangements with provider organisations, announced and unannounced visits, patient and partner feedback, use of 'soft intelligence' and working in a collaborative way with regulators, including CQC, NHSE and NHSI. We also have an opportunity to share our intelligence at Quality Surveillance Group, which is a regional group convened to share best practice and escalate any particular system wide issues of concern.

Emerging priorities for 2019/20 are:

- Reviewing mortality rates within 30 days of discharge;
- Reviewing cases of sepsis and patient deterioration;
- Support to care and residential homes from quality nurse advisors;
- Ensuring adherence to national CHC contract;
- Working with schools to assure support and services for CYP with SEND;
- Strengthen the monitoring of Safeguarding Children and Adults arrangements in all commissioned services;
- Continue to work closely with providers to strengthen reporting arrangements for our Looked After Children to ensure strategic oversight and enable more robust challenge, implementing any changes through the contract.

11. Engagement

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

Over the past 12 months, as part of our Black Country STP, we have worked with partners across the health and care system to develop Black Country-wide systems and processes. This is enabling us to involve local people in Black Country-wide service change, for example around learning disabilities and local maternity services. We will build on the collective work we have undertaken with partners so that we continue to play our part in delivering integrated care by place and across the Black Country. In this way, we will ensure Wolverhampton residents have a role in the developing health and care landscape and that their voices are heard.

The development of place-based care through PCNs will be an engagement priority for the CCG over the coming year. We will also continue to work with a range of patient and community groups including: HealthWatch, Citizen Forum, Wolverhampton Voluntary Sector and our Patient Partners. We will draw on a range of two-way communications channels and engagement techniques to reach and listen to our target groups, including:

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

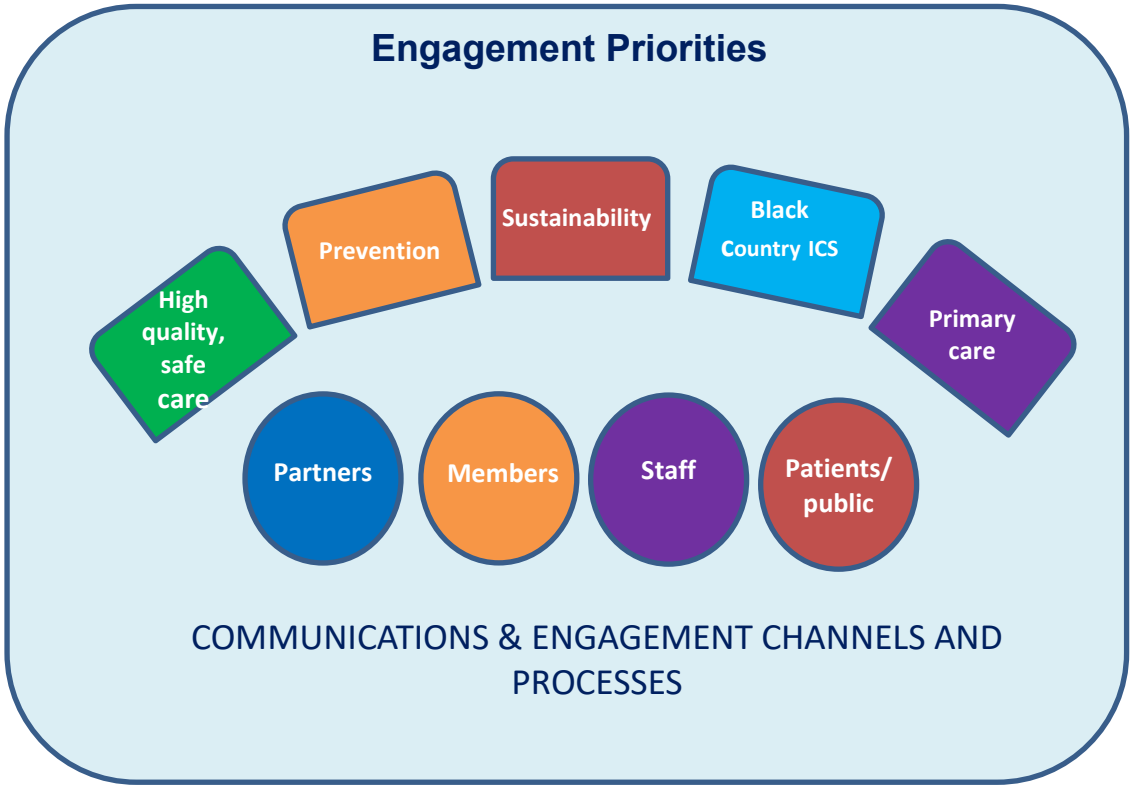


Figure 9: WCCG engagement priorities

12. Risks

The CCG monitors the potential risks to its activities at a strategic level through its corporate risk register. Those presently considered are presented in appendix A.

13. Concluding remarks

At the outset of this document we described the five priorities for WCCG for 2019/20:

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

This document has described the future national, system and local (place) context within which health and care will be delivered to populations. Incumbent within this future context is that organisations do not exceed their financial means by working at scale where appropriate and sharing risks and rewards. In section 4.2 the steps that will be taken to ensure financial sustainability have been highlighted and section 5 has demonstrated that within this financial settlement we can commission high quality, safe services locally that are cost effective and sustainable and align these services with partners through the emerging ICA, and also with the priorities set at the STP level.

Prevention will be a key feature of many of our commissioning decisions, particularly around cancer services, and PCNs will play an important role in acting before emergency intervention is required. To this end, this plan has described how primary and community care will be more closely integrated, with MDT models tested where a number of services will be mobilised to support patients in communities.

As has been alluded, during this year the building blocks must be secured for closer alignment between STP partners in view of transitioning towards an ICS. During 2019/20, we shall further develop our ambitions for more integrated working across Wolverhampton, as well as identifying and implementing opportunities for activity at the STP/ICS level.

Appendix A – Wolverhampton CCG Corporate Risks

Relevant Departmental/ Programme Risks & Committee Risk IDs	Title and Summary
QIPP: Delivery of Targeted GP Peer Review Scheme	**Failure to meet QIPP Targets** QIPP Delivery is vital to ensuring that the CCG meets its financial targets. A challenging QIPP target of 3.5% has been set equivalent to £14m in 2018-19
	Cyber Attacks Cyber attacks on the IT network infrastructure could potentially lead to the loss of confidential data into the public domain if relevant security measures are not in place. There is also serious clinical/financial and operational risks should there be a major failure leaving the organisation unable to function normally. In such an instance, Business Continuity Plans would need to be enacted.
Increased Activity at RWT 62 Day Cancer Target	**NHS Constitutional Targets** There is a risk that ongoing pressure in the system will lead to Providers missing statutory NHS Constitutional targets with the associated impact on patient outcomes
	EPPR Support There is a risk that effective plans will not be in place for CCG and other agencies will not be in place
Executive capacity	**New Ways of Working across the STP** The STP is complex and works across both providers commissioners and local authorities. This requires building new relationships and overcoming organisational barriers . Management capacity to fulfil new roles will be a risk to the CCG as well as the move to new ways of working with partners in a complex system
	BCF Programme Success The Better Care Fund Programme is an ambitious programme of work based on developing much closer integration between NHS and Local Authority Social Care services. There are significant risks associated with the programme not meeting its targets both financially and for patient outcomes
	New Ways of Working in Primary Care There are a number of issues with the developing new approach to working. This potentially puts at risk the benefits for patients and the prospect of system change
Maternity Capacity & Demand	**Maternity Services** Following the decision to transfer a number of births from Walsall to Royal Wolverhampton Trust there have been consistently high midwife to birth ratios and there is a risk that the level of demand may affect the safety and sustainability of services

Relationship with Local Authority Capacity of Public Health to contribute to strategic change Relationship with local providers Complexity of financial modelling	**Developing Local Accountable Care Models** The potential complexity of the developing new models locally will mean having to balance competing priorities for different organisations and against other drivers in the system to clearly articulate the rationale for change and the direction of travel. This means that there is a risk that the objectives of improving patient care and delivering financial stability across the system will not be realised
Workload pressures of STP Workload pressures - Black Country Joint Commissioning Committee Impact of unexpected events on overall workload CSU Capacity	**CCG Staff Capacity Challenges** The level of change across the system means that existing staff resources are stretched to contribute to change based work streams including Black Country Joint Commissioning, STP and local models of care in addition to existing responsibilities. This creates a risk that gaps will be created as well as the existing risk of recruiting sufficiently skilled staff to fill any vacancies that arise in an uncertain environment.
	Governing Body Leadership The recent changes in the CCG's Governing Body, including changes in the Executive Team and the resignation of the chair have created a risk that it will become more difficult for the Governing Body to provide clear strategic leadership as new individuals familiarise themselves with the CCG and the issues it faces.
Primary Care estate improvements	**Failure to secure appropriate Estates Infrastructure Funding** Much of the plans to improve services, particularly in Primary Care, is dependent on securing improvements in the facilities across Wolverhampton. There are a number of possible avenues for funding these improvements but there is a risk that the complex nature of the funding streams and the profile of the estate itself may put delivery of improvements at risk
Over Performance Acute Contract Prescribing Budget CHC Budget	**Failure to Deliver Long Term Financial Strategy** Recurrent Financial pressures across the system may make it difficult to deliver the CCG's financial plans for future years
Transforming Care - Financial Impact	**Transforming Care Partnership** There are a number of risks to the delivery of the Black Country Transforming Care Partnership's programme of work that cause result in a failure to deliver improvements in the quality of service for patients with Learning Disabilities
	Insight Shared Care Record – Governance Arrangements If robust governance arrangements are not put in place to support the implementation of the Insight Shared Care record then it may not be possible to deliver the intended benefits of the programme to support direct care for patients and improved population health planning in order to support overall strategic aims across the health economy.

Appendix B – Cancer priorities at national, system and place

Achieving World Class Cancer Outcomes	Black Country STP Clinical Strategy	Wolverhampton CCG and CWC Joint Cancer Strategy 2019-2024
Spearhead a radical upgrade in prevention and public health	Achieving the 62-day waiting time standard	Reduce the overall growth in the number of all cancer cases
Drive a national ambition to achieve earlier diagnosis	Implementing early diagnosis by 2020	Improve survival of people diagnosed with cancer
Establish patient experience on par with clinical effectiveness and safety	Improving patient experience, incl. through the national Recovery Package	Improve the quality of life of patients after treatment and at the end of life
Transform our approach to support people living with and beyond cancer	Improving patient experience, incl. through the national Recovery Package	Improve the quality of life of patients after treatment and at the end of life
Make the necessary investments required to deliver a modern, high quality service	Review options for collaboration between Walsall cancer unit and Wolverhampton cancer centre	
Ensure commissioning, provision and accountability processes are fit-for-purpose	Review options for collaboration between Walsall cancer unit and Wolverhampton cancer centre	

Appendix C – Mental health priorities at national, system and place

Mental Health Forward View	Black Country STP Clinical Strategy	Wolverhampton CCG Mental Health commissioning strategy 2018-2021
A 7 day NHS – right care, right time, right quality	Improved access to universal and specialist mental health and mental wellbeing initiatives	Closing the treatment gap
Building a better future		Closing the data quality gap
An integrated mental and physical health approach	Improved access to integrated health and social care	Closing the mortality gap
Creating mentally healthy communities	Transformed outcomes, experience and reduced demand on mental and physical health secondary and tertiary services	Closing the parity of esteem / funding gap
Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens/Prevention at key moments in life	Increased focus upon prevention and early intervention at key moments in life, including focus on the wider determinants of mental ill health	Closing the early intervention and prevention gap
Building a better future		Closing the information gap.
A 7 day NHS – right care, right time, right quality	Releasing savings through reductions in inappropriate out of area placements	Closing the workforce gap.

Appendix D – Learning disabilities and autism priorities at national, system and place

Building the Right Support	Black Country STP Clinical Strategy	Wolverhampton
Specialist multidisciplinary health and social care support in the community	The right specialist community services will be in place	Increased access to intensive support services
Where I live and who I live with and the right hospital services	People with LD and/or autism will be seen as citizens with rights, who should expect to live active lives in the community	Supported discharge into appropriate community placements for citizens with forensic needs
Mainstream health services and hospital services	Reduced reliance on bed-based care, reduced A&E attendances, less inpatient admissions and fewer delayed discharges of care will release costs	Better use of data to improve the quality, safety and effectiveness of services, and improve both citizen experience and outcomes.
Support to my family and paid staff	People with LD and/or autism will be seen as citizens with rights, who should expect to live active lives in the community	Review the requirements for the LD workforce and increase awareness of LD across health and care workforce
Mainstream health services and specialist multidisciplinary health and social care support in the community	The right specialist community services will be in place	Embed preventative work as part of MDT working
A good and meaningful life	Citizens will benefit from maintaining links with their local support network and family.	Increased agency for citizens through more personalised care

Appendix E – Primary and community care priorities at national, system and place

General Practice Forward View	Black Country STP Clinical Strategy	Wolverhampton CCG Primary Health Care Strategy 2016-2020
Expansion of workforce capacity	Networks supporting local populations will allow the provision of personal care.	GPs to provide a cradle to crave prevention and treatment service
Support to strengthen and redesign general practice	Rebalancing the investment between primary and secondary care providers makes sense as optimising the use of out of hospital services averts the current waste.	There is continuity in an individual's care
Expansion of workforce capacity	Networks supporting local populations will allow the provision of personal care.	Practices will work as part of a Primary Care Network providing patients with essential services 7 days a week
Support to strengthen and redesign general practice	Move from disease management alone, towards prevention, wellbeing and self-care, optimising patient outcomes.	Patient are empowered to manage their own health
More integration with the wider health care system; support to strengthen and redesign general practice	Networks supporting local populations will allow the provision of personal care.	Care will be provided by integrated community teams including social care and the voluntary sector
	Involving GPs in commissioning discussions and decision making enables new approaches to prevention and management of ill health for	Take a population health management approach

	our population.	
Increase the level of investment in primary care; More integration with the wider health care system	Rebalancing the investment between primary and secondary care providers makes sense as optimising the use of out of hospital services averts the current waste.	Using innovative tools and methods to manage more care outside of hospital – including technology and access to specialists
Invest in better technology	Working with STP partners to implement a shared patient record	Patients will have a single record accessible to all appropriate healthcare professionals