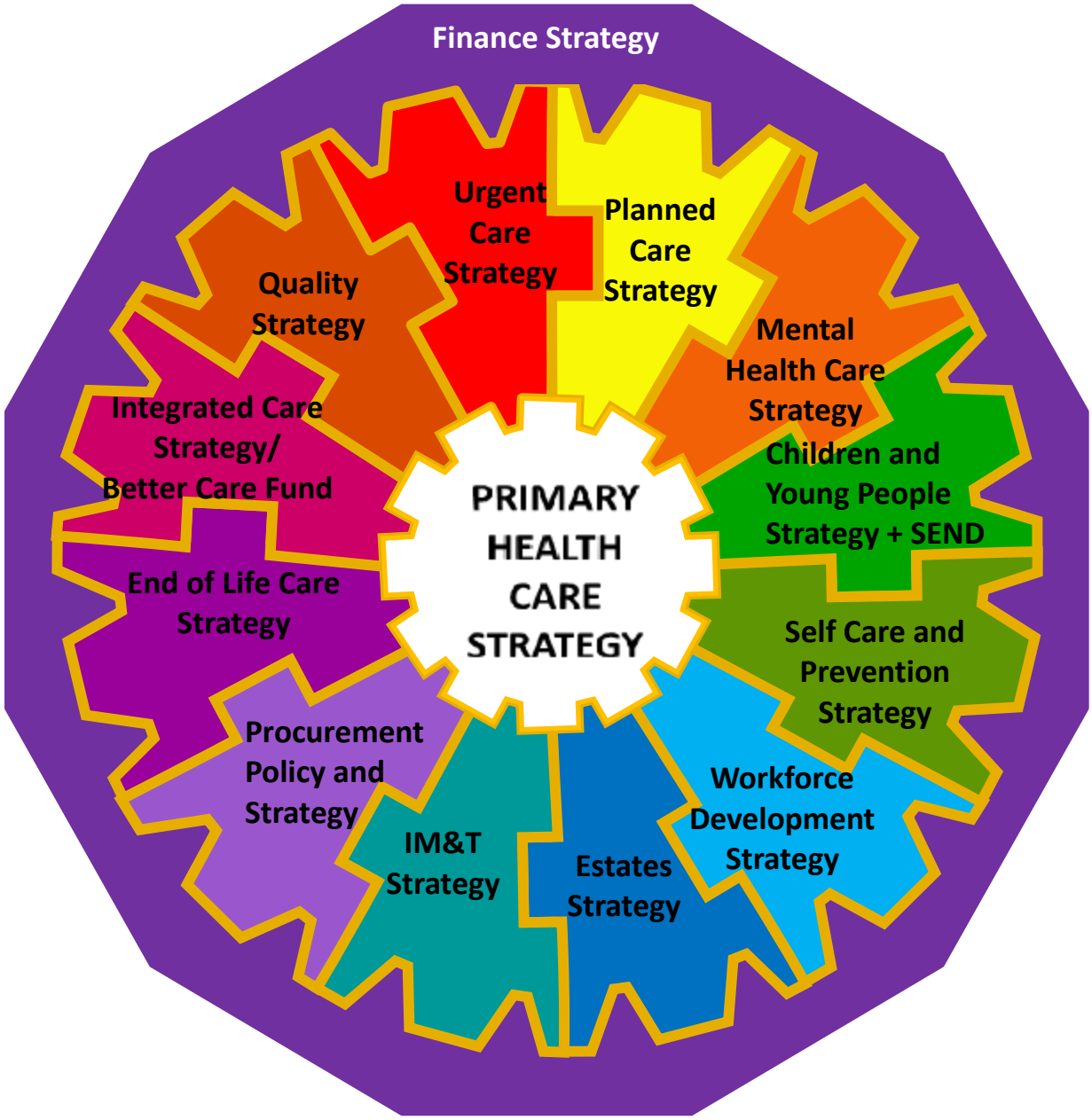

Wolverhampton CCG Primary Health Care Strategy 2016-2020

January 2016

Dr Margaret Chirgwin

As a living document the data/information in this document will be changing throughout implementation and the CCG will be monitoring this data throughout the life of the Strategy

Document revision history

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Document approval

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12/01/2016	Draft 2		Governing Body	In principle approval
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Contents

1. GLOSSARY

A&E	Accident and Emergency	**CQC**	Care Quality Commission
ACS	Ambulatory Care Sensitive	**CQUINs**	Commissioning for Quality and Innovation
ADQ	Average Daily Quantities	**CSP**	Commissioning Strategic Plan
AF	Atrial Fibrillation	**CSU**	Clinical Support Unit
APMS	Alternative Provider Medical Services	**CVD**	Cardiovascular Disease
AQP	Any Qualified Provider	**DC**	Day case
BCP	Black Country Partnership NHS Foundation Trust	**DES**	Directly Enhanced Scheme
BME	Black and Ethnic Minority	**DOS**	Directory of Services
BMI	Body Mass Index	**DQ**	Data Quality
BP	Blood Pressure	**DSX**	DSX Point of Care Software
BPAS	British Pregnancy Advisory Service	**DSR**	Directly Standardised rate
CAMHS	Child and Adolescent Mental Health Services	**ECG**	Electrocardiogram
C2C	Consultant to consultant	**EMIS**	Egton Medical Information Systems
CAPI	Computer-Assisted Personal Interviewing	**ENT**	Ear Nose and Throat
CBT	Cognitive Behavioural Therapy	**EOLC**	End of Life Care
CCG	Clinical Commissioning Group	**EPCS**	Extended Primary Care Services
CEG	Clinical Effectiveness Group	**EPS R2**	Electronic Prescribing Service Release 2
CHD	Coronary Heart Disease	**EU**	European Union
CHP/LIFTCo	Community Health Partnership	**FACET Survey**	Combination of 6 surveys
Co-op	Cooperative (not for profit)	**FM**	Facilities Maintenance
COPD	Chronic Obstructive Pulmonary Disease	**FTE**	Full Time Equivalent

GCSE	**General Certificate of Secondary Education**	**IT**	**Information Technology**
GIA	Gross Internal Area	**IV**	Intravenous
GMS	General Medical Services	**IVF**	In Vitro Fertilisation
GP	General Practitioner	**JCC**	Primary Care Joint Commissioning Committee
GP2GP	GP to GP notes transfer	**JSNA**	Joint Strategic Needs Assessment
GPHLI	GP High Level Indicators	**KPI**	Key Performance Indicators
GPOS	GP Outcome Standards	**LA**	Local Authority
GPwSI	General Practitioner with a Special Interest	**LAS**	London Ambulance Survey
HbA1C	Glycerated Haemoglobin	**LAT**	Local Area Team
HCA	Health Care Assistant	**LBW**	Low Birth Weight
Hib	Haemophilus b	**LES**	Local Enhanced Scheme
HIV	Human immunodeficiency virus	**LETB**	Local Education and Training Board
HMRC	Her Majesty's Revenue & Customs	**LIFT**	Local Improvement Finance Trust
HPV	Human papilloma virus	**LSOA**	Local Super Output Area
HSMR	Hospital Standard Mortality Ratio	**LSS**	Large Scale Strategy
ICT	Information and communications technology	**LTCs**	Long term Conditions
IFCC	International Federation of Clinical Chemistry	**Ltd**	Limited (for profit)
IM&T	Information Management and Technology	**MCP**	Multi-professional Community Provider
IMD	Index of Multiple Deprivation	**MH**	Mental Health
IP	In Patient	**MI**	Myocardia-Infarction (Heart Attack)

MRI	Magnetic resonance imaging	PCT	**Primary Care Trust**
MRSA	Methicillin-Resistant Staphylococcus Aureus	**PDQI**	Primary care data quality indicators
MSK	Musculoskeletal	**PHSO**	Parliamentary Health Service Ombudsman
NCB	National Commissioning Board	**PMS**	Personal Medical Services
NCMP	National Child Measurement Programme	**PPIG**	Practice and Performer Information Group
NE	North East	**PPV**	Pneumococcal Polysaccharide Vaccine
NELs	Non-Electives	**PROMS**	Patient Reported Outcome Measures
NHS	National Health Service	**QIPP**	Quality Innovation Productivity and Prevention
NICE	National Institute for Clinical Excellence	**QOF**	Quality Outcome Framework
NOAC	Novel Oral Anticoagulants	**QSG**	Quality Surveillance
NSAID	Non-steroidal Anti-Inflammatory Drugs	**NHSE**	National Health Service England
OBC	Outline Business Case	**NHSPS**	NHS Property Services
ONS	Office for National Statistics	**RAG**	Red Amber Green
OOH	Out of Hours	**RWT**	Royal Wolverhampton Hospitals NHS Trust
OP	Out Patient	**SDIPs**	Service Development and Improvement Plans
OPD	Out Patient Department	**SE**	South East
PACS	Primary and Acute Care System	**SEND**	Children and Young People with Special Education Needs and Disability
PAG	Primary Care Advisory Group	**SHMI**	Summary Hospital-level Mortality Indicator
PALS	Patient Advice and Liaison Service	**SLA**	Service Level Agreement

SMI	Severe Mental Illness	**TOPs**	**Termination of pregnancy**
SOM	Single Operating Model	**TOR**	Terms of Reference
Star-PU	Specific Therapeutic group Age-sex Related Prescribing Units	**u75**	Under 75 years old
SW	South West	**UCC**	Urgent Care Centre
TB	Tuberculosis	**UK**	United Kingdom
tbc	to be confirmed	**VTS**	Vocational Training Scheme
TDA	NHS Trust Development Authority	**WCC**	Wolverhampton City Council

2. Executive Summary

Why do we need a Primary Health Care Strategy? (pages 14-18) - health knowledge and technology is changing; the people we serve are changing; demands are changing and the workforce and some buildings are not fit for purpose. In response NHSE has developed the 5 Year Forward View which envisages a number of new models of care to which this Strategy is Wolverhampton CCG's response.

Our Vision for Primary Health Care in Wolverhampton (page 19) - to deliver universally accessible high quality out of hospital services that:

- promote the health and wellbeing of our local community
- ensure that our population receive the right treatment at the right time and in the right place
- reduce early death and improve the quality of life of those living with long term conditions; and
- reduce health inequalities

Treating Patients in the Community (pages 23-28) - from 2016-2021 the CCG will prioritise developing:

- General Practice Clinical Networks and Integrated Community Teams
- Self-Care – with WCC develop a balanced portfolio of self-care initiatives including managing short-term self-limiting ill-health and injury and self-care following discharge from hospital.
- Access to a range of standard primary medical services 8am to 8 pm 7 days a week through a combination of GP practice, Extended Hours and Out of Hours Services provision with full access to a patient's notes irrespective of how or where access occurs. This will include use of technology to develop a number of non-face-to-face consultations including emails and telephone triage of the majority of appointment requests

A range of Extended Primary Care Services that will provide more services closer to home

- GPs able to consult consultants using emails/texts/phone/advice and guidance/Skype
- A range of health and social care services that will support an individual to be treated at home or in a nursing home when previously they would have been treated in a hospital.
- A full range of support services to allow all those who wish to die at home to do so.
- **Refugees and Migrants** – services specifically tailored to this population
- **Looked After Children** – to ensure this population receives all necessary support
- **Children and Young People with Special Educational Needs and Disability Strategy** – support implementation of the strategy particularly at transition to adult health services
- **Young People** – primary care services tailored reduce unnecessary use of emergency and GP services

A range of Secondary Care Services being provided in a primary care setting

- Outreach of elderly care specialist services in the primary care setting including a patient's home and local residential care homes (already in place in nursing homes)
- Outreach of cardiology and respiratory specialist services in the primary care setting including a patient's home and local residential and nursing care homes (this is already in place for diabetes)

General Practices as Providers (pages 29-31)

- GP Clinical Networks covering 20-30,000 population with Community Teams wrapped around these networks
- The CCG will support the development of Federations/collaborations between practices that support practices with back office, CQC inspections, HR and other services they need to function to a high standard
- General Practices and Networks of General Practices as Extended Primary Care Service Providers – the CCG will support the development of local General Practices and Networks of General Practices to provide a wide range of services as close as possible to the patient. We will support Networks of GP Practices to achieve activity and access targets for their populations. We will purchase Extended Primary Care Services from General Practices using the National Standard Contract which allows sub-contracting of service provision to other providers.

Enablers

IT Infrastructure and capabilities (pages 31-33) – the CCG at present manages a delegated IT budget from NHSE to support IT for core GMS/PMS/APMS service provision. The CCG will identify an additional IT budget which in combination with the NHSE budget will provide training, software and hardware in support of this Strategy. The CCG IM&T Strategy focuses on supporting General Practices to improve patient experience, patient care, safety and access to information. The key IM&T priority to support this Strategy is full read-write compatibility between the patient record systems being used by all providers working in the community with a focus on GP practices, community services, OOH and the UCCs. Other IM&T priorities are Mobile Working, Patient Access, use of mobile phones, GP access to the Directory of Services (DOS), decision support services; and standardisation of templates and coding.

Workforce development (page 34) - the CCG will support the development of a comprehensive Workforce Strategy including programmes to recruit, train and retain workforce in Wolverhampton.

Estates development (pages 34) – the CCG will develop a comprehensive Health Services Estates Strategy that supports the Primary Health Care Strategy.

Specific Outputs/Outcomes from Implementing the Strategy (pages 35-36) – there are 12 defined outcomes: 2 for Access, 4 for Quality and 6 for the key Enablers.

Development of Member Practices as Commissioners (pages 37-41) - the CCG will invest in the development of the skills necessary in both its GP member practices and the CCG staff for Practices to be fully involved with the Governing Body, Locality Boards and in the review of present services and the development of new services. In particular there will be an investment in developing the 3 Locality Boards to take on increasing responsibility for the commissioning of services. How far this will develop will depend on regular review of progress and cost effectiveness. In particular this will depend on which new model of care the Member Practices choose.

Procurement of out of hospital services (pages 41-42) - the CCG's procurement policy focuses on achieving the best services for the patients in terms of quality and cost effectiveness. For each new service to be provided in an out of hospital setting the Commissioning Committee will consider the procurement route options.

Working with our Stakeholder (pages 42-43) – the CCG involved members of the public, local PPGs and the voluntary sector in the development of the outcomes of this strategy. We will report regularly against these to all participation forums. Patients will be represented in the process to develop new out of hospital care pathways that the Strategy supports. The Health and Wellbeing Board, Health Scrutiny Committee, Healthwatch, NHSE, WCC and other relevant third sector organisations will be kept informed and involved as the Strategy is implemented.

Contract and Performance Management (pages 44-47)

- Co-commissioning and delegated commissioning of Primary Medical Services -the CCG will work with the NHSE Area Team to ensure the smooth transition of contract management to the CCG and to ensure practices are supported to develop new ways of working with all patients having equal access to these services
- The CCG will use the National Standard Contract with all out-of-hospital service providers including General Practices. All service specifications will clearly state the staff skills and equipment requirements that must be met to provide the service. Prices will be explicit about how it has been calculated. Subcontracting to another Wolverhampton General Practice will be allowed as long as there is full access to the patient notes.
- A performance management system will be put in place following the processes defined in the National Standard Contract and the CCG Quality and Patient Safety Strategy. There will be quarterly Quality and Activity Performance Management meetings at the level of the 9 Clinical Networks. It is hoped that these meetings will, by the end of the Strategy period, cover all contracts held by General Practices i.e. the core GMS/PMS/APMS contract, the NHS Standard contracts and those held by Public Health.
- At these meetings the CCG will provide quality and activity performance data and facilitate Practices as providers to discuss and agree what they need to do as individual providers to reduce any validated quality variations and to develop and manage sub-contracting within the Clinical Network. For those practices that NHSE, the CCG and/or Public Health have serious concerns about the CCG's Quality and Patient Safety Strategy Trigger & Escalation Model will apply.

Implementation Plan (pages 48-51) – this establishes an Implementation project with the following deliverables over the 5 years:

I. Functional Clinical Networks covering 20-30,000 population with Community Services wrapped around these Networks
II. Single clinical system for most out of hospital services. Aspiration is for all GP practices, OOH, UCC, Rapid Response, DNs, virtual wards, hospital at home
III. Effective support service provided to the practices covering, quality and contract requirements, IM&T, Estates, Workforce and back office
IV. Effective contract management ensuring high quality of service provision
V. Increased range of services available through general practice to all patients registered with Wolverhampton GPs
VI. Increased cost effectiveness of service provision
VII. Member practices highly satisfied with the way the CCG is commissioning services for their population
VIII. CCG Organisation Structure and Staffing recognises the Primary Health Care Strategy change programme and also integration into standard operations

Investment Plan (page 51) – this will support implementation of the strategy.

3. Introduction

3.1. A definition of Primary Health Care

The World Health Organization (WHO) Alma-Ata declaration of 1978 defined primary health care as:

> *Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.*
>
> *It forms an integral part both of the country's health system,* ***of which it is the central function and main focus****, and of the overall social and economic development of the community.* ***It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.***[1]

Though written over 30 years ago this remains a good definition of Primary Health Care.

For the purposes of this Primary Health Care Strategy ***Primary Health Care*** will include all non-specialist health care provided outside of hospitals but not those health services in the community that are commissioned by other parts of the system and for which the CCG has no responsibility. In particular: community pharmacists, opticians and dentists but also those services purchased by WCC Public Health and NHSE that are not purchased from General Practices.

3.2. General Practice

The European Definition of General Practice/Family Medicine was used to develop the competences that the RCGP 2006 General Practitioner curriculum develops and as such is the best available definition of General Practice in the UK. The contracts that GPs hold with the NHS all rely on these competencies but are regularly changing and themselves cannot be used as a definition of General Practice. In England General Practice:

- is available to all the English population through registration at a practice which means that the individual becomes part of the practice list. The services an individual receives directly from the practice are therefore often referred to as “list based” services. As

[1] World Health Organization, 1978. Declaration of Alma Ata, International conference on PHC, *Alma-Ata*, USSR, 6-12 September, available from: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (accessed June 2009).

General Practices develop and form new structures they will continue to hold lists. For clarity, throughout this document any new grouping of practices providing Extended Primary Care Services to those on their lists will be called Groups of General Practices.

- is normally the point of first medical contact within the healthcare system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned
- makes efficient use of healthcare resources through co-ordinating care, working with other professionals in the primary care setting, and by managing the interface with other specialities. It also means taking on an advocacy role for the patient when needed
- develops a person-centred approach, orientated to individuals, their family, and their community
- has a unique consultation process, which establishes a relationship over time through effective communication between doctor and patient
- is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient
- has a specific decision-making process determined by the prevalence and incidence of illness in the community
- manages simultaneously both the acute and chronic health problems of individual patients
- manages illness which presents in an undifferentiated way at an early stage in its development, some of which may require urgent intervention
- promotes health and well-being by both appropriate and effective intervention
- has a specific responsibility for the health of the community
- deals with health problems in their physical, psychological, social, cultural and existential dimensions.

3.3. Why does Wolverhampton CCG need a Primary Health Care Strategy?

In general terms the NHS in England needs to change in response to a number of factors:

- Changes in health knowledge and technology
    - So much more can now be done than when the NHS was established. The structure and function of the different parts of the NHS system was set up in a very different technological age without computers, transplantation, clot busting drugs and the pill

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- Changes in the people the NHS serves

    1. The age profile of the population of England is changing with a projected massive increase in the percentage of the population over the age of 65, 75 and 85 in the next 30 years

    2. Increasing levels of obesity, lack of exercise and alcohol but less smoking

    3. Patterns of disease are changing with less infections and more time spent living with a disease such as diabetes or high blood pressure

- Changes in demand

    1. Individual expectations are changing with most patients expecting more involvement in decisions about their health and more understanding of their options

    2. Patients wish to have a choice about when and where they are treated and about who will provide their care (this is not universally the case. Its importance varies with the kind of care being provided. For some kinds of care it is not important if quality is guaranteed)

    3. How individuals want to use the service is changing with a greater demand for immediate access to services and increasing expectations that access may not need to be face to face. Thus increasing use of texts, email, phone and on line

- Workforce challenges

    - The workforce was developed for a service which was structured differently and functioned very differently. Many GPs are now approaching retirement whilst the new generation has a different expectation of how they will work (a reduction in GP partners and an increase in salaried GPs of particular note)

- Premises Challenge

    - Many GP premises were developed from residential housing and are simply unable to expand any further causing a problem for developing 21st century health care

- Funding Gap

    - NHS England predicts a minimum of £16 billion and a maximum of £30 billion shortfall by 2020.

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3.4. The 5 Year Forward View

The Policy Environment laid out in the 5 Year Forward View is an additional reason for Wolverhampton CCG to realise a Primary Health Care Strategy. In particular the 5 Year Forward View puts forwards a response to the problems in 3.3 above and generates some additional priorities. In particular it prioritises:

- Care Closer to Home; and
- 7 day services.

The 5 Year Forward View proposes a number of possible ways for services to develop in response to these pressures, three of which are relevant to primary care and thus this Strategy.

1. **New Model of Care - Multi Speciality Community Providers (MCP)** will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients. To offer this wider scope of services, and enable new ways of delivering care, NHSE will make it possible for extended group practices to form – either as federations, networks or single organisations. These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.

   This is seen as "horizontal integration".

   Over time, these providers might take on delegated responsibility for managing NHS budgets (or combined health and social care budgets) for their registered patients very similar to the accountable care model below.

2. **New Model of Care - Primary and acute care systems (PACS)** would provide list-based GP and hospital services, together with mental health and community care, in a single NHS organisation for the first time. They could evolve in different ways, for example, by hospital trusts opening their own GP surgeries. In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.

   At their most radical, PACS would take accountability for the all the health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

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This is seen as “vertical integration”.

3. **New Model of Care - Enhanced health in care homes** - in partnership with local authority social services departments, and using the opportunity created by the establishment of the Better Care Fund, NHSE will work with the NHS locally and the care home sector to develop new shared models of in-reach support, including medical reviews, medication reviews, and rehab services. In doing so we will build on the success of models which have been shown to improve quality of life, reduce hospital bed use by a third, and save significantly more than they cost.

   The 5 Year Froward View includes 4 other “new models of care” that are of less relevance to the Primary Care Strategy but still need to be understood as they will impact on primary care. These are:

   a. New Model of Care - Urgent and emergency care networks which aim to provide better integration between A&E departments and other services that provide and support urgent treatments. Changes include the development of hospital networks with access to specialist centres, new partnership options for smaller hospitals and greater use of pharmacists and out-of-hours GP services.

   b. New Model of Care - Acute care collaborations which will ensure the viability of smaller acute hospitals. These may include the formation of ‘hospital chains’ as operated in Germany and Scandinavia, or some services being offered by specialised providers on satellite sites. To complement these models, NHS England and Monitor will examine new approaches to medical staffing, and other ways for smaller hospitals to achieve sustainable cost structures

   c. New Model of Care - Specialised care - new models will develop where there is strong evidence for concentrating care in specialist centres (as in stroke or some cancer services); the NHS England will seek to drive consolidation through a programme of three-year rolling reviews. The establishment of specialist centres for rare diseases will also be considered to improve the coordination of care for patients. As part of this new care model, specialised providers will be encouraged to develop networks of services over a wider area, integrating different organisations and services around patient need

   d. Modern maternity services new model of care - a review of future models for maternity units will recommend how best to sustain and develop maternity units across the NHS in England. NHS leaders have also pledged to make it easier for groups of midwives to set up

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their own NHS-funded midwifery services, and to ensure that tariff-based funding supports patient choices.

Wolverhampton has its own local mix of these national issues and needs to respond to the 5 Year Forward View.

This strategy is the CCG's response to these challenges.

3.5. This strategy states:

1. The CCG's Vision and Aims and the planned overarching outcomes we expect from implementing this Primary Health Care Strategy over the next 5 years
2. Where we are now
3. Treating People in the Community - the Services we plan to develop over the next 5 years to provide treatment closer to home
4. Our vision of General Practices as Providers including our response to the New Models of Care in the 5 Year Forward View. This includes sections on:
    a. 9 Clinical Networks
    b. Non-clinical support groups - Federations/collaborations
    c. GP IT
    d. Workforce
    e. Estates
    f. Specific primary care outputs/outcomes we expect from implementing this Primary Health Care Strategy over the next 5 years
5. Our vision of General Practices as Commissioners
6. Procurement - how we plan to procure services to provide treatment in the community
7. Working with our stakeholders - how we will work with our population, NHSE, WCC and local providers to a) develop and manage providers; and b) develop new services.
8. Contract Management - how we plan to contract and performance manage these services including co-commissioning
9. A Strategy Implementation plan
    a. How we will support development of General Practices as Providers including sections on:
        i. Networks

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ii. Co- and Delegated Commissioning

iii. GP IT

iv. Estates

v. Workforce

vi. Contract and performance management (GMS/AMPS, EPCSs and PH)

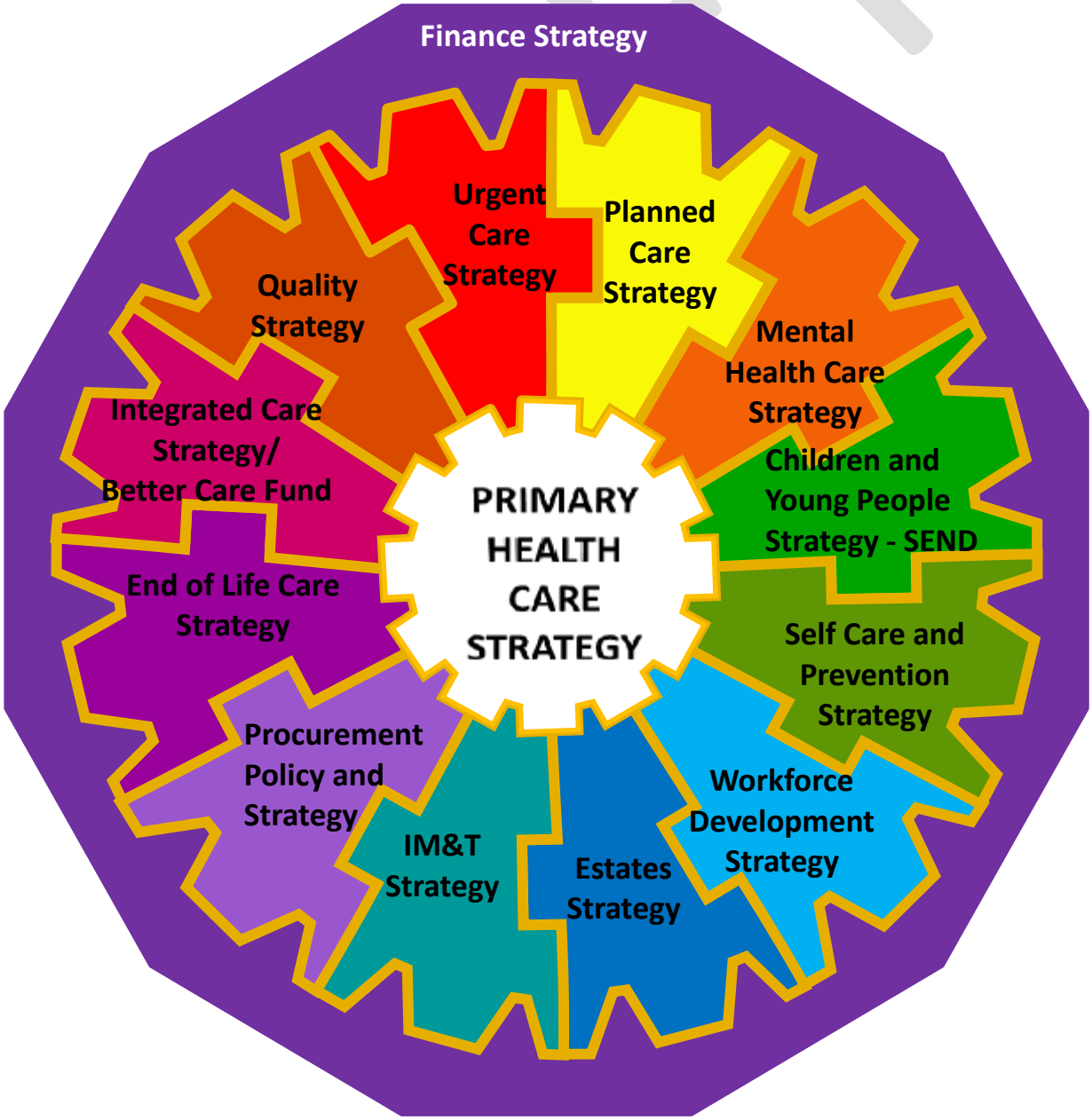
b. How we will develop more out of hospital services

c. How we will support the development of General Practices as Commissioners

10. A Strategy Investment plan to support the implementation of the Strategy

4. Wolverhampton CCG's Vision

Wolverhampton CCG's Vision is for **the right care at the right place at the right time for all of our population**. Our patients will experience seamless care, integrated around their needs, and they will live longer with improved quality of life.



This vision and these outcomes are for the whole health system and all the work of the CCG is committed to achieving this vision.

We aim to:

- Reduce the years of life lost from causes amenable to health care by 13.5% over 5 years to 1,985 by 2020 (Baseline 2013: 2361; Targets 2015/16: 2295; 2015/17: 2250)[2]
- Reduce the gap in life expectancy between wards by 10% by 2020. Male 7.9 years and Female 5.3 years (Baseline 2010-12 Male 8.8 years, Female 5.9 years)
- Reduce the gap in healthy life expectancy at birth between Wolverhampton men and women and the national average by 10% by 2020. Male 6 years and Female 4.6 years (Baseline 2011-13 Male 6.7 years, Female 5.1 years)
- Remain within the allocated CCG budget each year of the strategy.

5. Where we are now[3]

5.1. The Population and Health Outcomes

Estimated population	252,900 (290,470 at 2011 census) 265,636 (GP practice population April 2015)
Age distribution	• Average age: 39 (close to the average for England) • High proportion of under 19s
Ethnic background	• White: 68% (with a growing population from Eastern Europe) • BME: 32% (higher than the national average of 14.3%)
Population growth	• High number of new arrivals (e.g. 2700 traveller families in 2012) • Number of children (0-15) projected to increase from 50,000 in 2012 to 54,300 in 2037 - 8.6% growth • Number of people aged 65 or older is projected to grow from 41,400 in 2012 to 59,900 in 2037 - 44.7% growth • Number aged people aged 85 or older is projected to grow from 5,800 in 2012 to 12,000 in 2037 - 106.9% growth
Life expectancy	Based on 2010-12 figures: both 2 years less than national average • Males: 77.4 years • Females: 81.7 years
Quality of life	• Males: 58 years (3 years lower than national average) • Females: 61 years (2 years lower than national average)

[2] WCCG Operating Plan 2015-17

[3] More details can be found in Appendix B.

Deprivation	• 21st most deprived local authority and expected to worsen • 51.1% of population amongst the 20% most deprived nationally • Most deprived: North East Wolverhampton • Least deprived: South East Wolverhampton Life expectancy gap between the most and the last deprived: • Males: 7 years • Females: 3 years
Morbidity	27.27% suffer from one or more LTC • Single greatest cause of years of life lost – infant mortality • Second greatest cause – cardiovascular disease
Infant mortality	6.8. per 1,000 live births (one of the highest in England. Was 7.7 in 2010-12 which was highest in England). England average 4.0

5.2. The CCG

The CCG is responsible for spending almost £1m a day on healthcare for the city's 266,000 registered patients. The CCG Commissions everything from emergency/A&E care, routine operations, community clinics, health tests and checks, nursing homes, mental health and learning disability services.

2015-16 Annual Spending Plan

Acute Services	174,000	39.83%
Mental Health Services	32,531	7.45%
Community Services	33,107	7.58%
Continuing Care/FNC	13,198	3.02%
Prescribing	46,976	10.75%
Quality/LAC	2,771	0.63%
GP Enhanced Services	819	0.19%
Other programme	20,722	4.74%
Total Programme	**324,124**	**74.20%**
Running Costs	5,556	1.27%
Reserves	4,830	1.11%
Total Mandate Spend	**334,510**	**76.58%**
NHSE portfolio – primary care spend	33,552	7.68%
Specialist spending	68,761	15.74%
Grand Total	**436,823**	**100.00%**

Wolverhampton CCG has 46 member GP practices. The full list is in Appendix A. These have been grouped into three Localities:

	Locality	Number of Practices	2014/15 Population ONS (Carr Hill weighted)
1	South West	14	90,657 (91,899)
2	South East	16	82,124 (84,016)
3	North East	16	92,855 (93,197)
	TOTAL	**46**	**265,636 (269,112)**

5.3. The Services

The CCG and NHSE purchase primary and enhanced primary care services from the 46 General Practices in Wolverhampton.

	2015/16 Budget		Forecast Outturn as at M8	
	Recurrent £'000	Non Recurrent £'000	Recurrent £'000	Non Recurrent £'000 (u)/o
Primary Care services within CCG portfolio				
Prescribing	45,958		45,959	-1,072
Prescribing Incentive schemes	250		250	
Prescribing Advisors	653		653	
Scriptswitch	114		114	
Enhanced Services	819		804	-47
GPIT		832		832
Sub Total - CCG portfolio	**47,794**	**832**	**47,780**	**-287**
Primary Care services within NHSE portfolio				
General Practice - APMS	2,820		2,820	
General Practice - GMS	18,408		18,408	
General Practice - PMS	1,713		1,713	
QOF	3,414		3,414	
Enhanced Service	1,732		1,732	
Dispensing/Prescribing Fees	223		223	
Premises Costs reimbursements	2,677		2,677	
Other Premises	31		31	
Other GP services	921		921	
PMS Premium	128		128	
1% Non-Recurrent transformation Fund	324		324	
0.5% Contingency	149		149	
0.6% Reserve	180		180	
Sub Total -NHSE portfolio	**32,720**		**32,720**	
GRAND TOTAL	**80,514**	**832**	**80,500**	**-287**

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In addition the following provide primary health care services in Wolverhampton:

- RWT – Community Services
- OOH – Wolverhampton Drs on Call then Northern Doctors Urgent Care Ltd (from April 2016)
- 111 – at present being provided on an interim basis by Vocare trading as West Midlands Doctors Urgent Care Service
- WICs/UCC – Showell Park APMS until end March 2016 and RWT at the Phoenix Centre
- Compton Hospice

5.4. The Service Users

The two key issues for the population are:

1. Easy access to **urgent GP services** 24 hours a day 7 days a week – different individuals wanting this provided in different ways but the key themes were urgent and preferably with a GP who has access to information about their health problems; and
2. **Less urgent access** to as wide a range of services as possible close to home – with this access being as equal as possible for all – debate on when these less urgent services should be available – different for different patient groups – and questions on what the NHS can afford and if there are enough staff to provide it.

Most of those who attended the public participation event for this strategy wanted more less-urgent appointments to be available during normal working hours rather than extended hours or weekends but recognised that other age groups might want increased appointments at other times.

6. Treating People in the Community

The Vision of this Strategy is to ensure the building blocks are in place to allow the provision of high quality accessible primary medical services, extended primary care and secondary care provided in a primary care setting. The CCG has a number of Strategies, all of which need services to change and develop in General Practice. The Primary Health Care Strategy therefore supports the implementation of these Strategies with a focus on the Primary Care developments required to support system transformation.

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The sections below give an idea of the kind of services that we expect to be providing outside the hospital setting by 2020. The building blocks (physical infrastructure, provider organisations and commissioning and provider skills and expertise) will take time to develop and the movement of services from their present setting to closer to the patient's home or at least commissioned by the CCG using new contracting options will be progressive. No big bang is planned. The CCG will encourage and support natural growth of the types of providers we believe are needed.

Out of Hospital Services may be provided by:

- individual General Practices
- Networks of General Practices
- a Grouping of all General Practices in Wolverhampton

- pharmacists
- optometrists
- RWT - acute
- RWT – community
- Any NHS or non-NHS health care organisation
- third sector organisations
- AQP

6.1. General Practice Clinical Networks and Integrated Community Teams

The most important initial development is of Community Teams wrapped around the Networks of General practices serving a population of 20-30,000. The Vision is that these teams will be providing most of the community services required by this population 7 days a week but will be supported by more specialist teams such as the Falls or Tissue Viability Service and Out of Hours community services such as Out of Hours District Nursing and End of Life Care 24/7 support services. It is proposed that there will be 9 Teams, roughly 3 per Locality, and the Teams will serve the population served by the practices wherever they live in Wolverhampton or a short distance into other areas.

6.2. Self-Care

Our Vision for Self-Care is an empowered population equipped with the knowledge and motivation to self-care. A population with greater confidence to look after themselves: knowing when it's safe to self-care, when professional help is needed and from where is should be sought.

Self-care includes: primal (pre-conception), primary (pre-disease), secondary (early disease) and tertiary prevention (late disease); management of minor illness and injury; and self-care following discharge from hospital. Wolverhampton Public Health has a 5 year prevention strategy: *Improving Lifestyle Choices 2015-2020* which is focussed on primary and secondary prevention but is less focussed on other aspects of Self-care – in particular managing short term self-limiting ill-health and injury and self-care following discharge from hospital.

The CCG will work with WCC Public Health to implement their Improving Life Style Choices Strategy but also to develop and implement activities across the whole Self-care agenda.

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Implementation will be phased over the 5 years with the focus being on having a balanced and coordinated portfolio of self-care interventions across the CCG and WCC.

Improvements in Self-care will be monitored through improvements in a set of Outcome Framework measures, a decrease in health inequalities and a decrease in the growth of NELs for LTCs, A&E and UCC activity.

6.3. Primary Medical Services

Access to a full range of standard primary medical services during the core working hours and to essential services 24 hours 7 days a week, through a combination of GP practice, Extended Hours and Out of Hours Services provision with full access to a patient's notes irrespective of how or where access occurs. This will include development of a range of non-face-to-face consultations (including Skype and email consultations) and the option of a telephone appointment for the majority of appointment requests.

The intention is to ensure that a full range of services is available to all patients irrespective of whether they are registered with a PMS, GMS or APMS practice.

6.4. Extended Primary Care Services

We will work to develop new models of care around primary care and encourage the innovative use of technologies such as emails/texts/phone/advice and guidance/Skype to:

- Support an individual to be treated at home or in a nursing home when previously they would have been treated in a hospital. This may include increasing rapid access to investigations to avoid the admission.
- Increase the palliative care services available to those who wish to die at their place of choice
- Optimise the health and social care of people with Long Term Conditions
    - diabetes (already well developed but further development of the service specification will be required),
    - CVD (AF diagnosis, warfarinisation and NOACs, hypertension, heart failure and stroke, cardiac rehab following MI)
    - COPD
- Optimise the health and social care of those with ambulatory care conditions
- Optimise the health and social care of the frail elderly.

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6.5. Refugees and Migrants

This population has particular health needs and presents particular challenges to the local health services. They require more than the services provided through a standard primary medical services contract in particular because their English is often very limited and their understanding of the NHS equally limited but also because they have not had access to effective health care or have experienced particular health stresses before arriving in the UK.

The CCG will work with NHSE, local practices and Public Health to develop a model of General Practice and extended service provision to meet this population's specific needs.

6.6. Looked After Children

This group of children is known to be poorly served by the mainstream NHS services because they move around. The CCG is committed to ensuring that these children are recognised and their health care prioritised. The CCG will work with local practices to ensure that:

- there is GP-GP notes transfer;
- a GP System (EMIS or other) template completed annually to be included in these children's statutory annual health review (undertaken by specialised nurses); and
- there is a flag on the GP system for Looked After Children as well as At Risk Children.

6.7. Children and Young People with Special Education Needs and Disability (SEND) Strategy implementation

A Special Educational Needs and Disability (SEND) Strategy has recently been developed by the Wolverhampton SEND Partnership Board. This outlines the commitment from partners in education, health and social care to make sure that disabled children and young people get the same life chances as children who do not have a disability. As with Looked After Children it has been recognised that at the moment this is not the case. The CCG is committed during the life of this strategy to improving the primary health care services for this population with a particular focus on the transition to adult services when the role of the General practitioner often will need to increase significantly.

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6.8. Young People

We know that young people use health services differently from their parents but lack a clear picture in Wolverhampton of how they understand and use the NHS. In particular it is believed that they use urgent services when self-care or General Practice would be more appropriate. During the life of this strategy the CCG will work with local young people to:

- find out what they know about the NHS and how they would like to access General Practice;
- develop an education/information strategy for Wolverhampton young people that encourages self-care as well as the use of pharmacists and their GP rather than walk-in centres or A&E; and
- develop primary care services and forms of access to these services that meet their real needs with a particular focus on increasing mental health services in the community.

6.9. Secondary (specialist) care to be provided in a primary care setting

There are already on-going developments in this area using both consultants and GPs with special interest. Pathways with the fewest possible interfaces between providers will be commissioned for those with long -term conditions and the frail elderly.

The priorities for 2016-20 will be to:

- Further develop outreach of elderly care specialist services in the primary care setting including a patient's home and local nursing homes
- Continue outreach of diabetology specialist services in the primary care setting including a patient's home and local nursing homes
- Improve outreach of cardiology specialist services in the primary care setting including a patient's home and local nursing homes
- Improve outreach of respiratory specialist services in the primary care setting including a patient's home and local nursing homes

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7. Our Vision of General Practices as Providers

In 5 Years' time it is envisaged that General Practices, as providers, will be:

- Providing a cradle to grave prevention (primary, secondary and tertiary) and treatment service with the GP as the named and accountable clinician for his or her patients i.e. the GP will be the key to the effective integration of an individual's care
- Ensuring continuity of an individual's care
- Working with neighbouring practices in Networks covering populations of 20-30,000 to provide a wider range of services to their registered populations than would be possible as individual practices
- Ensuring their patients have access to high quality essential services 7 days a week through these Networks.
- Working in an equal partnership with patients, their families and carers with each contact empowering the patient and their family and carers to manage their health and make informed choices about their care
- Accessing a wide variety of other skilled workers to support the GPs in providing holistic and integrated care to their patients – in particular a Core identifiable community team will be providing services to each of the Networks 7 days a week
- Proactively identifying those at risk of ill-health
- Diagnosing and managing the risk factors for long term conditions and the long term conditions over the patient's life time and through the course of the disease with support from secondary care experts
- Managing as much ill-health as possible outside of hospital and using technology where appropriate to facilitate this
- Accessing secondary care expertise to support a patient's care without needing the patient to visit the hospital except when this is the best place for the care to be provided
- Working in collaboration with social care and the voluntary sector
- Using a single patient record and, with the patient's consent, sharing relevant parts of this record with all local health and social care providers who will be able to add information directly to the patient record

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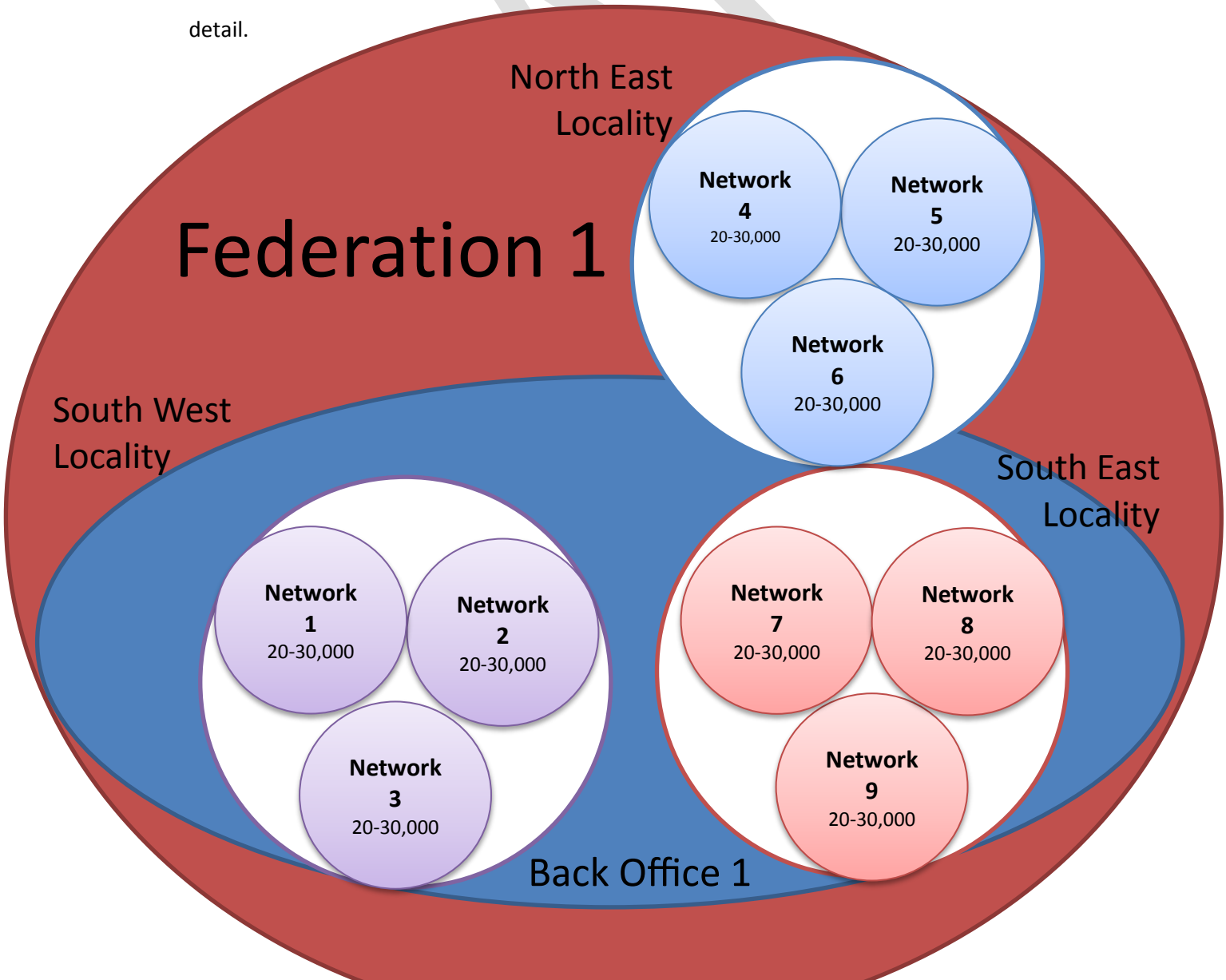
7.1. General Practice Clinical Networks

The vision above involves Networks of practices covering 20-30,000 focused on clinical service provision for the defined population. The CCG believes that the process of developing these clinical networks will encourage relationships of trust and mutual respect and learning to develop between practices. As the CCG purchases an increasing range of Extended Primary Care Services from practices this will also generate opportunities to share resources and reduce duplication of effort.

7.2. General Practice non-clinical collaborations

Within the 5 years of this Strategy it is expected that a number of practices will be choosing to share back office activities such as purchasing of supplies and HR support and be able together to reduce the unit cost and management time required for individual practices.

The footprint of these collaborations may be smaller than the Clinical Networks or for some activities cover all Wolverhampton practices. What is included in these support services and how they are structured will develop over the life of the Strategy. Appendix C provides more detail.



7.3. General Practices and Networks of General Practices as Extended Primary Care Services Providers

There will be legally enforceable contracts between the CCG as the commissioner and each of our 46 local General Practices who choose to provide these Extended Primary Care Services. The service specifications will clearly define the quality and activity requirements of the contract. Performance against these will be monitored by the contracting team and actions taken as defined in the contract.

There will be two possible kinds of providers of Extended Primary Care Services: 1) GP Practices and 2) groupings of GP Practices into Networks of some kind. Networks will not hold the patient lists so the CCG plans to purchase these services from all 46 practices. If a service is not limited to a list based provider a competitive tendering process will need to be undertaken.

There is much on-going debate as to what is the ideal model for groupings of practices and national and local evidence is lacking as to which structure and contracting will work best. As noted above the 5 Year Forward View has put forward 2 possible New Models of Care - PACS which are a form of vertical integration with Acute providers and MCPs which are a form of horizontal integration with GP practice and community providers coming together in a single organisation. The CCG has committed itself in its Annual Operating Plan for 2015/16 to developing towards an MCP New Model of Care. It is noted that a small number of the CCG practices are exploring vertical integration.

GP Practices themselves come in a number of forms and with great variation in size with the smallest in Wolverhampton having 1,733 patients and the largest 13,763 with the average practice having 5,245 patients. What is clear is that the pressure on practices is ever increasing and that small practices will have much greater difficulty providing long opening hours such as the suggested 8.00-20.00hrs 7 days a week**.**

Therefore the CCG will support practices to work together to share capacity, specialist skills and facilities to ensure all services are universally available to patients on every practice's list**.**

The payment structure and local tariff will be developed based on actual local cost to provide the service.

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7.4. IT infrastructure and capabilities

The CCG has an IM&T Strategy 2014-2017 which:

"aims to link IT development into the CCG's overall objectives and details the governance arrangements underpinning further investment in IT. The Strategy argues that the implementation of the IT systems it describes is a critical factor in improving efficiency and patient safety and underpins the overall strategy of the CCG.

3.1 Vision

To provide support to the CCG and GP Practices in Wolverhampton, to improve patient experience, patient care, safety and access to information within Wolverhampton, through the deployment of new digital technologies, information systems, world-class IT infrastructure and IT support to Wolverhampton CCG. The CCG will support improved patient outcomes through the delivery of NHS initiatives such as "The Power of Information" and the Better Care Fund."[4]

The key IM&T priorities for the Primary Health Care Strategy are:

1. **An integrated patient record that enables practices to provide a full GP service within the Networks covering a population of 20-30,000.** For a practice to provide a service on behalf of another practice in the Network there will need to be access to the complete GP record so the service in the provider practice can be the same as if the patient's practice was providing the service.

   This will ideally require all practices in a Network to be using the same GP system as full read-write compatibility between different GP systems is still some way off. In addition there will be data sharing agreements between practices for the particular service that is being sub-contracted and the patient will be asked to give consent for the sharing when the service is being offered and during a consultation at the sub-contracting practice.

   Therefore the CCG's vision is for all practices to be using a single system which will improve inter-provider working.

[4] Wolverhampton CCG IM&T Three Year Strategy 2014-2017 page 9

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The CCG's Vision is for as many providers as possible to be encouraged and when possible (for new services) to have a patient record system that is fully (coded and un-coded data) read-write compatible with the GP's patient record system. Key services initially will be those provided by clinicians in the community. The core community team wrapped around the practices should be using a mobile form of such a system as soon as practically possible

2. **Mobile working** – the CCG will work towards mobile technology being available to all service providers working in community settings.
3. **Patient Access** – throughout the life of this Strategy the CCG will support the increased use of IT solutions to access. Initially this will be supporting patients to access their notes online, to book appointments on line and to request their repeat prescriptions on line. This may progress to the use of email and Skype consultations for some patients.
4. **Mobile phones** – will be prioritised as a communication tool with patients. Clearly this does not work for all patients but most people have access to a mobile phone. The CCG's Vision is for a wide variety of information being provided to patients on their mobile phone this will include:
    - Appointment reminders which will reduce DNAs
    - Friends and Family Test questions after an appointment
    - Call and recall activities for targeted patient groups – e.g. those who should have a flu jab, health check or whose last blood test or BP result showed their Long term condition to not be as well controlled as we would like etc. etc.
    - General health messages such as "you do not need to see a doctor to get paracetamol for your child", "keep warm in winter" etc. etc.
    - Availability of texting and health app solutions.
5. **Ensuring GPs and other practice staff have easily accessible information on local services, particularly third sector services –** this will be based on the Directory of Services (DOS) used by 111 with information being provided about those services that are close to the practice
6. **Appropriate Primary Care decision support tools and capabilities** that allows them to pick up their patients as soon as they are discharged, to identify those who are at high risk of an admission and to identify cohorts of patients for targeted interventions such as health checks.

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7. **Standardisation of templates and coding** for use when providing services purchased by the CCG and other commissioners.

7.5. Workforce Development

NHS Workforce planning and development has a difficult job ensuring the right clinicians with the right skills are available in the right quantity in the right place as there is a long lag time between starting training and having a fully qualified clinician. As highlighted in Section 4 of this strategy Wolverhampton is short of all types of health care professionals and unfortunately this is a nationwide problem.

The Vision is to have a fully developed Workforce Strategy which will include:

1) Baseline and annually updated Primary Health Care workforce training requirements;
2) A comprehensive training and development programme for present staff to ensure accreditation is developed and maintained for all services purchased from General Practice;
3) A programme to recruit individuals from Wolverhampton where possible, i.e. those most likely to remain in Wolverhampton;
4) A programme to recruit individuals from Wolverhampton where possible and train them locally as HCAs and practices nurses;
5) A programme to encourage and support those living in the area with suitable qualification but not working or only working part time to return to work/increase their working hours; and
6) A programme to attract trainees and fully trained professionals to work in Wolverhampton.

There are a number of NHS bodies that have responsibilities and resources for on-going professional development as well as the initial training of the different health professions and the CCG will be working closely with these organisations to access these resources to benefit Wolverhampton as much as possible.

7.6. Estates

Wolverhampton CCG has undertaken a baseline survey of local health service estate to identify the state of all facilities and vacant estate which will be developed into an Estates Strategy to support the Primary Health Care Strategy early in 2016.

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7.7. Specific Outputs/Outcomes from implementing the Primary Health Care Strategy

	Outcome measure	Baseline 2016	By March 2017	By March 2018	By March 2019	By March 2020	By March 2021
Access							
1	% of Wolverhampton practice population able to access Primary Health Care Advice from a clinician who has full access to their notes within 4 hours 24 hours a day (i.e. through OOH or their practice)	0%					
2	% of consultations provided face to face		reduced	reduced	reduced	reduced	reduced
Quality – CCG Outcome Framework Measures							
3	Proportion of people feeling supported to manage their condition England average 64.4%	July 14-March 15 61.5%					
4	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) per 100,000 of population (indirectly standardised) England average 808.5	April 2014-March 2015 1,068.7					
5	Unplanned hospitalisations for asthma, diabetes and epilepsy in under 19s per 100,000 of population (indirectly standardised) England Average 326.7	April 2014-March 2015 679.4					
6	Emergency admissions for acute conditions that should not usually require hospital admission per 100,000 of population (indirectly standardised) England average 1,272.4	April 2014 – March 2015 1,798.3					

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Enablers							
7	Percentage of CCG budget spent on out of hospital services						
8	% of community service specifications reviewed and approved	0%	50%	75%	100%		
9	Number of providers using a patient records system for recording all patient contact activity, which are live read write compatible. This must include the ability to import coded and un-coded data between the systems and have a clinical governance compliant patient consent control system.	36 GP Practices					
10	Increase in total FTE clinical staff employed in General Practice: FTE GPs FTE Practice nurses FTE HCAs FTE Practice Pharmacists FTE Physician's Assistants	2015 162.5 55.5					
11	Number of GP Premises in the with category C in any of the 5 facets (Operational – requires capital investment)	2015 40/59					
12	How involved, if at all, do you feel you are in your CCG's decision making process? (from annual NHSE 360 – Member Practice question)	2014 47% 2015 55%					

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8. Our Vision of Member General Practices as Commissioners

Our Mission:

> *We will be an expert clinical commissioning organisation, working collaboratively with our patients, practices and partners across health and social care to ensure evidence-based, equitable, high quality and sustainable services for all of our population.*[5]

The Vision is for Member Practices to be taking full responsibility for their roles and responsibilities as Members of the CCG by March 2019.

These roles and responsibilities are defined by the 2006 Health and Social Care Act as Amended by the 2012 Act. Of particular note is the following duty found in section 13 of the Act:

> "*A CCG has responsibility for –*
>
> *a) Persons who are provided with primary medical services by a member of the group, and*
>
> *b) Persons who usually reside in the group's area and are not provided with primary medical services by a member of any CCG."*

Thus the CCG's Members, when acting as Members, have a responsibility for the whole population of Wolverhampton not just those registered at their practice.

There are three ways in which our Member Practices will be involved in the commissioning undertaken by the CCG on their behalf:

- By full involvement with the Governing Body
- By full involvement with the Localities
- By full involvement in the review of present services and the development of new services

8.1. Full involvement with the Governing Body

The CCG Members have delegated their responsibilities for the population of Wolverhampton to the Governing Body and their key roles are to:

[5] Wolverhampton CCG Constitution Version: 6 1 April 2015

- Hold the Governing Body to account – to ensure that they are representing the will of the Members and purchasing high quality, cost effective services for the population of Wolverhampton and ensuring that providers are providing the contracted services; and
- Monitor and assist local implementation of Governing Body decisions.

To hold the Governing Body to account our Member Practices will be:

- Ensuring that their nominated Practice Representative attends all meetings that the Governing Body calls to keep the practices informed and in particular those at which a vote of the membership is required. There will be a minimum of 4 Ordinary meetings per year [6];
- Ensuring that there are GPs willing and able to stand for all Governing Body roles; and
- Communicating with their Locality Board Chair, their Elected Representative on the Governing Body, if they have concerns about decisions being made by the Governing Body.

To monitor and assist local implementation of Governing Body decisions our Member Practices will be:

- Ensuring their Practice Representative feedback to all practice staff the decisions being made by the Governing Body on their behalf; and
- Feeding back any issues around local implementation to their Locality Board Chair.

8.2. Full involvement with the Localities

The Vision for our General Practices as Commissioners is a work in progress with the recent introduction of the Locality Boards with their central role of involving Member Practices in the Commissioning Cycle. Their role is articulated by Paragraph 6.9.3 of the Wolverhampton CCG Constitution (pp21-22)[4]:

Locality Boards

Functions - the Locality Boards covering North East, South East and South West Wolverhampton are to be established as advisory Boards only and regulated by their

[6] NHS Wolverhampton CCG Constitution Version 6 1 April 2015

terms of reference which shall initially have the following functions, (which may alter from time to time as reflected in their terms of reference to be determined by the governing body). The Locality Board(s) may also have functions of the group delegated to it by the governing body. The Locality Boards have responsibility for:

a) *ensuring that the localities have appropriate arrangements in place to exercise their functions effectively, efficiently and economically (see 5.2.5 above) and in accordance with the group's principles of good governance;*
b) *helping the governing body in leading the setting of vision and strategy and commissioning plans (Prime Financial Policy7), monitoring performance against budgets, plans and contracts (PFP 14) and providing assurance with regard to strategic risk management (PFP 15.3);*
c) *helping the governing body in delivering the group's duty with regard to commissioning health services consistently with the duty of the Secretary of State and NHS England to promote a comprehensive health service and the objectives and requirements placed on NHS England through the Secretary of State's mandate (see 5.1.2(a) above);*
d) *representing the views of local people and practices in order to develop locally sensitive services, thereby creating local ownership of the Group's vision and values;*
e) *promoting a sense of locality and care closer to home in a patient-centred way;*
f) *helping to promote high quality primary care via quality monitoring and peer support in a facilitative way via mentoring, buddying and practical support.*

At the end of the 5 years of this Strategy it is expected that the roles and responsibility of the Locality Boards will have develop to a point where they will be involved in many aspects of the commissioning cycle with the CCG staff providing all necessary support. Over time they will develop an understanding of and involvement with many of the following:

- Monitoring of activity and spend against plan by contract and responding as required to ensure the CCG and Locality live within budget
- Using all the clauses of the National Standard Contract to full effect to increase the quality and cost effectiveness of all CCG held contracts and thus reduce risk
- The commissioning/contracting cycle
    - Commissioning Strategic Planning (CSP)
    - Commissioning Intentions

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- Commissioning for Quality and Innovation (CQUINs) for the main contracts and for GP Practices as providers of Extended Primary Care
- Development of the Local Incentive Scheme and other schedules of the National Standard Contract for Extended Primary Care Services contracts; and
- Contract management processes through Quality Matters or feeding back their and their patient's experience of using the CCG commissioned services

- The development of and actively supporting the implementation of QIPP Plans, Quality Premium spending plans, Annual Operating Plan etc. as required by NHSE.

As the Localities develop their understanding and capacity they will increasingly be involved in the decision making processes of the CCG.

8.3. Full involvement in the review of present services and the development of new services

Paragraph 7.2.13 of the Wolverhampton CCG Constitution (p27)[4] identifies the need for other GPs and Primary Health Care professionals to represent the CCG in a variety of roles. The Vision is to have GPs involved in both contract management processes and the review and development of services. These individuals will have developed a wide ranging understanding of how services are commissioned and contracted and will ensure that this is at all times informed by clinical understanding and is clinically lead. The table below identifies areas of responsibility where the CCG may need regular clinical input. There will be additional one off needs as particular pathways are worked up.

	Area of responsibility
1	Acute Contact (RWT)
2	Community Contract (RWT)
3	Mental Health Contract (BCP)
4	Quality
5	Unplanned Care/Urgent Care/OOH
6	Planned Care
7	Primary Care
8	Children and Young People including CAMHS

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9	Maternity
10	Health and Social Care Integration
11	EOLC
12	IM&T
13	Prescribing
14	Estates
15	Workforce
16	Diabetes
17	Respiratory
18	Cardiology
19	Other pathways such as dermatology or ENT as required

9. Procurement

9.1. Wolverhampton CCG Procurement Policy

As noted above to keep more people out of hospital we will need to procure new services and/or transform present service provision. This will require the transformation of our present local providers so that they are capable of providing the new services and when necessary attracting new providers to Wolverhampton or developing new local providers to fill capacity/skills gaps, to increase choice and when necessary to increase quality.

The challenge for Wolverhampton CCG is to commission services that offer the best quality and value for money within a finite resource. Many of these new services will be best purchased from the patient's GP and it will therefore be extremely important for the CCG to be transparent in its decision making on its route to market for any particular service to avoid any possible accusation of a conflict of interest affecting the decision taken by the CCG.

The developing landscape for procurement of NHS funded healthcare services requires a consistent but flexible approach rather than a rigid application of any particular procedure. The CCG's policy has been written with this in mind and to ensure that the CCG's statutory and regulatory duties and obligations are clear and complied with.

The CCG has established the Commissioning Committee as the forum for considering and approving the route to purchase any particular service. The Committee will deliver assurance that that there is a formal record of the decision to go to the market or to enter a contractual

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agreement with a current provider without undertaking a competitive process. When the services are likely to be provided from local General Practices, or other organisations in which GPs have a financial interest, the CCG Conflict of Interest Policy will be followed which includes the NHS England document: *Managing conflicts of interest: Statutory Guidance for CCGs 2014* Template (Appendix D) for completion in this circumstance.

10. Working with our Stakeholders

10.1. Our population

During the development of this strategy Patient Participation Groups (PPGs) and local voluntary organisations have helped to set the outcomes this strategy seeks to achieve.

The Wolverhampton CCG Communication and Engagement Strategy 2012-2015 provides details of how the CCG plans to work with our population. Wolverhampton Clinical Commissioning Group (CCG) knows how important patient engagement and communications is to improve and enhance local health services. A key part of our vision for an improved and more responsive health services is to see patients at the centre of all that we commission and do.

10.2. Health and Well-being Board

The CCG is a full member of the Wolverhampton Health and Well-being Board (HWBB) and is fully committed to the Health and Well-being Strategy (HWBS), therefore the Primary Health Care Strategy is one of the ways the CCG will implement the health service elements of the HWBS. The HWBB will be regularly briefed on the implementation of the Primary Health Care Strategy and as the HWBB develops new streams of work the Strategy will implement those elements that need to occur in a primary care setting.

10.3. Health Scrutiny Committee

The primary aim of heath scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery and it has a strategic role in taking an overview of how well integration of health, public health and social care is working. As such it will be important for the CCG to ensure that members of the Health Scrutiny Committee are fully briefed on the Primary Health Care Strategy and to provide information as requested to the Committee as implementation proceeds.

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10.4. Healthwatch

Healthwatch has a statutory role in promoting ad supporting the involvement of local people in:

- the commissioning, provision and scrutiny of local care services,
- enabling local people to monitor the standards of local services; and
- obtaining the views of local people regarding their needs.

As such it will be important for the CCG to ensure that members Healthwatch are fully briefed on the Primary Health Care Strategy and to provide information as requested to Healthwatch as implementation proceeds.

10.5. NHSE and WCC

As noted in 11.1 below although in the life of this strategy Wolverhampton CCG expects to have fully delegated responsibility for the core Primary Medical Services contracts there will always be a need to work closely with NHSE and keep them informed on the quality of these services. WCC Public Health and Public Health England will also be purchasing services from General Practices as such the CCG will work closely to ensure alignment and streamlining of demands made on General Practice to ensure the complexity of holding contracts with a number of commissioners does not create conflicts for practices or excessive bureaucracy within the healthcare system.

10.6. Third Sector

We believe that the third sector is a key player in bringing care closer to home and our vision is to increase the links between the CCG and local third sector services. The use of the Directory of Services (DOS), at present used by 111, to allow practices to inform patients of very locally available services will be the key. Within the life of this Strategy this should become available for practice use and we will work to support practices to access this information effectively.

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11. Contract management

11.1. Co-commissioning and Delegated commissioning – GMS, PMS, APMS

It is clear that in the near future all CCGs will move to fully delegated responsibility for the core General Practice contracts. It is likely that for Wolverhampton CCG this will be on 1st April 2017 or possibly earlier if NHSE believes that the CCG has the necessary competency.

The local Vision for these contracts is that the CCG will be responsible for the monitoring of contracts that are negotiated nationally. Performance against the contract will be monitored by the contracting team and actions taken as defined in the contract if a Practice is failing to provide the agreed service in terms of quality and or quantity.

Once the CCG has fully delegated responsibility it will be responsible for:

a) Decisions in relation to Enhanced Services;
b) Decisions in relation to Local Incentives Schemes, including the design of such schemes;
c) Decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;
d) Decisions about commissioning urgent care for out of area registered patients;
e) The approval of practice mergers;
f) Planning primary medical care services in the Area, including carrying out needs assessments;
g) Reviewing primary medical services in the Area;
h) Decisions relating to the management of poorly performing GP practices;
i) Managing the funds delegated to the CCG for the purpose of meeting expenditure in respect of the Delegated Functions;
j) Premises Costs Directions Functions;
k) Co-ordinating a common approach to primary care commissioning with other commissioners in the Area; and
l) Any other activities necessary to support the above functions.

11.2. Full use of the NHS Standard Contract

Any new services will need to be clearly specified as additional services that the CCG is purchasing above the PMS/GMS/APMS contract a practice holds.

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The normal contracting cycle (including issuing of 6 month commissioning intentions letters to all Providers including practices on 30th September each year), and contract levers including: KPIs, Service Development and Improvement Plans (SDIPs), Data Improvement Plans (DIPs), Local Incentive Schemes (LISs) and CQUINs, will be used.

The CCG will agree a pricing methodology with the LMC, as a representative of the local practices, which ensures that practices are paid a fair price for providing the new services.

The LMC will negotiate all the schedules of the contract and the price for each service with the CCG on an annual basis and will recommend the final contract to practices for signature.

Activity and price for an individual practice will be defined in Schedule 4 of the contract and the CCG will consider and agree the length of the contract term in the same way as for other NHS and Non-NHS providers. Common practice would be for a period of 3 years however this may vary depending on the requirements of the service.

Performance against these contracts will be monitored by the contracting team and actions taken as defined in the contract if the provider is failing to provide the agreed service in terms of quality and or quantity.

11.3. Quality and Activity Performance Management Processes

As with all CCG contracts we will follow Wolverhampton CCG's Quality and Patient Safety Strategy to develop the quality performance processes for these contracts.

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11.3.1. QUALITY FRAMEWORK

QUALITY & SAFETY COMMITTEE
Commissioner Mortality Oversight Group
Primary Care Operational Group
NICE Assurance Group
Serious Incident Scrutiny Group
Clinical Practice Group

CCG GOVERNING BODY
Executive Team
Senior Management Team
Health & Wellbeing Board

NHS ENGAND
Area Team (PPIG/PAG/JCC/QSG)

LOCAL APPROACH TO QUALITY MONITORING

NHS Contract	Assurance Reporting	Triangulation of Data Sources
Quality Review Meetings	CQUINs	Performance Monitoring
Quality Visits	Quality Indicators/Dashboards	Collaborative Working LA/CQC/CCGs etc

NOTE: The ***Quality Escalation Model*** is actively applied (comprising 4 levels of concern with corresponding CCG Responses)

SECTORS

- *Acute & Community (RWT)*
- *Care Homes Sector (nursing & residential)*
- *Mental Health (BCP)*
- *Private Sector (Spot Purchases – adults/children)*
- *Primary Care (GP's & enhanced services)*

SAFETY
Incident Prevalence
Serious Incidents/Never Events
Investigation & Learning
Safeguarding Adults/Children
Safety Thermometer
Medicines Management
Mortality
Infection Prevention
Alerts & Risks
Litigation/Claims

EXPERIENCE
PALS/Complaints
Quality Matters
Surveys (staff/service user)
Consultations
Friends & Family Test
NHS Choices
Health Service Ombudsman
Public Inquiries & Reports
Engagement Forums
Public Events
Healthwatch Wolverhampton

CLINICAL EFFECTIVENESS
Regulator Compliance (CQC, Monitor, professional bodies etc)
Revalidation & Appraisal Rates
Clinical Research
Clinical Audit
NICE / National Guidance
QIPP
Better Care Fund

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Once the CCG has fully delegated responsibility for GMS/APMS contract the vision is to have one contract management process ideally with WCC Public Health also involved in this process as this will streamline the contract management process for the Practices which is at the moment complicated by having 4 different commissioners. This will be subject to the rules for contracting as laid out by the NHSE.

GP CPD/Appraisals/Revalidation and poorly performing doctor's processes and responsibility all remain with NHSE/Deanery etc.

The vision is to have quarterly Quality and Activity Performance Management meetings with each of the 9 Clinical Networks with the results of these meetings reported to the Quality and Safety and Finance and Performance Committees. The following will be discussed in a peer review type way at these meetings:

- CQC reports and requirements
- 41 GP High Level Indicators (GPHLI) (including 4 locally defined Indicators covering 1) GP OPD referrals, 2) % patients discharged at first OPD, 3) IP and Day Case procedures, and 4) Prescribing cost per ASTRO-PU)
- GP Outcome Standards
- prescribing data
- activity data for CCG purchased services
- performance against budget and rectification plans.

The Quality and Patient Safety Strategy Trigger and Escalation model (Appendix E) will be applied to General Practice contracts with formal contract management visits to a practice only undertaken when there is concern about the quality or safety of the services being provided by a practice either in their core GMS/APMS contract, their EPCS contract or one of the Public health contracts.

Measures of success of this contract management process will be:

- No practices are found inadequate by the CQC
- 100% of practices will be using Datex (or another demonstrable system) to record all patient quality and safety issues
- The number of GPOS trigger 1's and 2's will be reduced
- There will be a reduction in the number of Wolverhampton Practices with "review identified" and an increase in the Achieving and High Achieving categories

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- All patients will be getting as similar levels of access as possible to all the core, DES and EPCSs available in Wolverhampton.

Practice Support Visits will constitute an annual visit by the Locality Lead to give the practice opportunity to bring up issues and for the Locality Lead to get to know the practices in their patch and provide solutions.

11.4. Activity and Quality Reports

The CCG will develop an automated activity and quality reporting system using standardised templates and searches. The vision is to also have an automated invoicing system from these reports to reduce the administrative burden on the practices. The CCG will have the right to audit to ensure that the coding that is generating the activity and quality reports is a correct reflection of activity.

12. Implementation Plan

12.1. Establish a Wolverhampton CCG Primary Health Care Strategy Implementation Project

Main deliverables:

i. Functional Clinical Networks with Community Services wrapped around Networks covering approximately 20-30,000 patients
ii. Single clinical system for most out of hospital services. At least for all GP practices, OOH, UCC, Rapid Response, DNs, virtual wards, hospital at home
iii. Effective support service provided to the practices covering, quality and contract requirements, IM&T, Estates, Workforce and back office
iv. Effective contract management ensuring high quality of service provision
v. Increased range of services available through general practice to all patients registered with Wolverhampton GPs
vi. Increased cost effectiveness of service provision
vii. Member practices highly satisfied with the way the CCG is commissioning services for their population
viii. CCG Organisation Structure and Staffing recognises the Primary Health Care Strategy change programme and also integration into standard operations

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12.2. Primary Health Care Strategy Strategic Roadmap 2015/16 – 2020/21

There are 5 work streams:

1. GP Practices as Providers
2. Integrated Community Teams
3. Development of Other Out of Hospital Services
4. GP Practices as Commissioners
5. Contract Management

In addition there are 3 enabling work streams:

1. Project Management, Monitoring and Reporting;
2. CCG Organisational Development; and
3. Communications and Participation.

There is a detailed Implementation Plan document including key actions and milestones however this is a living document that will develop over the life of the Strategy and will depend on the political and financial situation the CCG faces annually.

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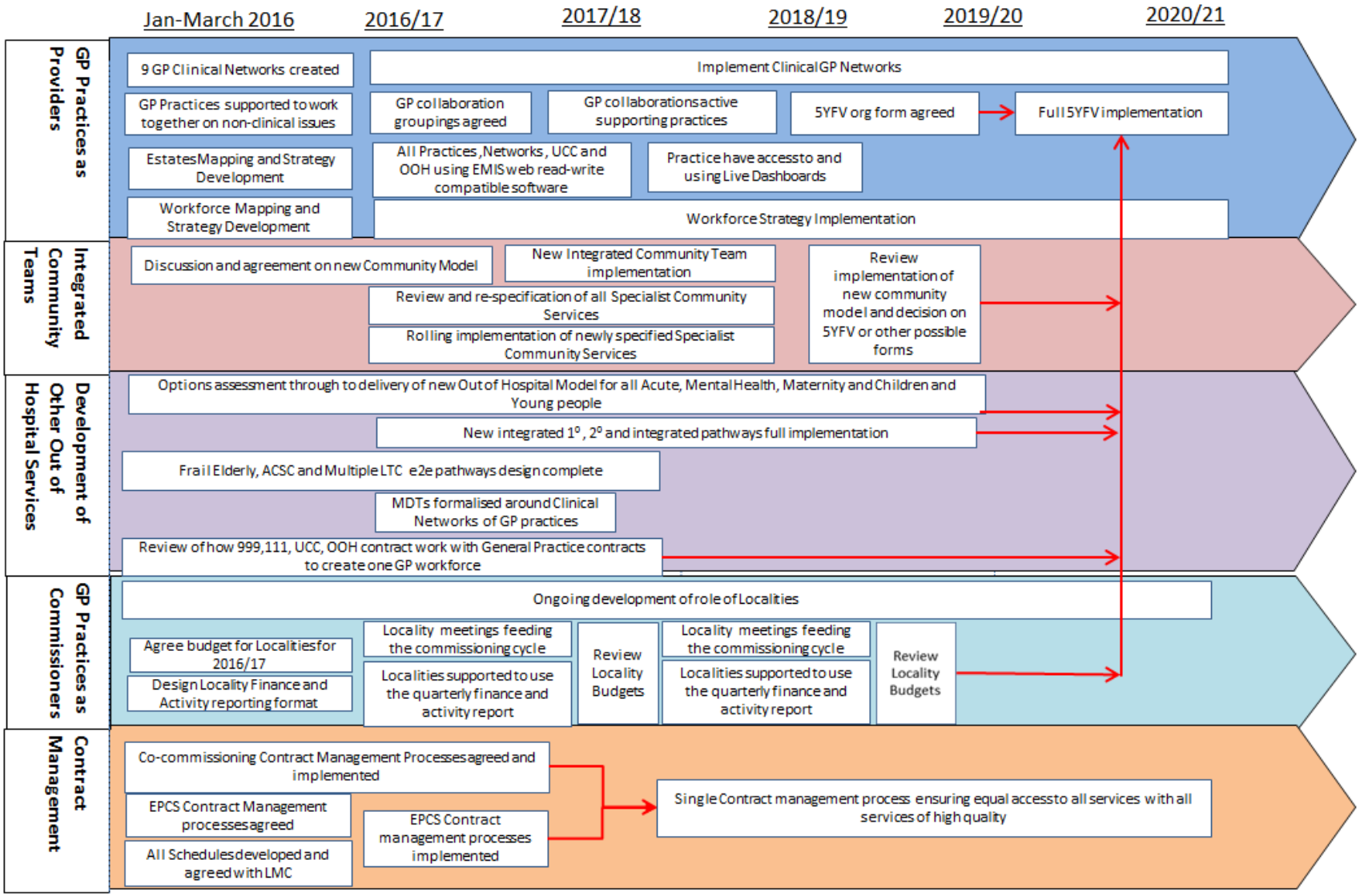
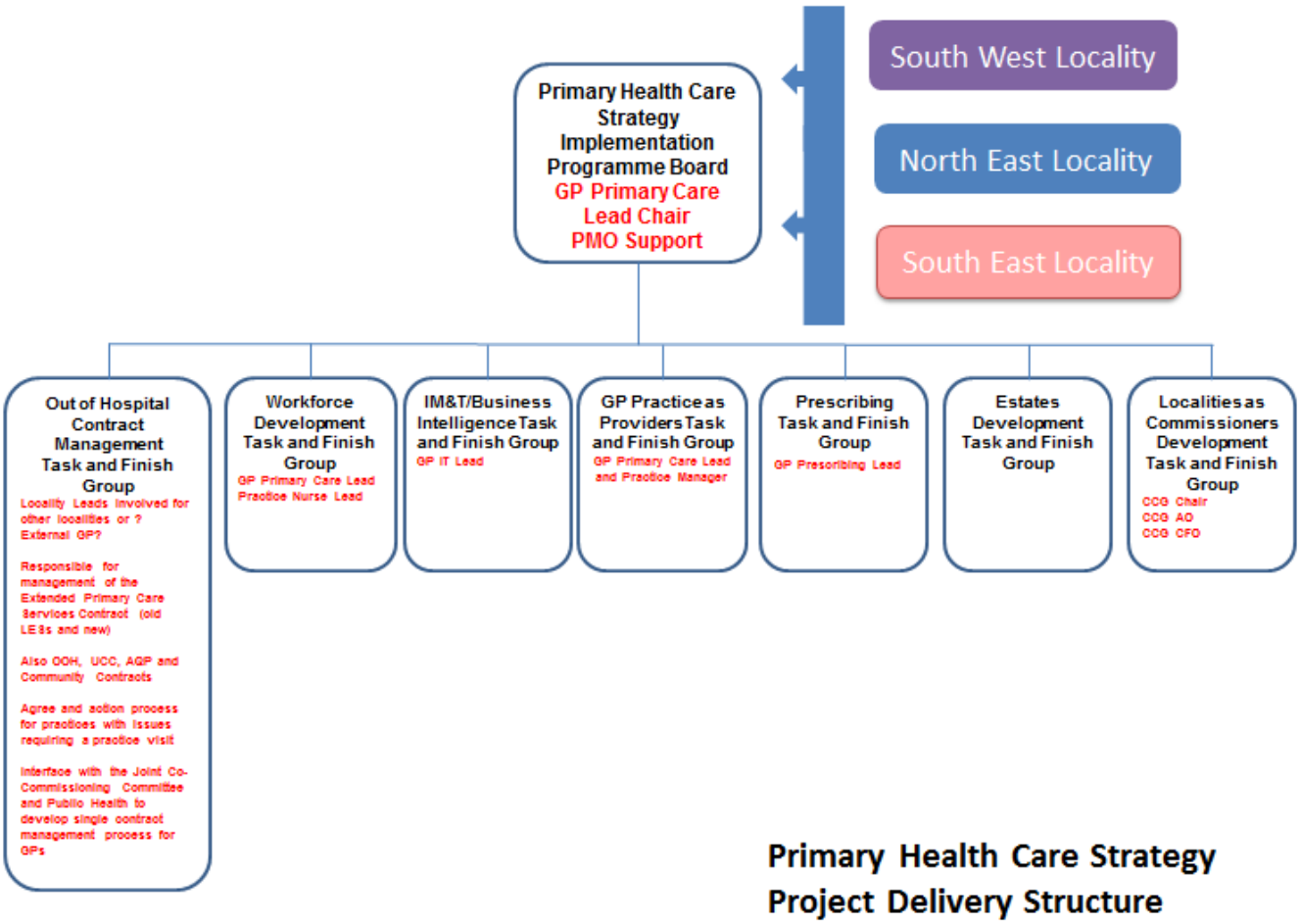
Primary Health Care Strategy Strategic Roadmap 2015/16 – 2020/21



12.3. Project Governance

There will be a Primary Health Care Strategy Programme Board supported by the Project Management Office.



Primary Health Care Strategy Project Delivery Structure

13. Investment Plan

As with the Implementation Plan the Investment Plan will develop over the life of the Strategy and will depend on the financial situation the CCG faces annually. An indicative 16/17 investment plan will be made available to the Governing Body as soon as possible. Without recurrent and non-recurrent investments it will not be possible to implement the Strategy. The speed of the change can however be modified depending on the resources available.

Appendices

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Appendix A. Wolverhampton Practices

	Locality	Practice	Contract type	Registered Population April 2015	Carr Hill weighted population April 2015	% difference
1	NE	M92643 - DR CHRISTOPHER	GMS	2474	2241	-9%
2	NE	M92022 - DR RAJCHOLAN & DR GEORGE	GMS	3787	3943	4%
3	NE	M92014 - DR FOWLER	GMS	2061	2254	9%
4	NE	M92004 - PRIMROSE LANE PRACTICE	GMS	2885	3290	14%
5	NE	M92629 - DRS KHARWADKAR & MAJI	GMS	3332	3720	12%
6	NE	M92013 - WODEN ROAD SURGERY	GMS	6852	7474	9%
7	NE	M92041 - PROBERT ROAD SURGERY	still PMS	4626	4418	-4%
8	NE	M92009 - PRESTBURY MEDICAL PRACTICE	GMS	13763	15451	12%
9	NE	M92002 - THE GROUP PRACTICE ALFRED SQUIRE ROAD	GMS	8415	9641	15%
10	NE	M92019 - KEATS GROVE SURGERY	GMS	6387	6305	-1%
11	NE	Y02736 - SHOWELL PARK HEALTH & WALK IN CENTRE	APMS	4811	4675	-3%
12	NE	M92001 - POPLARS MEDICAL CENTRE	GMS	3320	3125	-6%
13	NE	M92016 - TUDOR MEDICAL CENTRE	GMS	6471	7038	9%
14	NE	M92609 - ASHFIELD ROAD SURGERY	GMS	4930	4540	-8%
15	NE	M92039 - DR ST PIERRE-LIBBERTON	GMS	6574	2839	-57%
16	NE	M92026 - DR BILAS	GMS	3866	3949	2%
17	SE	M92647 - BRADLEY MEDICAL CENTRE	GMS	3010	3554	18%
18	SE	M92015 - DRS PAHWA	GMS	3865	4182	8%
19	SE	M92003 - DR SURYANI	GMS	1733	1960	13%
20	SE	M92627 - DR SHARMA	GMS	3178	3720	17%
21	SE	M92024 - PARKFIELD MEDICAL CENTRE	GMS	12858	13345	4%
22	SE	M92040 - MAYFIELD MEDICAL CENTRE	ex PMS	6348	6650	5%
23	SE	M92012 - DUNCAN STREET PRIMARY CARE PARTNERSHIP	ex PMS	9491	10050	6%
24	SE	M92612 - GROVE MEDICAL CENTRE	GMS	3319	3284	-1%
25	SE	Y02757 - BILSTON URBAN VILLAGE MEDICAL CENTRE	APMS	5542	4806	-13%
26	SE	M92630 - EAST PARK MEDICAL PRACTICE	ex PMS	4884	4991	2%
27	SE	M92027 - CAERLEON SURGERY	still PMS	3319	4247	28%
28	SE	Y02735 - ETTINGSHALL MEDICAL CENTRE	APMS	3374	3392	1%
29	SE	M92035 - ALL SAINTS SURGERY M92642 - DR KANCHAN	GMS GMS	3500 2111	3189 2030	-9% -4%
30	SE	M92030 - CHURCH STREET SURGERY	GMS	5414	5669	5%
31	SE	M92654 - BRADLEY CLINIC PRACTICE	ex PMS	7494	4840	-35%
32	SE	M92649 - DR MUDIGONDA	ex PMS	3605	3889	8%

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33	SW	M92640 - TETTENHALL ROAD MEDICAL PRACTICE	GMS	2242	2110	-6%
34	SW	M92028 - THORNLEY STREET MEDICAL CENTRE	ex PMS	9683	9516	-2%
35	SW	M92031 - DRS PASSI & HANDA	GMS	6527	6728	3%
36	SW	M92607 - WHITMORE REANS MEDICAL PRACTICE	GMS	12325	12253	-1%
37	SW	M92007 - LEA ROAD MEDICAL PRACTICE	GMS	6467	6624	2%
38	SW	M92043 - PENN SURGERY	GMS	4956	5061	2%
39	SW	M92011 - PENN MANOR MEDICAL PRACTICE	ex PMS	11478	11799	3%
40	SW	M92042 - 80 TETTENHALL ROAD SURGERY	GMS	3387	3526	4%
41	SW	M92029 - NEWBRIDGE SURGERY	GMS	4449	4701	6%
42	SW	M92008 - CASTLECROFT MEDICAL PRACTICE	ex PMS	12128	12764	5%
43	SW	M92006 - COALWAY ROAD MEDICAL PRACTICE	ex PMS	5255	5397	3%
44	SW	Y02636 - INTRA HEALTH LIMITED	APMS	3211	2571	-20%
45	SW	M92044 - DRS DE ROSA & WILLIAMS	GMS	4248	4477	5%
46	SW	M92010 - TETTENHALL MEDICAL PRACTICE	GMS	11681	12359	6%

The Carr-Hill formula is a complex formula and distributes the core funding (the global sum) to general practices for essential and some additional services. Payments are made according to the needs of a practice's patients and the cost of providing primary care services. The formula takes into account issues such as age and deprivation.

Practice's Carr Hill population is greater than registered which is likely to indicate a combination of deprivation and older patients

Practice's Carr Hill population is less than registered which is likely to indicate less deprivation and/or less older patients

2 practices whose Carr Hill population is very significantly less than list size. This is probably due to these being recently merged practices and the figures are not yet correct.

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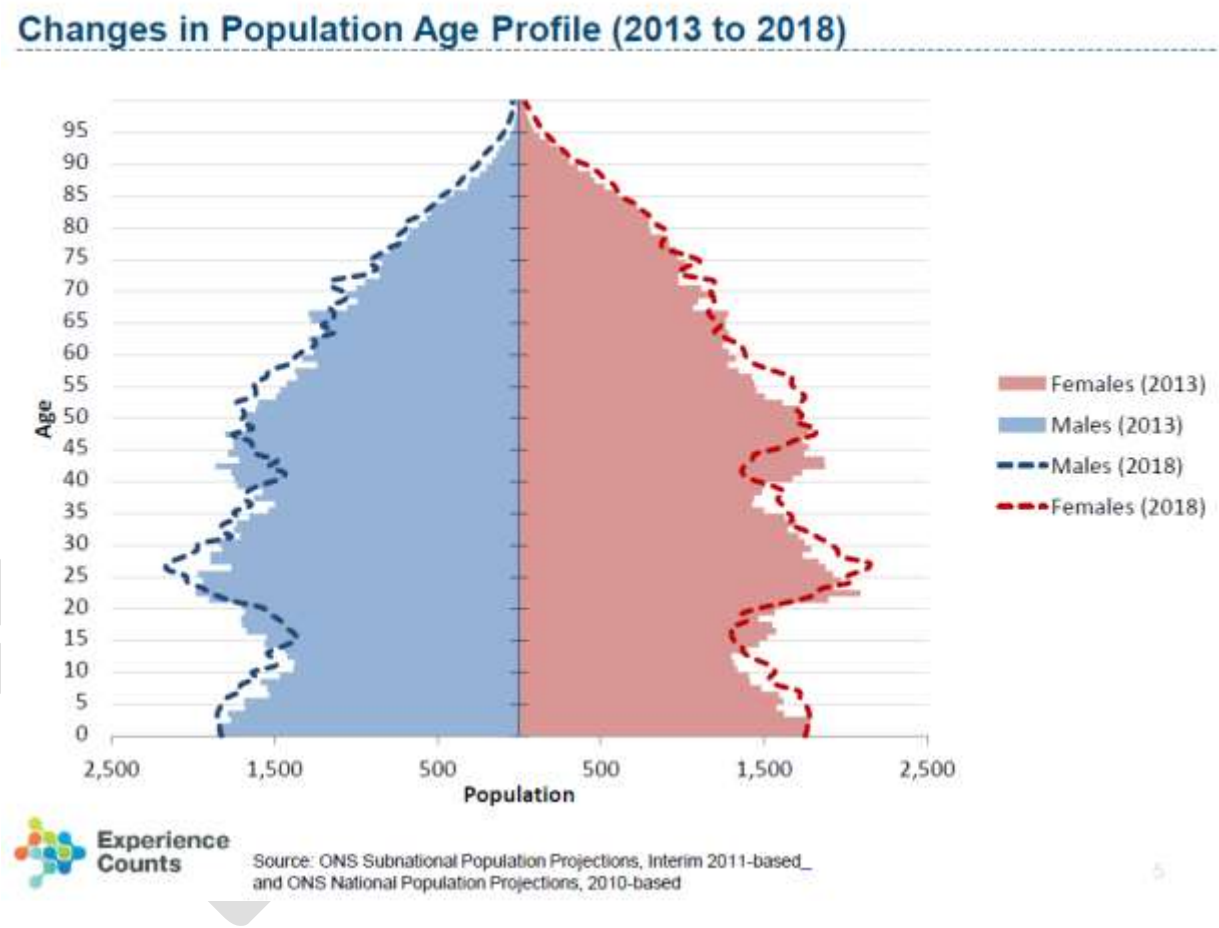
Appendix B. **Where we are now**

14. Where we are now

14.1. The Population[7]

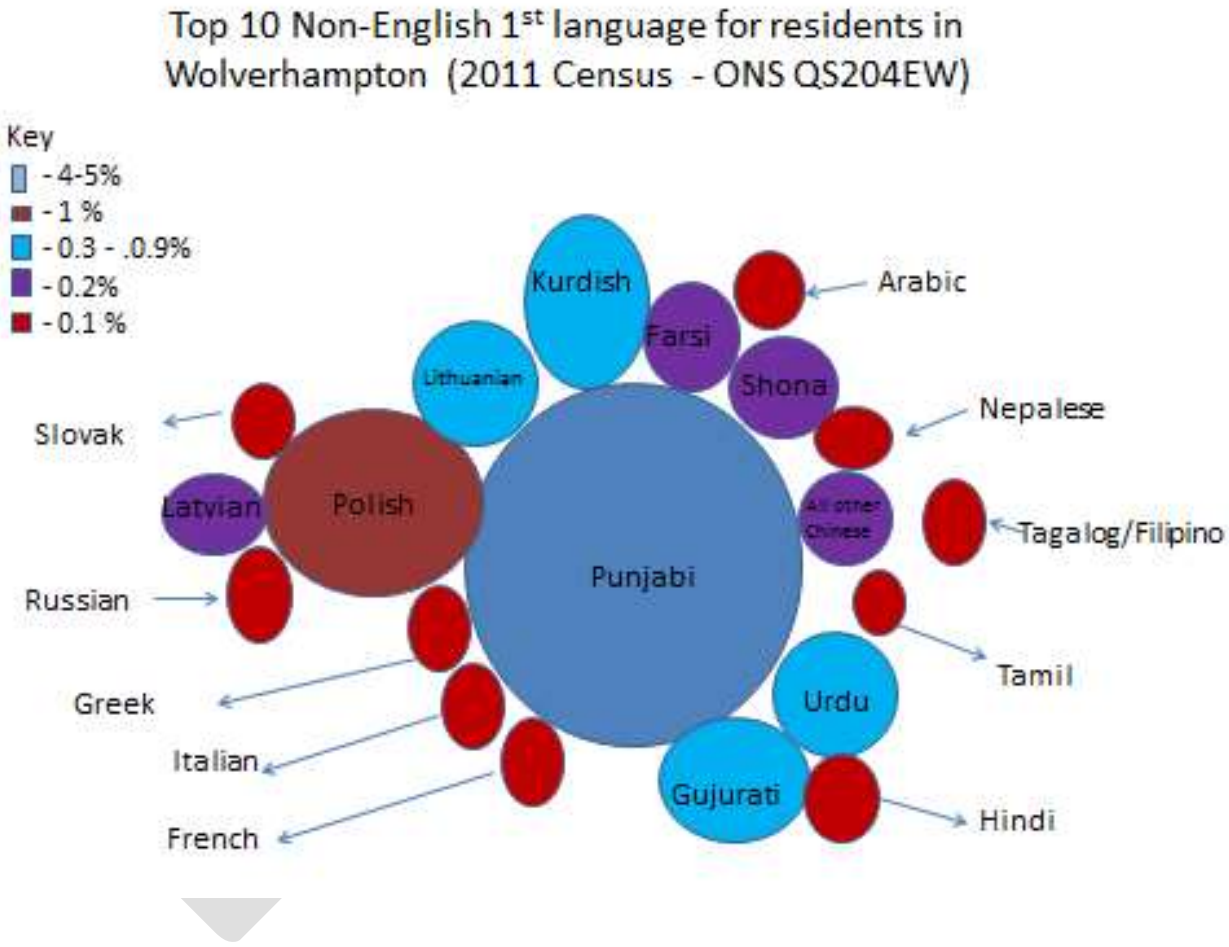
The estimated population in 2013 was 252,000. The average age is 39, which is similar to the England average but Wolverhampton has a slightly higher proportion of children aged under 16. The majority of the population (68%) is from a white ethnic background with the remaining 32% from black minority ethnic (BME) backgrounds (England average is 14%). The largest BME group is Asian at 18.8% followed by black (6.9%) and mixed (5.1%).

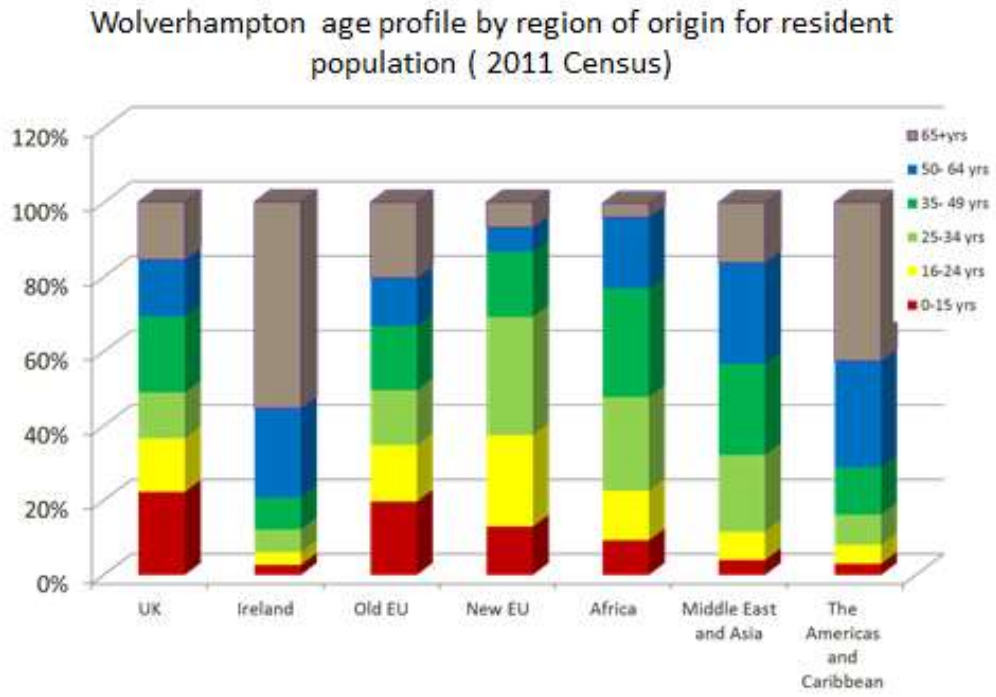


[7] More information on this can be found on the Wolverhampton CC website: http://www.wolverhampton.gov.uk/article/3647/Joint-Strategic-Needs-Assessment-JSNA

Refugees and Migrants

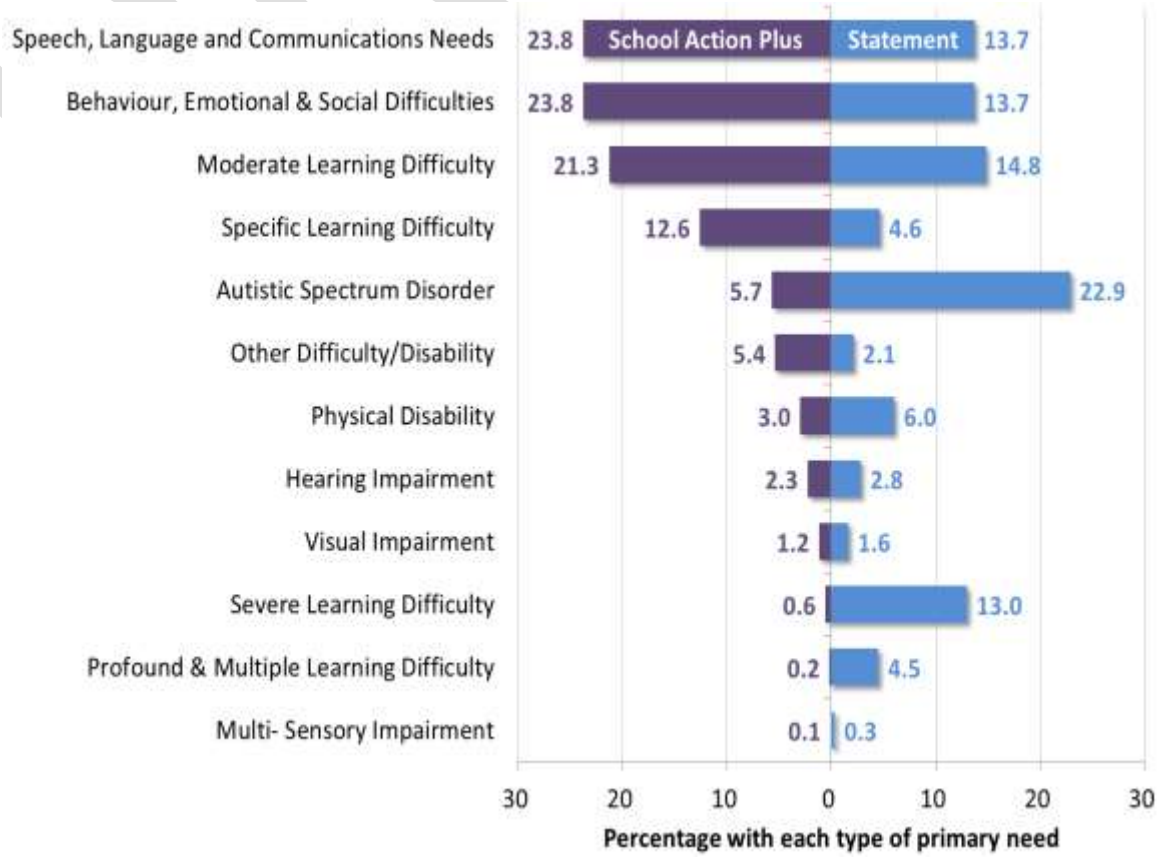
- 16.4% of the population was born outside of the UK (2011)
- 18,042 individuals arrived from outside the UK during 2001-2010 in and were resident in the City at the last census
- 10% of the population had a non-English 1st language
- Non-UK born population is concentrated in wards like St Peters, Blakenhall, Heath Town, Graiseley & Park
- There were 3,536 National insurance numbers issued to foreign nationals in 2014
- There were 3,434 new migrant GP registrations 2014
- There were 650+ asylum seekers in accommodation in the City at the end of 2014
- There is an emerging EU Roma community – Czech, Slovak and Romanian





Children and Young People

The number of children in the city will be increasing by approximately 1,000 children to 64,200 over the next 10 years. 4.9% (3,146) of these children will have some form of disability, up to 10% (6,420) of children will have some type of learning disability or difficulty and 1 in 100 (642) children will be diagnosed with an autistic spectrum condition, of which 50% (321) will also have some degree of learning disability.



There were 698 Wolverhampton children in the Care System in November 2015 with 280 of these children living in Wolverhampton.

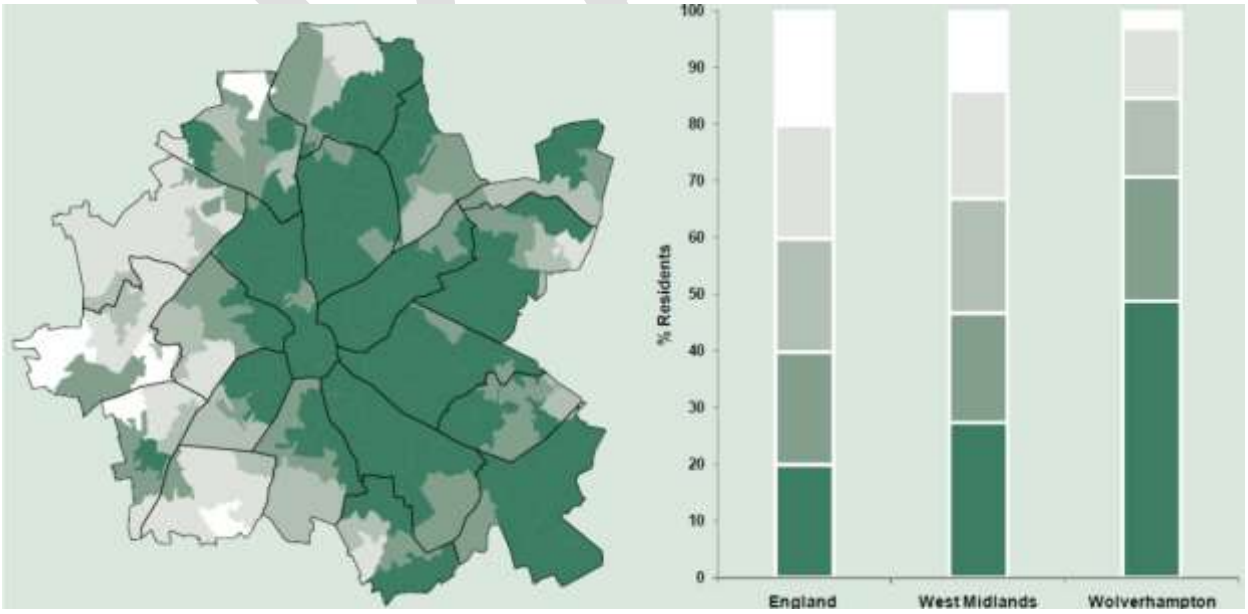
14.1.1. Social Determinants of Health

Deprivation is higher than average and about 30.2% (15,000) children live in poverty this is 11% higher than the England average. Fewer children have a good level of development at age 5 – 52% compared to 59% nationally. There is little evidence of inequalities in terms of ethnicity, except for the Asia population who have a slightly higher proportion of good development than other ethnic groups.

Indicators relating to the wider determinants of health show higher rates of violent crime, more people affected by noise, higher numbers of homeless people and more household affected by fuel poverty when compared to the national average.

Wolverhampton is the 21st most deprived Local Authority in the country, with 51.1% of its population falling amongst the most deprived 20% nationally. Deprivation is disproportionate across the city, with the most affluent wards in the West of the city.

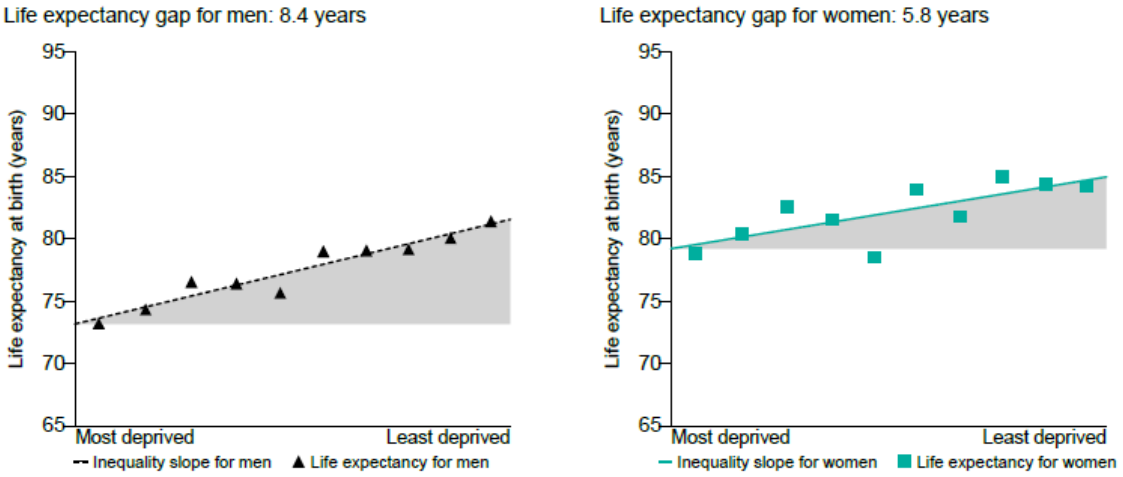
The tables below show the deprivation level comparator between Wolverhampton, the West Midlands region and England, the darker the green the more deprived, which shows Wolverhampton as a city area experiencing more than 2x the level of most significant deprivation than the national average, and proportionately much lower areas of prosperity.



14.1.2. Health Outcomes[8]

The health of people in Wolverhampton is generally worse than the England average. Life expectancy for both men and women is lower than the England average – 76.7 years for men and 80.8 years for women which is nearly 2 years less than the national average for both. This reduction is no spread equally with a gap of approximately 8.4 years for men and 5.8 for women between the life expectancy of the most and least affluent in Wolverhampton.

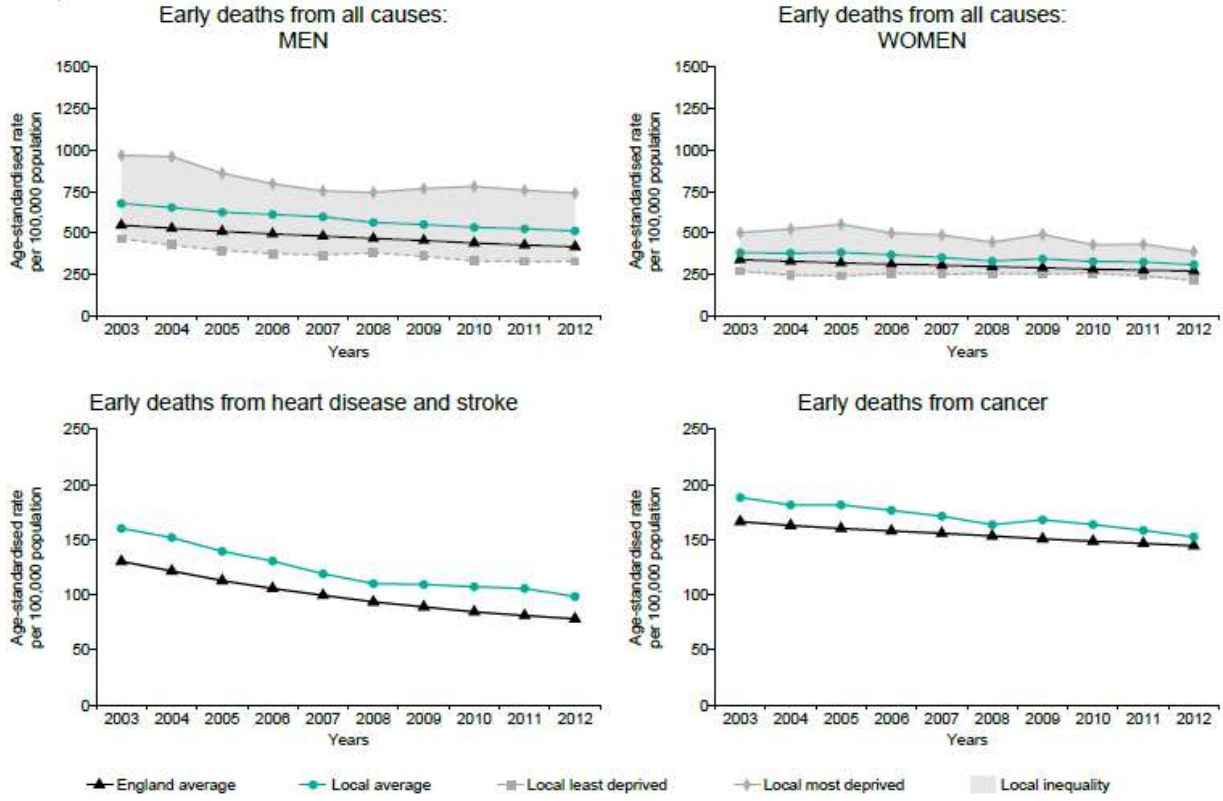
The charts below show life expectancy for men and women in this local authority for 2011-2013. Each chart is divided into deciles (tenths) by deprivation, from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there were no inequality in life expectancy as a result of deprivation, the line would be horizontal.



In addition Men in Wolverhampton can expect to live 58 years free from disability and women 61 – over 3 years less than the national average. Therefore, not only do Wolverhampton residents live shorter lives but they also spend more of their lives experiencing ill health and disability.

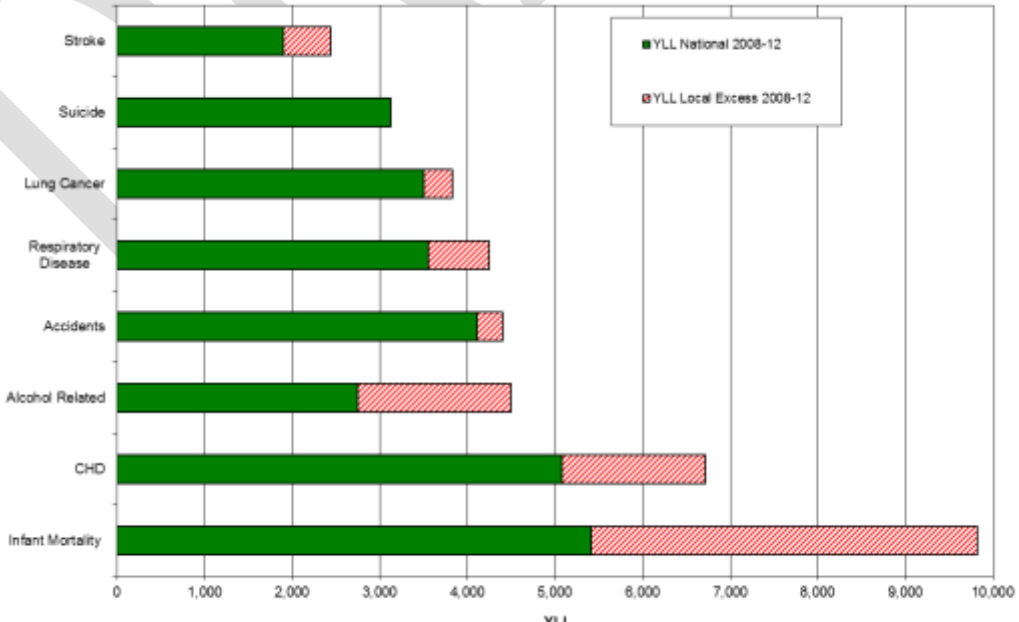
[8] More information can be found in the Wolverhampton Health Profile 2015 at: www.apho.org.uk/resource/view.aspx?RID=171742

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).



After infant mortality, cardiovascular disease (CVD) remains the single greatest cause of lost life years in Wolverhampton and although improving this remains considerably higher than the national average.

Causes of excess YLL in the under 75s 2008-2012



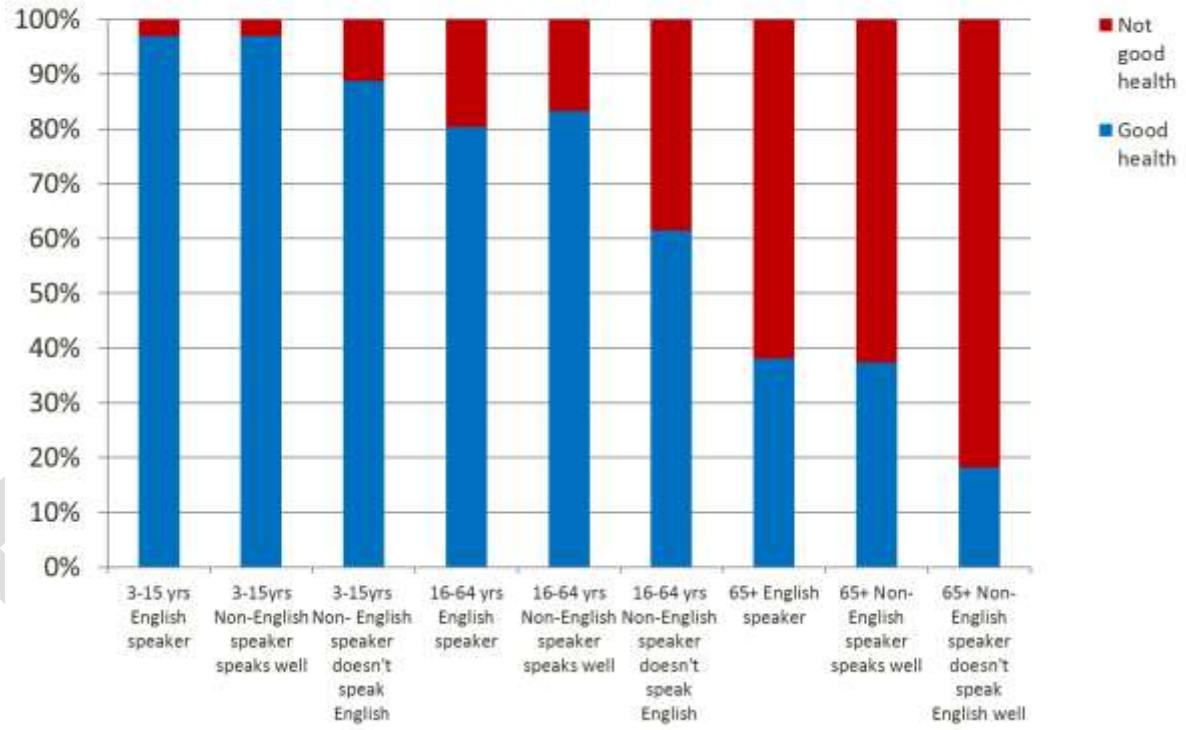
Child health – in Year 6 26.3% (711) of children are classified as obese which is almost 5% higher than the England average. The rate of alcohol-specific hospital stays among those

under 18 was 34.3/100,000 which represents 20 stays per year. Levels of teenage smoking, GCSE attainment, breast feeding and smoking at time of delivery are all worse than the England average.

Adult health – in 2012 the following measures were all worse than the average for England: 28.5% of adults are classified as obese; the rate of alcohol related harm hospital stays was 851/100,000, this represents 1,956 stays per year; the rate of self-harm was 200.5/100,000 representing 518 stays per year; the rate of smoking related deaths was 317/100,000 representing 414 deaths per year; rates of STDs and TB were significantly worse than average.

Refugee and Migrant health - there is limited information on the health outcomes of this group.

Self rated health by English proficiency for Wolverhampton residents over 3 years old (2011 Census)



In all age groups not speaking English correlates with reported poor health.

This population has a high rate of Latent TB and a significant risk of active TB in the first 10 years after coming to the UK. There are increased risks of a number of other infectious diseases as well as increased mental health issues for many of those arriving from areas of conflict or as refugees from persecution with a significant number having suffered torture.

A recent survey of recent refugee and migrant arrivals in Wolverhampton found the following:

- Females were most likely to have seen their GP in last 3 months

- Satisfaction levels with GP provision varied by region and gender
- No evidence of higher levels of A & E and Walk-in Centre use
- GPs seen as most common point of contact for pregnancy, although some African women would go to RWT
- 55% of respondents didn't know where to go for an HIV test if they wanted one
- 55% indicated they know where to go for family planning or sexual health advice
- 22% of sample smoked, in contrast 50% of Eastern European males told us they smoked
- Over half respondents never drink. Drinking is higher in some communities.

Children and Young People with Special Educational Needs and Disability – these children have a wide range of health problems so it is not possible to generalise about their health outcomes and life-expectancy. However it is well recognised that many will have less than average life expectancy and the causes are complex. Access to high quality responsive health care will maximise quality years of life.

Looked After Children's health – this group is also known to have reduced life expectancy with complex causes. Looked After Children (LAC) are one of the most vulnerable groups in society. The majority of children who remain in care are there because they have suffered abuse or neglect. It is recognised that children in care have significantly higher levels of health needs than children and young people from comparable socio-economic backgrounds who have not been looked after. Their life opportunities and outcomes are also often much poorer and poor health is a factor in this. Past experiences, poor start in life, care processes, placement moves and many transitions mean that these children are often at risk of having inequitable access to health services, both universal and specialist.

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The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Regional average^ / England Average / England Worst / 25th Percentile / 75th Percentile / England Range / England Best	Eng best
Our communities	1	Deprivation	135,428	53.8	20.4	83.8		0.0
	2	Children in poverty (under 16s)	15,040	30.2	19.2	37.9		5.8
	3	Statutory homelessness	337	3.3	2.3	12.5		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	1,329	46.9	56.8	35.4		79.9
	5	Violent crime (violence offences)	3,180	12.7	11.1	27.8		2.8
	6	Long term unemployment	3,473	21.8	7.1	23.5		0.9
Children's and young people's health	7	Smoking status at time of delivery	633	18.7	12.0	27.5		1.9
	8	Breastfeeding initiation	2,261	65.5	73.9			
	9	Obese children (Year 6)	711	26.3	19.1	27.1		9.4
	10	Alcohol-specific hospital stays (under 18)†	20.0	34.3	40.1	105.8		11.2
	11	Under 18 conceptions	148	31.5	24.3	44.0		7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	22.0	18.4	30.0		9.0
	13	Percentage of physically active adults	238	54.1	56.0	43.5		69.7
	14	Obese adults	n/a	28.5	23.0	35.2		11.2
	15	Excess weight in adults	437	69.8	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma†	17.0	8.6	18.4	38.0		4.8
	17	Hospital stays for self-harm	518	200.5	203.2	682.7		60.9
	18	Hospital stays for alcohol related harm†	1,956	851	645	1231		366
	19	Prevalence of opiate and/or crack use	2,282	14.0	8.4	25.0		1.4
	20	Recorded diabetes	16,448	7.9	6.2	9.0		3.4
	21	Incidence of TB†	83.0	33.1	14.8	113.7		0.0
	22	New STI (exc Chlamydia aged under 25)	1,467	901	832	3269		172
	23	Hip fractures in people aged 65 and over	285	585	580	838		354
Life expectancy and causes of death	24	Excess winter deaths (three year)	156.8	20.8	17.4	34.3		3.9
	25	Life expectancy at birth (Male)	n/a	77.5	79.4	74.3		83.0
	26	Life expectancy at birth (Female)	n/a	82.0	83.1	80.0		86.4
	27	Infant mortality	24	6.8	4.0	7.6		1.1
	28	Smoking related deaths	414	317.4	288.7	471.6		167.4
	29	Suicide rate	21	8.5	8.8			
	30	Under 75 mortality rate: cardiovascular	188	98.4	78.2	137.0		37.1
	31	Under 75 mortality rate: cancer	287	152.4	144.4	202.9		104.0
	32	Killed and seriously injured on roads	78	31.2	39.7	119.6		7.8

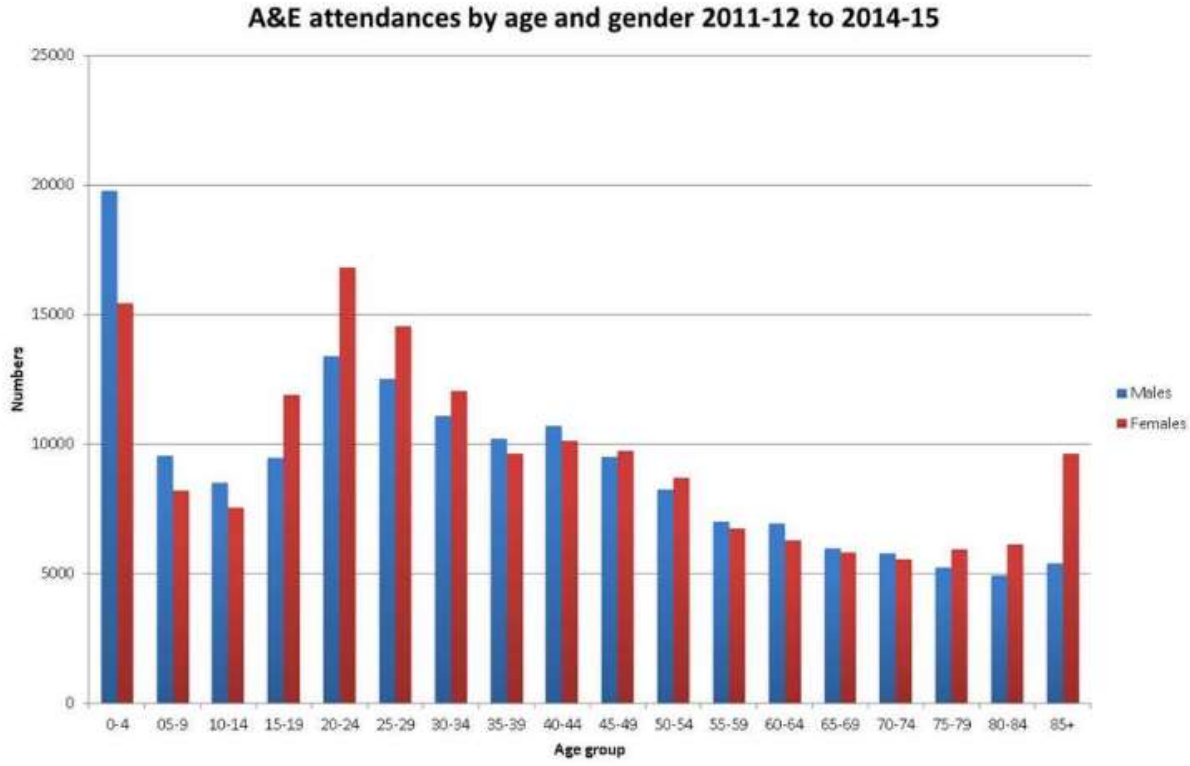
Indicator notes

1 % people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits & low income, 2012 3 Crude rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14 6 Crude rate per 1,000 population aged 16-64, 2014 7 % of women who smoke at time of delivery, 2013/14 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14 9 % school children in Year 6 (age 10-11), 2013/14 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013 12 % adults aged 18 and over who smoke, 2013 13 % adults achieving at least 150 mins physical activity per week, 2013 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2010-12 17 Directly age sex standardised rate per 100,000 population, 2013/14 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12 20 % people on GP registers with a recorded diagnosis of diabetes 2013/14 21 Crude rate per 100,000 population, 2011-13, local number per year figure is the average count 22 All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13 25, 26 At birth, 2011-13 27 Rate per 1,000 live births, 2011-13 28 Directly age standardised rate per 100,000 population aged 35 and over, 2011-13 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13 30 Directly age standardised rate per 100,000 population aged under 75, 2011-13 31 Directly age standardised rate per 100,000 population aged under 75, 2011-13 32 Rate per 100,000 population, 2011-13

† Indicator has had methodological changes so is not directly comparable with previously released values. ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

14.1.3. Young People's use of urgent health services



14.1.4. Ward and Locality Profiles

Indicators have been provided for each ward in each locality under the 5 domains

- Overarching
- Wider determinants
- Health improvement
- Health protection
- Mortality

Each indicator has been given a RAG rating; this is then used to calculate an overall index of need for each ward**.** Wards within each locality used instead of a locality average due to the significant variation between wards in locality areas. These can be found in Appendix F.

14.2. The CCG

Clinical commissioning groups are established under the Health and Social Care Act 2012 ("the 2012 Act") and came into existence on April 1st 2013. They are statutory bodies which have the function of commissioning services for the purposes of the health service in England and are treated as NHS bodies for the purposes of the National Health Service Act 2006 ("the 2006 Act"). The duties of clinical commissioning groups to commission certain health services are

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set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations made under that provision.

Clinical commissioning groups are clinically led membership organisations made up of general practices. The members of the clinical commissioning group are responsible for determining the governing arrangements for their organisations, which they are required to set out in a constitution.

The CCG is responsible for spending almost £1m a day on healthcare for the city's 266,000 registered patients. The CCG Commissions everything from emergency/A&E care, routine operations, community clinics, health tests and checks, nursing homes, mental health and learning disability services.

To be a member the organisation must hold a GMS, PMS or APMS contract with NHS England.

Wolverhampton CCG has 46 member GP practices within the city. The full list is in Appendix A. These have been grouped into three Localities:

	Locality	**Number of Practices**	**2014/15 Population ONS (Carr Hill weighted)**
1	South West	14	90,657 (91,899)
2	South East	16	82,124 (84,016)
3	North East	16	92,855 (93,197)
	TOTAL	**46**	**265,636 (269,112)**

The CCG 2015-17 Operating Plan represents the **second and third year** of delivering our Five Year Strategic Plan for Wolverhampton (Figure 1). The intent and strategic direction remains the same, though there are many new elements that shape our local landscape and the national picture:

- Approval of our Better Care Fund plans
- The Dalton Review
- The Five Year Forward View

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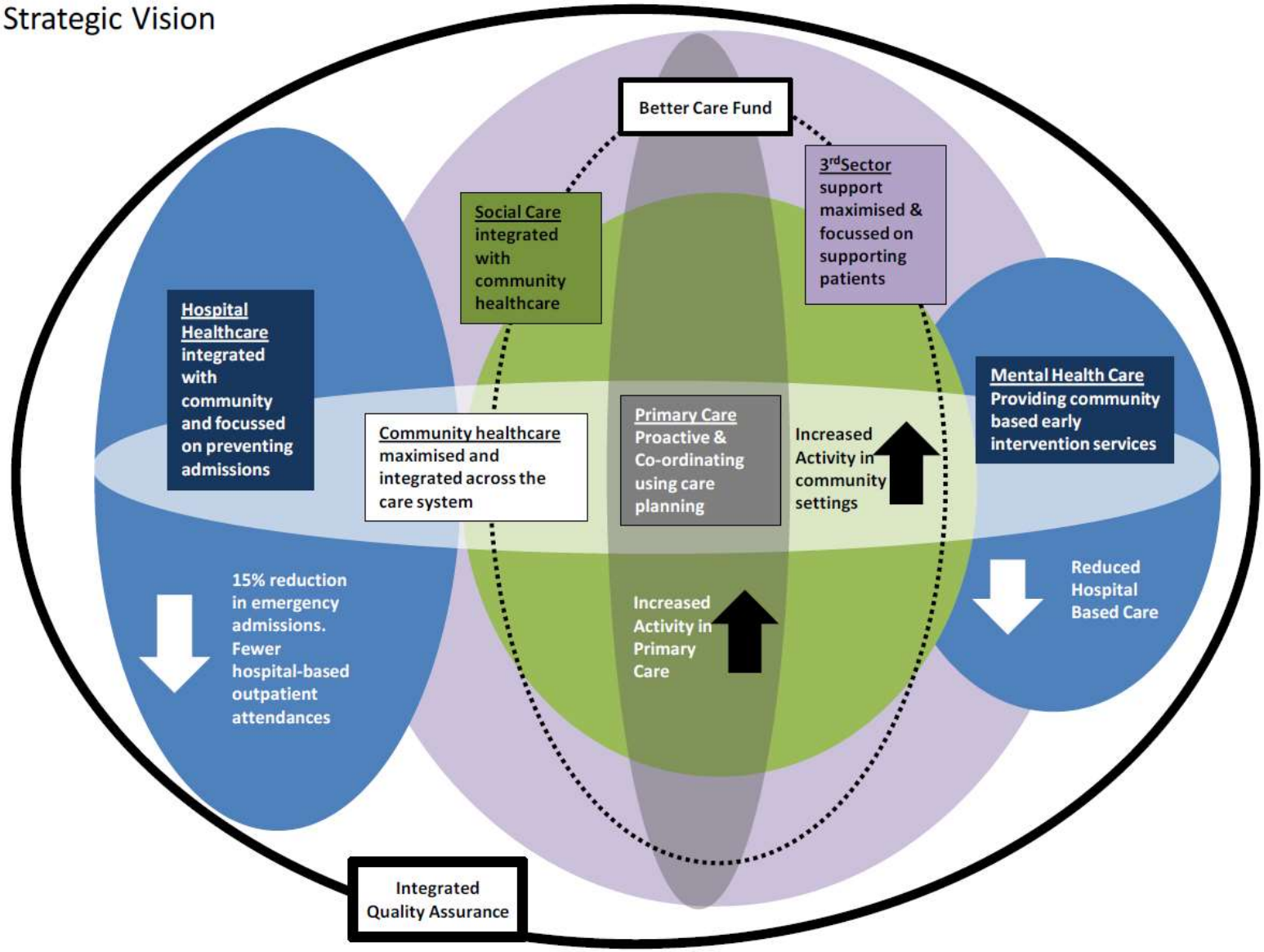
Strategic Vision



14.2.1. CCG Membership Roles, Responsibilities and Engagement

The CCG members have a number of roles and responsibilities defined by the constitution and events at which they interact with the executives and salaried employees. Each Practice has a nominated representative who is empowered by their practice to take decisions on their behalf. The Practice Representatives have delegated their responsibilities for commissioning to the Board but retain a number of key responsibilities and in particular must approve any changes to the constitution.

Significant changes were made to the Constitution in April 2015 in particular with the creation of the Locality Boards which are intended to increase Member's involvement in the work of the CCG.

The Constitution of April 2015 reduced the number of elected GPs from 10 to 8 and it should be noted at this **time there are only 7 GPs** on the Governing Body excluding Dr Helen Hibbs the Accountable Officer as she is there in this role not as an elected GP on the Board. The Board should have 16 members with the Chair having the casting vote but at this time there are only 15 members.

The constitution in Section 7 identifies, in addition to Practice Representatives, a number of other GPs/primary care health professionals from member practices to support the work of the group and/or represent the group rather than represent their own individual practices to work on:

a) developing proposals for changes to care pathways;

b) developing proposals for other significant changes to the group's commissioning portfolio;

c) monitoring a provider's delivery against its contract with the group in terms of activity or quality;

d) liaising with practices and consulting with patients/carers in support of these activities;

e) education and research in support of these activities.

At this time Board member GPs and two additional GPs acting in these role. Appendix G is a list of the GP leads and the areas they cover.

Paragraph 6.9.3 of the Wolverhampton CCG Constitution states:

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The Locality Boards

Functions - the Locality Boards covering North East, South East and South West Wolverhampton are to be established as advisory Boards only and regulated by their terms of reference which shall initially have the following functions, (which may alter from time to time as reflected in their terms of reference to be determined by the governing body). The Locality Board(s) may also have functions of the group delegated to it by the governing body. The Locality Boards have responsibility for:

a) ensuring that the localities have appropriate arrangements in place to exercise their functions effectively, efficiently and economically (see 5.2.3 above) and in accordance with the group's principles of good governance48;

b) helping the governing body in leading the setting of vision and strategy and commissioning plans (Prime Financial Policy 7), monitoring performance against budgets, plans and contracts (PFP 14) and providing assurance with regard to strategic risk management (PFP 15.3);

c) helping the governing body in delivering the group's duty with regard to commissioning health services consistently with the duty of the Secretary of State and NHS England to promote a comprehensive health service and the objectives and requirements placed on NHS England through the Secretary of State's mandate (see 5.1.2(a) above);

d) representing the views of local people and practices in order to develop locally sensitive services, thereby creating local ownership of the Group's vision and values;

e) promoting a sense of locality and care closer to home in a patient-centred way

f) helping to promote high quality primary care via quality monitoring and peer support in a facilitative way via mentoring, buddying and practical support.

Paragraph 6.9.4 Composition of the Locality Boards

– when established the locality boards will be comprised of the nominated representatives from each practice and the group's support staff

a) the chair, will be a democratically elected by the locality to a three year term by the GP members across the locality

b) the Chair will be supported by the group's management staff, namely,

- *the finance lead;*

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- *data and informatics lead;*
- *quality lead; and*
- *other staff as necessary;*

c) practice representatives either GP or other healthcare professional.

Localities have now been meeting monthly for nearly a year. At present their role as a group of primary care providers and as commissioners are not clearly separated. Appendix A identifies practices by their Locality.

CCG 360° stakeholder survey 2015

This annual survey has a section on Member Practices and their relationship with the CCG. Appendix H has the relevant section.

14.2.2. Finance

2015-16 Annual Recurrent & non-Recurrent Spending Plan (not including Specialist Spend)

Area of spend	Annual Plan Recurrent £'000	% of Recurrent Grand Total budget	2015/16 Non-recurrent Annual Plan £'000	% of Non-recurrent Grand Total budget
Acute Services	172,449	47.4%	1,551	38.4%
Mental Health Services	31,377	8.6%	1,154	28.6%
Community Services	33,009	9.1%	98	2.4%
Continuing Care/FNC	12,373	3.4%	825	20.4%
Prescribing	46,976	12.9%		0.0%
Quality/LAC	2,744	0.8%	27	0.7%
GP Enhanced Services	819	0.2%		0.0%
Other programme	20,722	5.7%		0.0%
Total Programme	**320,469**	**88.0%**	**3,655**	**90.6%**
Running Costs	5,556	1.5%		0.0%
Reserves	5,281	1.5%	-451	-11.2%
Total Mandate Spend	**331,306**	**91.0%**	**3,204**	**79.4%**
NHSE portfolio – primary care spend	32,720	9.0%	832	20.6%
Grand Total	**364,026**	**100.0%**	**4,036**	**100.0%**

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14.2.3. Wolverhampton CCG Outcome Framework 2014/15

	Reporting period	Current performance	England average
Female potential years of life lost from causes amenable to health care	2014	2,273	1,845
Male potential years of life lost from causes amenable to health care	2014	2,451	2,215
Under 75 mortality from cardiovascular disease	2014	77.3	64.9
Under 75 mortality from respiratory disease	2014	41.0	28.1
Under 75 mortality from liver disease	2014	23.27	15.5
Under 75 mortality from cancer	2014	128.7	122.1
People with severe mental illness who have received a list of physical checks	FY2013/14	82	86
Antenatal assessments < 13 weeks	Q2 14/15	97.7	90% national target, 86.3% England Average
Maternal smoking a delivery	Q4 14/15	19.0	12.7%
Breastfeeding prevalence at 6-8 weeks	Q3 14/15	31.7 (29-35 95% confidence limits)	47.4%
Domain 2: Enhancing quality of life for people living with long-term conditions	Reporting period	Current performance	England average
Dementia diagnosis rates (prevalence – QOF data)	March 2015	60.25%	60.78%
Proportion of people feeling supported to manage their condition	July 2014-March 2015	61.5%	64.4%
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) per 100,000 of population (indirectly standardised)	April 2014-March 2015 (provisional)	1,068.7	808.5
Unplanned hospitalisations for asthma, diabetes and epilepsy in under 19s per 100,000 of population (indirectly standardised)	April 2014-March 2015 (provisional)	679.4	326.7

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Domain 3: Helping people to recover from episodes of ill health or following injury	Reporting period	Current performance	England average
Emergency admissions for acute conditions that should not usually require hospital admission per 100,000 of population (indirectly standardised)	April 2014-March 2015 (provisional)	1,798.3	1,272.4
Patient Reported Outcomes Measures (PROMS) for elective procedures: i) Hip Replacement, ii) Knee Replacement, iii) Groin Hernia, iv) Varicose veins	2013/14	i) 0.435 ii) 0.331 iii) 0.072 iv) 0.139	i) 0.411 ii) 0.299 iii) 0.087 iv) 0.094
Emergency admissions for children with lower respiratory tract infections per 100,000 of population (indirectly standardised)	April 2014-March 2015 (provisional)	440.3	394.9
Emergency alcohol-specific readmission to any hospital within 30 days of discharge following an alcohol-specific admission	April 2012- March 2015 (provisional)	123.2	100.0
Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over	2014/15	127.2	100.0
Domain 4: Ensuring that people have a positive experience of care	**Reporting period**	**Current performance**	**England average**
Patient experience of GP services (overall experience of GP surgery)	Q2 2014/15	85%	85%
Patient experience of Out of Hours services	07/2014 – 03/2015	66.9%	68.6%
Patient experience of hospital care	2013/2014	73%	76.5%
Responsiveness to Inpatient personal needs	2013/2014	63%	68.4%
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	**Reporting period**	**Current performance**	**England average**
Incidence of healthcare associated infection: MRSA	10/2011 – 09/2012	0.76	1.6
Incidence of health care associated infection: C. difficile	04/2012 – 03/13	28.67	24.1

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14.2.4. Joint commissioning of Primary Care

Wolverhampton CCG has been approved to be jointly responsible for commissioning Primary Medical Services. They are in the process of establishing with NHSE the Joint Primary Care Commissioning Committee which will meet in shadow form until March 2016 and then in public.

The role of the Joint Committee is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act 2006 except those relating to individual GP performance management, which have been reserved to NHS England. This includes the following activities:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

The Terms of Reference of this committee can be found in Appendix I.

The CCG will have support to fulfil these functions from the NHS West Midlands Primary Care Hub.

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14.2.5. CCG purchasing of Services from General Practices

	Present Locally Enhanced Services		Money
1)	**Minor Injury Service**	The following list provides guidance on the types of injuries and circumstances that lead to the use of a Minor Injuries service within general practice: • Lacerations capable of closure by simple techniques (stripping, gluing, suturing) • Bruises • Minor dislocations of phalanges • Foreign bodies • Following advice to attend specifically given by a general practitioner • Following recent injury of a severity not amenable to simple domestic first aid • Following recent injury where it is suspected stitches may be required • Following blows to the head where there has been no loss of consciousness • Recent eye injury • Partial thickness thermal burns or scalds involving broken skin: • not over 1 inch diameter • not involving the hands, feet, face, neck, genital areas • Foreign bodies superficially embedded in tissues • Minor trauma to hands, limbs or feet.	**£70.37/activity** **Total value in 2014/15 £273,176**
2)	**Denosumab**	The initiation of Denosumab should be prescribed by a secondary care specialist; GPs should only prescribe and administer follow-up injections under the shared care agreement (ESCA: Denosumab. For the treatment of osteoporosis in postmenopausal women.) Patients must be stable and free from adverse reactions before Primary Care administration occurs.	**£55.44/administration** **Total value in 2014/15 £6,486**
3)	**Anti-coag**	An anti-coagulation monitoring service with therapy initiated in secondary care.	**£131.63/year of care** **Total value in 2014/15 £118,203**
4)	**Basket**	Must be undertaken as a direct result of secondary care treatment and / or at the express request from a secondary care provider: • Suture removal • Clip / staple removal • Pre-op checks • Dressing changes for post-secondary care treatment	**£15.44/activity** **Total value in 2014/15 £267,560**

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		• 12 Lead ECG's as part of a pre-op and at the request of secondary care • Ear Syringe as part of audiology preparation • Pessary changes • Post op Checks • Hormone Implants • Subcutaneous injection of heparin (Injection of anti-coagulation)	
5)	**Near Patient Testing**	Shared care of patients on following drugs: • Sodium aurothiomalate • Lithium • Methotrexate (rheumatology only) • Penicillamine • Sulfasalazine (rheumatology only) • Azathoprine (rheumatology only)	**£80.88/year of care** **Total value in 2014/15 78,858.00**
6)	**Prescribing incentive scheme**	At present this is written as a service specification but can simply become a Local Incentive Scheme Schedule of the contract	**Total value in 2014/15** **Total value in 2014/15 £224,510**
7)	**Eclipse Incentive scheme**	One off payment in 2014/15 to use Eclipse – this has been continued to the end of 2015/16	**Total value in 2014/15 £78,129**
New in 2015/16 but funded non recurrently through bids approved by NHSE			
1)	**Residential Home Weekly Ward Round**	This might not be suitable for main EPCS contract as not all practices will provide. However most practice will have patients in a residential care home so perhaps should be offered to all practices	**£219,150**
2)	**GP Resource Centre Cover**	Not part of main EPCS contract and will probably have to be tendered	**£21,000**
3)	**Sever and Moderate Asthma patient extended service**	Proposal to do initial assessment and regular follow up to decrease change of admission	**£72,000**
4)	**Peer Review**		**£36,360**
CCG recurrent spend in practices in 2014/15 £976,978 and 2015/16 **CCG non-recurrent spend in practices in 2014/15 £78,129 and £348,510 in 2015/16**			

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14.2.6. Primary Care Finance

	2015/16 Budget		Forecast Outturn as at M8	
	Recurrent	Non Recurrent	Recurrent	Non Recurrent
	£'000	£'000	£'000	£'000 (u)/o
Primary Care services within CCG portfolio				
Prescribing	45,958		45,959	-1,072
Prescribing Incentive schemes	250		250	
Prescribing Advisors	653		653	
Scriptswitch	114		114	
Enhanced Services	819		804	-47
GPIT		832		832
Sub Total - CCG portfolio	**47,794**	**832**	**47,780**	**-287**
Primary Care services within NHSE portfolio				
General Practice - APMS	2,820		2,820	
General Practice - GMS	18,408		18,408	
General Practice - PMS	1,713		1,713	
QOF	3,414		3,414	
Enhanced Service	1,732		1,732	
Dispensing/Prescribing Fees	223		223	
Premises Costs reimbursements	2,677		2,677	
Other Premises	31		31	
Other GP services	921		921	
PMS Premium	128		128	
1% Non-Recurrent transformation Fund	324		324	
0.5% Contingency	149		149	
0.6% Reserve	180		180	
Sub Total -NHSE portfolio	**32,720**		**32,720**	
Grand Total	**80,514**	**832**	**80,500**	**-287**

Primary Care and Community services total spend was planned to be £113,630 in 2015 which is 30% of total CCG and NHSE primary care spend.

14.3. The Services

14.3.1. General practices

There are 46 practices - 2 PMS, 9 practices moving from PMS to GMS and 31 long term GMS and 4 APMS. The list of practices with their contract type and population size can be found in Appendix A.

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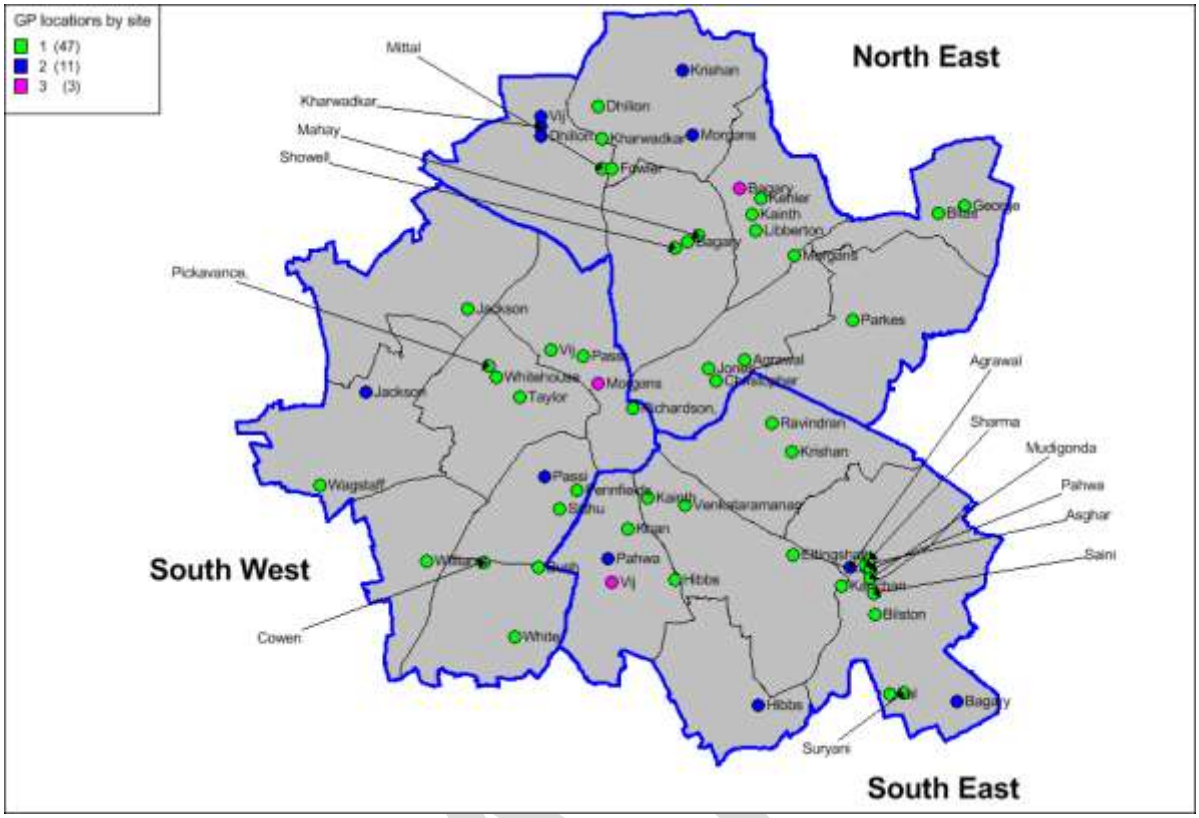

A legacy of NHS development is these different types of contract for primary care providers which makes it difficult to ensure financial resources are deployed evenly, on a per-patient basis, within a defined geography. GMS contracts are negotiated nationally. PMS are locally negotiated contracts designed to reflect local conditions and objectives. This has led to significantly different levels of funding to practices. During 13/14 the local Area Team reviewed all the PMS contracts and all non-APMS practices will move onto GMS contracts (2 are still on PMS contracts but will shortly move to GMS). There will be a 7 year tapering of the PMS funding with this “PMS Premium” funding being released for re-investment by NHSE jointly with the CCG. (Appendix J is the National Guidance on how the PMS Premium should be used locally).

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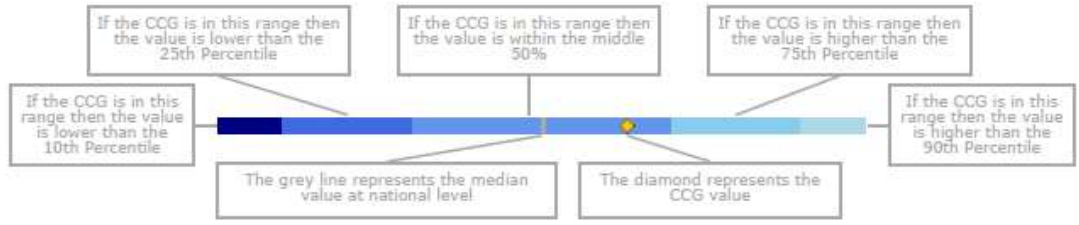
Summary of Wolverhampton practices compared to the National average

Demographics

Indicator Name	Period	CCG Mean	National Mean
List Size	Sep 2011	5245.56	7085.38
Carr Hill List Size	Sep 2011	5507.74	7086.2
Annual Turnover	Sep 2011	0.07	0.08
No of Male Patient	Sep 2011	50%	50%
No of Female Patients	Sep 2011	50%	50%
% of patients in a Nursing Home	Sep 2011	0%	1%
% of pts from a BME population	Sep 2011	27%	16%
% of pop. on Disability Living	Sep 2011	6%	5%
Patients aged 0-4 years	Sep 2011	7%	6%
Patients aged 5-14 years	2011-12	12%	11%
Patients aged 15-44 years	Nov 2011	42%	41%
Patients aged 45-64 years		24%	25%
Patients aged 65-74 years		8%	9%
Patients aged 75-84 years		5%	5%
Patients aged 85 years or older		2%	2%

Deprivation

IMD	2010	36.89	23.85
IDACI	2010	0.34	0.23
IDAOPI	2010	0.32	0.23



Source: www.primarcare.nhs.uk

Of note Wolverhampton practices have smaller than average practice populations, high levels of Black and Ethnic Minority (BME) patients and high levels of deprivation. When comparing Practice level achievements the CCG will seek CCGs with a similar profile and practices with similar profiles.

Practice profiles can be found on www.primarycare.nhs.uk. The table below provides some of the key differences between the practices which will impact on the practice's outcomes.

	Locality	Row Labels	No GPs	GP FTEs	Contract type	Registered Population April 2015	Carr Hill weighted population April 2015	Standard Mortality rate	Deprivation (IMD)	% of patients in nursing homes	% Disability living allowance	%BME	Annual List Turnover
1	NE	M92022 - DR RAJCHOLAN & DR GEORGE	2	1.56	GMS	3787	3943	101.76	15.18	0.34%	7.20%	5.32%	8.85%
2	NE	M92014 - DR FOWLER	1	1.00	GMS	2061	2254	103.73	30.96	0.19%	5.87%	8.14%	6.42%
3	NE	M92041 - PROBERT ROAD SURGERY	1	1.00	still PMS	4626	4418	105.37	33.03	0.13%	5.90%	10.39%	8.70%
4	NE	M92004 - PRIMROSE LANE PRACTICE	1	1.00	GMS	2885	3290	106.68	23.41	0.35%	6.67%	21.97%	6.10%
5	NE	M92001 - POPLARS MEDICAL CENTRE	1	0.56	GMS	3320	3125	108.95	33.5	0.00%	6.69%	23.43%	6.36%
6	NE	M92016 - TUDOR MEDICAL CENTRE	4	4.00	GMS	6471	7038	109.82	30.94	0.04%	6.40%	32.84%	11.43%
7	NE	M92002 - THE GROUP PRACTICE ALFRED SQUIRE ROAD	5	4.39	GMS	8415	9641	124.65	28.4	0.04%	6.49%	3.36%	4.36%
8	NE	M92009 - PRESTBURY MEDICAL PRACTICE	11	9.00	GMS	13763	15451	130.46	31.32	0.31%	6.17%	13.52%	7.02%
9	NE	M92609 - ASHFIELD ROAD SURGERY	2	2.00	GMS	4930	4540	130.7	45.31	0.04%	5.79%	16.46%	5.28%
10	NE	M92019 - KEATS GROVE SURGERY	5	3.70	GMS	6387	6305	133.15	43.94	0.00%	6.97%	3.42%	5.75%
11	NE	M92039 - DR LINNEMANN/DR ST PIERRE-LIBBERTON	4	2.56	GMS	6574	2839	133.19	34.96	0.12%	6.23%	20.52%	?
12	NE	M92643 - DR CHRISTOPHER	1	1.00	GMS	2474	2241	133.91	48.28	0.04%	6.08%	49.16%	7.29%
13	NE	M92629 - DRS KHARWADKAR & MAJI	1	1.00	GMS	3332	3720	139.75	40.5	0.06%	5.85%	27.51%	6.86%
14	NE	Y02736 - SHOWELL PARK HEALTH & WALK IN CENTRE	8	5.46	APMS	4811	4675	140.2	53.88	0.50%	6.57%	32.81%	13.36%
15	NE	M92013 - WODEN ROAD SURGERY	9	7.45	GMS	6852	7474	142.00	42.48	0.19%	6.28%	44.38%	9.11%
16	NE	M92026 - DR BILAS	2	2.00	GMS	3866	3949	153.38	53.31	0.03%	7.24%	5.83%	5.88%
17	SE	M92024 - PARKFIELD MEDICAL CENTRE	12	11.2	GMS	12858	13345	125.76	34.94	1.24%	6.34%	21.55%	7.89%
18	SE	M92649 - DR MUDIGONDA	3	3.00	ex PMS	3605	3889	128.3	29.54	0.25%	7.66%	13.90%	5.37%
19	SE	M92627 - DR SHARMA	3	3.35	GMS	3178	3720	129.73	44.52	0.16%	7.58%	13.57%	4.92%
20	SE	M92027 - CAERLEON SURGERY	2	2.00	still PMS	3319	4247	129.73	44.52	2.56%	7.64%	8.11%	7.68%
21	SE	M92030 - CHURCH STREET SURGERY	2	2.00	GMS	5414	5669	130.39	36.89	0.09%	7.82%	23.95%	9.36%
22	SE	M92015 - DRS PAHWA	2	2.00	GMS	3865	4182	130.59	37.68	0.41%	6.45%	59.02%	7.26%
23 a	SE	M92035 - ALL SAINTS SURGERY	3	1.66	GMS	3500	3189	131.94	42.74	0.06%	6.11%	82.21%	6.09%
23b	SE	M92642 - DR KANCHAN	4	3.18	GMS	2111	2030	143.97	39.79	0.09%	7.14%	81.15%	5.74%
24	SE	M92040 - MAYFIELD MEDICAL CENTRE	3	2.32	ex PMS	6348	6650	132.92	38.64	0.02%	6.63%	29.82%	7.04%
25	SE	M92647 - BRADLEY MEDICAL CENTRE	2	2.00	GMS	3010	3554	135.31	38.92	0.17%	7.40%	11.42%	3.97%

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	Locality	Row Labels	No GPs	GP FTEs	Contract type	Registered Population April 2015	Carr Hill weighted population April 2015	Standard Mortality rate	Deprivation (IMD)	% of patients in nursing homes	% Disability living allowance	%BME	Annual List Turnover
26	SE	Y02757 - BILSTON URBAN VILLAGE MEDICAL CENTRE	6	3.81	APMS	5542	4806	136.48	45.27	0.07%	7.01%	29.75%	9.31%
27	SE	Y02735 - ETTINGSHALL MEDICAL CENTRE	3	2.44	APMS	3374	3392	136.6	4878	5.93%	6.84%	18.40%	10.29%
28	SE	M92003 - DR SURYANI	2	2.00	GMS	1733	1960	136.82	42.48	0.00%	7.49%	10.87%	6.43%
29	SE	M92012 - DUNCAN STREET PRIMARY CARE PARTNERSHIP	10	9.38	ex PMS	9491	10050	137.43	37.25	0.47%	5.98%	57.56%	8.54%
30	SE	M92612 - GROVE MEDICAL CENTRE	2	1.39	GMS	3319	3284	139.21	39.74	0.00%	6.10%	81.16%	7.91%
31	SE	M92654 - BRADLEY CLINIC PRACTICE	3	3.00	ex PMS	7494	4840	139.26	44.74	0.08%	7.76%	9.35%	?
32	SE	M92630 - EAST PARK MEDICAL PRACTICE	4	3.43	ex PMS	4884	4991	142.8	46.79	0.00%	7.07%	15.49%	4.97%
33	SW	M92011 - PENN MANOR MEDICAL PRACTICE	9	8.46	ex PMS	11478	11799	105.62	15.86	1.39%	4.15%	8.95%	5.97%
34	SW	M92008 - CASTLECROFT MEDICAL PRACTICE	7	6.00	ex PMS	12128	12764	105.64	20.2	0.74%	4.52%	17.93%	5.29%
35	SW	M92043 - PENN SURGERY	4	3.22	GMS	4956	5061	107.61	20.76	1.23%	5.02%	15.61%	6.17%
36	SW	M92640 - TETTENHALL ROAD MEDICAL PRACTICE	1	1.00	GMS	2242	2110	111.26	31.61	0.27%	5.03%	7.24%	10.94%
37	SW	M92006 - COALWAY ROAD MEDICAL PRACTICE	4	3.50	ex PMS	5255	5397	117.11	22.05	0.42%	4.89%	27.22%	6.78%
38	SW	M92042 - 80 TETTENHALL ROAD SURGERY	3	2.60	GMS	3387	3526	122.62	28.08	0.62%	5.07%	24.14%	8.17%
39	SW	M92029 - NEWBRIDGE SURGERY	4	3.06	GMS	4449	4701	124.73	25.41	0.88%	4.92%	29.07%	9.49%
40	SW	M92010 - TETTENHALL MEDICAL PRACTICE	5	5.00	GMS	11681	12359	129.73	45.52	0.95%	4.11%	6.43%	7.10%
41	SW	M92607 - WHITMORE REANS MEDICAL PRACTICE	5	4.53	GMS	12325	12253	136.49	34.91	0.14%	5.63%	53.83%	7.87%
42	SW	M92044 - DRS DE ROSA & WILLIAMS	2	2.00	GMS	4248	4477	138.52	45.47	0.24%	5.16%	7.75%	6.26%
43	SW	M92007 - LEA ROAD MEDICAL PRACTICE	6	5.60	GMS	6467	6624	142.01	34.68	1.38%	5.58%	44.63%	7.20%
44	SW	M92031 - DRS PASSI & HANDA	2	2.00	GMS	6527	6728	148.76	37.7	0.03%	5.64%	74.52%	10.28%
45	SW	M92028 - THORNLEY STREET MEDICAL CENTRE	7	6.75	ex PMS	9683	9516	150.99	43.28	0.36%	5.95%	37.81%	13.98%
46	SW	Y02636 - INTRA HEALTH LIMITED	5	2.92	APMS	3211	2571	151.58	41.83	1.56%	5.25%	44.12%	19.60%

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Federation

Wolverhampton GPs formed Wolverhampton Doctors on Call as a Limited Company providing Out of Hours Services. Over 50% of practices had shares in this organisation. In the last 12 months they have been seeking to develop their role to support practices in Wolverhampton across a broad range of areas. They have registered a sister company as a Community Interest Company, to provide these additional supports, which is looking to offer a number of supports to all practices for example assistance to prepare for CQC visits. They have been involved in supporting the development of a number of bids including for Pharmacists in General Practice, a pilot Community Education Provider Network (with Walsall GP Federation) and the Primary Care Home Model pilot below.

Wolverhampton Total Health Care

In November 2015 26 GPs, providing Primary and Extended Primary Care to 47,000 patients through 8 practices, put in a bid to become one the National Association of Primary Care's (NAPC's) Primary Care Home Model pilot sites. Their bid was one of 14 that were approved in December 2015 and work is now ongoing to agree how this will develop over the next few months with some activities being live from April 2016 but with 2016/17 being seen as a shadow or developmental year.

The proposal is for these practices to form a not-for-profit Social Enterprise or Community Interest Company that will offer multi-speciality working through a "Home", creating a "one organisation" approach to delivering bespoke population health to the registered lists of all 26 constituent GPs – whilst ensuring they retain personalised care for individuals, and continue to identify at risk patient groups.

	Locality	Row Labels	Contract type	Registered Population April 2015	Carr Hill weighted population April 2015
1	NE	M92016 - TUDOR MEDICAL CENTRE	GMS	6471	7038
2	NE	M92629 - DRS KHARWADKAR & MAJI	GMS	3332	3720
3	NE	M92019 - KEATS GROVE SURGERY	GMS	6387	6305
4	SE	M92030 - CHURCH STREET SURGERY	GMS	5414	5669
5	SE	M92630 - EAST PARK MEDICAL PRACTICE	ex PMS	4884	4991
6	SE	M92027 - CAERLEON SURGERY	still PMS	3319	4247
7	SW	M92607 - WHITMORE REANS MEDICAL PRACTICE	GMS	12325	12253
8	SW	M92029 - NEWBRIDGE SURGERY	GMS	4449	4701
		TOTAL		**46581**	**48923**

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Vertical Integration model

Since September 2015 two Wolverhampton CCG practices, with 11 GPs covering a population of 14,882, have been in discussions with Royal Wolverhampton Trust to integrate vertically. Exactly how this might be done is still in discussion.

	Locality	Row Labels	Contract type	Registered Population April 2015	Carr Hill weighted population April 2015
1	NE	M92002 - THE GROUP PRACTICE ALFRED SQUIRE ROAD	GMS	8415	9641
2	SW	M92007 - LEA ROAD MEDICAL PRACTICE	GMS	6467	6624
		TOTAL		**14882**	**16265**

Contract Management – www.primarycare.nhs.uk

Part of the approach taken by NHSE to quality and activity contract management has been the development of the Primary Care Web Tool which provides GPs, NHS England, it's Area Teams and strategic partners (including Department of Health and CCGs) with access to practice level information (i.e. data indicators) relating to outcomes, quality and patient experience.

There are 38 indicators which have been defined for assurance management (called General Practice High Level Indicators (GPHLIs)) and a further 28 outcome standards for quality improvement (called General Practice Outcome Standards ((GPOS). There is much debate about the timeliness of this data and also accuracy and interpretation but at this time these are the key tools being used to assess General Practice providers. They are based on data from a number of sources: QOF (collected annually), SUS (available monthly 3months in arears) and patient survey data (collected twice a year).

Clearly there may be a very good reason why a practice is an outlier on a GPHLI or trigger a GPOS and NHSE has made it clear that they will only use these measures to ask questions not to make judgements. Practices being able to explain why an indicator is out of line with the National averages.

General Practice High Level Indicators (GPHLI)

Appendix K is the CCG average achievement of these Indicators is compared to the national average. In addition individual practices are plotted on a National Funnel Plot. This shows that Wolverhampton Practices are practicing very similarly to all England practices with no significant statistically valid variation between practices. For many indicators all practices are within the England funnel, and behaving and achieving very similarly to each other.

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Of the 46 practices some are "outliers" against particular indicators. Below are listed those indicators with 5 or more outliers:

GP High Level Indicator with high numbers of outlier practices

	Indicator	Number of Outlier Practices
1	Emergency Cancer admissions per 100 population	7
2	Emergency Asthma admissions per 100 patients on disease register	5
3	The percentage of patients with diabetes who last measured cholesterol within the previous 15 months was 5mm0l/l or less	7
4	Diabetes Prevalence ratio	5
5	Ezetimibe as a proportion of all Lipid modifying drugs	5

Source: www.primarycare.nhs.uk

The high prevalence of diabetes in Wolverhampton is due to the ethnic makeup of the population means the prevalence ratio outliers are to be expected – in fact we might expect more practices to be outliers.

The CCG has 6 practices with 6 or more outliers:

- M92001-POPLARS MEDICAL CENTRE- Number of Outlying Datapoints:7
- M92013-WODEN ROAD SURGERY- Number of Outlying Datapoints:6
- M92015-DRS PAHWA- Number of Outlying Datapoints:7
- M92026-DR BILAS- Number of Outlying Datapoints:6
- M92607-WHITMORE REANS MEDICAL PRACTICE- Number of Outlying Datapoints:7
- Y02736-SHOWELL PARK HEALTH & WALK IN CENTRE- Number of Outlying Datapoints:6

Note Dudley CCG has 3/47; Walsall CCG has 2/62; and Sandwell and West Birmingham 8/101.

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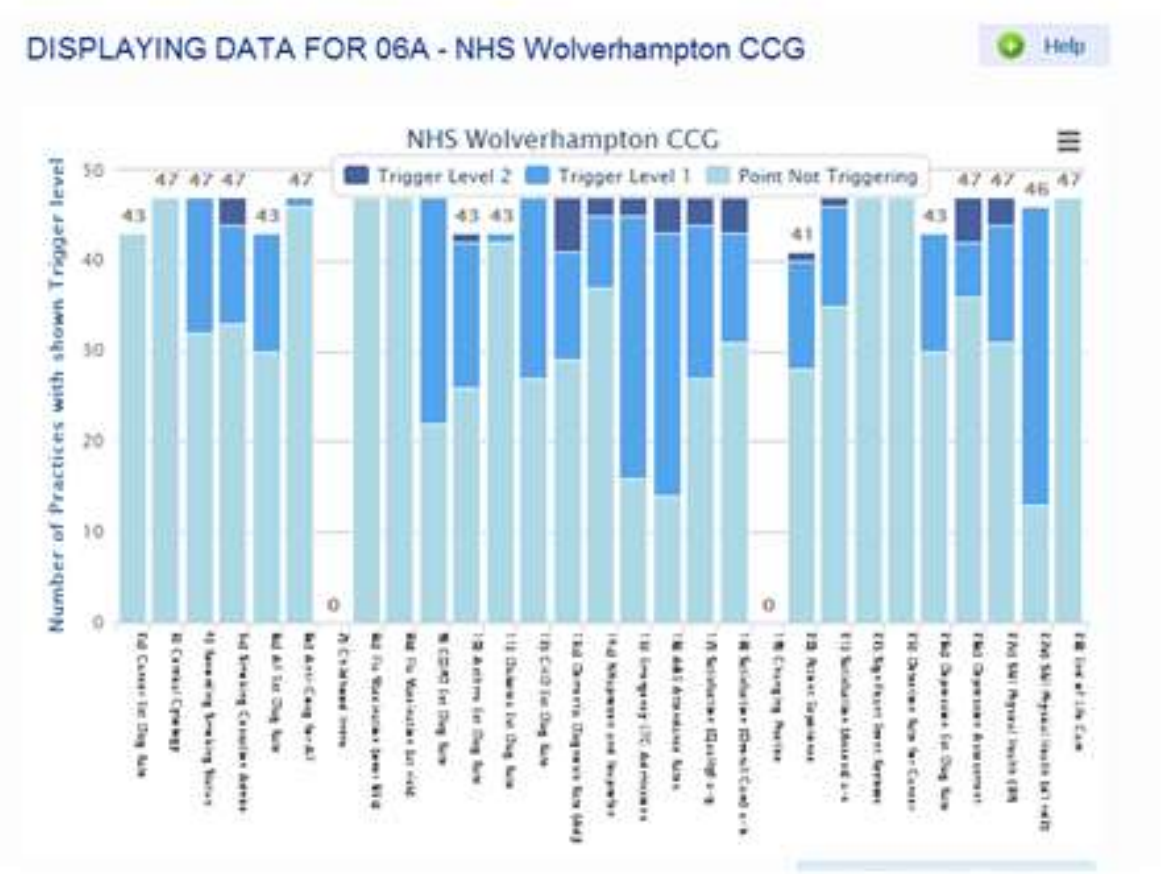
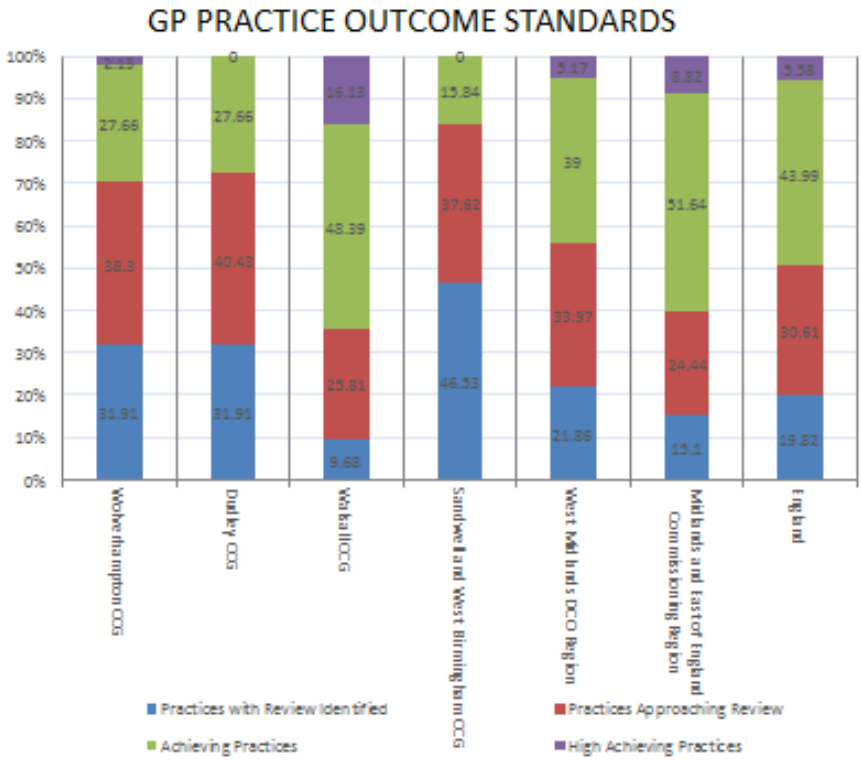
General Practice Outcome Standards

Each standard has a defined "Trigger" 1 and 2. These standards are used to define 4 types of Practice: High Achieving Practices, Achieving Practices, Practices Approaching Review and Practices with Review identified.



Areas with most practices triggering:

- A&E Attendance rates - 33 practices high (4 trigger 2)
- Emergency LTC admissions – 31 practices high (2 trigger 2)
- COPD Estimated diagnosis rate – 25 practices are low (all trigger 1s)



IT – HARDWARE, SOFTWARE AND UTILISATION

36 practices are now using EMIS web with the last few Vision practices in the process of moving over to EMIS. The remaining 10 practices use System One. Appendix L is a list of the practices showing which system they are using. 26 practices now have EMIS mobile.

Use of other functions of EMIS or System One such as Enhanced Patient Access and GP-GP Notes transfer is patchy as is the use of DSX and e-referrals. The GPIT team continues to provide practices with training and support to use these facilities.

GPIT has a broad range of ongoing projects that support practices to develop their IT systems and use of the systems they have. All are in process of being rolled out.

• DSX
• GP2GP
• EPS R2
• DQ/PDQI (Formerly IM & T DES
• Emis mobile
• Eclipse Live
• Mobile Device Management

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• NHSmail – Care Homes Project
• Telemedicine – IPhone apps from patient.co.uk
• Direct Script requests to practices
• Instant Messaging
• Jayex – Web Media
• Jayex – Questionnaire Module
• E-Referral System Advice & Guidance
• E-Referral System Community Services
• Enhanced Patient Access

WORKFORCE

The following charts and information comes from the general practice census for 30 September 2014.[9] The data, collected each year, records the numbers and details of GPs, nurses, staff, patients and the services that are provided in England. This does not give any information on vacancies or staff turnover or sickness absences etc.

According to the census, Wolverhampton's General Practitioner total headcount in November 2014 was 188 (162.5 FTE). The nursing headcount (including ANPs) was 92, (55.5 FTE). This shows that the Wolverhampton General Practice workforce to be significantly below both England and Birmingham and the Black Country.

Patients per GP headcount

* WCCG 1,486
* England 1,391
* Birmingham and Black Country 1,419

Patients per GP FTE

* WCCG 1,604
* England 1,503
* Birmingham and Black Country 1,552

Patients per nurse headcount

* WCCG 2,605
* England 2,305
* Birmingham and Black Country 2,370

Patients per nurse FTE

* WCCG 4,347
* England 3,704
* Birmingham and Black Country 3,846

9 http://www.hscic.gov.uk/article/2021/WebsiteSearch?productid=17387&q=general+practitioners&sort=Relevance&size=10&page=1&area=both#top

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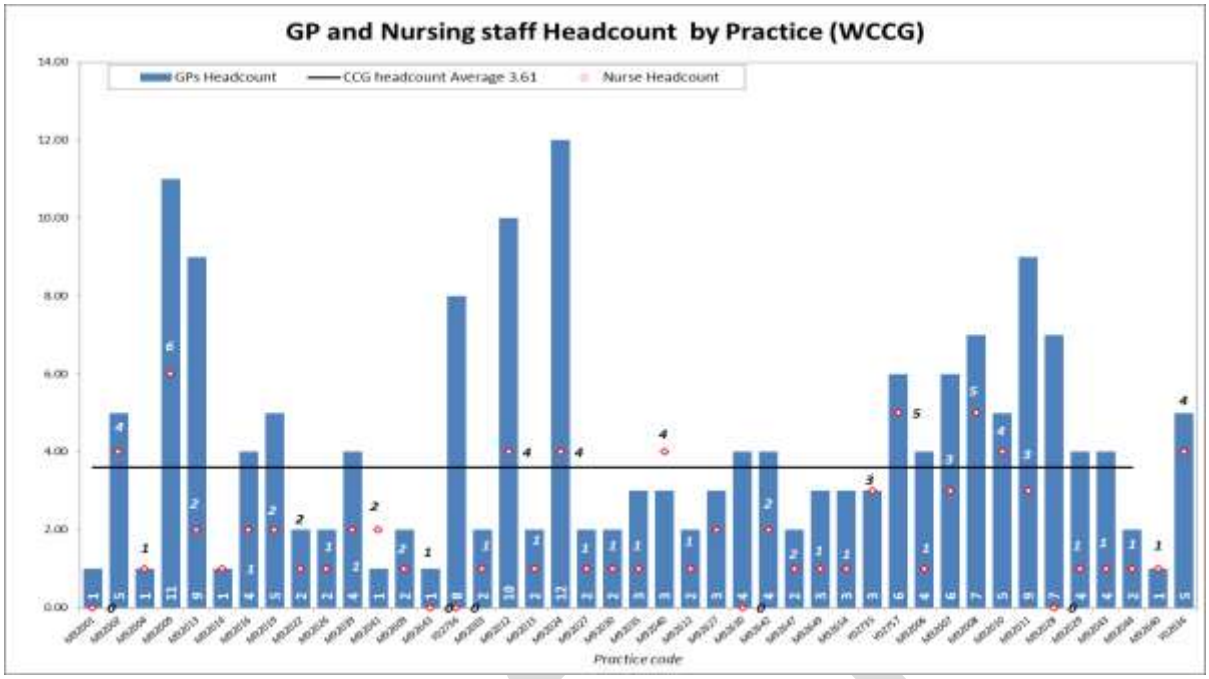

Gender split

In 2014, the national average was 48% male and 52% females. The Wolverhampton CCG average is higher at 56% males and 44% females. Of the 188 GPs in Wolverhampton, the gender split is 106 males and 82 females. Of the 162.5 full time equivalents, the split is 91.5 FTE males and 71 FTE females.

Aging Workforce

In 2014 the percentage of GPs over 55 years in England was 21.9%; Wolverhampton's was higher at 25%.

Details are not available for age profiling nurses in Wolverhampton.

ESTATES

A survey has recently been undertaken as the basis for the Estates Strategy that is being developed.

Overview of GP Estate

Of the 59 GP practices surveyed, 54% of premises are owned Freehold by the GP practices and 46% are Leasehold.

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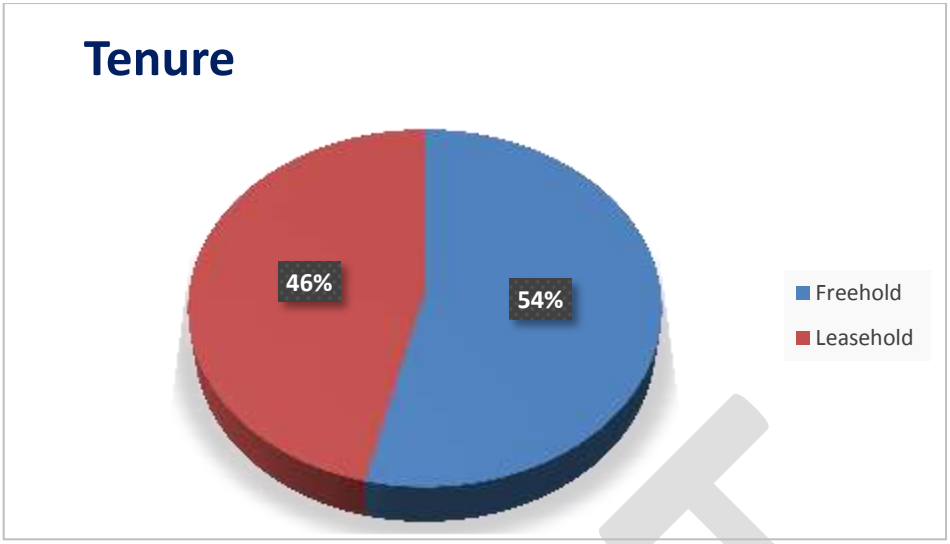

Number of holdings and GIA m2

The following GP estate is currently mapped on SHAPE

- 2 LIFT
- 79 Wolverhampton CCG

Tenure, Condition and Utilisation of GP Estate

Tenure and condition information has been provided in the form of a 5-facet survey report which assessed 59 of the GP premises across Wolverhampton CCG. The summary of this report can be seen in the following five figures and the general criteria on which the methodology is based is outlined below.

Functional Suitability, Physical Condition, Quality and Statutory Standards were assessed with a scoring system:

- A – Excellent (As New)
- B – Satisfactory (General Maintenance only)
- C – Operational (Requires Capital Investment)
- D – Very Poor (Serious Risk)

Space Utilisation was assessed with a scoring system:

- 4 – Overused
- 3 – Full (over 85% usage)
- 2 – Spare Capacity

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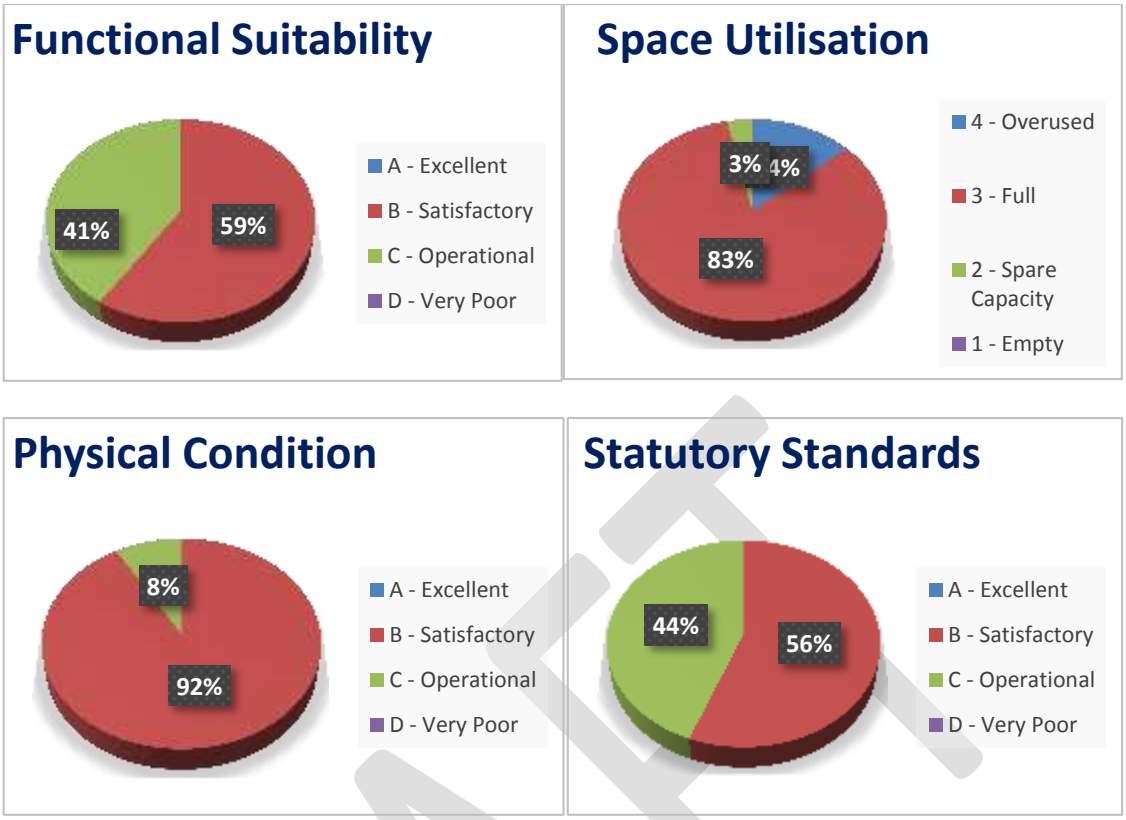
Locality	Code	Practice Name	Post Code	List Size	Tenure	Functional Suitability	Physical Condition	Space Utilisation	Quality	Stautory Standards
NE	M92016	Tudor Medical Practice, Heath Town	WV10 0LT	4,728	Freehold	B	B	3	B	C
NE	M92654	MGS Medical Practice, 191 First Ave, Low Hill	WV10 9SX	7700 over 3 sites	Freehold	B	B	3	B	B
NE	M92654	MGS Medical Practice, 30-32 Ruskin Road, Low Hill	WV10 8DJ	7700 over 3 sites	Freehold	B	B	3	B	B
NE	M92026	Dr Bilas, Wednesfield	WV11 2JN	3,890	Freehold	B	B	3	B	C
NE	M92643	Heath Town Medical, Heath Town	WV10 0HP	2,500	Leasehold	C	B	4	C	B
NE	M92609	Ashfield Road Surgery, Fordhouses	WV10 6QX	2,600	Freehold	B	B	3	B	B
NE	M92609	Pendeford Health Centre (Dr Dhillon & Nandanavanam)	WV9 5NJ	2,600	Leasehold	B	B	3	B	B
NE	M92607	Pendeford Health Centre (Dr Vij)	WV9 5NJ	2,100	Leasehold	B	B	3	B	B
NE	M92014	Dr Fowler, Oxley	WV10 6AR	2,020	Freehold	C	B	3	B	C
NE	M92022	Ashmore Park Health Centre, Ashmore Park	WV11 2LH	3,948		B	B	3	B	B
NE	M92013	Woden Road Surgery	WV10 0BD	7,000	Freehold	B	B	3	B	C
NE	M92004	Primrose Lane Clinic, Scotlands	WV10 8RN	3,000	Leasehold	B	B	3	B	B
NE	M92019	Keats Grove Surgery, Scotlands	WV10 8LY	6,400	Leasehold	B	B	3	B	C
NE	M92629	Fordhouses Medical Centre, Fordhouses	WV10 6RU	3335		B	B	3	B	B
NE	M92629	Pendeford Health Centre (Dr Kharwadkar)	WV9 5NJ	3,335	Leasehold	C	B	3	B	B
NE	M92040	Cromwell Road Surgery, Bushbury	WV10 8UT	6,513	Freehold	B	B	2	B	B
NE	M92039	Cannock Road Practice, Wednesfield	WV10 8PJ							
NE	M92001	Poplars Medical Practice, Low Hill	WV10 9PG	3,558	Freehold	C	B	3	B	C
NE	M92041	Probert Road Surgery	WV10 6UF	4,650	Leasehold	B	B	3	C	C
NE	M92009	Prestbury Medical Practice, Wednesfield	WV11 1HT	6,500	Freehold	C	B	4	B	B
NE	M92009	Prestbury Medical Practice, Bushbury	WV10 8ED	6,500	Leasehold	B	B	3	B	B
NE	M92002	Alfred Squire Medical Practice, Wednesfield	WV11 1XU	8,430	Leasehold	C	B	3	C	B
NE	Y02736	Showell Park Health and Walk In Centre, Low Hill	WV10 9ST	4,800	Leasehold	B	B	3	B	B
SE	M92016	Wellington Road Surgery, Bilston	WV14 6AQ	2,100	Freehold	B	B	3	B	C
SE	M92017	Caerleon Surgery, Bilston	WV14 6AL	3,315	Freehold	C	B	4	B	B
SE	M92035	All Saints Surgery, Wolverhampton	WV2 1EU	3,500	Freehold	C	C	3	C	C
SE	Y02757	Bilston Urban Village Medical Centre, Bilston	WV14 0EE	5,920	Leasehold	B	B	3	B	B
SE	Y02735	Ettingshall Medical Centre, Ettingshall	WV14 0NF	3,787		B	B	3	B	B
SE	M92024	Parkfield Medical Centre, Parkfields	WV4 6EG	13,500	Freehold	B	B	3	C	B
SE	M92024	Woodcross Health Centre, Bilston	WV14 9BX	13,500	Leasehold	B	B	3	B	B
SE	M92035	Shale Street Surgery, Bilston	WV14 0HF	2,500		C	C	4	C	C
SE	M92012	Duncan St Primary Care Centre, Blakenhall	WV2 3AN	9,400	Freehold	B	B	3	B	C
SE	M92040	Mayfield Medical Centre, Willenhall	WV1 2GZ	6,600	Freehold	C	B	3	B	C
SE	M92647	Bradley Medical Centre, Bradley	WV14 8TH	3,000	Freehold	C	B	3	B	C
SE	M92649	Bilston Health Centre (Dr Mudigonda), Bilston	WV14 6PW	3,700	Leasehold	B	B	3	C	B
SE	M92015	Bilston Health Centre (Dr Pahwa), Bilston	WV14 6PW	3,385	Leasehold	B	B	3	B	B
SE	M92630	East Park Medical Practice, East Park	WV1 2LW	5,000	Freehold	B	B	3	B	B
SE	M92030	Church Street Surgery, Bilston	WV14 0AX	5,500	Freehold	C	B	3	B	B
SE	M92627	Bilston Health Centre (Dr Sharma), Bilston	WV14 6PW	3,200	Leasehold	C	B	3	B	B
SE	M92003	Hill St Surgery, Bradley	WV14 8SE	1,800	Freehold	C	B	4	C	B
SE	M92654	MGS Medical Practice, Wallace Road, Bradley	WV14 8BW	7700 over 3 sites	Leasehold	C	C	3	C	C
SE	M92607	Ednam Road Surgery, Goldthorn Park	WV14 5BL	2,700	Freehold	C	B	4	B	C
SE	M92612	Grove Medical Centre, Wolverhampton	WV2 2AU	3,300	Freehold	C	B	3	B	C
SW	M92043	Penn Surgery, Penn	WV3 7LR	5,000	Freehold	C	B	3	B	C
SW	M92006	Coalway Road Surgery, Penn	WV3 7NA	5,260	Freehold	B	B	2	B	B
SW	M92044	Warstones Health Centre, Penn	WV4 4PS	4,264	Leasehold	C	B	4	C	B
SW	M92010	Lower Green Health Centre, Tettenhall	WV6 9LL	11,700	Leasehold	B	B	3	B	B
SW	M92010	Wood Road Clinic, Tettenhall Wood	WV6 8NF	4,000		B	B	3	B	B
SW	M92007	Lea Road Medical Practice, Pennfields	WV3 0LS	6,500	Freehold	C	B	3	B	B
SW	M92009	Prestbury Medical Practice, Dunkley Street	WV1 4AN	1,283	Leasehold	C	B	3	C	C
SW	M92031	Leicester St Medical Centre, Whitmore Reans	WV6 0PS	3,900	Freehold	C	B	4	C	C
SW	M92031	Owen Road Surgery, Pennfields	WV3 0AJ	3,500	Freehold	C	B	3	B	C
SW	Y02636	Pennfields Medical Centre, Pennfields	WV3 0JH	3,500	Leasehold	B	B	3	B	B
SW	M92029	Newbridge Surgery, Tettenhall	WV6 0DE	4,480	Freehold	B	B	3	B	C
SW	M92028	Thornley Street Surgery	WV1 1JP	9,600	Freehold	C	B	3	C	C
SW	M92042	Tettenhall Road Surgery, Tettenhall	WV1 4TF	3,400	Leasehold	B	C	3	C	C
SW	M92607	Whitmore Reans Health Centre, Whitmore Reans	WV6 0QL	8,000	Leasehold	B	B	3	B	C
SW	M92008	Castlecroft Medical Practice, Castlecroft	WV3 8JN	12,100	Leasehold	B	B	3	B	B
SW	M92011	Penn Manor Medical Centre, Penn	WV4 5PY	11,500	Leasehold	B	B	3	B	C
SW	M92640	Dr Whitehouse Surgery, Wolverhampton	WV6 0DD	2,100	Leasehold	B	C	3	C	C



The 5 facet survey report highlights that the GP estate is well utilised and on the whole in good condition with regard to building structures. There is evidence of ongoing investment in building structures by GPs, but further targeted investment is required to enhance particular engineering services such as heating, fire and door access. Further investment is also required in order to improve some areas of poor quality and address areas of non-compliance of statutory standards such as infection control and Disability Discrimination Act, although generally there is good compliance on other standards.

The key areas for concern are functional suitability and space utilisation of the GP estate. Some sites already appear to be over-utilised and the majority of the estate is at full utilisation, which indicates over 85% capacity. Poor functional suitability is an issue across the GP estate, particularly within those sites which have been converted from alternative uses such as residential or retail properties.

14.3.2. Community Services

Community Services are provided by Royal Wolverhampton Trust (RWT).

14.3.3. Out of Hours (OOH)

The Out of Hours contract was put out to tender during 2015/16 and the contract has been awarded to Northern Doctors Urgent Care Ltd. The service will be provided from the new

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Urgent Care Centre on the RWT site (see below) from April 2016. At present it is provided at Showell Park by Wolverhampton Doctors on Call.

14.3.4. Urgent Care and Walk In Centres

There are at present two Walk In Centres (WICs) that provide slightly different services. The two centres are: Showell Park (APMS) and the Phoenix Centre (RWT).

Following consultation and then a tendering process the Showell Park WIC has been decommissioned from end March 2016 and Northern Doctors Urgent Care Ltd, will run the new Urgent Care Centre at the Royal Wolverhampton Trust New Cross Hospital site.

The Urgent Care Centre will be operating 24 hours a day, seven days a week for people who walk in or are referred there having contacted NHS111 first. The service incorporates the existing Showell Park WIC and the GP Out of Hours service currently based at the Phoenix Centre.

The service will be provided to patients of all ages and cover conditions such as:

- Minor burns and bites
- Fever and raised temperatures
- Sickness and vomiting
- Irritation and rashes
- Mild breathing difficulties
- Cuts and scrapes

The Walk-in Centre, based at the Phoenix Health Centre, is a nurse-led service provided by RWT offering on-the-spot treatment (without an appointment) and advice for minor health problems, minor illnesses, ailments and minor injuries. This service will continue and is open 365 days a year: Monday - Friday: 10.00 am - 7.00 pm and Saturdays, Sundays and Bank Holidays: 10.00 am - 4.00 pm.

14.3.5. 111

Following the outcome of the recent NHS111 re-procurement process in the West Midlands the West Midlands Ambulance Service ceased to deliver the service in August 2015 and Vocare, trading as West Midlands Doctors Urgent Care took over temporary provision.

The 111 service that covers the Wolverhampton population is in the process of being tendered for. The exact specification of the new service is still being developed but, as

required nationally, will be fully integrated with the OOH and ambulance service to ensure patients do not experience problems at the interface between these services.

The Directory of Services (DOS) is a key resource for this service to direct patients to the relevant local services. Development and up keep of this data base is an important element of this service.

14.3.6. Other out of hospital services

There are a small number of providers of services out in the community:

2015/16

Provider	Service Description
Acorns Children's Hospice	Home Care
Birmingham Women's Hospital Foundation Trust	IVF
Christine Harrison (Physio)	Extended Primary Care Services - Physiotherapy
Complete Price Ear Wear	AQP Hearing
Compton Hospice - Main Contract (inc Tettenhall Wood Pharmacy)	Community Services
Concordia	Dermatology
Dr Mittal - Community Ultra Sound Service	Community Services
Dr Morgans and Partners (Probert Court)	Community Services
Dudley Group NHS Foundation Trust	AQP Podiatry
Dudley Group NHS Foundation Trust	AQP Hearing
FE Physiotherapy Ltd	Extended Primary Care Services - Physiotherapy
Heantun Care Housing Association - Priority Care Project	Home Care / Visiting Service

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Heantun House Association - Probert Continuing Care (CHC)	Continuing Healthcare Beds / Step Down Beds
HEFT – AQP	AQP Hearing
In Health LTD	AQP Hearing
Marie Stopes International LTD	Termination of Pregnancy
Midland Heart	Mental Health Services - Residential
NHS Direct NHS Trust	111 Service
Peter Evans	Extended Primary Care Services - Physiotherapy
Primary Care Medicines Team	Community Services
Primary Eye-Care Assessment and Referral Service – AQP	Community Service
Primecare	Out of Hours Services
Royal Wolverhampton NHS Trust - AQP	AQP Hearing
Royal Wolverhampton NHS Trust- AQP	AQP Podiatry
Sandwell & West Birmingham Hospitals NHS Trust - AQP	AQP Hearing
Sandwell & West Birmingham NHS Trust	AQP Podiatry
Scrivens – AQP	AQP Hearing
Sickle Cell and Thalassaemia Support Project	Community Services
Specsavers – AQP	AQP Hearing
Sue Arch (Physio)	Extended Primary Care Services - Physiotherapy
University Hospital Birmingham	AQP Podiatry
Walsall Healthcare NHS Trust	AQP Podiatry
Walsall Hospital NHS Trust - AQP	AQP Hearing

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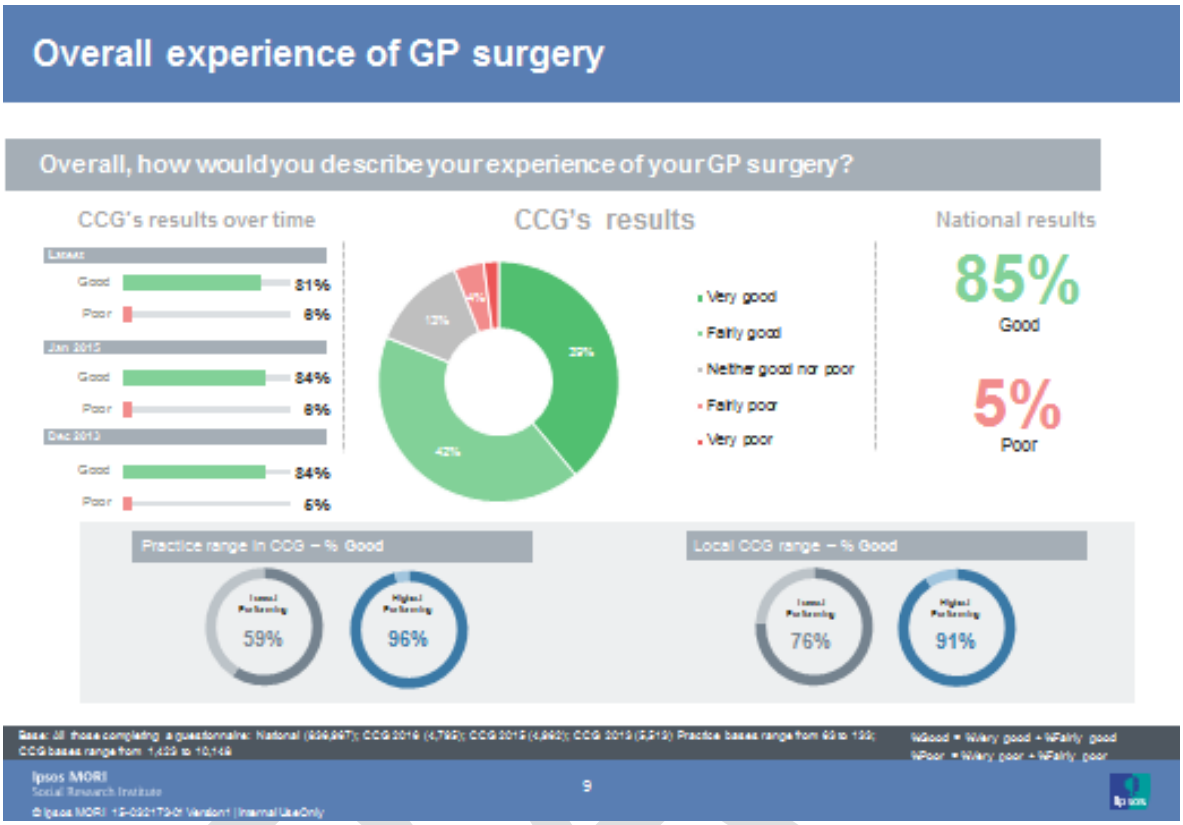
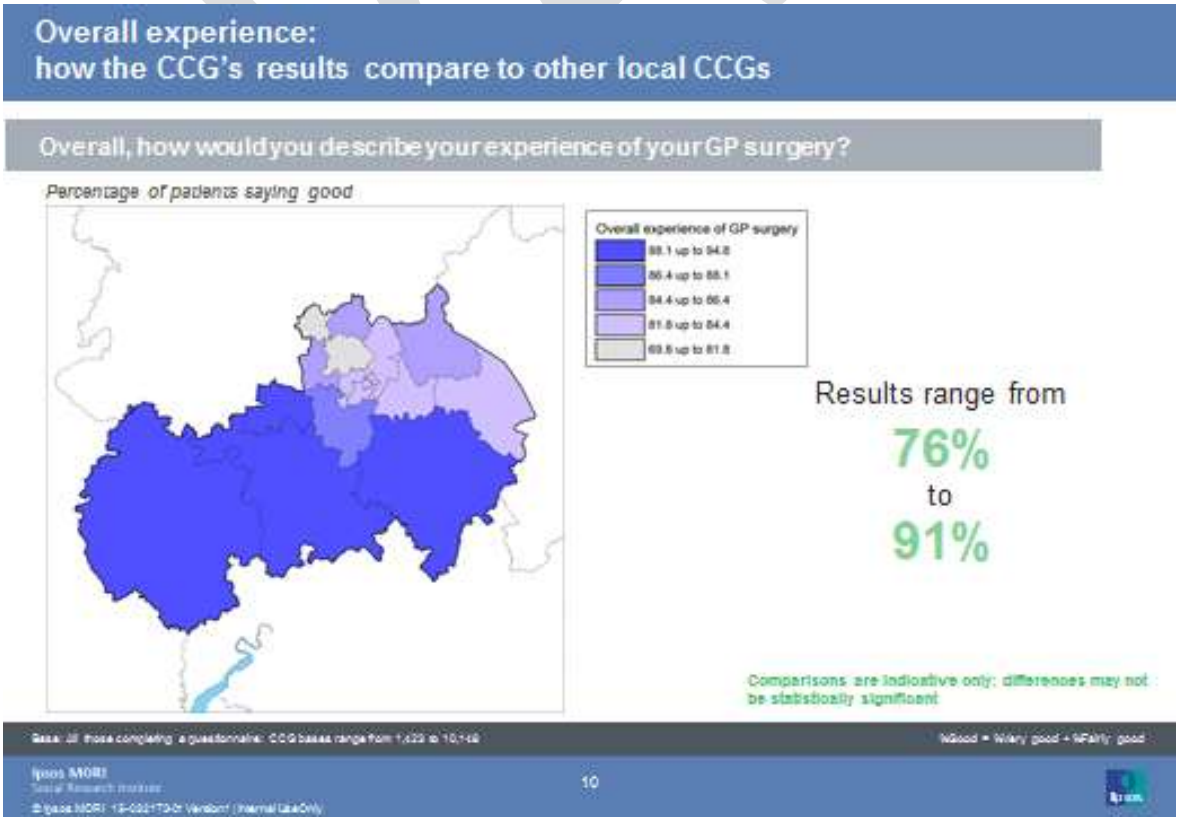
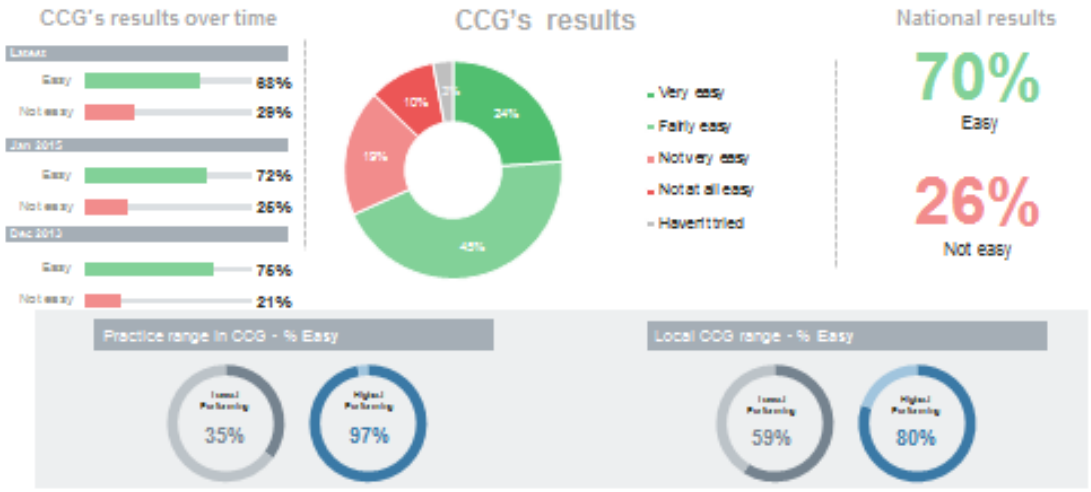
14.4. What our population says about their local health services – January 2016 GP Practice Patient Survey





Ease of getting through to GP surgery on the phone

Generally, how easy is it to get through to someone at your GP surgery on the phone?

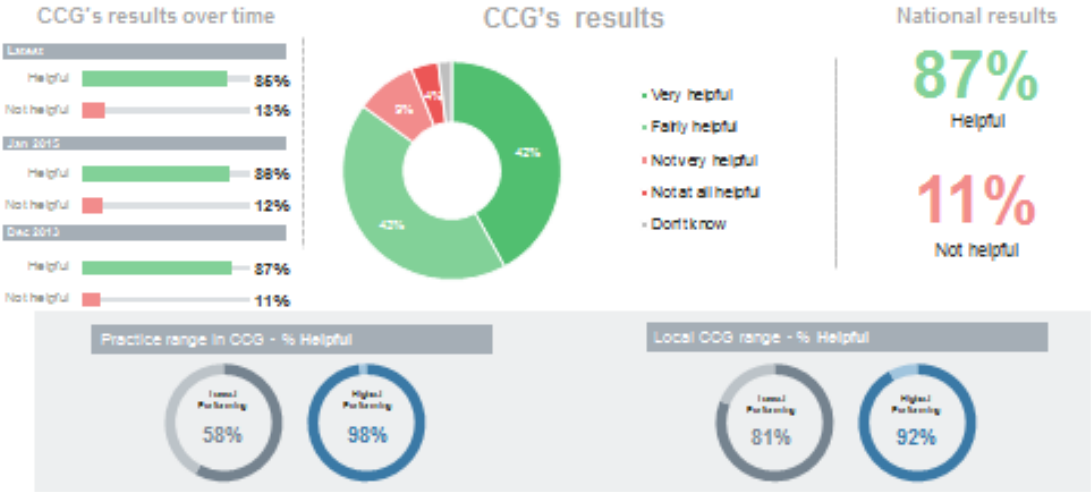


Base: All those completing a questionnaire: National (849,770); CCG 2013 (4,872); CCG 2013 (5,041); CCG 2013 (5,939) Practice bases range from 93 to 134; CCG bases range from 1,447 to 10,313

%Easy = %Very easy + %Fairly easy
%Not easy = %Not very easy + %Not at all easy

Helpfulness of receptionists at GP surgery

How helpful do you find the receptionists at your GP surgery?

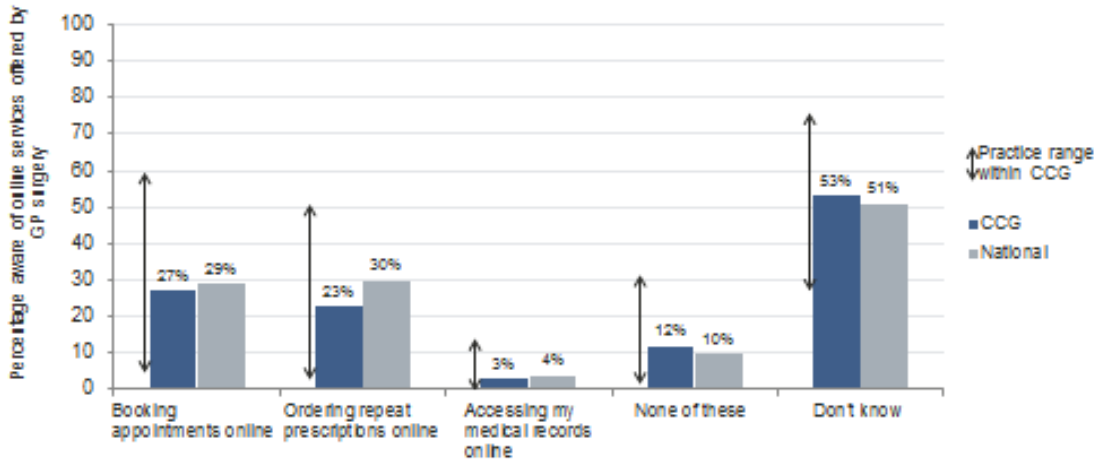


Base: All those completing a questionnaire: National (849,199); CCG 2013 (4,860); CCG 2013 (5,037); CCG 2013 (5,933) Practice bases range from 93 to 133; CCG bases range from 1,446 to 10,316

%Helpful = %Very helpful + %Fairly helpful
%Not helpful = %Not very helpful + %Not at all helpful

Awareness of online services

As far as you know, which of the following online services does your GP surgery offer?

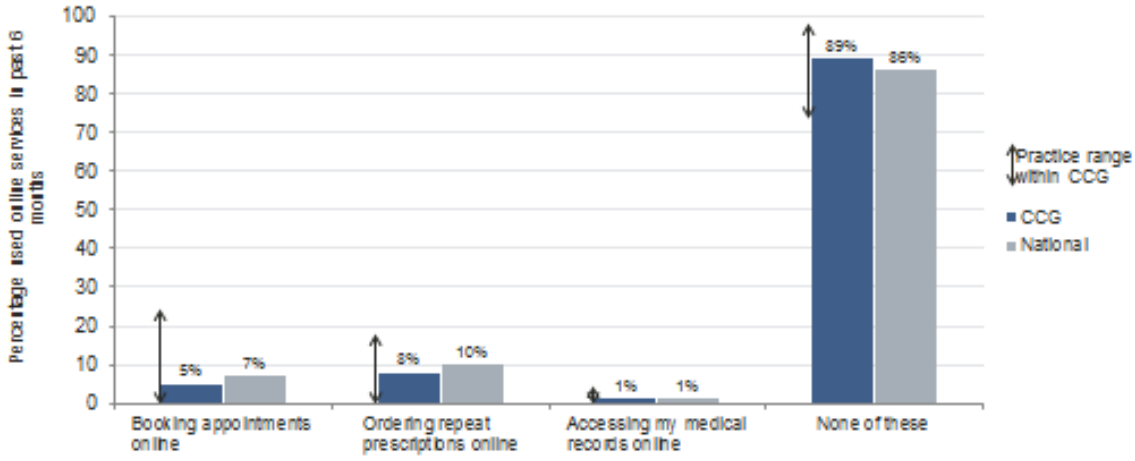


Comparisons are indicative only: differences may not be statistically significant

Base: All those completing a questionnaire: National (823,614); CCG (4,731); Practice bases range from 61 to 127

Online service use

And in the past 6 months, which of the following online services have you used at your GP surgery?



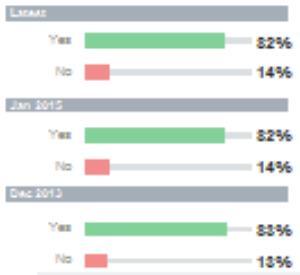
Comparisons are indicative only: differences may not be statistically significant

Base: All those completing a questionnaire: National (823,662); CCG (4,732); Practice bases range from 61 to 130

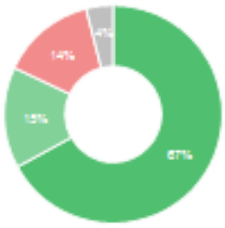
Success in getting an appointment

The last time you wanted to see or speak to a GP or nurse, were you able to get an appointment to see or speak to someone?

CCG's results over time



CCG's results



National results

85%
Yes

11%
No

Practice range in CCG - % Yes

Local CCG range - % Yes

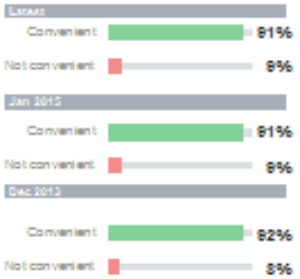
Base: All those completing a questionnaire: National (615,057); CCG 2014 (4,992); CCG 2015 (4,827); CCG 2013 (3,441) Practice bases range from 56 to 133; CCG bases range from 1,405 to 9,815

Yes = Yes + Yes, but I had to call back closer to or on the day

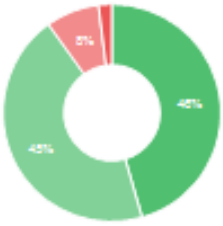
Convenience of appointment

How convenient was the appointment you were able to get?

CCG's results over time



CCG's results



National results

92%
Convenient

8%
Not convenient

Practice range in CCG - % Convenient

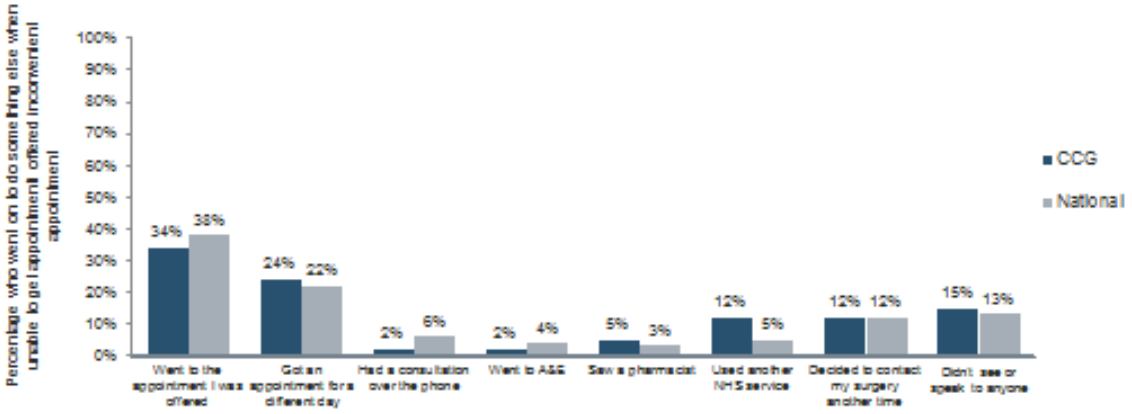
Local CCG range - % Convenient

Base: All those able to get an appointment: National (703,162); CCG 2014 (3,991); CCG 2015 (4,041); CCG 2013 (4,372) Practice bases range from 40 to 116; CCG bases range from 1,286 to 9,222

%Convenient = %Very convenient + %Fairly convenient
%Not convenient = %Not very convenient + Not at all convenient

What patients do when they are unable to get appointment / are offered an inconvenient appointment

What did you do on that occasion?*



* The answer codes for this question were updated for July-September fieldwork to reflect changes to service provision. As such the results shown here are based on July-September 2015 figures only.

Comparisons are indicative only: differences may not be statistically significant

Base: All those who were not able to get an appointment or were offered an inconvenient appointment: National (29,627); CCG (416)

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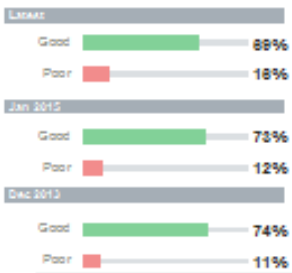
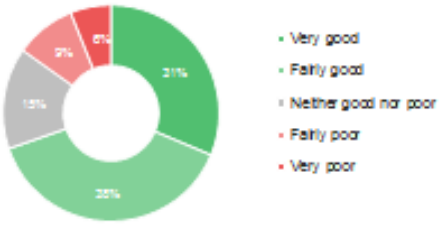
Overall experience of making an appointment

Overall, how would you describe your experience of making an appointment?

CCG's results over time



CCG's results



National results

73%
Good

12%
Poor

Practice range in CCG - % Good

Local CCG range - % Good

Base: All those completing a questionnaire: National (611,392); CCG 2016 (4,679); CCG 2015 (4,819); CCG 2013 (3,442) Practice bases range from 28 to 135; CCG bases range from 1,393 to 9,939

%Good = %Very good + %Fairly good
%Poor = %Fairly poor + %Very poor

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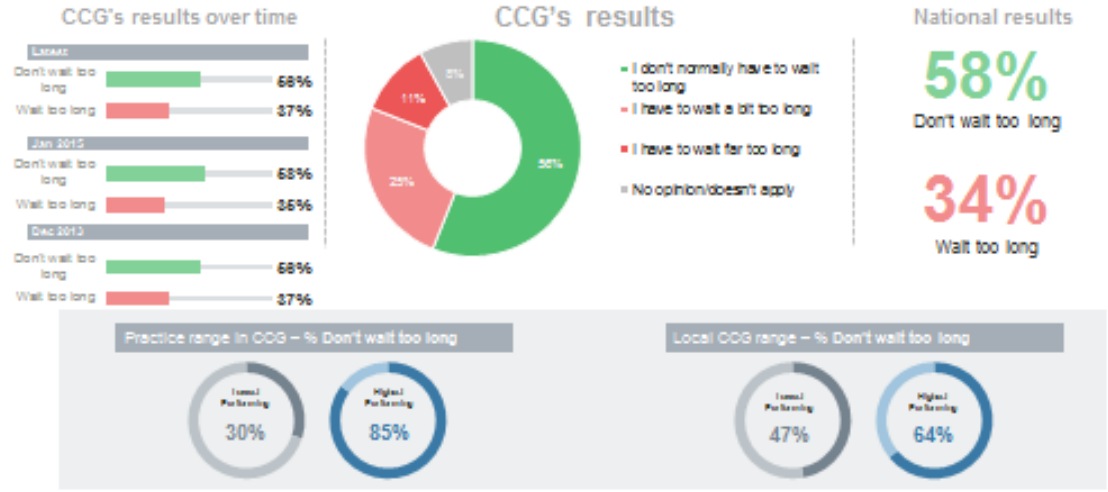
Waiting times at the GP surgery

How do you feel about how long you normally have to wait to be seen?

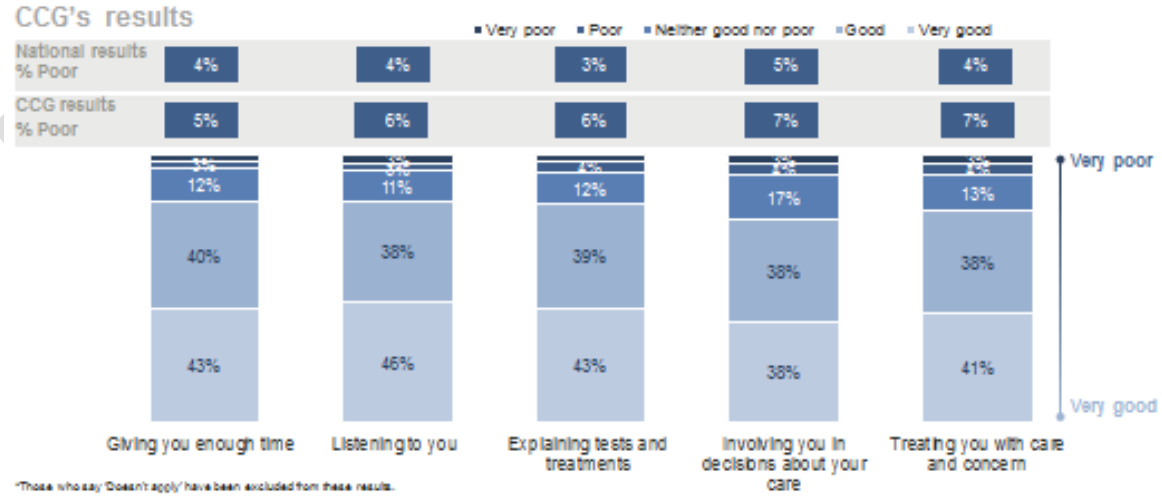


Base: All those completing a questionnaire: National (812,894); CCG 2014 (4,992); CCG 2013 (4,843); CCG 2012 (5,094) Practice bases range from 90 to 127; CCG bases range from 1,402 to 9,949

%Wait too long= %I have to wait a bit too long + %I have to wait far too long

Perceptions of care at last GP appointment

The last time you saw or spoke to a GP from your GP surgery, how good was that GP at each of the following?*



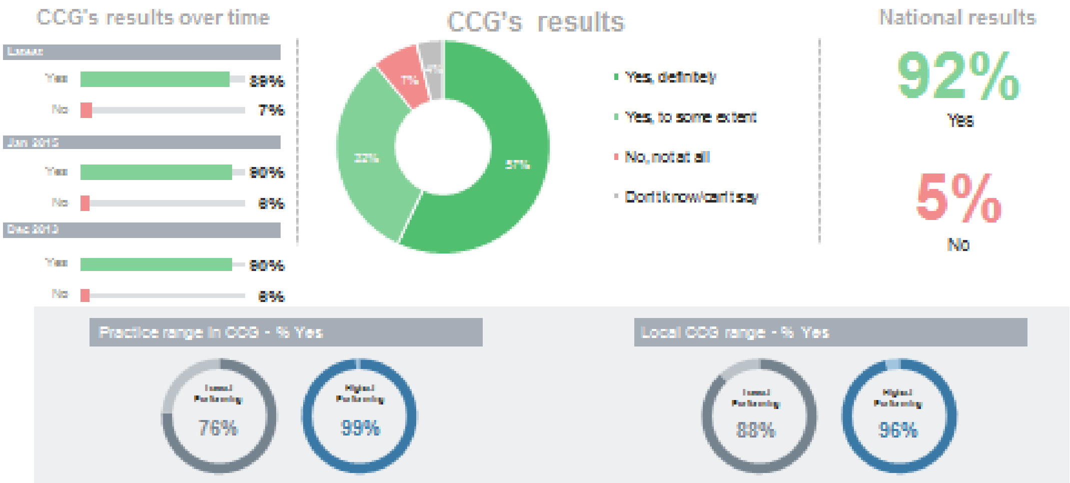
*Those who say 'Doesn't apply' have been excluded from these results.

Base: All those completing a questionnaire: CCG (4,990; 4,976; 4,919; 4,920; 4,890); National (812,087; 810,197; 779,287; 748,894; 797,664)

%Poor = %Very poor + %Poor

Confidence and trust in the GP

Did you have confidence and trust in the GP you saw or spoke to?



Base: All those completing a questionnaire: National (821,488); CCG 2016 (4,748); CCG 2015 (4,879); CCG 2013 (5,485) Practice bases range from 60 to 128; CCG bases range from 1,408 to 10,039

%Yes = %Yes, definitely + %Yes, to some extent

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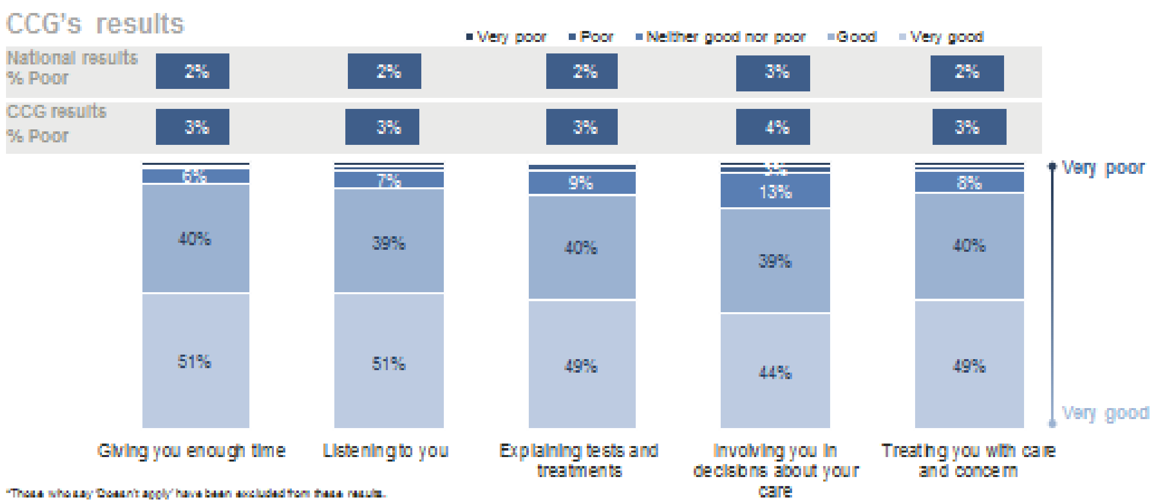
Perceptions of care at last nurse appointment

The last time you saw or spoke to a nurse from your GP surgery, how good was that nurse at each of the following?*



*Those who say 'Doesn't apply' have been excluded from these results.

Base: All those completing a questionnaire: CCG (4,123; 4,109; 3,983; 3,707; 4,036); National (729,838; 731,082; 701,838; 698,960; 710,852)

%Poor = %Very poor + %Poor

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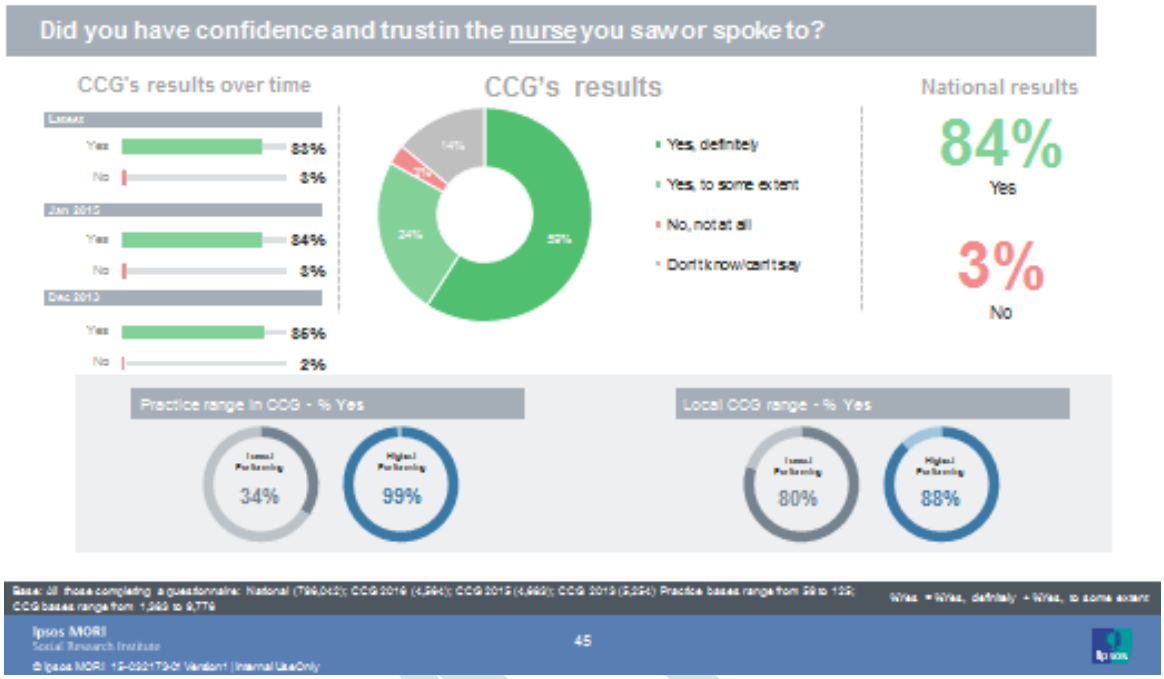
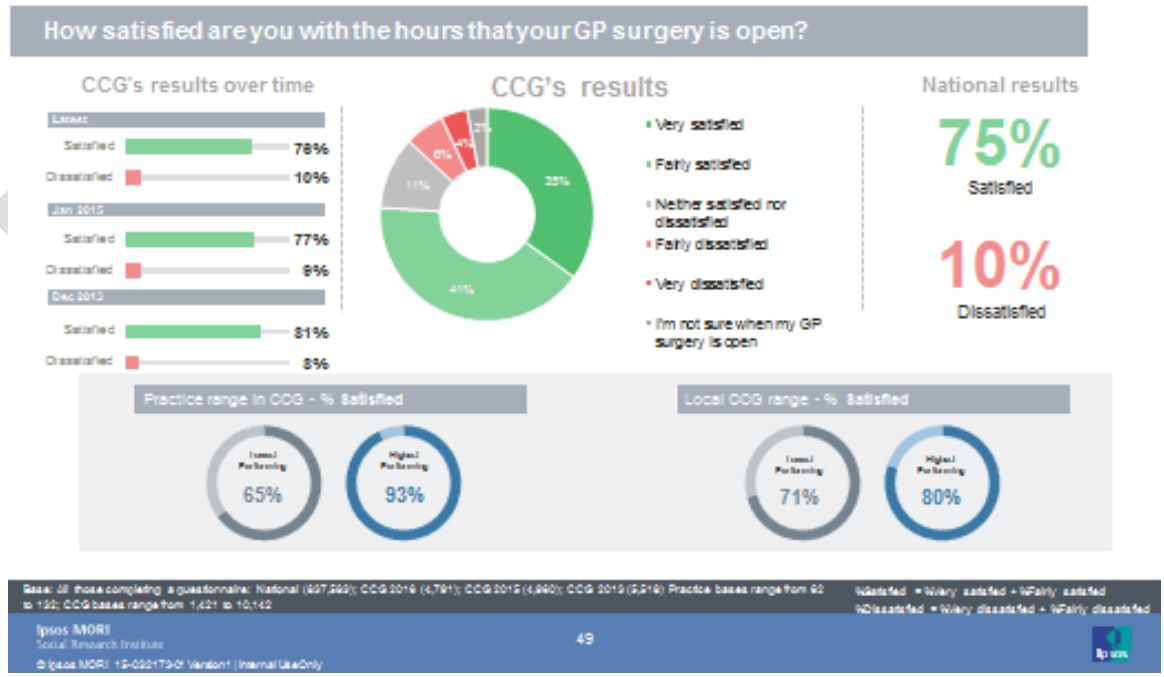
Confidence and trust in the nurse

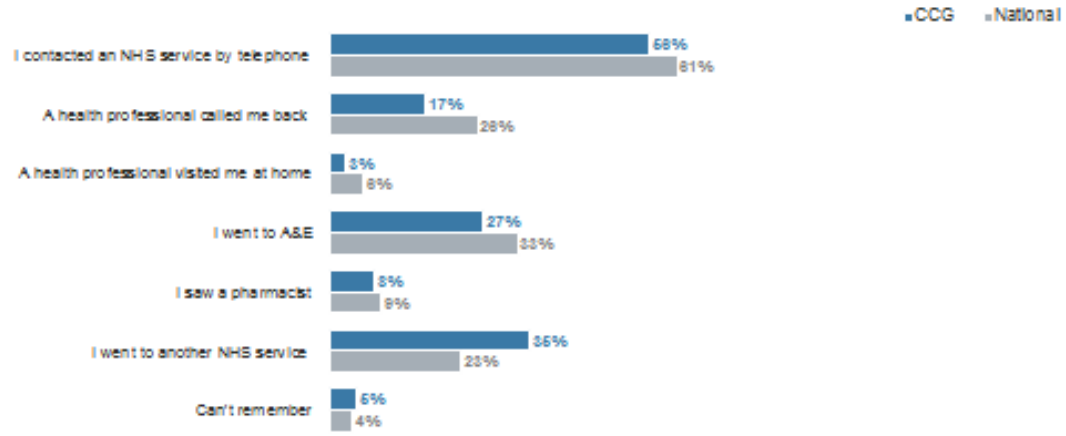


Satisfaction with opening hours



Use of out-of-hours services*

Considering all of the services you contacted, which of the following happened on that occasion?



*The out of hours questions were redesigned for July - September fieldwork to reflect changes to service provision. As such the results shown here are based on July-September 2013 figures only.

Base: All those who tried to contact an NHS service when GP surgery closed in past 6 months: National (67,666); CCG (457)

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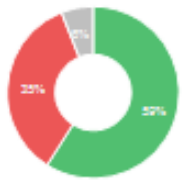
Use of out-of-hours services*

How do you feel about how quickly you received care or advice on that occasion?

Base: All those who tried to contact an NHS service when GP surgery closed in past 6 months: National (68,038); CCG (454)



National results 62% About right 32% Took too long

Considering all of the people you saw or spoke to on that occasion, did you have confidence and trust in them?

Base: All those who tried to contact an NHS service when GP surgery closed in past 6 months: National (68,118); CCG (456)

National results 86% Yes 9% No

*The out of hours questions were redesigned for July - September fieldwork to reflect changes to service provision. As such the results shown here are based on July-September 2013 figures only.

Yes = Yes, definitely + % Yes, to some extent

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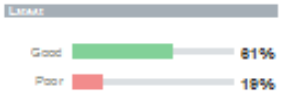
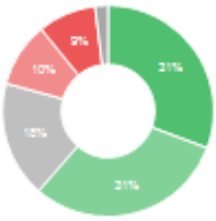
Overall experience of out-of-hours services

Overall, how would you describe your last experience of NHS services when you wanted to see a GP but your GP surgery was closed?*

CCG's results over time



CCG's results



National results

67%
Good

15%
Poor

*The out of hours questions were redesigned for July-September fieldwork to reflect changes to service provision. As such the results shown here are based on July-September 2015 figures only. As the results shown are only for one wave of the survey, comparisons between practices will not be shown until the July 2016 publication.

Base: All those who tried to contact an NHS service when GP surgery closed in past 6 months: National (66,172); CCG (422); CCG bases range from 105 to 1,031

%Good = %Very good + %Fairly good
%Poor = %Fairly poor + %Very poor

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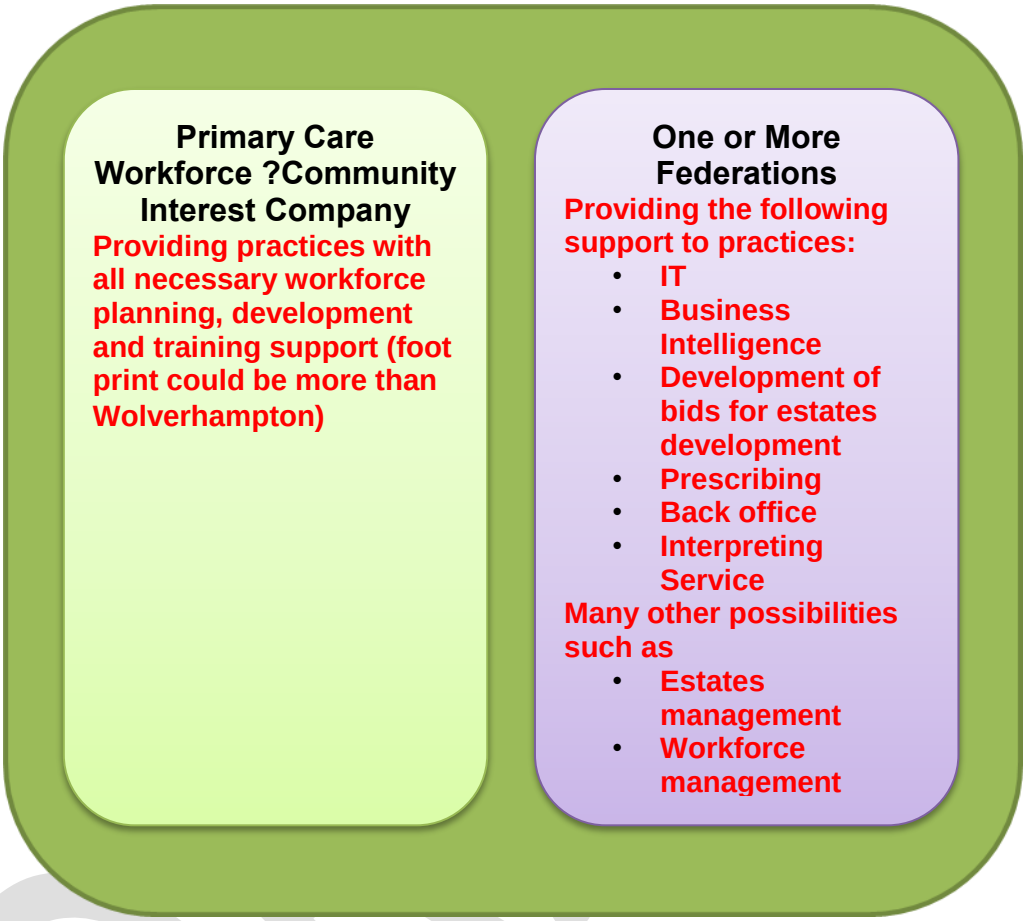
Appendix C. Practice Support Services

The configuration of these support services will develop over the life time of the Strategy. They could all be provided by a single organization or different supports could be provided from different organisations.



Could all be in Federation(s) or a MCP or being provided by RWT or still inside the CCG

Appendix D. **Procurement Template**

Annex 4: Procurement template

Template

[To be used when commissioning services from GP practices, including provider consortia, or organisations in which GPs have a financial interest]

NHS [*geographical reference*] Clinical Commissioning Group

Service:	
Question	**Comment/Evidence**
How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG's proposed commissioning priorities? How does it comply with the CCG's commissioning obligations?	
How have you involved the public in the decision to commission this service?	
What range of health professionals have been involved in designing the proposed service?	
What range of potential providers have been involved in considering the proposals?	
How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?	
What are the proposals for monitoring the quality of the service?	
What systems will there be to monitor and publish data on referral patterns?	

Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available? Have you recorded how you have managed any conflict or potential conflict?	
Why have you chosen this procurement route?[19]	
What additional external involvement will there be in scrutinising the proposed decisions?	
How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?	

Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)	
How have you determined a fair price for the service?	

Additional questions when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers	
How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?	

Additional questions for proposed direct awards to GP providers	
What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?	
In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?	

What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?	

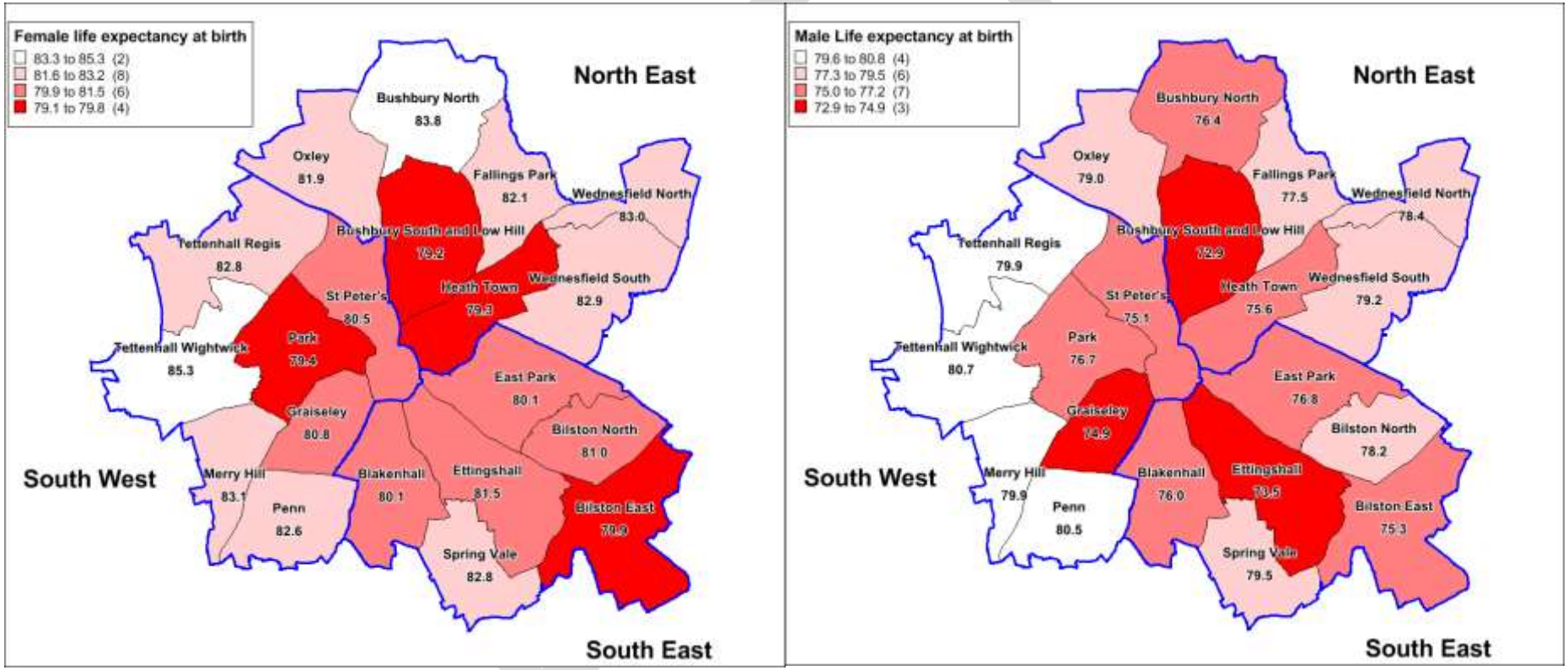
Appendix E. **Quality, Patient Safety & Risk Trigger And Escalation Model**

Measurement of quality is achieved through correlation with the CCGs Quality Strategy, Capabilities and Structure within the CCG and commissioned providers, processes and structures in place to sustain high standards of clinical care. Measurement is achieved with appropriate quality information being analysed and challenged so that the CCG is assured of the robustness of the information being afforded. CCG can then be assured of the effectiveness of compensatory actions and control measures that have been put in place to address the level of concern and take proportionate action.

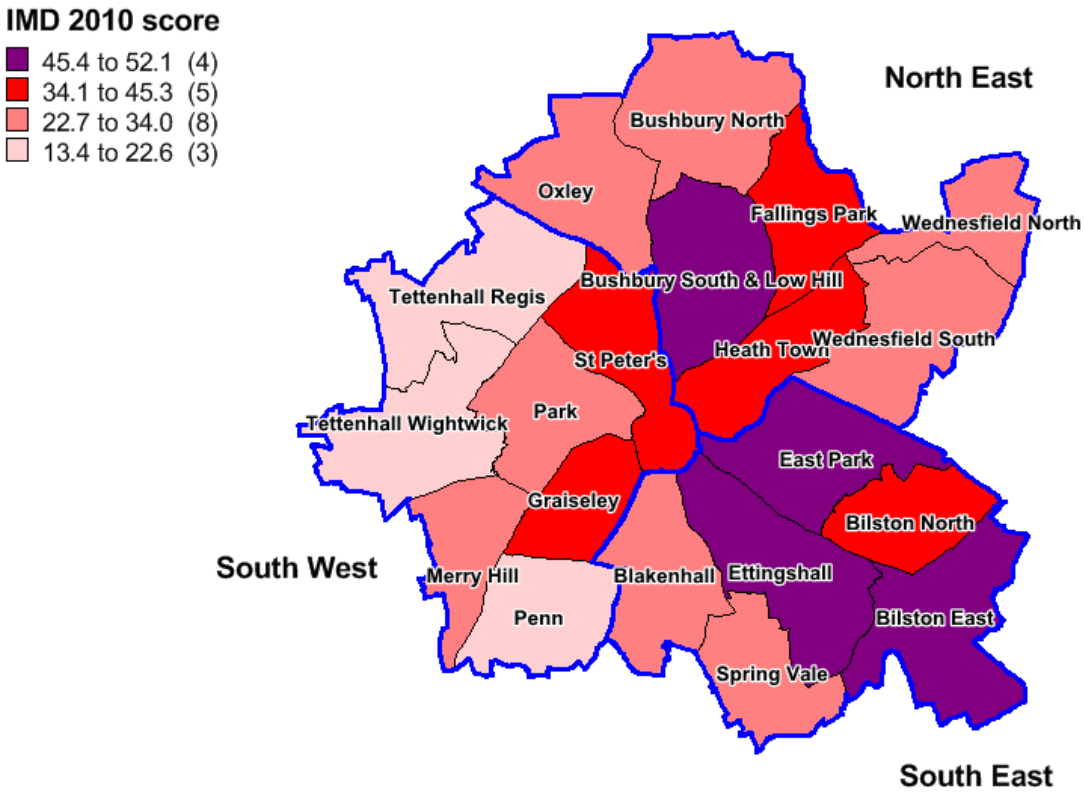
LEVEL OF CONCERN	CCG RESPONSE
Level 1 – Business as Usual • Untoward Incidents • Serious Incidents/Bay Closure • Complaints • Increased Supervision/Special Measures (ward level)	**Level 1 – Business as Usual** • Routine Quality Monitoring/Visits/Initial Lines of Enquiry • Clinical Quality Review Meetings • Relevant contractual levers • Monthly Heads Up from Provider(s) • Chief Nurse 1:1 Meetings
Level 2 – Moderate Concern • Infection Control Outbreak - ward/home closure(s) • 8 Hour A&E Breach • Recurring Serious Incident (same category) • CQC Concern(s) • Never Event • Whistleblowing • Ombudsman Investigation Upheld • Recurring shortfall in Quality Dashboard performance • Local Authority Commissioning/Quality Concerns	**Level 2 – Moderate Concern** As above plus a combination or all of the following:- • Conference Call with Medical Director and/or Chief Nurse • Update(s) to NHSE West Midlands • Unannounced Visit(s)/Themed Visit(s) • Responsive meeting between both parties • Consideration of suspension to new business (care homes) • Request Responsive Action Plan from Provider • Contractual Levers as appropriate • Conference Call with CQC, PHSO, Local Authority, Monitor or TDA
Level 3 - Enhanced Concern Prevalence from Levels 1 & 2 • Serious Incident - unsatisfactory 72 hour report • 12 hour A&E Breach • HSMR/SHMI higher than expected • High profile media interest • Slippage in high level Quality Indicators/Performance • Care Home in Large Scale Strategy (LSS)	**Level 3 – Enhanced Concern** As above plus a combination or all of the following:- • Extra-ordinary Clinical Quality Review Meeting • Appreciative Enquiry • Independent Review/Support • Discussion at Quality Surveillance Group • Escalation to regulator(s)/professional body • Large Scale Strategy Meeting (commissioner/provider)
Level 4 – Major Concern Prevalence from Levels 1, 2 or 3 • Infection Control Outbreak (multiple areas) • Safeguarding Concerns • Never Event • Whistleblowing • Slippage in high level Quality Indicators/Performance	**Level 4 – Major Concern** As above plus:- • ***** Board to Board • ***** Multi Agency Risk Summit • * Weekly scrutiny meetings • * Enhanced Surveillance at QSG until improvement sustained

NOTE: This model is applied on an accumulative basis when care quality is perceived to be deteriorating and requires intervention. The corresponding response for each level will be applied in line the level of concern also on an accumulative basis.

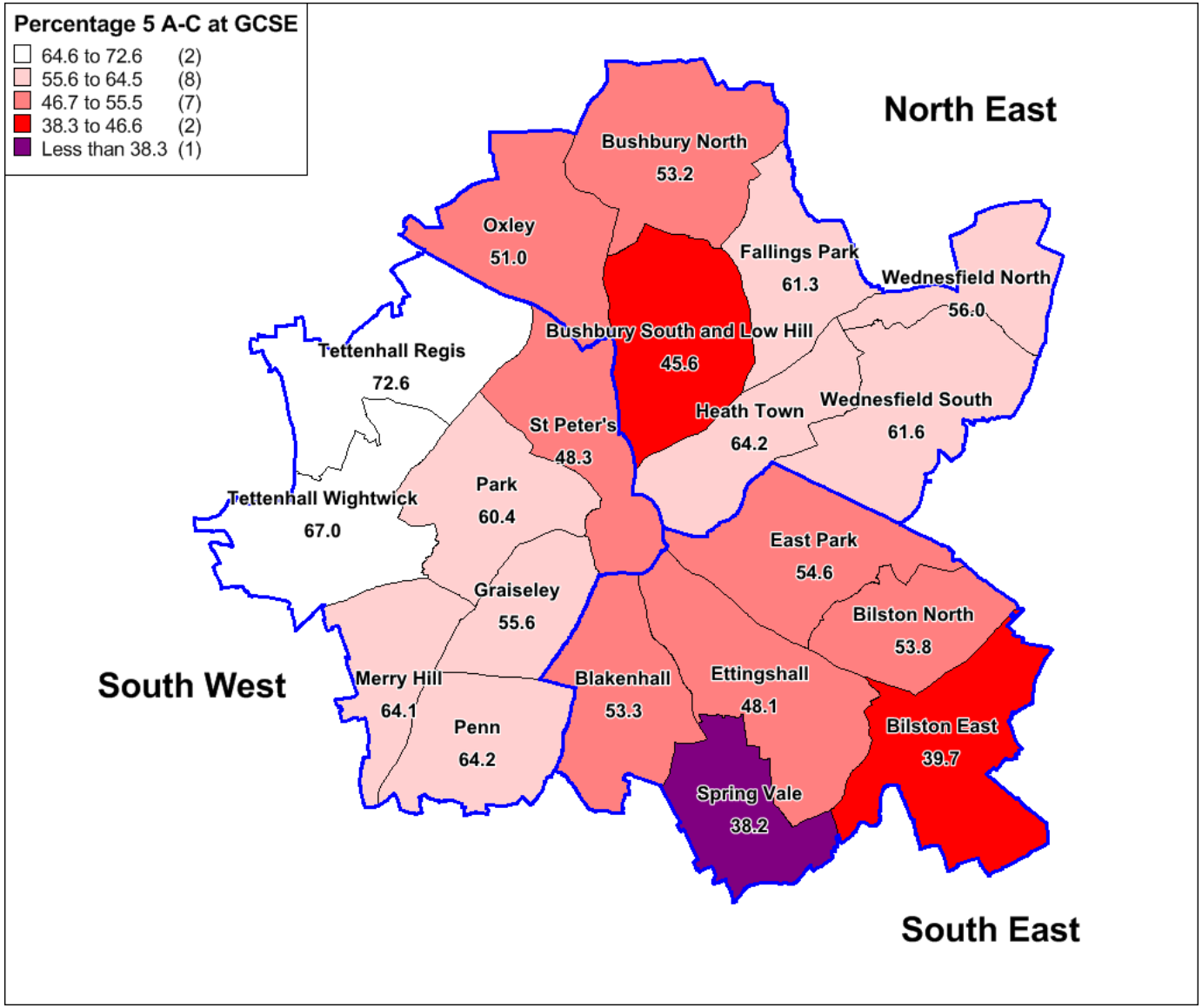
Male and female life expectancy



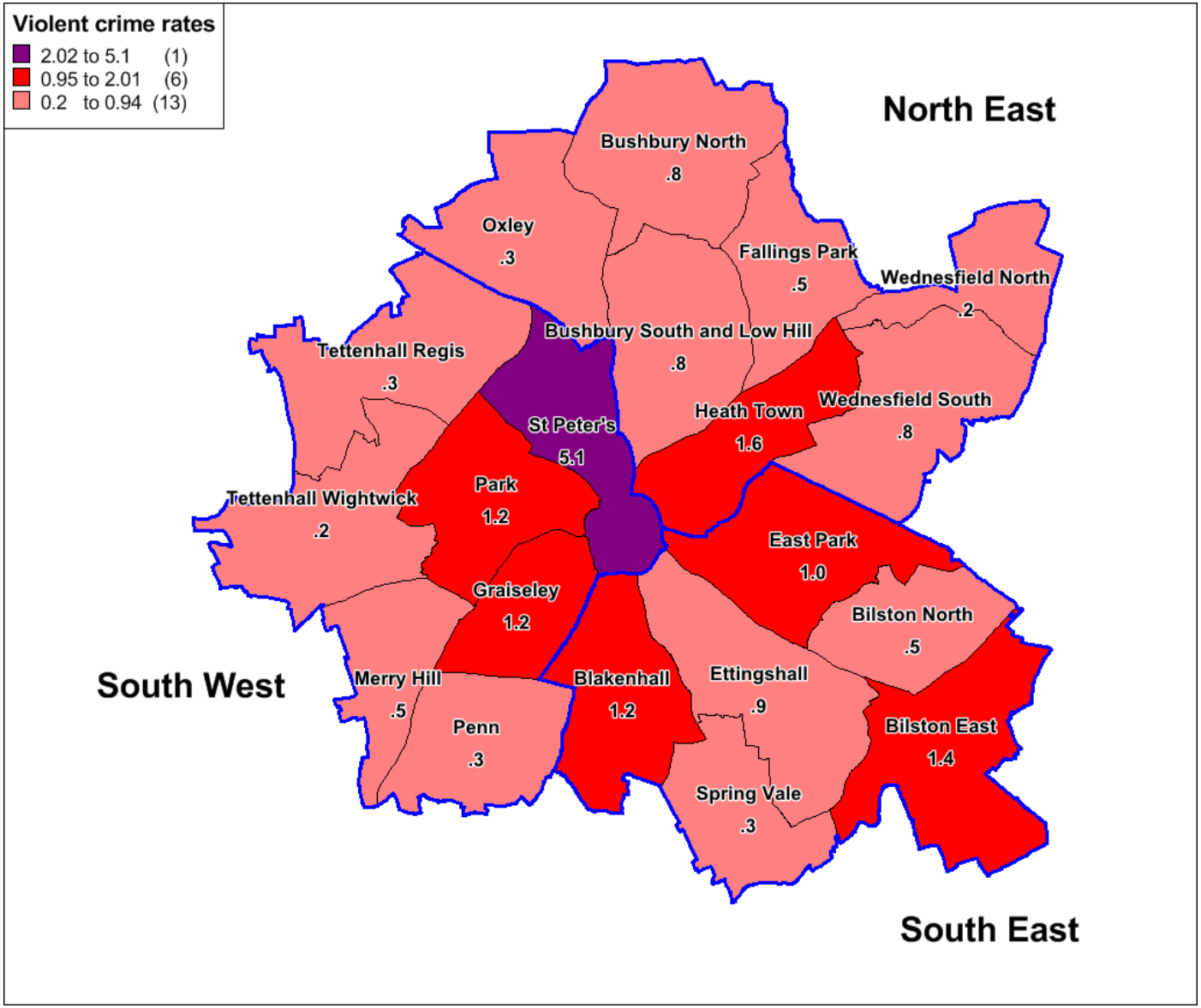
Deprivation by ward



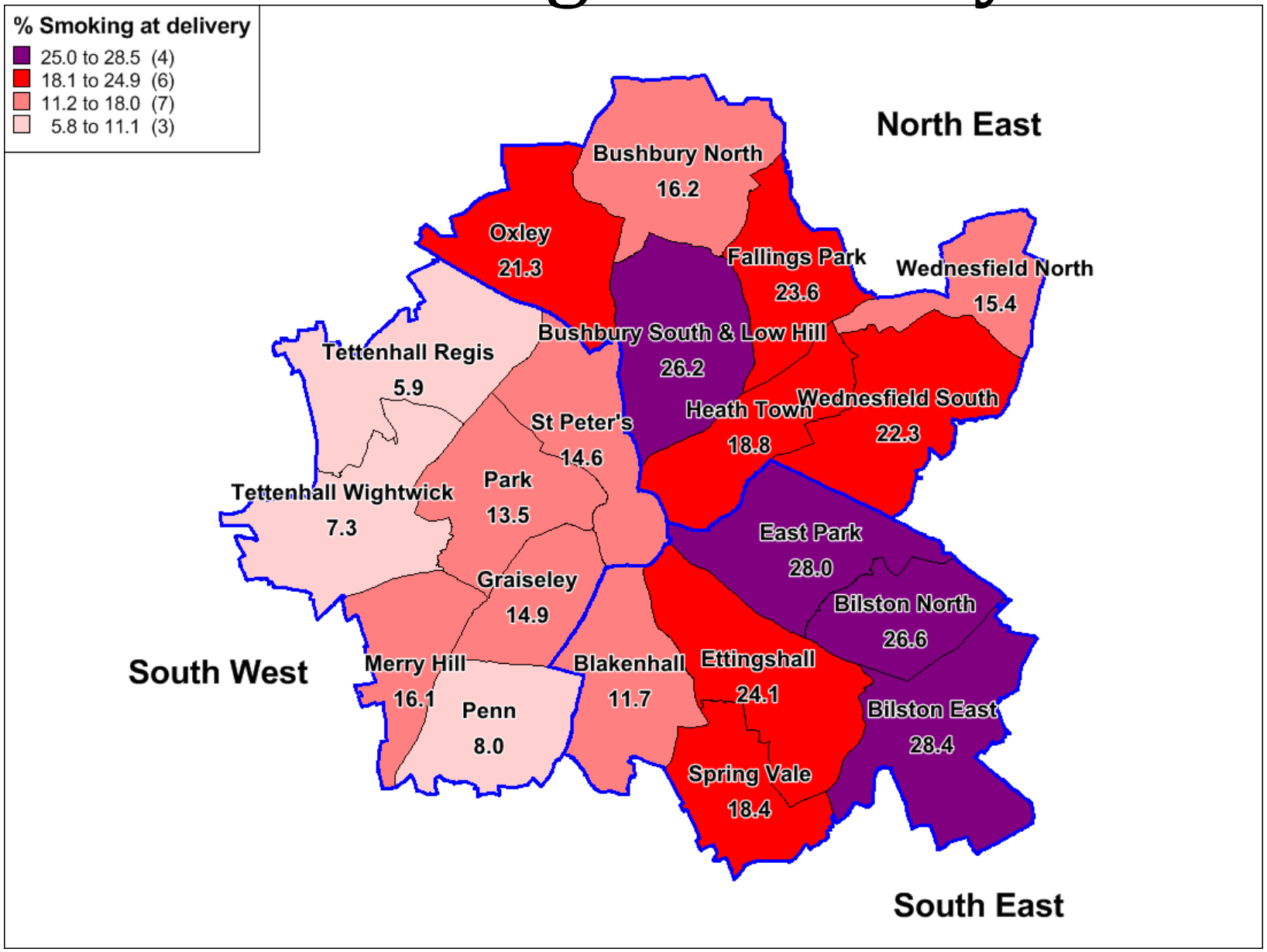
GCSE 5 A-C


Percentage 5 A-C at GCSE
64.6 to 72.6 (2)
55.6 to 64.5 (8)
46.7 to 55.5 (7)
38.3 to 46.6 (2)
Less than 38.3 (1)
North East
Bushbury North
53.2
Oxley
51.0
Fallings Park
61.3
Wednesfield North
56.0
Bushbury South and Low Hill
45.6
Tettenhall Regis
72.6
Heath Town
64.2
Wednesfield South
61.6
St Peter's
48.3
Park
60.4
Tettenhall Wightwick
67.0
East Park
54.6
Graiseley
55.6
Bilston North
53.8
South West
Merry Hill
64.1
Blakenhall
53.3
Ettingshall
48.1
Penn
64.2
Bilston East
39.7
Spring Vale
38.2
South East

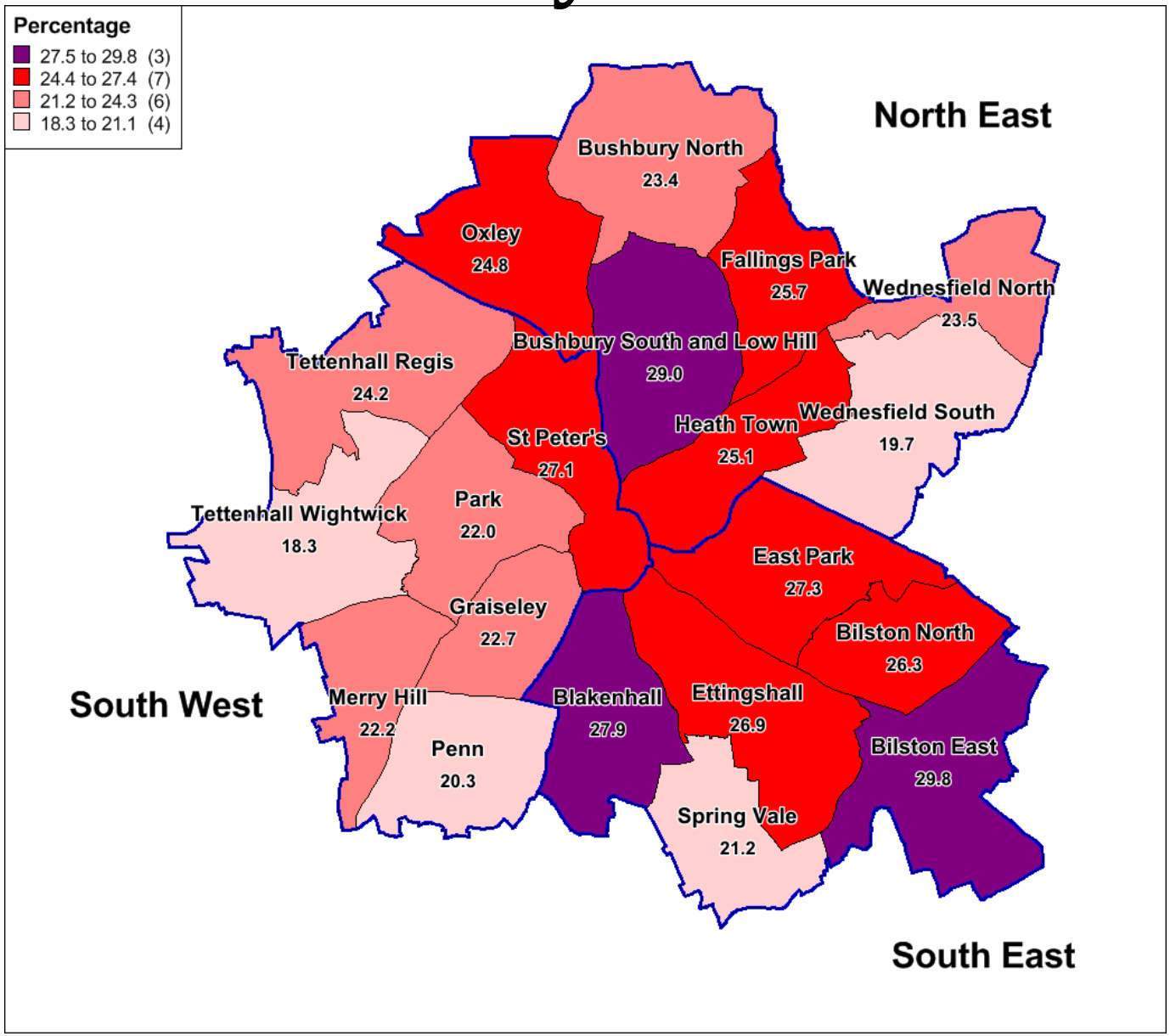
Violent crime



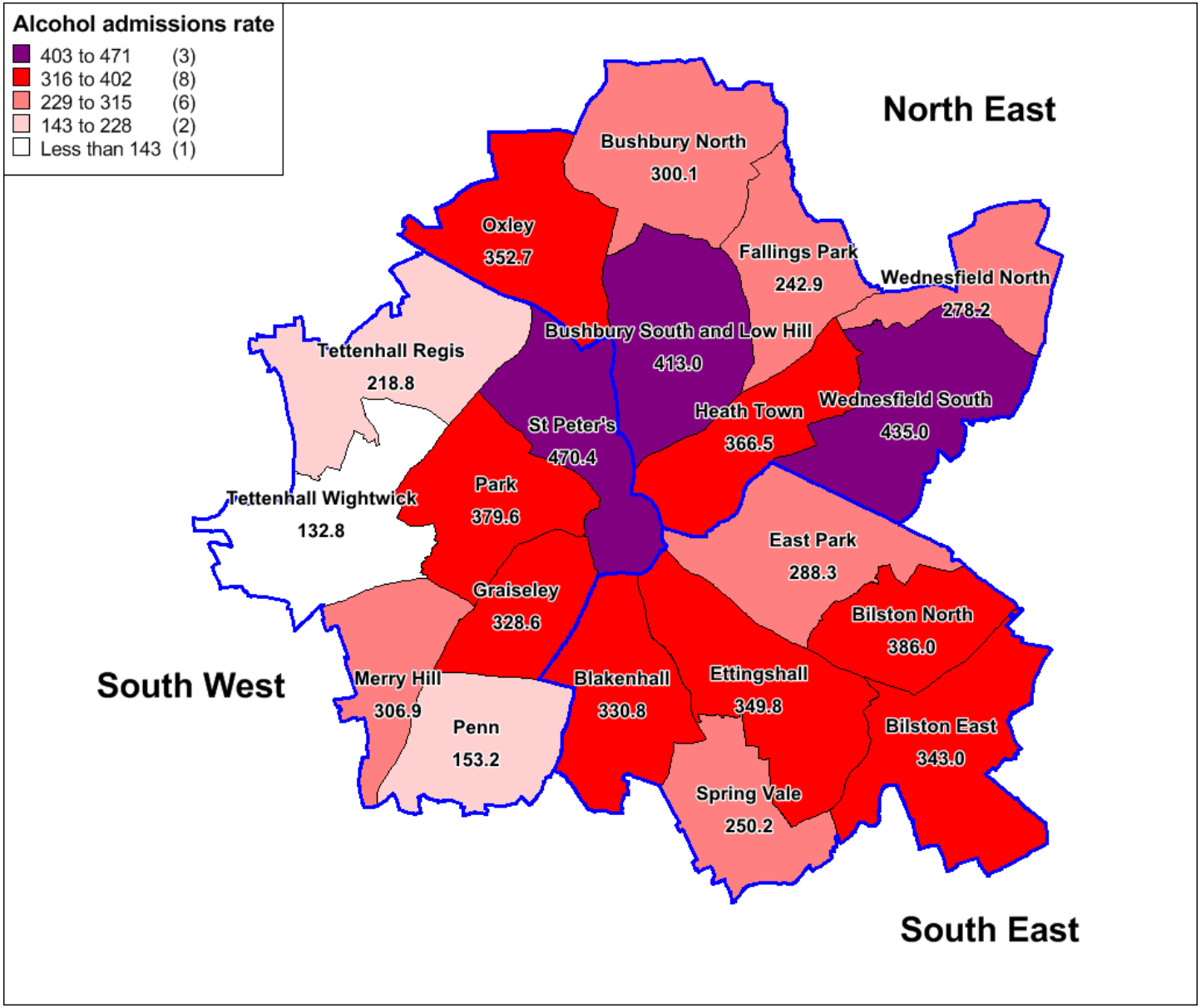
Smoking at delivery



Obesity Year 6

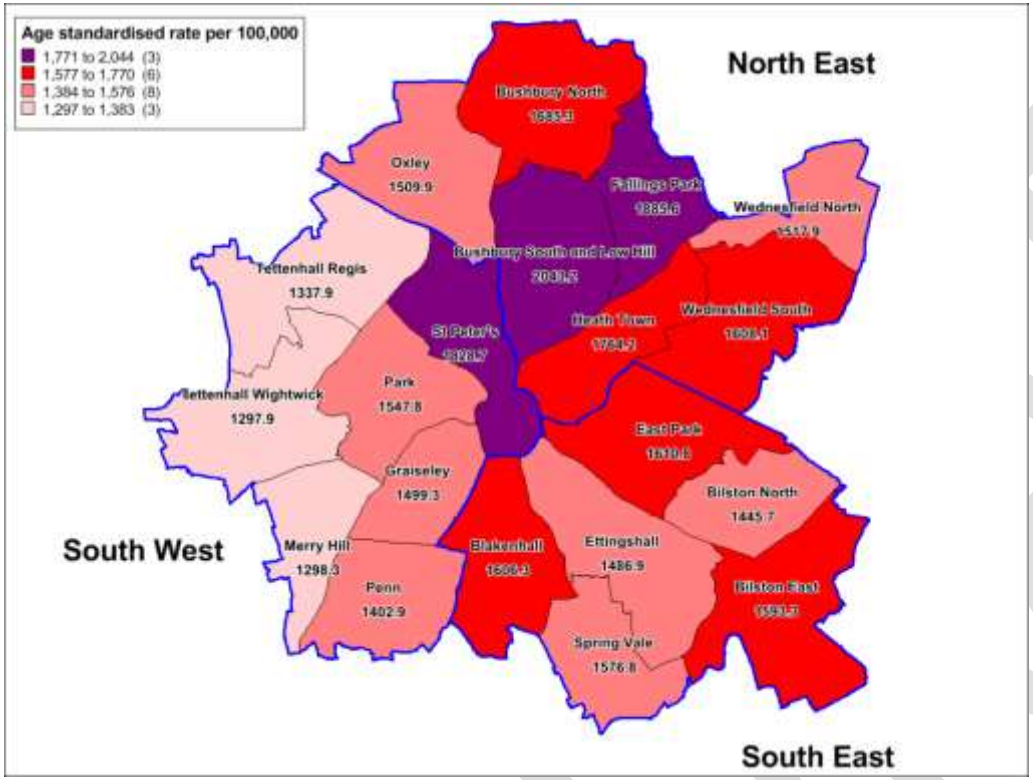


Alcohol Admissions

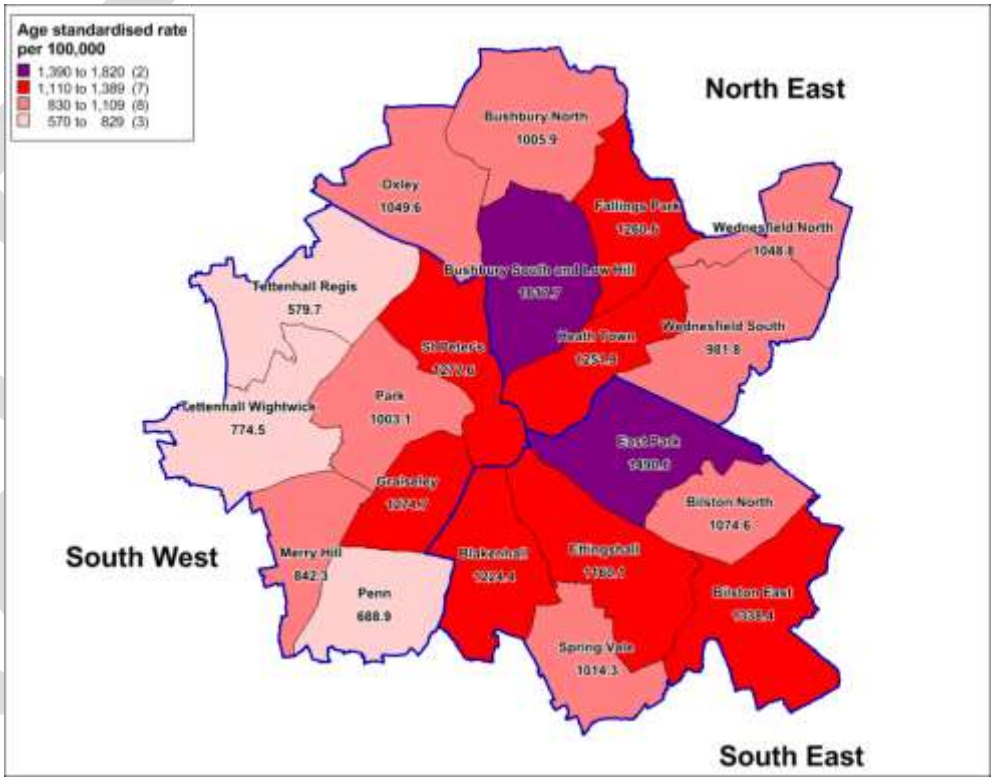


Ambulatory care conditions

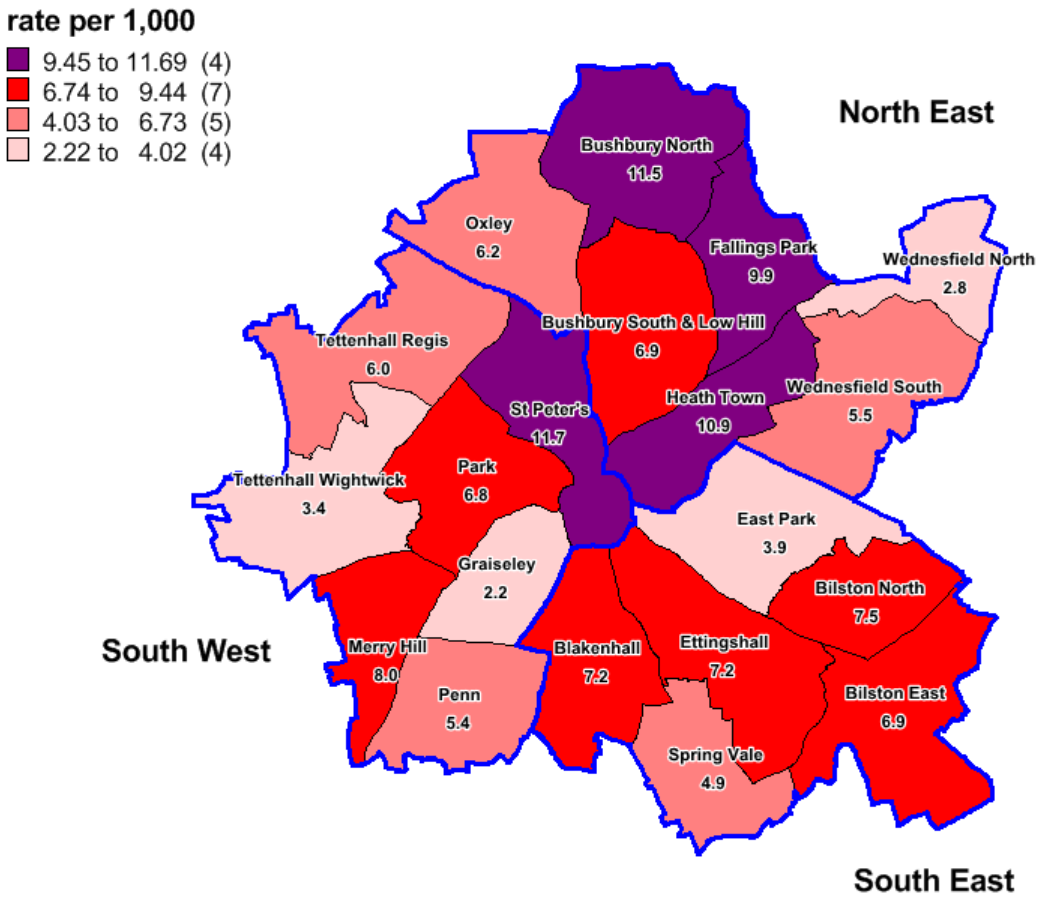
Conditions not usually requiring admission



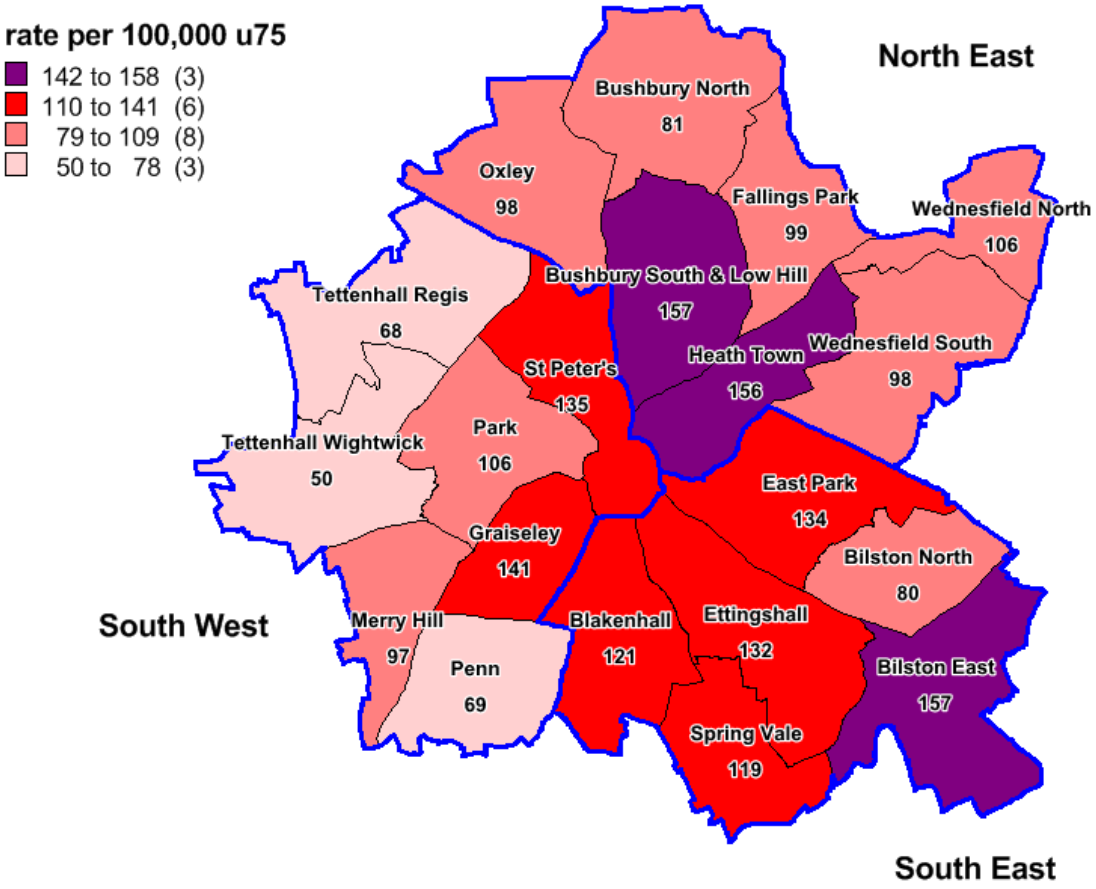
Chronic Ambulatory care conditions



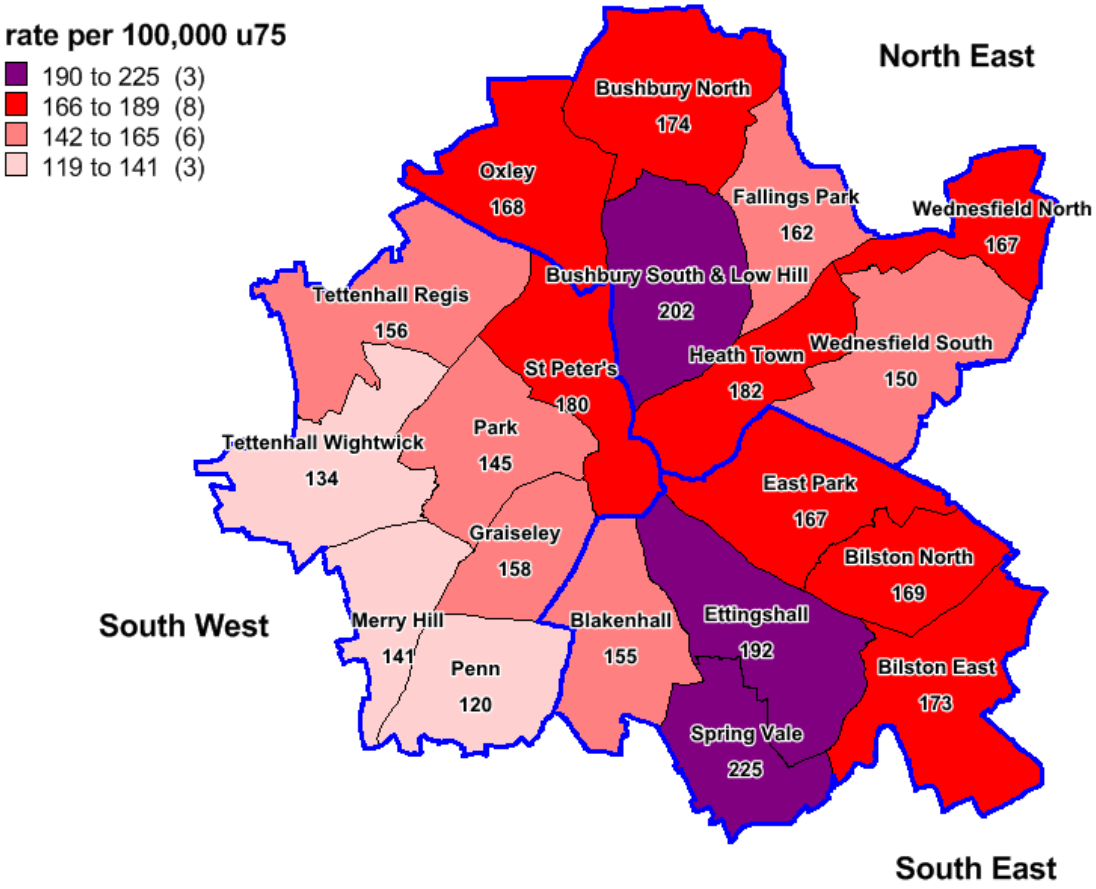
Infant Mortality



CVD Mortality



Cancer Mortality



Appendix G. **GP Clinical Representatives**

	Area	GP Lead	Governing Body Members
1	SW Locality	David Bush	Yes
2	NE Locality	Manjit Kainth	Yes
3	SE Locality	Anant Sharma	Yes
4	Acute Contract	Julian Morgans	Yes
5	Community Contract	Julian Morgans	Yes
6	Mental Health Contract	Alison Lennox	No
7	Quality	Rajshree Rajcholan	Yes
13	Children and Youth/ Maternity	Rajshree Rajcholan	
16	EOLC		
18	Prescribing	Julian Parkes	No

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NHS England

Domain 1: Are patients receiving clinically commissioned, high quality services?

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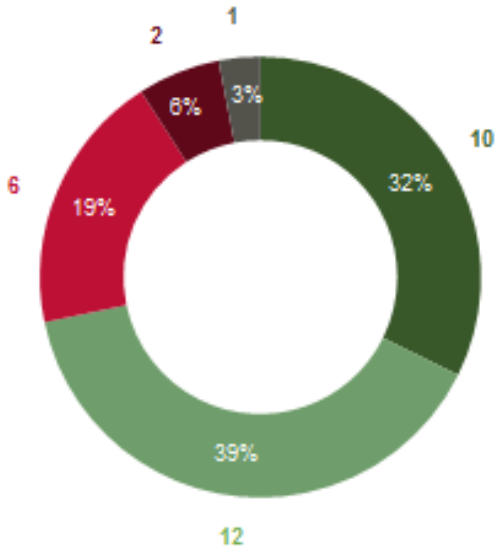
How effective, if at all, would you say the arrangements are for member participation and decision-making in your CCG?

NHS England

All member practices



71% (22)	Very / Fairly effective 2015
83% (25)	Very / Fairly effective 2014

■ Very effective ■ Fairly effective ■ Not very effective ■ Not at all effective ■ Don't know

Total responses: All member practices (2015: 31); (2014: 30)

Fieldwork: 10 March - 7 April 2015

Wolverhampton CCG

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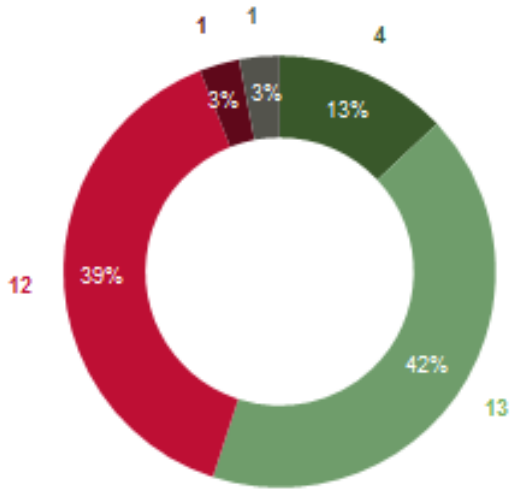
14

How involved, if at all, do you feel you are in your CCG's decision making process?

All member practices



55% (17)	Very / Fairly involved 2015
47% (14)	Very / Fairly involved 2014

■Very involved ■Fairly involved ■Not very involved ■Not at all involved ■Don't know

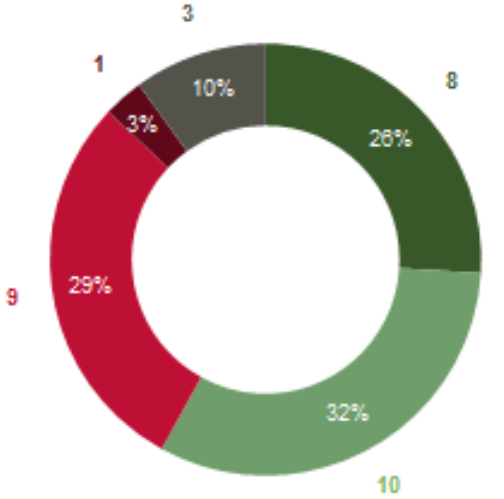
Total responses: All member practices (2015: 31); (2014: 30)

Fieldwork: 10 March - 7 April 2015

Wolverhampton CCG

How confident are you, if at all, in the systems to sustain two-way accountability between your CCG and its member practices in the CCG?

All member practices



58% (18)	Very / Fairly confident 2015
73% (22)	Very / Fairly confident 2014

■Very confident ■Fairly confident ■Not very confident ■Not at all confident ■Don't know

Total responses: All member practices (2015: 31); (2014: 30)

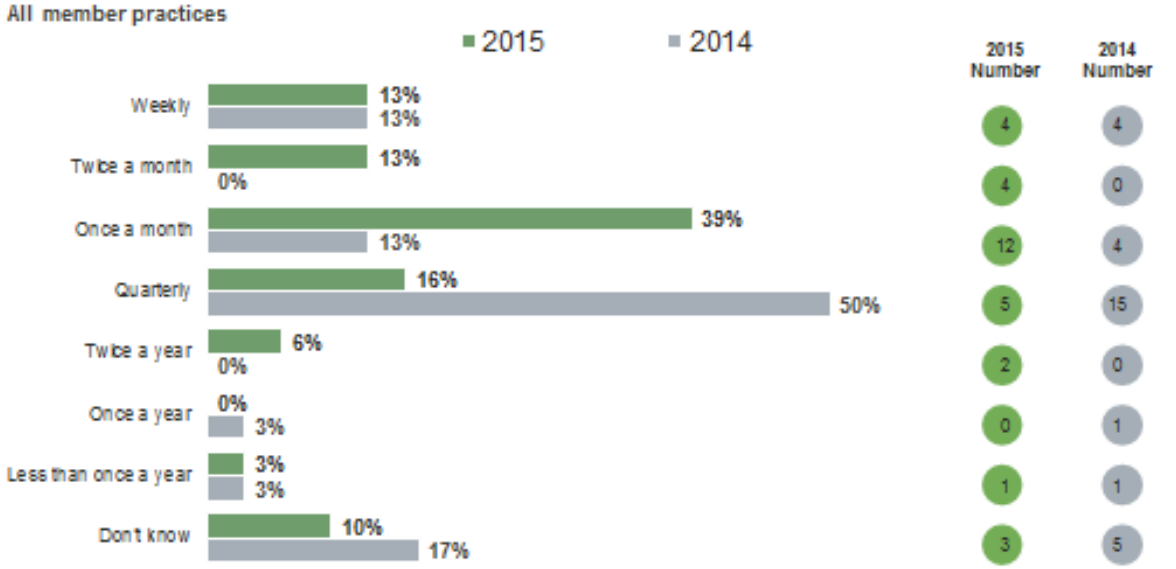
Fieldwork: 10 March - 7 April 2015

Wolverhampton CCG

Approximately how often, if at all, do you have the opportunity for direct discussions with your CCG's leaders?

NHS England

All member practices



Total responses: All member practices (2015: 31); (2014: 30)

Fieldwork: 10 March - 7 April 2015

Wolverhampton CCG

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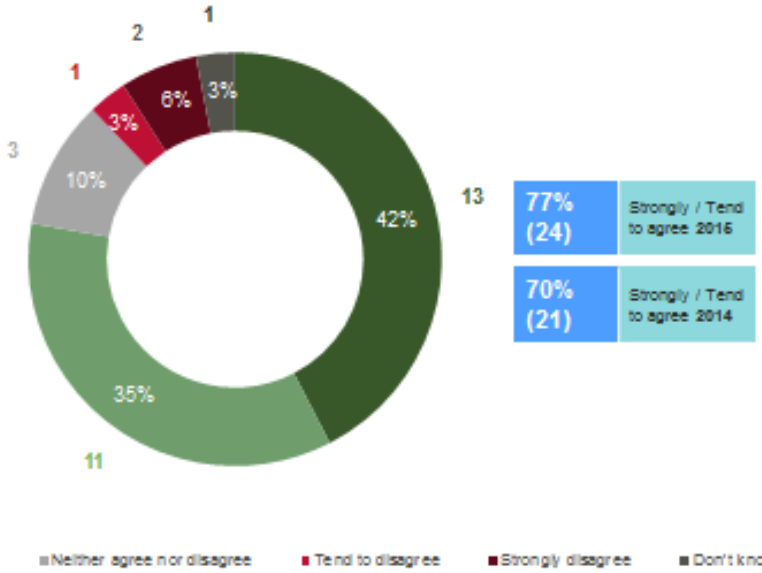
To what extent do you agree or disagree that representatives from member practices are able to take a leadership role within the CCG if they want to?

NHS England

All member practices



Total responses: All member practices (2015: 31); (2014: 30)

Fieldwork: 10 March - 7 April 2015

Wolverhampton CCG

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Domain 1: Summary

		Base
How effective, if at all, would you say the arrangements are for member participation and decision making in your CCG?	71% (22) very / fairly effective	*All member practices (31)*
How involved, if at all, do you feel you are in your CCG's decision making process?	55% (17) very / fairly involved	*All member practices (31)*
How confident are you, if at all, in the systems to sustain two-way accountability between your CCG and its member practices in the CCG?	58% (18) very / fairly confident	*All member practices (31)*
To what extent do you agree or disagree that representatives from member practices are able to take a leadership role within the CCG if they want to?	77% (24) strongly / tend to agree	*All member practices (31)*
To what extent do you agree or disagree that the quality of services is a key focus of your contracts with the CCG?	-% (0) strongly / tend to agree	*All NHS providers (2)*
How involved, if at all, would you say clinicians from the CCG are in discussions about...? A. Quality B. Service redesign	 50% (1) very / fairly involved 50% (1) very / fairly involved	*All NHS providers (2)*

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Appendix I. The NHS England and Wolverhampton CCG Primary Care Joint Commissioning Committee TOR

1. Introduction

1.1 Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England and CCGs would jointly commission primary medical services.

1.2 The NHS England and Wolverhampton CCG Primary Care joint commissioning committee is a joint committee with the primary purpose of jointly commissioning primary medical services for the people of Wolverhampton.

2. Statutory Framework

2.1 The National Health Service Act 2006 (as amended) ("NHS Act") provides, at section 13Z, that NHS England's functions may be exercised jointly with a CCG, and that functions exercised jointly in accordance with that section may be exercised by a joint committee of NHS England and the CCG. Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions as may be agreed between NHS England and the CCG.

3. Role of the Joint Committee

3.1 The role of the Joint Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act 2006 except those relating to individual GP performance management, which have been reserved to NHS England. This includes the following activities:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

3.2 The Committee will contribute to the delivery of the CCG's Primary Care strategy, ensuring that its work programme and decisions support the outcomes set out in the strategy. This will include:-

- Promoting the right care at the right time in the right place
- Developing strategies to support self-care and improved information about services
- Improved access to community and primary care facing services

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- Enhanced clinical leadership that ensures GPs are at the centre of a neighbourhood approach.
- Improved care coordination, particularly for individuals with complex, life limiting conditions or at risk of hospital admission
- Ensuring wider patient and key stakeholder engagement in the development of future primary care development plans.
- Improvements in the quality and performance of primary medical services

3.3 In performing its role the Joint Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Wolverhampton CCG, which will sit alongside the delegation and terms of reference.

4. Geographical coverage

4.1 The Joint Committee will comprise NHS England West Midlands Sub-Region (The Sub-Regional Team) and the NHS Wolverhampton CCG (The CCG). It will undertake the function of jointly commissioning primary medical services for Wolverhampton.

5. Membership

5.1 The Membership of the Joint Committee shall consist of:-

- The Deputy Chair of the CCG's Governing Body (Lay Member for Patient and Public Involvement)
- Two Executive Members of the CCG's Governing Body
- One of the 3 GP Locality Leads on the CCG's Governing Body who will attend meetings in rotation
- Three representatives from the Sub-Regional Team (One from each of the Medical, Finance and Primary Care Directorates)
- Two Patient (Lay) representatives

5.2 The Chair of the Joint Committee shall be the Deputy Chair of the CCG's Governing Body

5.3 The Vice Chair of the Joint Committee shall be the one of the lay patient representatives.

5.4 Any member of the committee may nominate a substitute to attend a meeting on their behalf, provided that they notify the Chair 24 hours before the meeting.

6. Invited Attendees

6.1 Both a representative of Healthwatch Wolverhampton and a representative of the Wolverhampton Health and Wellbeing Board (who must represent Wolverhampton City Council on the Board) shall be invited to attend meetings of the Committee as a non-voting observer.

6.2 The observers shall be invited to provide assurance that the provisions for managing conflicts of interest are being correctly applied and shall be entitled to attend private sessions of the Joint Committee.

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6.3 Additional attendees will be invited to attend public committee meetings from the Local Medical Council, Local Pharmaceutical Council and the Public Health Department of Wolverhampton City Council. The Joint Committee may also call additional experts to attend meetings on an ad hoc basis to inform discussions.

7. Meetings and Voting

7.1 The Joint Committee shall adopt the Standing Orders of the CCG insofar as they relate to the:

- Notice of meetings;
- Handling of meetings;
- Agendas;
- Circulation of papers; and
- Conflicts of interest

7.2 Decisions of the Joint Committee should be reached by consensus where possible. Where this is not possible, a vote will be taken with a simple majority of the votes cast being required to reach a decision unless the decision relates to a statutory function of NHS England outlined in Paragraph 3.1. When the Joint Committee exercises these functions, the votes of the Sub-Regional team representatives shall be weighted so that, when cast together, they shall be sufficient to give the sub-regional team a casting vote. (E.g. If 4 of the CCG's representatives are present and voting, the sub-regional team's representatives votes will be weighted so that they total 5, etc.).

7.3 Meetings of the Joint Committee shall be held in public, unless the Joint Committee resolves to exclude the public from either the whole or part of the proceedings whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

7.4 Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7.5 Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the joint committee in which event these shall be observed.

8. Quorum

8.1 Meetings of the Joint Committee shall be quorate when there is at least one lay representative, one executive representative of the CCG and two representative of the Sub-Regional team present and the overall make up of those present is such that there is a majority of non-clinical members.

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9. Frequency of Meetings

9.1 The Joint Committee shall agree a regular programme of meetings each year. In addition, the Chair may call additional meetings if they are required in line with the provisions for notice of meetings set out above.

10. Secretary

10.1 A named individual (or his/her nominee) shall be responsible for supporting the Chair in the management of the Joint Committee's business and for drawing members' attention to best practice, national guidance and other relevant documents as appropriate.

10.2 The Secretary will be responsible for circulating the agenda and papers 5 clear working days before the meeting and will circulate the minutes and action notes of the committee within 3 working days of the meeting to all members and present the minutes and action notes to the Sub-Regional Team and the governing body of the CCG.

10.3 The Secretary will also provide an executive summary report which will presented to the Sub-Regional team and the governing body of the CCG each month for information.

11. Decisions

11.1 The Joint Committee will make decisions within the bounds of its remit set out in paragraph 3 above. The decisions of the Joint Committee shall be binding on NHS England and NHS Wolverhampton CCG and will be published by both parties.

12. Annual Report

12.1 The Committee will review its performance annually and produce a report on its work. This report will include a summary of decisions taken and details of how any conflicts of interest have been managed.

13. Review of Terms of Reference

13.1 These terms of reference will be formally reviewed by the sub-regional team and the CCG in April of each year, following the year in which the joint committee is created, and may be amended by mutual agreement between both parties at any time to reflect changes in circumstances which may arise.

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Appendix J. **NHSE Guidance on use of PMS Premium**

Publications Gateway Reference 01091

Annex

PMS Review Criteria

To ensure NHS England is able to secure best value from future investment of the premium element of PMS funding area teams are asked to ensure available resources for investment over above core funding for core services expected from all GP practices meets the following criteria:

a) **Reflect joint area team/CCG strategic plans for primary care.** The use of any premium funding over and above funding for core services should reflect strategic plans for primary care that have been developed jointly between area teams and CCGs and support a more integrated approach to delivering community-based services, including general practice. This could include collaborative commissioning arrangements between area teams and CCGs including pooling of funding.

b) **Secure services or outcomes that go beyond what is expected of core general practice or improving primary care premises.** There should be no premium funding that is not tangibly linked to providing a wider range of services, or providing services to higher quality standards or providing services for a population with specific needs that are not adequately captured by the Carr-Hill formula. Funding could also be used to support improving the quality of primary care premises, for example, to support delivery at scale.

c) **Help reduce health inequalities.** Premium funding should be used as far as possible to help reduce health inequalities. This may include, for example, providing funding for practices that provide services for populations with specific needs, e.g. homeless people.

d) **Give equality of opportunity to all GP practices.** In line with the principles of equitable funding, all GP practices should have the opportunity of earning premium funding if they are capable of meeting the required standards. The only exception to this is when the funding is being used to reflect a specific population served by a particular practice. For instance, if an area team defines a basket of services that practices have to provide – and KPIs that they have to meet – in order to earn this funding, the opportunity to provide these services should not be restricted to current PMS practices. Equally if premium funding is intended to improve the quality of primary care premises this should also not be restricted to current PMS practices.

e) **Support fairer distribution of funding at a locality level.** Premium funding should be used in a way that, where possible, supports fairer distribution of overall funding at a locality level. The publication by area teams of primary care funding at an illustrative locality level will give a clearer sense of the total resources for a local health community and support area teams and CCGs in moving towards a fairer allocation of those resources.

Appendix K. GP High Level Indicators – CCG average achievement

	GPHLI	Reporting period	Current performance	England average
1	Cancer Admissions	2014 (Calendar/Fiscal)	17.23	11.4
2	2 week wait	2013-14 (Financial)	0.41	0.48
3	Emergency Admissions	2014 (Calendar)	109.31	89.78
4	A&E Attendances	2014 (Calendar)	415.58	328.72
5	CHD Admissions/100 on register	2014 (Calendar/Fiscal)	6.33	7.99
6	Asthma Admissions/100 on register	2014 (Calendar/Fiscal)	2.87	2.11
7	Diabetes Admissions/100 on register	2014 (Calendar/Fiscal)	1.33	1.48
8	COPD Admissions/100 on register	2014 (Calendar/Fiscal)	15.42	12.66
9	Dementia Admissions/100 on register	2014 (Calendar/Fiscal)	4.81	3.17
10	Ambulatory Care Sensitive Admissions	2014 (Calendar)	20.06	15.76
11	Diabetes BP monitoring	2013-14 (Financial)	0.78	0.79
12	AF on anticoagulation	2013-14 (Financial)	0.81	0.85
13	Cervical Smears	2013-14 (Financial)	0.8	0.82
14	Diabetes Cholesterol monitoring	2013-14 (Financial)	0.78	0.81
15	Diabetes HbA1C monitoring	2013-14 (Financial)	0.75	0.77
16	CHD cholesterol monitoring	2013-14 (Financial)	0.8	0.83
17	Health check for mental illness	2013-14 (Financial)	0.82	0.86

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18	Flu Vaccination (over 65s)	2014-15 (Winter)	0.70	0.73
19	Flu Vaccinations (at risk)	2014-15 (Winter)	0.51	0.53
20	Diabetes Retinal Screening	2013-14 (Financial)	0.86	0.90
21	AF prevalence ratio to expected	2013-14 (Financial)	1.18	1.18
22	CHD prevalence to expected	2013-14 (Financial)	0.64	0.71
23	COPD prevalence to expected	2013-14 (Financial)	0.49	0.62
24	Asthma prevalence to expected	2013-14 (Financial)	0.67	0.65
25	Diabetes prevalence ratio to expected	2013-14 (Financial)	1.5	1.18
26	COPD Diagnosis	2013-14 (Financial)	0.88	0.90
27	Asthma Diagnosis	2013-14 (Financial)	0.9	0.89
28	Exception rate	2013-14 (Financial)	0.04	0.04
29	Antidepressant use	2014 (Calendar)	0.26	0.31
30	Insulin prescribing	2014 (Calendar)	0.76	0.31
31	Ezetimibe prescribing	2014 (Calendar)	0.03	0.03
32	Antibacterial prescribing	2014 (Calendar)	0.29	0.31
33	Cephalosporins and Quinolones	2014 (Calendar)	0.03	0.05
34	Hypnotics prescribing	2014 (Calendar)	0.31	0.3
35	NSAID prescribing	2014 (Calendar)	0.77	0.76
36	Patient Experience	Q2 2014-15	0.85	0.85

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37	Getting through by phone	Q2 2014-15	0.76	0.75
38	Making an Appointment	Q2 2014-15	0.75	0.75
39	Assessment of Depression Severity	2013-14 (Financial)	0.87	0.89
40	SMI and a BP check	2013-14 (Financial)	0.91	0.92
41	SMI and a Cholesterol Check	2013-14 (Financial)	0.77	0.81
42	SMI and a BM Check	2013-14 (Financial)	0.85	0.86
+	Outpatients First Attendance/1,000 population	09/2014-08/2015	252 SAR 98	England no info SAR 100 Central Mid Av
+	Percentage of Outpatients Discharged at first appointment	2014/15	7.2%	England Central Mid Av
+	Total Inpatient + Day case/1,000 pop	09/2014-08/2015	SAR 96	England no info SAR 100 Central Mid Av
+	Net ingredient cost per ASTRO PU	2014-15 (Financial)	50.64	43.80 England 47.71 Central Mid Av

	Statistically significantly worse than England Average
	England Average or better
	Very close but worse than England Average – not statistically significantly worse
	High but should be high because of our ethnic mix leading to higher levels of diabetes than the modelling produces
	Seeking information on National Bench Mark – do have Regional Bench Mark for 2 of these (SAR with Region being 100)

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Appendix L. **List of Practices and GP IT system**

Locality	Doctors	National Code	Supplier	Version
NE	Agrawal, Agrawal, Agrawal & Ram	M92016	EMIS	Web
NE	Bagary, Bagary, Sidhu - Branch	-	EMIS	Web
NE	Bilas & Thomas	M92026	SystmOne	TPP
NE	Christopher	M92643	SystmOne	TPP
NE	Dhillon, Nandanavanam	M92609	EMIS	Web
NE	Dhillon, Nandanavanam - Branch	-	EMIS	Web
NE	Fowler	M92014	EMIS	Web
NE	Rajcholan & George	M92022	EMIS	Web
NE	Jones, Grinsted, Sinha, Gowda	M92013	EMIS	Web
NE	Kainth M	M92004	EMIS	Web
NE	Kehler, Aung & Naz	M92019	EMIS	Web
NE	Kharwadkar	M92629	SystmOne	TPP
NE	Kharwadkar - Branch	-	SystmOne	TPP
NE	Krishan, Ohri, Glover - Branch	-	EMIS	Web
NE	Libberton, Ram, Turner & Reddy	M92039	EMIS	Web
NE	Mahay	M92001	EMIS	Web
NE	Mittal	M92041	EMIS	Web
NE	Morgans, Luis, Ball, Pillay, Rafiq, Cook, McDermott, Tahir	M92009	EMIS	Web
NE	Morgans, Luis, Ball, Pillay, Rafiq, Cook, McDermott, Tahir - Branch	-	EMIS	Web
NE	Parkes, Stoves, Lakha, Burnett & Doggett	M92002	EMIS	Web
NE	Showell Park: Chelliah, Koodaruth, Qureshi, Obi, Ravindran, Dunn	Y02736	SystmOne	TPP
NE	Vij, Vij, Mohindroo, Hamdy - Branch	-	EMIS	Web

Locality	Doctors	National Code	Supplier	Version
SE	Agrawal, Agrawal, Agrawal & Ram - Branch	-	EMIS	Web
SE	Asghar, Labutale	M92027	EMIS	Web
SE	Bagary, Bagary, Sidhu	M92654	EMIS	Web
SE	Bagary, Bagary, Sidhu - Branch	-	EMIS	Web
SE	Bilston Urban Village: Ahmed, Rai, Farhat, Mahmood	Y02757	SystmOne	TPP
SE	Ettingshall Medical Centre: Rana, Chobayan, Hibbs	Y02735	SystmOne	TPP
SE	Hibbs, Johnson, Latunji, Meredith, Narhlya, Dowell, Hussain, Aggarwal, Patara, Swanston, Sood, Sangha	M92024	EMIS	Web
SE	Hibbs, Johnson, Latunji, Meredith, Narhlya, Dowell, Hussain, Aggarwal, Patara, Swanston, Sood, Sangha - Branch	-	EMIS	Web
SE	Kainth J, Kainth P, Mundlur	M92035	EMIS	Web
SE	Kainth J, Kainth P, Mundlur - Branch	-	EMIS	Web
SE	Khan, Agrawal, Aggarwal, Saini, Nazir	M92012	EMIS	Web
SE	Krishan, Ohri, Glover	M92040	EMIS	Web
SE	Lal & New	M92647	EMIS	Web
SE	Mudigonda & Mudigonda	M92649	EMIS	Web
SE	Pahwa & Pahwa	M92015	EMIS	Web
SE	Pahwa & Pahwa - Branch	-	EMIS	Web
SE	Ravindran, Ravindran, Majid, Rosh	M92630	EMIS	Web
SE	Saini & Mehta	M92030	EMIS	Web
SE	Sharma, Walker, Mason	M92627	EMIS	Web
SE	Suryani, Hook	M92003	EMIS	Web
SE	Venkataramanan & Julka	M92612	EMIS	Web
SE	Vij, Vij, Mohindroo, Hamdy - Branch	-	EMIS	Web

Locality	Doctors	National Code	Supplier	Version
SW	Bush, Pamma, Axon, Sandu	M92043	EMIS	Web
SW	Cowen, Manley, Guest (system change Jan 13 - TPP to emisweb)	M92006	SystmOne	TPP
SW	Williams, DeRosa, Koodaruth	M92044	EMIS	Web
SW	Jackson, Ashton, Bright, Smissaert, Shafi	M92010	EMIS	Web
SW	Jackson, Ashton, Bright, Smissaert, Shafi - Branch	-	EMIS	Web
SW	Sidhu, Bird, Maarouf	M92007	EMIS	Web
SW	Morgans, Luis, Ball, Pillay, Rafiq, Cook, McDermott, Tahir - Branch	-	EMIS	Web
SW	Passi & Handa	M92031	EMIS	Web
SW	Passi & Handa - Branch	-	EMIS	Web
SW	Pennfields Health Centre: Ahmed, Rai, Farhat, Mahmood	Y02636	SystmOne	TPP
SW	Pickavance, Nazir, Badr	M92029	EMIS	Web
SW	Richardson, Stone, Mahmood, Dobie, Kashif	M92028	EMIS	Web
SW	Taylor & Cam	M92042	EMIS	Web
SW	Vij, Vij, Mohindroo, Hamdy	M92607	EMIS	Web
SW	Wagstaff, Shaw, Patel, Roberts, Lennox, Gill, Bassi	M92008	SystmOne	TPP
SW	White, Burell, Samra, Strieder, Booshan, Glover, Kalhan (system change 9/12/14 vision to emis web)	M92011	EMIS	Web
SW	Whitehouse	M92640	EMIS	Web

Appendix M. List of Practices with EMIS Mobile

Practice Name (NE)	Practice Code	PM Name
Asghar	M92027	Anita Small
Kainth MS	M92004	Slinder Uppal
Lal C	M92647	Savita Lal
Libberton	M92039	Sharon Bibb
Dhillon G	M92609	Sharon Harris
Practice Name (SW)	**Practice Code**	
Agrawal SR	M92016	Steve Powell (interim)
Richardson	M92028	Keely Ryder
Whitehouse NJ	M92640	Lorraine Kellar
Sidhu M	M92007	Sharon Want (Interim)
De Rosa D	M92044	Pam Kandola
Bush DM	M92043	Janice Taylor
Kehler M U	M92019	Carol Kenny
Vij SK	M92607	Suresh Cartigasu
Burrel J	M92011	Helen Ryan
Wilkinson JS	M92029	Jackie Smith
Jackson	M92010	Sue Sephton
Practice Name (SE)	**Practice Code**	
Bagary	M92654	Jas Bagary
Hibbs	M92024	Sue Thornhill
Suriyani S	M92003	Shoeb Suryani
Krishan KS	M92040	Parkash Krishan
Noble BS	M92012	Jacqui Squire
Pahwa MK	M92015	Ved Pahwa
Ravindran TS	M92630	Nira Ravindran
Mudigonda N	M92649	Mohan Mudigonda
Saini & Mehta	M92030	Lisa Hayden

DRAFT