Draft Five Year Strategic Plan for the Wolverhampton Health and Social Care Economy

Draft for submission to NHS England 20th June 2014

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Contents

1. Introduction

In 'Everyone counts: planning for patients 2014/15 to 2018/19' published by NHS England, there is a requirement on Clinical Commissioning Groups and partner organisations to develop five year strategic plans.

The five year strategic plan for Wolverhampton sets out:

- a vision for what the health and social care system should look like in 2018/19
- the values and principles underpinning this vision
- the case for change, that is, the reasons why we need to transform the current system
- the main transformational programmes of work to deliver this vision
- the governance structure to ensure progress is made.

The Unit of Planning covers the population of Wolverhampton and concerns the commissioning of health and social care, comprising the following statutory organisations: Wolverhampton Clinical Commissioning Group, Wolverhampton City Council, Black Country Partnership Foundation Trust and The Royal Wolverhampton NHS Trust.

There are a number of key documents on which this five year strategic plan draws upon and is aligned with including:

- Joint Strategic Needs Assessment
- Health and Wellbeing Board strategy
- Two-year Operational Plan
- Better Care Fund.

2. The Vision

2.1 What will the Wolverhampton health and social care system look like in 2018/2019?

In 5 years time we will have a streamlined health economy with reduced reliance on the acute sector and increased capacity in primary and community care with accessible high quality services. By 2018/19 significant progress will have been made towards making sure that within the available resources, people in Wolverhampton will receive the right care, in the right place, at the right time.

- There will be a marked improvement in the health outcomes for those people in Wolverhampton who currently have relatively poor outcomes.
- Resources will be directed to helping people to stay healthy for as long as possible.
- People will receive the right care and particular priority will be given to the very young, the very old and those people with life limiting conditions.
- Services will be delivered to the right standards; they will be safe and reliable, and the people of Wolverhampton will have confidence in them.
- Patients will be seen by the appropriate professional at the right time.
- Quality will be at the heart commissioning decisions and the focus of service delivery will be the patients and their needs.

The system vision is shown in the diagram below and in Wolverhampton this translates to strategic priorities of:

- **More primary care:** a developed/expanded primary care provision which is proactive and central to the coordination of the integrated health and social care system. This also includes standardisation of primary care services with longer opening times and full use of skill mix with the offer of more diagnostics and minor procedures as add on services.
- **Less but more streamlined secondary care:** the acute hospital sector focuses both on its specialist functions, reduces its general bedded activity and develops its integration with the community
- **More community care**: increased activity in community-based settings
- **More third sector provision**: an expanded role focusing on supporting patients
- **More integrated care**: social care is central to the integration with the acute/mental health sectors, third sector, primary, and community based services especially for those with long term conditions. the Better Care Fund is the mechanism for driving integration
- **Improved services for children**: Commissioning of services will adhere to care centred around the child using the new SEND reforms and children's continuing care framework.
- **Improved services for older adults**: availability of a named GP and possibly a patient advocate to ensure there care is patient centred and not just disease specific. They will have personal health budgets where appropriate
- **Improved services for mental health**: easily accessed and providing the correct model of care at the correct time. A reduction in bedded activity to focus on early intervention in the community.

  Improved quality: integrated quality assurance is wrapped around the whole system

Strategic Vision

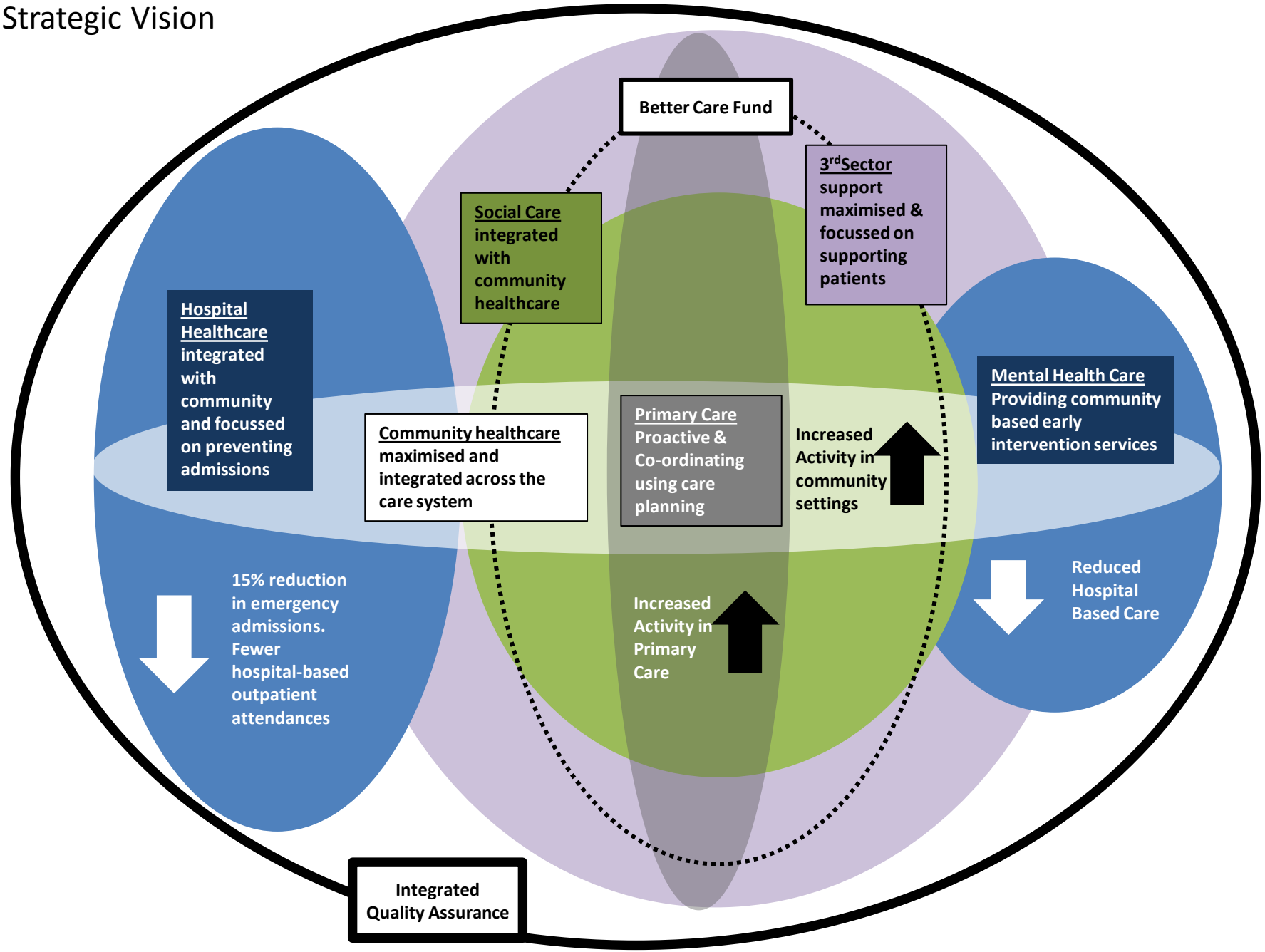


Figure 1: Wolverhampton CCG Strategic Vision

2.2 Values and Principles

The values and principles which underpin and drive our vision of are:

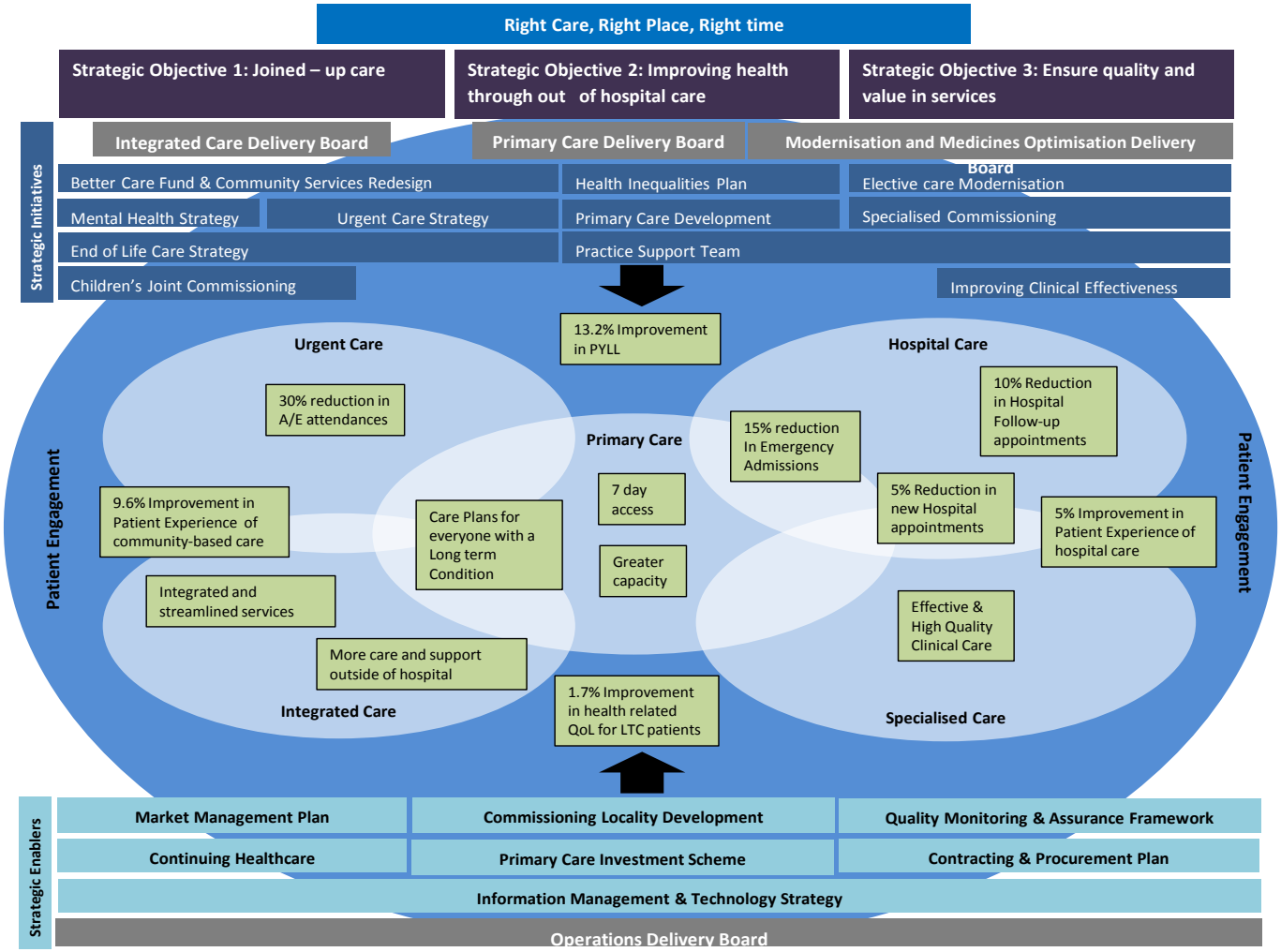
- Respect and value people – personalisation of service and choice are at the core of the delivery agenda
- Listen and engage with local people – we are committed to involving patients, carers, clinicians and communities in the design and improvement of their services
- Ensure clear accountability and transparency – we value feedback and a clear sense of accountability and responsibility for our decisions. We intend to strengthen the links between our decision making and the views of local people
- Fairness and equity – we will maintain a focus on disadvantage in communities ensuring that they have genuine opportunities to access health services. We intend to promote a sense of right of entitlement within our communities, in line with the NHS constitution
- Drive clinical leadership – we recognise the need for and will develop and support clinical leadership in service planning, redesign and delivery in order to ensure the highest levels of quality and efficiency
- Quality – We will continuously improve the quality of the services that we commission and demonstrate improvements to the public
- Innovation – we will make best use of all the best ideas available, in order to be a dynamic, responsive and innovative organisation
- Prevention - we will work to prevent poor health starting early, before birth, and working through the whole life cycle
- Partnership and collaboration – we will work closely with our partners in the health, local authority and third sectors in an integrated way in order to ensure a holistic approach to promoting health and equality in the community
- Productivity – we will monitor the effectiveness of our services and the impact on outcomes to ensure the best of our resources
- To have a proactive, inclusive, equitable and professional approach that will secure best value for money and high quality in all that we do.

2.3 Quality and outcome ambitions to deliver the vision.

NHS Outcome Framework Domains	NHS Outcome Ambitions	Local Rationale	Baseline	Target 2015/16 (Year 2)	Target 2018/19 (Year 5)
Domain 1: Preventing people from dying prematurely	**1. Securing additional years of life for the people of England with treatable mental and physical health conditions** Measure: Decrease Potential Years of Life Lost (PYLL) from causes amenable to healthcare	The process for setting this target has been to take the data available from 2010-2013 (from ATLAS) and apply a logarithmic progression (R^2=9.001) up to 15 years. This gives ambitious targets initially, levelling out as successes reduce the cohort of patients. Projects are already underway via QIPP to improve on this position and the future multi agency projects (CCG, PH, MH, Provider etc.) have been tested for expected benefits. These have subsequently been converted into actual activity and cost savings which are applied to our current baselines to project future activity reductions.	2511 (2012/13 ATLAS Data)	2295	2180
Domain 2: Enhancing quality of life for people with long-term conditions	2.**Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions** measured using the EQ5D tool in the GP Patient Survey	The process for setting this target has been to take the data available from 2011/12 – 2012/13 (from ATLAS) and apply a linear trendline (R^2=1) up to 15 years. This takes into account the continuing programme of improvement over a long period – an essential requirement for LTCs. Projects are already underway via QIPP to improve on this position and the future multi agency projects (CCG, PH, MH, Provider etc.) have been tested for expected benefits.	69.9 (2012/13 ATLAS Data)	70.5	71.1

NHS Outcome Framework Domains	NHS Outcome Ambitions	Local Rationale	Baseline	Target 2015/16 (Year 2)	Target 2018/19 (Year 5)
Domain 3: Helping people to recover from episodes of ill health or following injury	**3.Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital** Composite of all emergency avoidable admissions (indirectly standardised)	The CCG has taken into account previous performance to set a trend line for the long term target. This was transposed to current baseline to set a start point; QIPP intentions were added for Y1 & Y2 targets; 15% ambition for reducing emergency ambitions added for Y5 target; Series extended to meet long term 15Y target based on 2009-2012 trend line data. The 2014/15 and 2015/16 targets have then been calculated from this data. Projects are already underway via QIPP to improve on this position and the future multi agency projects (CCG, PH, MH, Provider etc.) have been tested for expected benefits. These have subsequently been converted into actual activity and cost savings which are applied to our current baselines to project future activity reductions.	2641.0 (2012/13 ATLAS Data)	2466.1	2246.2
	4.Increasing the proportion of older people living independently at home following discharge from hospital BCF metric of: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services sourced from the Adult Social Care Frameworks Indicator	The process for setting this target has been to take the data available from 2008/09 – 2012/13 and extend the graph to a 5% increase in the metric over the next 2 years. This is seen as an stretch target due to recent years of decline in performance. Projects are already underway via QIPP to improve on this position and the future multi agency projects (CCG, PH, MH, Provider etc.) have been tested for expected benefits. These have subsequently been converted into actual activity and cost savings which are applied to our current baselines to project future activity reductions.	85.6 (2012/13 ATLAS data)	89.9	tbc
Domain 4: Ensuring that people have a positive experience	**5.Increasing the number of people having a positive experience of hospital care** Patient experience of inpatient care (Friends and Family)	WCCG are projecting 2% reduction in those patients reporting a poor experience of inpatient care. WCCG will continue to monitor performance of the combined FFT data via contracts as a monthly measure to performance manage. Projects are already in flight via QIPP to improve on this position and the future multi agency projects (CCG, PH, MH,	114.5 (2012 ATLAS data)	112.0	108.8

NHS Outcome Framework Domains	NHS Outcome Ambitions	Local Rationale	Baseline	Target 2015/16 (Year 2)	Target 2018/19 (Year 5)
of care		Provider etc.) listed below have been tested for expected benefits. These have subsequently been converted into actual activity and cost savings which are applied to our current baselines to project future activity reductions.			
	6.Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community Composite indicator comprised of (i) GP services, (ii) GP Out of Hours. Patient Survey	Due to the lack of national data, WCCG are proposing a 10% improvement (reduction) in negative responses for the patient experience of primary care over 2 years. Failing this data being available WCCG will define a more readily available performance measure.	Baseline: 7.3 (2012 ATLAS Data)	6.6	TBC with data availability
Domain 5: Treating and caring for people in a safe environment & protecting them from avoidable harm	**7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care**	The measure used is that weekend mortality should be no higher than any other day in the week. This is measured using 18 month's worth of comparison data from CISU. The CCG uses mortality data from the HED tool which contains the UHB's version of HSMR and SHMI (their SHMI is almost identical to the Information Centre's SHMI). The CCG are able to look at the difference between weekday and weekend mortality figures for RWT and plot the rate of change. To have this under control, the rolling average change in the difference between mortality at weekends compared to weekday needs to be a flat series. We are proposing that we use this information to monitor the outcomes of projects that are in flow or being set up to reduce mortality and specifically the differential between weekday and weekend rates – i.e. 7 day working initiatives etc.	18 month's worth of comparison data from CISU	1. Difference between wkday and wknd per month (0 indicates parity) 2. Change between the differences from month to month 3. Rolling average in change in difference (same as 2 but uses a 6 month average).	



The main features in delivering the vision in the context of outcome ambitions.

2.4 Characteristics of the high quality and sustainable service models

2.4.1 Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care

We have a comprehensive framework for engagement, the outcome from which is robust gathering, triangulation, reporting and responding to insights received from patient and community groups. Through this framework, which comprises a range of forums that meet quarterly, the CCG is able to collaborate with a diverse range of representative groups – residents, PPGs, patient/community groups, clinicians and allied health professionals, and Healthwatch. The groups are able to report their experiences, but also scrutinise and influence the CCG's plans and strategies, which are taken by CCG leaders to these groups. All reported insights are reviewed and discussed at the CCG's Joint Engagement Assurance Group which has multi-agency representation. An Assurance Framework comprising key risks around communications and engagement is overseen by the group ensuring both the performance of and confidence in our engagement framework is maintained.

We use a range of creative methods to engage with the wider community. Our call to action round tables in Autumn 2013 invited members of the public to discuss the challenges facing the NHS and opportunities for meeting their needs more effectively. We have continued this momentum with the Your Future NHS event, held in May of this year, attended by over 80 members of the public, patients and professionals; more than a quarter of those attending have expressed an interest in continuing to work with us on plans as they progress. We also work with the city's Equality and Diversity Forum to reach the seldom heard and we evaluate our self-selecting Patient Partner membership against the city's demography statistics (Census 2011) to ensure they are representative. Our forthcoming communications and engagement strategy aims to strengthen engagement with under-represented members of our community.

Our vision for engagement over the next 5 years is focused on 3 areas:

1. Listening to patient's views
We will put patients at the forefront of the decision-making process. We will do this by involving the population in regards to the planning and delivery of services and we will engage and empower patients to manage their own health condition and the care that they receive individually.

2. Delivering better care through the digital revolution
The CCG aims to review and assess the digital options available with the view to implementing solutions that offer both improved and directed care to patients, while improving efficiency of staff and reducing the cost of care provision. The key strands of this strategy will be to support patients through assisted living at home by implementing self-management of treatment and remote monitoring. The CHC nurses are being issued with tablet devices in order to increase the efficiency of their assessments out with patients. We are looking at implementing mobile clinical systems via tablets/smartphones for GP' to assist with home visits. The Shared Care Record being delivered via BCF will be available to all clinicians with a direct clinical relationship with patients via a mobile platform. This will also allow patients access to their own records to assist them with self - management. We would like to pilot consultations via webcam to test for appropriateness - this is

happening already in England and we will investigate this. This is all subject to appropriate funding for Telehealth and telemedicine via IM&T.

3. Transparency and sharing data

The CCG has a short and long term strategic plan to implement a solution that will enable interconnectivity across disparate clinical systems creating a fully populated and clinically complete Electronic 'Longitudinal' Patient Record. This is an economy wide plan involving all Health Care Provider Organisations and Social Care. It is the aim of the CCG to use this as a vehicle to improve transparency between Health Care professionals across all settings as well as empowering patients through access to their own health records. The CCG is actively involving key staff to ensure adherence to Information Governance requirements related to data sharing at all points through this process.

2.4.2 Wider primary care, provided at scale

The development of primary care is critical to the achievement of our vision. We will facilitate the transformation and development of Primary Care so that it is able to:

- Maximise the capacity, capability, flexibility of GP primary care in order that greater levels of access, healthcare and support activity can be undertaken outside of hospital in order to prevent unnecessary and avoidable hospitalisation.
- Improve health outcomes by focusing on primary and secondary prevention strategies in order to prevent ill-health in the whole population and improve the quality of life and management of patients who have a long-term and/or complex condition. This involves ensuring that high risk patients are identified and targeted for intervention that ensure the each individual patient's care is planned and encompasses a range of health improvement strategies, from education and self-care, through to treatment and beyond.
- Maximise the quality and productivity of services in order to ensure maximum value for money for care provided and that the highest standards of care are maintained and delivered to the population of Wolverhampton.

2.4.3 A modern model of integrated care

A range of services provided in the community are led by nursing and professions allied to medicine. Our vision focuses on these services to maximise their potential and impact on health outcome by ensuring integration with and coordination across other health and social care services. In particular, services will target patients with a long term condition and/or those are over 75.

We will establish the process of care planning for these patient groups in order to ensure there is a named senior clinician responsible for each patient and a care plan in place which has been initiated by the patient's GP. This will be aimed at disease and risk modification in order to proactively manage the patient's healthcare needs, concentrating on care outside of hospital and avoiding unnecessary requirement for emergency admission where appropriate.

We will deliver our model of integrated care through the following key initiatives:

- the Better Care Fund to maximise the potential of health and social care support in the community to facilitate the delivery of patient care plans.

- the GP contract changes for over 75s and the enhanced service to provide proactive case finding and care review for vulnerable people
- the £1m allocation for our Primary Care Investment Scheme.

We will:

- link each of these initiatives and associated services by the golden thread of a personalised patient care plan initiated by the GP in partnership with the patient.
- redesign community nursing services so that they are focused on supporting primary care in the delivery of out of hospital care
- ensure that other clinical support supports and professions allied to medicine are focused and integrated in order to support both the QIPP and health outcome challenges.
- maximise the support and potential of the third sector and voluntary agencies across health and social care in order to support patients in the community.

2.4.4 Access to the highest quality urgent and emergency care

Wolverhampton health economy has a strong history of networking across the local health economy. On a regional basis, Wolverhampton's acute hospital is part of the network of Trauma units in the Black Country which are networked with the Major Trauma Centres in the West Midlands in Stoke, Birmingham and Coventry. Working partnerships is evident in the work around critical care and the recent development work relating to mass casualty planning across the region. The Area Team have agreed to facilitate sub regional discussions to establish robust emergency care networks which Wolverhampton is fully committed to participating in.

Locally, the principles of the approach of networks to ensure the patients receive the right care, at the right time, in the right place is fully supported. The city has a history of separate organisations forming one urgent care system in the city. The Wolverhampton Urgent Care Working Group (UCWG) was established in order to develop an integrated system across the system involving primary, community, acute and social care. The UCWG has representation from the CCG, RWHT, LA and neighbouring CCG. Our vision for the urgent and emergency care system is built around the recommendations of the national review undertaken by Sir Bruce Keogh. The delivery of this vision will be interdependent with our vision for the development of primary care.

The Urgent Care Working Group is the key engagement mechanism across local, regional and national stakeholders and networks. This local network of individual providers (Acute, Community, WMAS, Local Authority, Public Health and Commissioners) has overseen the development of the Wolverhampton Urgent and Emergency Care Strategy. The three key principles of the strategy are:

- Firstly, working with Primary Care to improve access and ensure sharing of clinical information is enabled and maximised across the system in order facilitate consistent, high quality care.
- Secondly, to reduce duplication in service and minimise the confusion in the system for patients who felt that there are too many access points into the current urgent and emergency care system
- Thirdly, to ensure the infrastructure supports the integration of care provision. This will involve the building of a new Emergency and Urgent Care Centre. The new ED will be future proofed against increased emergency activity from both predicted surge and major incidents. A newly

established urgent care centre will be based above the ED with a signposting service at the front door to ensure that patients are seen in the right part of the system. This will include increased information to support patient self-care/management.

The UCWG also works with the Black Country Network in order to ensure the right co-ordination in both commissioning and provision across Wolverhampton, Dudley, Walsall and Sandwell. The UCWG will also engage with the NHS England, Critical Care and Stroke Services networks to the same end.

2.4.5 A step-change in the productivity of elective care

For people who need episodic, elective care, access to services must be designed and managed from start to finish to remove error, maximise quality, and achieve a major step – change in productivity.

We will work with our providers to deliver high quality care, treating adequate numbers in order to retain the required levels of skills, training, education and workforce, and with the most modern equipment available.

We will work with primary care in order to manage demand for services, to ensure those in the greatest need receive the right care, in the right place and at the right time. We will also develop a greater number of providers, particularly those that can be based in a community and/or purpose-built setting in order to provide greater choice and competition for elective care

International comparisons suggest that, as well as quality improvements, there are significant productivity gains to be made if we can change our model of delivering elective care – giving us the opportunity to treat even more patients at the same or lower cost.

2.4.6 Specialised services concentrated in centres of excellence

Specialised services are those services that are provided in relatively few hospitals to a catchment population of more than one million people. The number of patients accessing these rarer services is small and a critical mass of patients is needed in each centre in order to deliver the best outcomes. In addition a concentration of skills and expertise by the clinical team undertaking the treatment also benefits the standard of care delivered. These services are commissioned directly by NHS England and locally this is undertaken through the Birmingham, Solihull and Black Country Area Team for the West Midlands.

Specialised services are currently being delivered out of too many sites, with too much variety in quality and at too high a cost in some places. Nationally, and as outlined in NHS England planning guidance, the vision for these services is to concentrate them into a smaller number of centres for excellence. This will ensure that commissioners are able to maximise the quality, effectiveness and efficiency of these services because the providers are able to work at critical mass volumes while remaining integrated with research and teaching activity. The detailed strategy for Specialised Services will be developed and delivered within the timescales of this strategic plan and it is expected that care will be concentrated within 15-30 centres for the majority of specialisms, supported by the new Academic Health Science Networks.

3. The case for Change

3.1 Population

The Wolverhampton CCG registered population is 262,000 (the resident population is 250,000). Population projections to 2018 suggest a further increase in the resident population to 257,000. There is a five percent difference between the resident and registered population of Wolverhampton. It is estimated that the registered population will be 274,850 in 2018 if this difference maintained. Wolverhampton's predicted population growth rate is below the national, regional and Black Country averages.

Diversity

The majority of residents in the city belong to the white ethnic group (68%), with the remaining 32% from black minority ethnic backgrounds (BME). The largest of the BME groups is Asian at 18.8%, followed by black and mixed race at 6.9% and 5.1% respectively. This is quite different to the national distribution with only 14.3% from a BME background. The south east of the city has the highest proportion of BME residents. It is anticipated that the projected increase in the population will increase diversity in the City in 2018, but it is not possible to predict proportions in particular ethnic groups

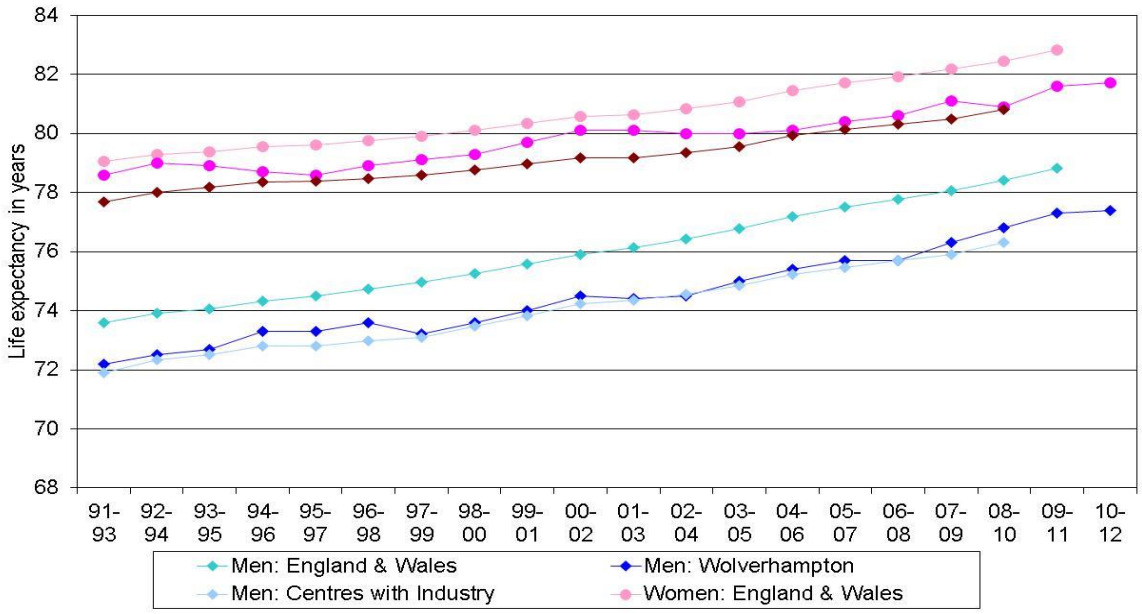
Deprivation

Deprivation is a fundamental determinant of poor health and dependence. There are significant levels of deprivation in the city. Wolverhampton is the 21st most deprived Local Authority in the country, with 51.1% of its population falling amongst the most deprived 20% nationally. This indicates that over half of Wolverhampton's population live in the poorest areas in England, which impacts on life expectancy and premature mortality rates in the city. Deprivation is disproportionate across the city, with the least deprived wards in the west of the city and the most deprived located in the north east and south east of the city (see figure above). This level of deprivation is unlikely to change over coming years and may worsen by 2018 due to the current levels of austerity.

Life expectancy

People in Wolverhampton are living longer than ever before, however, the gap between life expectancy in the city and the national figure is not closing. Both males and females in Wolverhampton experienced lower overall life expectancy in 2010-12; 77.4 years for males and 81.7 years for females. This is almost two years less than the national average for both males and females. In addition, a male in Wolverhampton can expect to live just over 58 years free of any disability which is almost three years less that the national average. Women can expect to live almost 61 years free of any disability which is two 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.

Table 1: Trend in male and female life expectancy in Wolverhampton



There are also considerable inequalities in the experience of life expectancy and healthy life expectancy (disability-free) across Wolverhampton. Local analysis shows that there is a gap of approximately seven years for males and four years for females between those who are least and most deprived in Wolverhampton. This gap has remained fairly consistent over time.

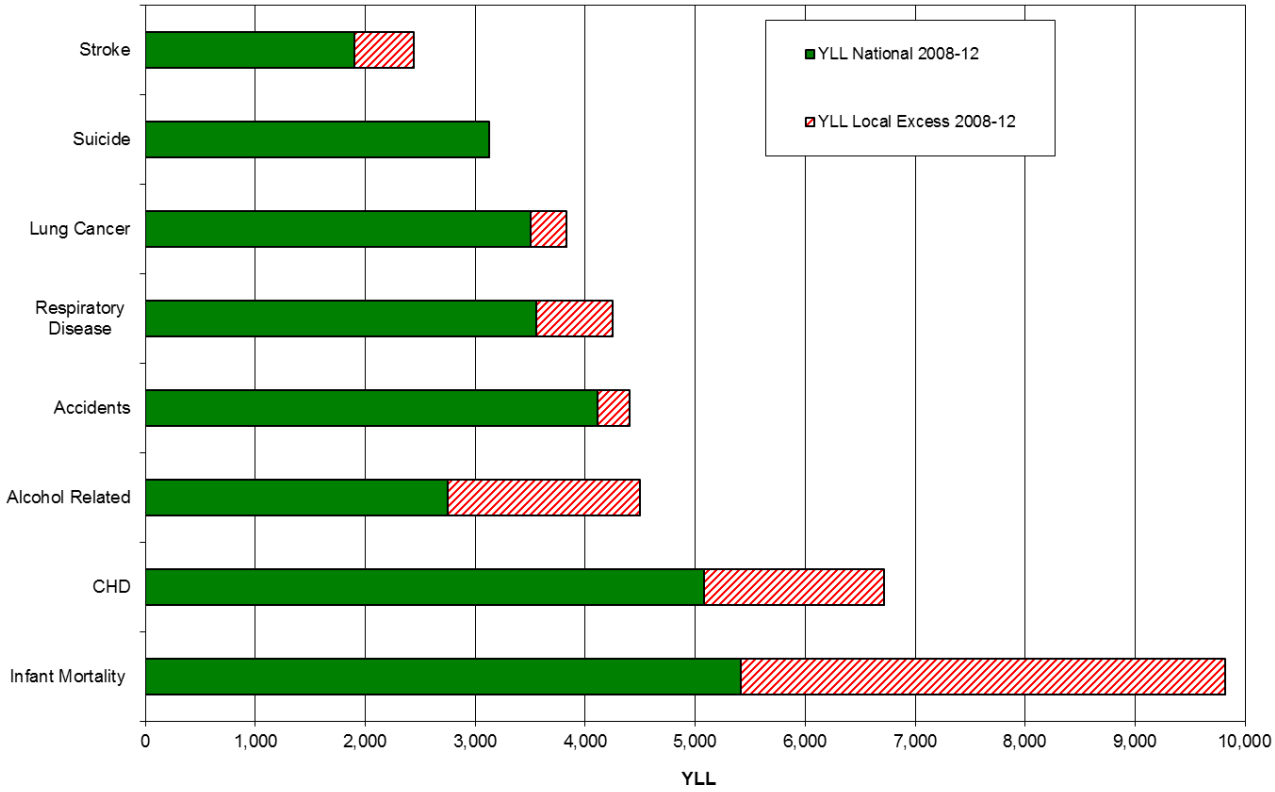
The analysis of these key health problems has been shared across the local health and social care economy. This is an emerging area of development in this domain of the commissioning for prevention framework. There is collaborative work in place to understand and act upon performance with anticipated improvement in outcomes by 2018.

The top six conditions that drive low life expectancy in Wolverhampton have been identified. These are the conditions causing the most avoidable life years lost (i.e. the number of years of life lost below the age of 75). The six conditions are:

1. Infant mortality
2. Alcohol related mortality
3. Coronary heart disease (CHD)
4. Accidents
5. Respiratory disease
6. Lung cancer

The graph below shows the number of life years lost from the top six causes mortality between 2008 and 2012. The length of the full bar (including green block and red and white striped block) show the total years of life lost in Wolverhampton. The green bar shows the numbers of life years lost if our mortality rates were the same as England. The red and white striped bar shows the local excess years of life lost and therefore the years of life Wolverhampton could potentially gain if death rates were similar to the national average.

Figure 2: Causes of Excess Years of life lost - persons under 75 years 2008-2012



The implementation of this strategic plan supported by various Public Health initiatives will deliver significant gains in these top six conditions, increasing life expectancy, reducing inequalities and improving quality of life by 2018.

3.2 Health Inequality

The delivery of the aims of this strategic plan will have a high impact on tackling local health inequalities through the commissioning of services and interventions to:

- address the high risk lifestyle choices that are strongly correlated to deprivation
- target specific population groups at greater risk of poor health and wellbeing
- ensure improved access to local high quality services
- focus on primary prevention.

There will also be a requirement to provide universal services to ensure that the needs of small pockets of 'more deprived' populations located in the 'less deprived' areas of the City are not neglected. This includes meeting the needs of local populations just above the threshold for poverty. These sections of the population are often difficult to identify and as a result, are at greater risk of inequitable service provision.

The inclusion of Equality Impact Assessments in the commissioning of services will highlight potential inequalities that may arise so that they can be addressed prior to service implementation. Therefore, more detailed work will be undertaken to promote the use of Equality Impact Assessments for commissioned services, supported by relevant Health Impact Assessments and

Health Equity Audits. Outcome-focused, needs-led commissioning and realistic target setting, combined with robust performance management and service evaluation will also inform the effectiveness of services in reducing health inequalities and improving the health of the local population.

Male and female life expectancy by ward 2008 to 2012

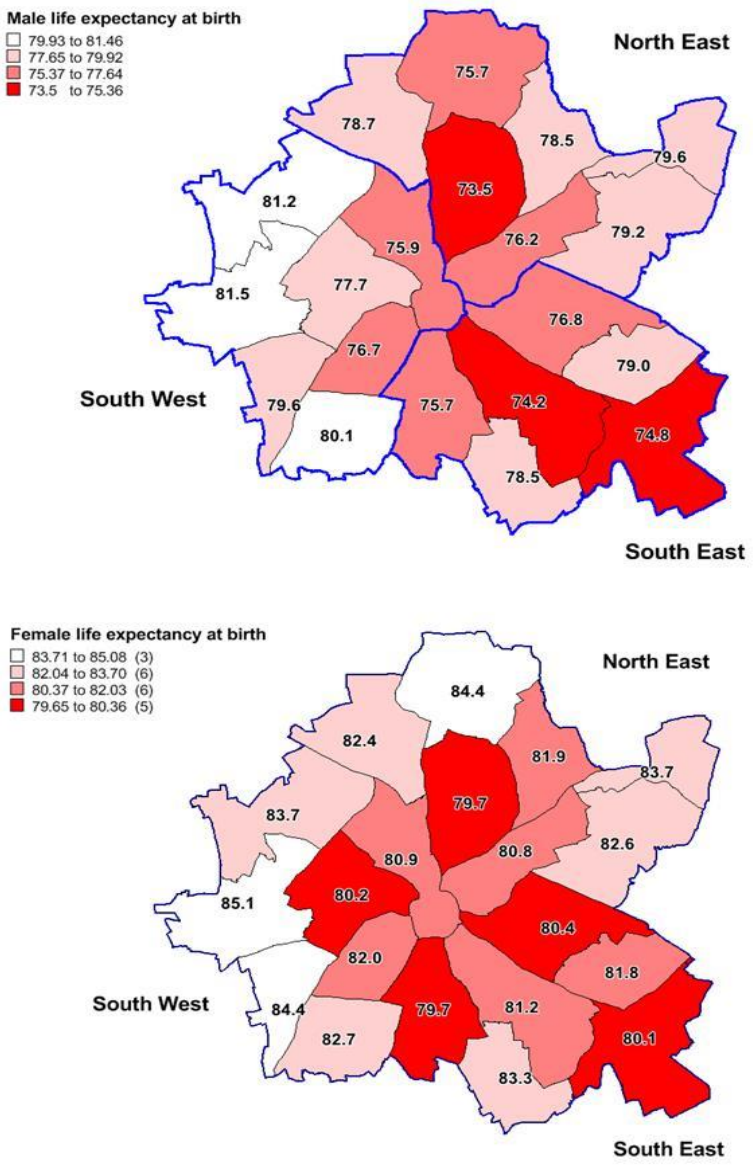


Figure 3: Male and Female Life Expectancy by ward 2008 to 2012

3.3 Joint Strategic Needs Assessment

Wolverhampton's Joint Strategic Needs Assessment (JSNA) has focussed on the outcomes contained in the three national outcome frameworks: Public Health (PHOF), NHS (NHSOF) and Adult Social Care (ASCOF). An additional locally developed outcomes framework for children and young people has been included. The key health needs identified from these frameworks highlight the priorities for commissioned services to improve health and reduce inequalities.

The JSNA process has informed the development of the Wolverhampton Joint Health and Wellbeing Strategy, produced by the Health and Wellbeing Board. The health and wellbeing priorities listed below have been selected to provide a number of high level evidenced-based priorities that are a challenge to resolve and span organisational responsibilities. The strategic outcomes for the strategy are aimed at increasing life expectancy, improving quality of life and reducing child poverty. Therefore, the top five priorities identified to achieve these outcomes are:

- Wider determinants of health
- Alcohol and drugs
- Dementia (early diagnosis)
- Mental Health (diagnosis and early intervention)
- Urgent Care (improving and simplifying).

This partnership approach to the setting of these priorities and the development of common goals demonstrates a predominantly mature approach to commissioning for prevention in this domain of the framework.

3.4 Lifestyle

Wolverhampton current performance against latest lifestyle indicators alongside the regional and national average is shown in table XX. Wolverhampton is significantly higher than the national average for all of the risk factors listed. The table also includes data on the performance of the NHS Health Check programme offered to the population aged between 40 years and 74 years. Wolverhampton has a statistically significant lower offer and uptake of this programme compared to the national average and there is a plan to increase this.

Table 2: Lifestyle risk factors performance measures for Wolverhampton

Indicator	Wolverhampton	West Midlands	England Average
Excess weight in children age 4-5 years (2012/13)	27.0%	22.7%	22.2%
Excess weight in children age 10-11 years (2012/13)	40.6%	35.5%	33.3%
Excess weight in adults (2012)	69.8%	65.7%	63.8%
Physically inactive adults (2012)	34.4%	31.8%	28.5%
Smoking Prevalence (2012)	22.9%	18.9%	19.5%
Offer of NHS Health Checks (2012/13)	10.9%	17.4%	16.5%
Take-up of NHS Health Checks (2012/13)	40.9%	45.8%	49.1%
Alcohol attributable alcohol admissions (2010/11 – All Age DSR /100,000)	2073.1	1910.3	1895.2

Source: Public Health Outcomes Framework http://www.phoutcomes.info/
Local Alcohol Profiles for England: http://www.lape.org.uk/data.html

Whilst there are interventions in place to address these lifestyle risk factors, obesity has been chosen as the subject for the Director of Public Health Annual report. The data available on obesity for children and adults in Wolverhampton indicates that levels of obesity are increasing year on year, with projected continual increase in the future. A number of severe and chronic long-term medical conditions are associated with overweight and obesity, including type 2 diabetes, hypertension, coronary heart disease, stroke, osteoarthritis and some cancers. Not only do medical conditions adversely affect people's health and quality of life, but they create serious, rising financial and social care burdens, which are not sustainable into the future. We know that obesity is related to age, ethnicity and where people live in Wolverhampton which should allow targeting of interventions and policies in the most appropriate way.

The Director of Public Health Annual Report is a call to action for Wolverhampton presenting multi-organisational local opportunities to make a difference to this difficult problem. The outcome of this call to action should deliver a significant change in the proportion of children and adults with excess weight and in physically inactive adults by 2018.

3.5 Current Performance

The drive in the strategy to relieve pressures on the acute hospital sector, should help to overcome the areas of concern about current performance.

The key performance indicators the CCG uses to monitor performance both at CCG and Provider level are taken from the, NHS Constitution, NHS Outcomes Framework, NHS Outcomes Indicator Set, Everyone Counts (Planning for Patients), NHS Operating Framework and Wolverhampton CCG Operating Plan Ambitions.

Performance is assessed against the baseline and/or target set by the Information Centre or set locally by the CCG, using historical data and forecast modelling. RAG ratings are applied to each performance indicator to enable the CCG to effectively monitor performance and the KPI's are reported on monthly, quarterly or annually.

Highlighted are a selection of KPI's which the CCG has recognised as particularly challenging and has focussed efforts on driving improvements.

- A&E 4 Hour Wait Targets – Supporting provider to meet 4 hour wait performance
- Cancer Waits – 62 day cancer waits
- Patient Experience Indicators (Friends and Family Test)
- MRSA – targeting zero breaches
- C Difficile – Reducing the number of instances
- Elective Activity – Reducing activity
- Non Elective – Reducing activity
- First Outpatient Attendances – Reducing activity.

These KPI's are performance managed within the terms agreed within the CCG/Provider contract and where applicable, fines and other sanctions can be imposed on Providers for breaches against performance.

3.6 Assessment of future demand

The longer people remain healthy as they grow older, the less growth in demand for healthcare services there will be. The pressure of an aging population is not in itself the key factor but rather how healthy people are, in particular whether they have a life limiting illness and/or long term medical condition as they grow old, in most cases these are typically driven by lifestyle factors eg smoking, obesity and alcohol consumption.

We have modelled the potential growth in demand for healthcare services by assessing changes in population size, the age profile and age specific health status over the next 5 years. Understanding how changes in demand is driven by changes in population size, age profile and age specific age status helps to identify what our objectives should be in terms of how we should respond to the predicted growth in demand for health services and what type and range of services we should commission.

We have undertaken work with the Wolverhampton Public Health team in order to understand the impact of demographic change and health status on hospital utilisation. This particularly focussed on the concept of *disability free life expectancy* and the analysis demonstrates that small changes in the health of the general population, linked to their overall life expectancy, will have a significant impact on the demand for healthcare services.

Cost pressures are commonly split into those that are associated with population change (demographic pressures), and those that are broadly independent of demography (non-demographic pressures). The drivers of non-demographic cost pressures include new medical technologies, new clinical guidelines and changes in patient expectations.

Guidance produced by NHS England for the Call to Action exercise suggests that non-demographic cost pressures for acute health services commissioned by CCGs will vary between 0.5% and 0.3% per annum over the 5 year planning period.

Table 3: Non-Demographic Cost Pressures

	Non-Demographic Cost Pressures £000	% cost pressure
12/13	-	-
13/14	1,126	0.4%
14/15	2,343	0.4%
15/16	3,871	0.5%
16/17	5,406	0.5%
17/18	6,332	0.3%
18/19	7,260	0.3%

It should be noted that in the CCGs five year financial plan, additional resources have been profiled over and above the national percentage assumptions shown above, which reflect the pressures of recent years, the local circumstances and defined areas of development.

Levels of healthcare utilisation are strongly associated with age, with costs rising as patients approach the end of their lives. To estimate demographic cost pressures we calculated PbR costs for the CCG by gender and single year of age. These were multiplied by ONS interim 2012-based subnational population projections.

This approach to estimating demographic cost pressures assumes that age specific healthcare costs are static. There is evidence to suggest however that age specific health status is improving and therefore this approach may overstate the demographic cost pressures.

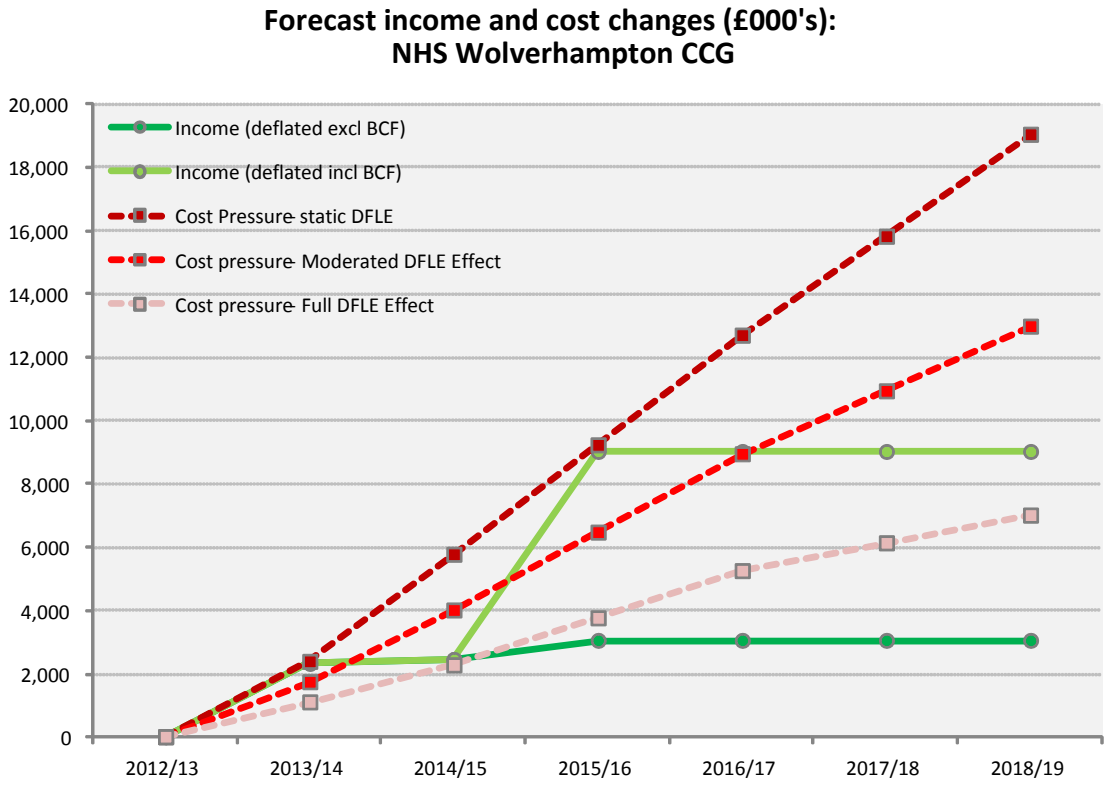
Two further estimates of demographic cost pressures have been produced:

- Full DFLE effect – this estimate assumes that age specific health status will improve by two years over the 5 year planning period (i.e. that an average 82 year old in 2018 will have the health status of an 80 year old today). These improvements are in line with recent trends in disability free life expectancy.
- Moderated DFLE effect - this estimate assumes that age specific health status will improve by one year over the 5 year planning period.

Table 4: Demographic Cost Pressure (£'000s)

	Demographic Pressure Static Age Specific Health Status	Demographic Pressure Moderated DFLE Effect	Demographic Pressure Full DFLE Effect
12/13	-	-	-
13/14	1,256	609	-28
14/15	3,420	1,659	-75
15/16	5,350	2,594	-117
16/17	7,279	3,530	-160
17/18	9,479	4,597	-208
18/19	11,772	5,709	-258

Table 5: The Gap between Forecast Income and Expenditure



Please note that since the publication of the CCG allocations used in the diagram above, adjustments have been made and the updated allocations are shown in section **3.9** The Financial Plan.

3.7 The opportunities

Anytown model

We have also analysed future demand using the NHS England *Anytown Model.* The Anytown Lite Model has been applied to Wolverhampton CCG and identifies that demographic and demand growth would add £39m by 2018/19 if there is no change to how the health care system works now.

The Anytown model shows how the implementation of a range of high impact interventions can help to address the challenge of growing demand for healthcare services.

The model shows the impact of 2 sets of interventions based on a set of case studies. These are:

- High Impact Interventions
- Early Adopter Interventions.

The model uses a set of population sub-groups in order to model changes in demand and the impact of the interventions in mitigating that demand.

Of the £39m demographic and demand growth £ 11.7 m (30%) can be tackled by implementing the High Impact Interventions as illustrated in the figure below

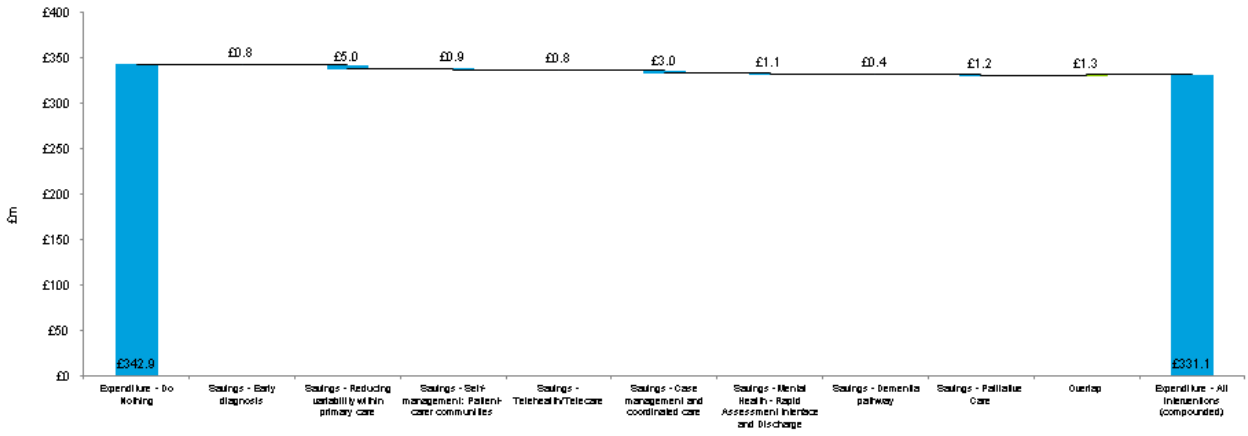


Figure 4: High Impact Interventions

A further £12.5m (32%) can be addressed by implementing the Early Adopter Interventions as demonstrated in the fig below

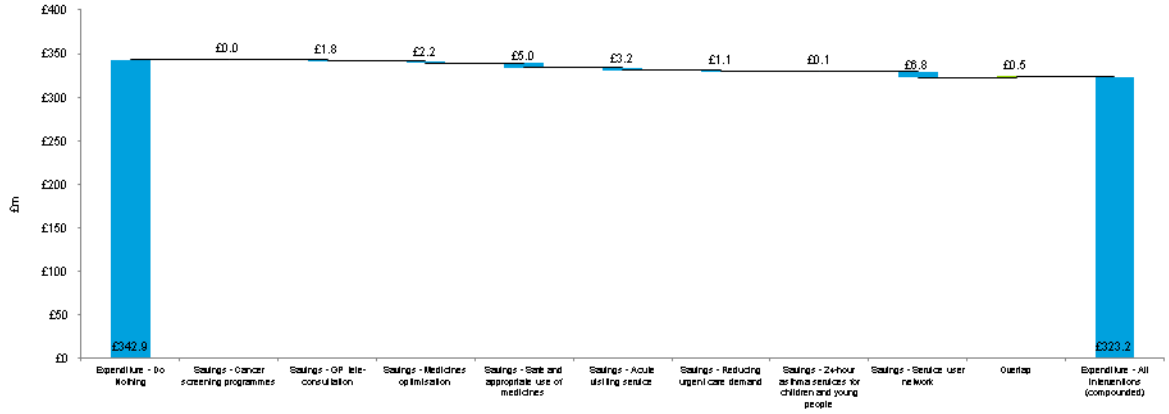


Figure 5: Early Adopter Interventions

Implementing all the High Impact and Early Adopter Interventions will save £24m (60%) of the predicted demand growth.

It should be stressed that , to the extent that in Wolverhampton some of these interventions have already commenced implementation, the levels of saving shown above may overestimate what can be achieved because these are calculated from a zero baseline and achieving 100% of savings.

Other opportunities to improve both quality and value by doing things differently have been assessed and compared with current local practice. In order to gauge the potential impact of our plans we have reviewed the following:

- Commissioning for Value
- Central Midland Commissioning Support Unit - Identifying Potential QIPP Opportunities
- Central Midlands Commissioning Support Unit - Future Impact of Demographic and Health
- Status Change on Hospital Utilisation
- NHS Rightcare - Commissioning for Value
- NHS Rightcare - Programme Budget Comparisons
- Public Health England - Spend and Outcomes Tool
- Wolverhampton City Council - Joint Strategic Needs Analysis
- NHS England Call to Action
- NHS England CCG outcomes tool
- NHS England Level of ambitions atlas
- NHS England operational planning atlas.

The table below provides a summary of the key areas of our commissioning expenditure where there is a significant variance in how the CCG benchmarks against other CCGs. It identifies that there are further opportunities for maximising the impact of our allocated resource in order to improve the health outcomes of our population across the QIPP spectrum.

Table 6: Summary Table QIPP Opportunities vs Commissioning for Value

Summary Table - QIPP Opportunities vs Commissioning for Value		Average	Top Quartile	Top decile
Alcohol	Marginally Attributable	£445,344	£1,872,692	£2,875,143
	Somewhat Attributable	£240,546	£375,417	£530,955
	Wholly Attributable	£25,080	£175,151	£247,927
Obesity	Marginally Attributable	£191,572	£234,468	£294,433
	Somewhat Attributable	£73,971	£148,706	£209,968
	Wholly Attributable	£1,871,176	£2,762,734	£3,176,958
Smoking	Marginally Attributable	£0	£0	£0
	Somewhat Attributable	£0	£10,599	£34,791
	Wholly Attributable	£1,282,580	£2,726,010	£3,346,966
ACS		£595,212	£358,338	£413,366
Medicines related		£0	£89,002	£186,170
Vaccine Preventable		£0	£0	£152,096
POLCV	Relatively ineffective	£0	£0	£5,611
	Probably aesthetic	£0	£0	£57,543
	Close benefit to harm ratio	£411,440	£702,646	£790,741
	Lower cost alternative	£156,109	£313,265	£576,173
Frail Elderly	Probable non-acute alternative	£0	£131,931	£1,316,556
	Possible non-acute alternative	£40,202	£230,956	£611,727
Admissions via A/E with primary MH diagnosis		£1,405,298	£3,282,944	£4,161,741
Readmission		£0	£1,112,936	£2,197,904
End of Life	3-5 days	£120,829	£286,217	£393,539
	Less than 3 days	£9,951	£72,809	£96,412
Medically unexplained symptoms		£0	£305,639	£343,624
Zero LoS, no procedure, discharged alive		£707,228	£1,508,472	£2,040,224
Cancelled procedures		£100,671	£142,225	£191,566
Falls related admissions		£0	£0	£358,023
Admission for self-harm		£0	£0	£0

QIPP Opportunities

Potential commissioner savings have been drawn from the 'QIPP Opportunities' packs produced by Central Midlands CSU for local CCGs in 2013. These packs identify a wide range of opportunities to reduce CCG expenditure on acute services (inpatients, outpatients and A&E).

Three savings estimates are calculated for each opportunity and CCG as the difference between the current level of expenditure per head of population and

- the West Midlands CCG average
- the West Midlands CCG best quartile
- the West Midlands CCG best decile.

These calculations assume no overlap between the opportunities and so may overstate the potential savings.

Table 7: QIPP Opportunities

Point of Delivery	West Midlands Average £000	West Midlands Best Quartile £000	West Midlands Best Decile £000
Inpatient	5,225	11,728	19,868
Outpatient	934	2,816	4,363
A&E	284	2,387	2,569
Total	**6,443**	**16,931**	**26,800**

The above analyses combined with our long term commissioning model, the Wolverhampton JSNA and the performance scorecard analysis, enable us to assess the relevant importance and priority of different initiatives. The purpose of this prioritisation is to identify those initiatives which:

- Focus on the delivery of strategic objectives and prioritised health outcomes
- Achieves significant QIPP impact
- Achievable within the acceptable planning timescales.

The conclusions that we draw from the analyses are that:

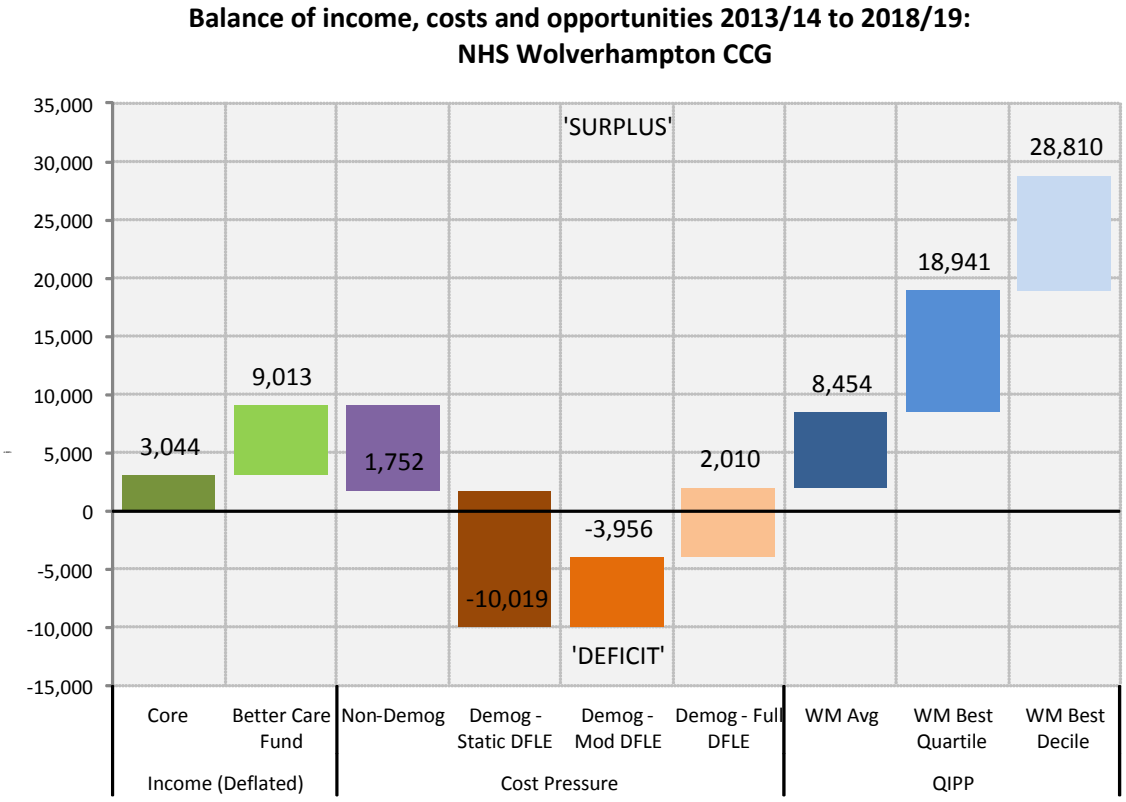
- The predicted growth in demand will contribute to a substantial increase in costs over the next 5 years
- Activity and cost growth can be mitigated through a range of interventions and QIPP initiatives
- Without introducing transformational change in the way that healthcare is delivered in Wolverhampton, a substantial gap between the cost of demand and allocated resource will ensue
- Our Strategic Plan will address the way that services are delivered as well as the way demand for those services are generated
- The impact of lifestyle choice and health inequality are key factors in the demand for services
- The management of patients with long term conditions and/or who are elderly is key to meeting the challenge of growing demand for healthcare services
- We will commission for maximum productivity for elective care services in order that we are target our resources effectively on those who are elderly and/or have a chronic health condition
- The demand for hospital services can be reduced and the quality of the care received improved through the development of more services provided outside of hospital by primary and community care
- The quality, health outcome and patient experience can be improved if services, across the local health and social care system, are better co-ordinated and integrated.

3.8 Cost pressures and QIPP opportunities

Taking the projections of cost pressures which arise from both demographic and non demographic increases in demand alongside the QIPP opportunities to save resources we can look at different scenarios over the period to 2018/19.

In the optimistic scenario, shown in a bridge diagram for the period below, the full impact of DFLE is assumed combined with achieving the top decile performance (in the West Midlands) on QIPP, which leads to a significant surplus in 2018/19.

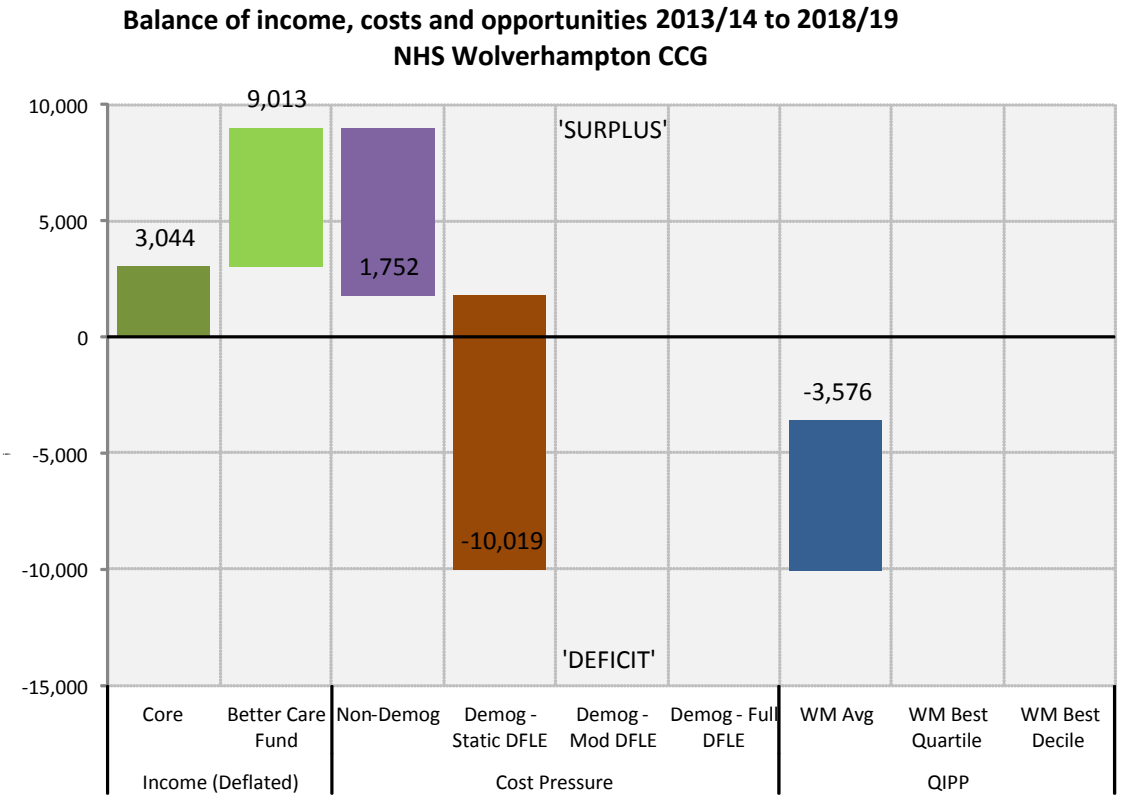
Figure 6: Cost Pressures and QIPP Opportunities (£'000s) – optimistic scenario



Figures on bars are cumulative surplus or deficit

In the pessimistic scenario, shown in a bridge diagram for the period below, there is no benefit from DFLE assumed and only average performance (in the West Midlands) is achieved on QIPP resulting in a deficit in 2018/19.

Figure 7: Cost Pressures and QIPP Opportunities (£'000s) – pessimistic scenario



Figures on bars are cumulative surplus or deficit

The table below shows the potential gap between forecast income and expenditure in 2018/19 given different QIPP saving and demographic cost pressure scenarios. In all but the most pessimistic scenarios, the CCG would have sufficient income and QIPP savings to cover the cost pressures if it were able to fully achieve the projected DFLE position *and* deliver all of the savings opportunities.

Table 8: Demographic Cost Pressure Scenario

	Gap (£'000s) @21/13 prices	Static DFLE	Moderated DFLE Effect	Full DFLE Effect
QIPP Savings Opportunity	**WM Average**	-3,576	2,487	8,454
	WM Best Quartile	6,912	12,975	18,941
	WM Best Decile	16,780	22,843	28,810

3.9 The Financial Plan

The CCG has produced a long term financial model (LTFM) which includes key assumptions for:

- demographic projections
- inflationary pressures
- efficiencies
- other factors impacting on contract growth.

For each of these key assumptions, three scenarios have been produced for the period, which include, 'best case', 'worst-case' and 'most likely'.

These assumptions, in the three scenarios are applied to the following budget categories:

- Prescribing
- Reserves
- Mental Health and Learning Difficulties
- Continuing Health care
- Secondary and tertiary care
- Running costs
- other PCT commissioning spend.

In the 'most likely scenario' challenging QIPP schemes are required to deliver financial balance.

The financial plan for the five year period shows that the predicted growth in demand cannot be afforded if the system continues to operate as it is currently because the additional allocations could not cope with those cost pressures. Significant efficiency gains are required in all sectors alongside the delivery of the QIPP programme.

The table below provides the summary level position for the CCG including:

- Recurrent and non-recurrent allocations
- Planned Programme expenditure
- Planned Running Cost expenditure
- QIPP.

The Revenue Resource Limit reflects the published figures for both Programme and Running Costs. In both 2014-15 and 2015-16 the CCG remains at c 3% Distance from Target which equates to spending of around £1,220 per head of registered population of around £39 per head over target spend .

Planned expenditure on running costs is in line with the published levels and reduces in 2014-15 from £24.73 per head to £21.53 in 2018-19.

The Acute Services portfolio continues to dominate the Commissioning profile being 53% of total Commissioning spend in 2014-15. QIPP levels as identified below have been incorporated into income and expenditure and are spread across all service areas. QIPP targets are extremely challenging but deliverable as transformation change occurs across the whole Health Economy.

Table 9: Commissioning and Sustainability Profile

Revenue Resource Limit

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent	317,590	320,162	331,237	336,397	342,040	347,778
Non-Recurrent	9,267	8,999	9,000	4,000	4,000	4,000
Total	**326,857**	**329,161**	**340,237**	**340,397**	**346,040**	**351,778**

Income and Expenditure

Acute	172,394	164,908	168,413	168,356	167,555	166,498
Mental Health	35,328	33,674	34,473	34,166	33,871	33,574
Community	34,828	34,055	34,020	34,604	34,878	35,153
Continuing Care	10,800	11,788	14,608	16,278	17,932	19,775
Primary Care	47,111	51,795	51,225	53,604	56,079	58,672
Other Programme	11,147	15,923	26,142	22,056	24,414	26,818
Total Programme Costs	**311,608**	**312,144**	**328,881**	**329,065**	**334,730**	**340,490**
Running Costs	6,249	6,201	5,556	5,532	5,510	5,488
Contingency	-	1,816	1,800	1,800	1,800	1,800
Total Costs	**317,857**	**320,161**	**336,237**	**336,397**	**342,040**	**347,778**

Net QIPP Savings (included in figures above)

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent (inclusive of full year effect)	7,330	10,600	9,000	6,800	7,000	7,000

There are a range of risks to the five year financial plan, two significant risks need to be highlighted. First is the loss of £125m from Local Authority budgets over the next five years plus the impact of the Care Bill that will increase hardship for a large number of people in Wolverhampton and therefore place further pressure on the health and social care system. Second is the move to the Better Care Fund pooled budget in 2015/16. The Better Care Fund model will bring together health and social care budgets and deliver joint services across the City. There are a number of risks relating to this work which are recorded in the operating plan however in the context of the finance plan there is a significant risk that as the fund develops it will draw funds out of the CCG that it does not have freely available to allocate hence increasing the cost burden to the organisation.

The detailed planning of the transformation programmes in the Strategic Plan will drive and determine the long-term financial plan. It is fully understood by all partners that QIPP schemes cannot be regarded simply in terms of financial savings, but have to be the means by which the shift of care away from the acute sector and into preventative interventions and primary/community based services, is achieved. The financial plan will therefore be revised as part of the planning of the transformation programmes, and it is anticipated that the agreement and implementation of schemes, will show an increase in the funding of primary and community services. Currently the five year financial plan, post 2015/16, (in the 'most likely scenario', of the LTFP), over and above increase spend to meet demographic and non-demographic pressures, shows additional resources in three

areas: growth across all contracts (between £2.8m and £3.0m pa); expenditure on high cost drugs; the phased investment in the emergency care centre, including CDU. The investment profile which is relatively flat across the range of service areas will change to reflect the strategic vision. It is important to maintain realism concerning the level of QIPP savings (as currently profiled over the five year period) therefore within the limited financial flexibility, all parties must be committed to the innovation required to achieve the redistribution of resources for the new models of care.

We are committed to focusing on the investment planning (which will require disinvestment and redistribution of resources) to meet the requirements in each of the transformation areas illustrated in the diagram below in the overlapping spheres of activity covering: urgent care; integrated care; primary care; hospital and specialised services.

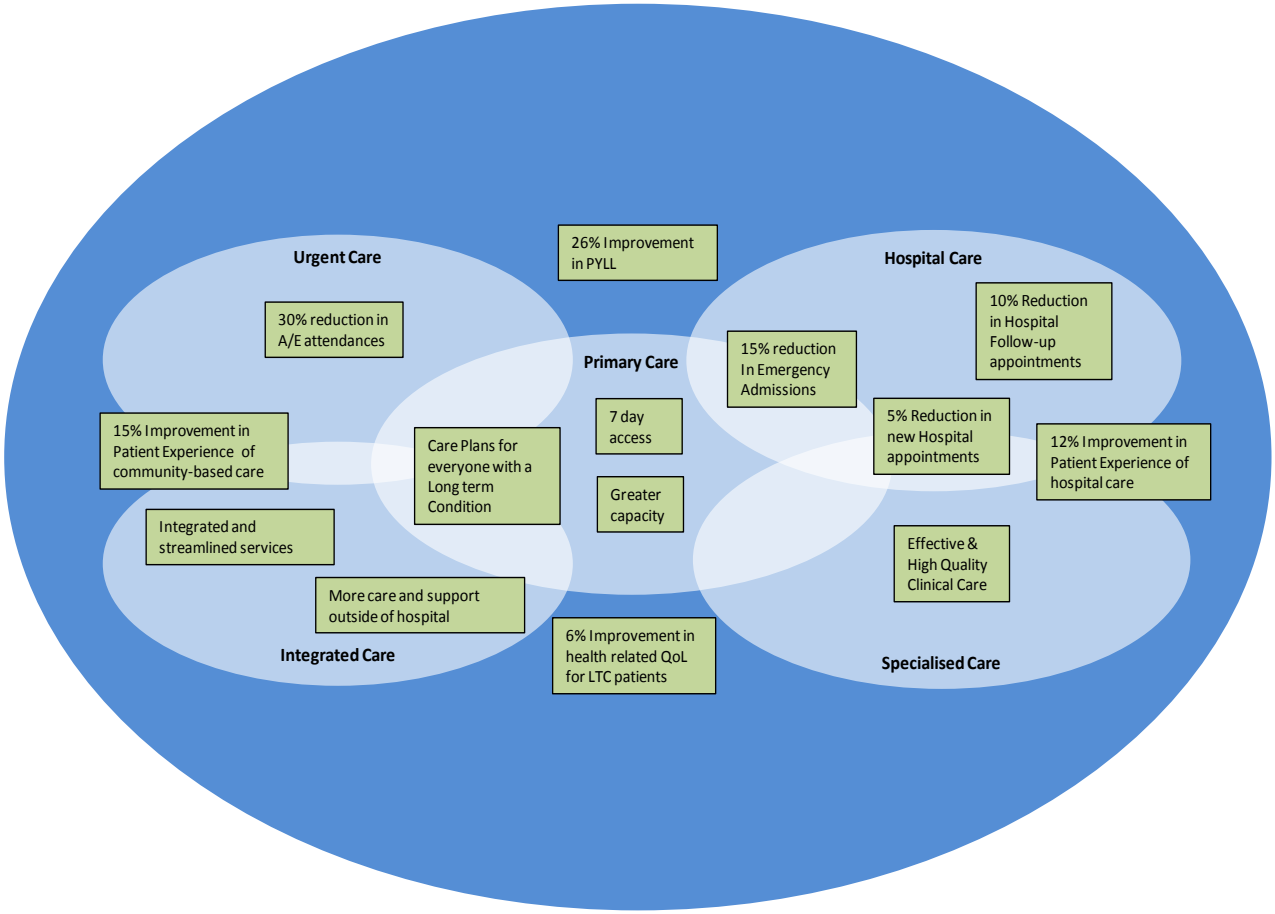


Figure 8: Transformation areas and Strategic programmes required to deliver the Vision

The CCG's business planning cycle and business case production will be reinforced in a way to ensure prioritisation is given to delivering these outcomes and service improvements.

4. Strategic Programmes to achieve the vision

During years 1 and 2, we will focus on building the foundations to prepare for the significant and transformative change planned for years 3 to 5. Specifically, the first 2 years will centre on:

- Delivery of agreed QIPP schemes in order to:
  - Release efficiency
  - Manage demand
  - Maximise quality
- Development of integration strategies and plans
- Building capacity and capability in primary and community care

During years 3 to 5, our plans will address:

- Major reconfiguration and transformation
- Harnessing integration
- Harnessing technology and innovation
- Risk modification, health inequalities and prevention agenda

Figure 9 below provides an overview of our strategic initiatives and enablers, mapped to our system objectives and outcome ambitions.

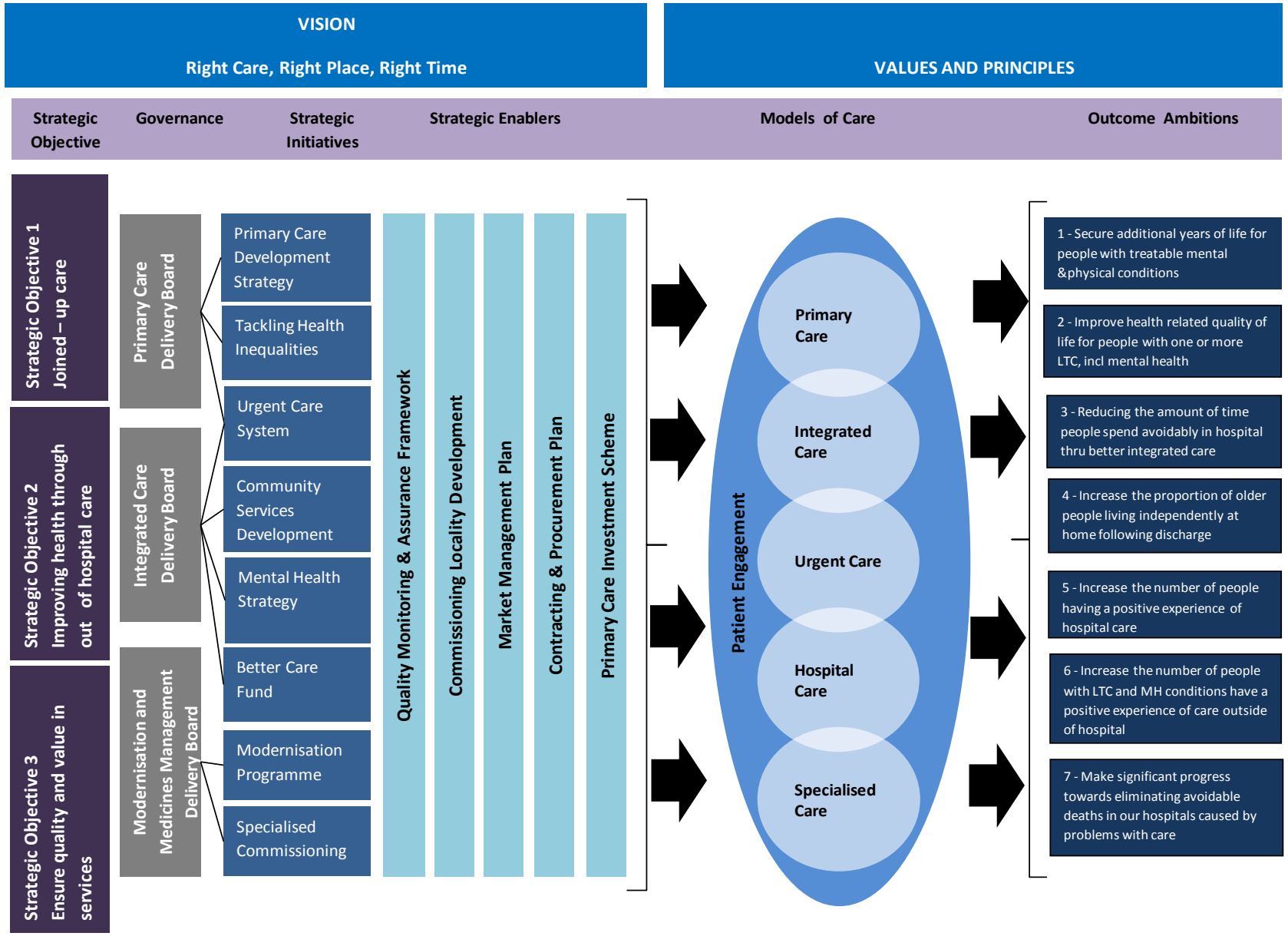


Figure 9: Strategic initiatives and enablers required to deliver the Vision

4.1 Primary care development

Our strategy for primary care development focuses on 8 key objectives:

1. Develop the primary care workforce so that it is more flexible and able to undertake a greater range healthcare interventions as part of a model of integrated delivery across health and social care;
2. Improve the primary care estate and IT infrastructure in order to facilitate improved access, healthcare delivery and information flows;
3. Facilitate and provide clinical training and education in order to maintain high clinical standards and skills within the primary care workforce;
4. Maximise primary care productivity by providing practice operational and business support;
5. Seed an approach to the federation of practices, which meets GP expectations and requirements that facilitates greater capacity and flexibility across primary care;
6. Develop clinical functional support and peer review in order to help target support where it is most required in order to reduce unwarranted variation;
7. Integrate service delivery at GP practice level with the provision of all other out of hospital services across community, social and voluntary sector care
8. Work in collaboration with the NHS England Area Team, its developing strategic framework, and the Local Professional Networks to develop collaborative approaches to service delivery across GP, Optometrists, Dentists and Pharmacies

Operational costs will be met within CCG management overheads. Development will be funded through the Primary Care Investment Scheme and supporting incentive schemes based on QIPP delivery and the transfer of activity from the acute to the primary, community and voluntary care sectors.

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
• Workforce review undertaken and plan developed • Estate review undertaken and plan developed • Review of practice business federation options undertaken •Increased access piloted to reduce emergency admissions	• Workforce development plan implemented • Estates development plan implemented • Shared business service plan implemented	• Primary care based services designed and developed • Federation support plan implemented • Workforce training and development plan in place • Single assessment process implemented in alignment with BCF plans • Community nursing service (focused on practice support) commissioned • 7 day working, 8-8 services	• Primary care based services implemented • GP practices using a federated model to support practice business function • Appropriately trained workforce in place	• Enhanced primary care commissioned from federations of GP practices which offer: o 7 day access o Diagnostics o Community-based acute services • Integrated virtual teams delivering health and social care services based around clusters of federated practices

It is recognised that a number of critical success factors need to be put in place to achieve our objectives:

- Sufficient provider engagement and support to deliver the strategy, including our Primary Care Support Team;
- Investment and resourcing via the Primary Care Investment Scheme and other means to facilitate the required levels of development and activity;
- Establishment of a sustainable investment and incentive scheme which integrates with QIPP delivery;
- Development of locality commissioning structures.

Expected outcomes

- A more flexible primary care workforce, able to undertake a greater range healthcare interventions as part of a model of integrated delivery across health and social care;
- High clinical standards and skills within the primary care workforce, maintained through clinical training and education;
- Improved primary care estate, facilitating improved access, capacity and healthcare delivery;
- Increased primary care productivity through practice operational and business support;
- An agreed approach to the federation of practices, meeting expectations and requirements and increasing capacity and flexibility;
- A collaborative approach to service delivery across general practice, optometry, dentistry and pharmacy, working in collaboration with the NHS England Area Team and local professional networks; for example, pharmacist-led interventions to support optimal prescribing and the use of medicine.

Progress will be monitored through the following KPIs: emergency admissions rates/health outcomes for LTC and over 75s/benchmarking against national quality measurement tools/workforce skill-mix benchmarks/GP referral rates/cost & productivity ratio benchmarks/A&E attendance rates.

4.2 Tackling health inequalities

Our approach to health improvement, ill-health prevention and tackling health inequalities is embedded throughout this plan and reflects significant joint working that we have undertaken with the Wolverhampton Public Health team. Our initial priorities are to ensure that the Wolverhampton population enjoy equity of access and high quality of care in the services that we fund. We will focus awareness, access, availability and acquisition. Our joint planning with Public Health is characterised by the recommended 5 steps for commissioning for prevention:

- Analysing key health problems at population level – we have undertaken joint work with Wolverhampton Public Health involving the Joint Strategic Needs Assessment, long-term demand modelling
- Working together with partners and community to set common goals – we have undertaken joint priority setting sessions with Governing Body, Executive team and the Public Health team
- Identifying high impact programmes focused on top causes of premature mortality and chronic disability – we have specifically set out on a journey to implement disease and risk modification programmes and will work together to develop joint intervention programmes to support the latter in the long term. This will include a consideration of the drivers of health inequality for each vulnerable group and how their attribution will be identified and interventions tailored to address them e.g. smokeless tobacco use in

ethnic populations to address oral cancers and CVD. We will look at how we can target income, education and deprivation and thereby help to address the social determinants of health

- Planning resource profile to deliver prevention goals – we have set aside funding to support disease modification through the Primary Care Investment Scheme, and the GP Enhanced Service for care reviews for vulnerable people as part of this plan
- Measuring impact and experiment rapidly - We will evaluate the impact year on year and adjust our priorities and plans in order to reflect our learning, working in partnership with Public Health and other key stakeholders.

In order to contribute to this aspect of our vision, and to the delivery of each of our strategic objectives as a whole, we will also engage the population, jointly with Wolverhampton Public Health, in the commissioning for prevention agenda in order to target health inequality across the city.

We will focus in particular on:

- Infant mortality and teenage pregnancy
- Disease and risk modification.

4.3 Children's Agenda

We plan to deliver the requirements of the Children and Families Act (2014) by an evidenced active collaboration with children, young people, parents and carers and between health, social care, education and third sector agencies and providers in order that children and young people have a range of services based on local choice and individual need and this is delivered in a planned and co-ordinated way. We also plan to improve transition arrangements between child and adult health services to support a seamless pathway for young adults with the most complex health needs and to align this with social care, education and other third sector provider arrangements.

As part of commissioning for children's services, our main aims are to: significantly reduce infant mortality, focus on improving the lives of children and young people with special educational needs and disabilities (SEND) and reduce teenage pregnancy in Wolverhampton.

The CCG is also committed to meeting its statutory safeguarding responsibilities for all children including Looked After Children (LAC). There has been a significant rise in the number of LAC in Wolverhampton. Since 2009 the number has risen from 374 to 800 in 2014. We are working with the Local Authority and Provider Trust to meet the statutory requirements to provide medical assessments to all LAC. There is ongoing work with the LA to establish a 'Charter' which will address the numbers of children going into looked after care, this will be agreed at end of June meeting. The CCG will ensure that there is adequate commissioning to address the health needs of these children.

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**

Review and develop Children's Commissioning Strategy with PH/LA JSNA refresh Multi agency action plan agreed	Implement plan and commission services Monitor KPIs Transfer of Health Visiting Services to PH	Performance manage delivery of commissioning plan jointly with PH/LA		
Infant mortality Working group established Maternity specifications for commissioning reviewed and aligned with PH FPNs programme commenced	The clinically led Infant Mortality Working Group will confirm further implementation plans on the 20th of June 2014. Expected workstreams include: Addressing high levels of growth retardation/restriction including smoking in pregnancy Early Intervention/Warning system for chaotic families Understanding 'vulnerability' in Wolverhampton			
Plan for SEND in the context of the requirements of the Children and Families Act (2014).	Local offer agreed across all sectors Adult (14+) framework implemented Complex care database for children implemented Patient partnership forum to co-produce consultation on health offer Young People/Changing Lives Governing Body and Consultation event Named GP for safeguarding in each practice, trained to level 3 Database established for Safeguarding leads and training Case conferences for Safeguarding to include GP reports	Review, evaluation and revision (where required) of frameworks Joint appeals and complaints process in place EHCP planning process in place for new entrants Personal Budgets offered in EHCPs Patient Partnership voice embedded within systems and processes and driving commissioning plans	Directory of Services - open and transparent publication of in-service provision and how to access it Young people with LDAs transferred to new system Transfer of funding and complex care commissioning service to the Better Care Fund Single complaints process within BCF covering all services including voluntary sector Advocacy arrangements embedded within systems and processes GPs routinely submitting reports 48 hours before case conferences	Children and young people with statements transferred to the new system Integrated provision of services Transition health plans established at16 for smooth transition into adult services Diversity of provision, wrapped around the child, offering patient control and choice

	Training for GPs on Complex care assessments (key worker) and Children and Families Act		Key workers (primary care) actively managing transition and complex care	

Expected outcomes:

- Reduce infant mortality to below benchmarked average for CGG comparator groups;
- Reduce teenage conception rates to below benchmarked average for CCG comparator group.
- Reduce SEND emergency admissions with greater efficiency and effectiveness in the use of allocated budget envelopes, better co-ordinated and integrated care, improved patient and carer experience of care, and deliver improved health outcomes

The programme will be delivered through existing management costs and Progress will be monitored through the following KPIs: infant mortality rates; smoking in pregnancy rates; teenage conception rates, experience of services, EHC plans completed and emergency admission rates decreased for SEND children.

Effective joint commissioning arrangements will underpin this work as part of a joint health inequalities plan, agreed with the local authority. In particular, alignment will be needed with commissioning plans for family nurse partnerships, maternity and other joint commissioning plans.

4.4 Disease and risk modification

Our approach to developing disease and risk modification is built upon the systems and processes that we have developed as part of the Diabetic Optimal Management Index, Integrated Care Pathway and the implementation of care planning via the Primary Care Investment Scheme. We will use the Optimal Management Index technical infrastructure, combined with clinical and managerial support, the Primary Care Investment Scheme and the enhanced service for care review for vulnerable people, to target specific patient cohorts for, initially, disease modification, graduating to risk modification intervention over this 5 year plan. In this way we will target those within the care system currently at greatest immediate health risk in order to proactively plan their care to improve their health outcome and reduce the need for emergency services. We will modify their disease risks so that they can live healthier and more fulfilling lives. As we do so, we will also start to shift our attention to those patient cohorts who are either at early, maybe undetected stages of disease or those who exhibit high risk factors. Using the same approach as our disease modification plans, and working in partnership with the Local Authority Commissioning and Public Health teams we will target patients and invite them to become involved in risk modification interventions using a proactive care planning approach, co-ordinated in primary care.

This long term approach will facilitate, either directly or indirectly, the local review, development and implementation of the following high impact and early achiever innovations:

- Early detection and diagnosis

- Optimisation of medicines use
- Case management and co-ordinated care
- Self-management
- Cancer screening programmes
- Integration of health and social care for older people

An investment of £1m has already been identified for 2014/15. Additionally, this will be supported through the Enhanced Scheme for LTC management.

Milestones	
Years 1-2	**Years 3-5**
Implement care planning for all over 75s and those with a long term condition in order to modify disease progression	• Implement risk stratification, targeting and care planning for patients at early disease stage and/or high risk of LTC. Extend care planning to over 65s • Implement joint commissioning plans with Wolverhampton Public Health team for health promotion, lifestyle management, self-care, early detection & diagnosis and screening programmes (cancer or other)

Expected outcomes

- Improved health outcome
- Reduced burden of demand on healthcare services, particularly in terms of emergency admissions
- Lower heath inequality
- More care delivered outside of hospital
- Greater focus on delivering proactive, co-ordinated and integrated care
- Increased engagement and empowerment of people to become involved in the management of their condition and the care they receive

Progress will be monitored through the following KPIs: Care planning rates/emergency admissions rates/QoF indicators & registers/Patient and stakeholder experience and feedback.

This programme of work is dependent on a number of other key strategic initiatives, notably: the primary care investment scheme; the GP enhanced service for LTC management; the Better Care Fund; and the primary care development strategy. Investment and development support will be needed to deliver alternative models in primary care.

4.5 Urgent care system

Our 5 year vision for the Urgent and Emergency Care System comprises 6 main themes:

1. Supporting Self Care – The urgent care centre will be designed in such a way that patients will be supported to manage their conditions through accessible support via face to face or telephone and information that gives greater confidence to manage their condition themselves

2. Helping people with urgent care needs to get the right advice or treatment in the right place, first time – we will streamline services into one urgent care system that is accessible 24/7 and will ensure patients entering the urgent care system are appropriately sign-posted to the right service. We will work across organisational boundaries, in order to ensure that the services patients need are on hand (Social Care, Mental Health, diagnostics) regardless of who the provider is. The urgent care centre will be the portal for both NHS111 referral (telephone or face to face) as well as the central hub for health care professionals to access the necessary services that have potential to reduce emergency ad missions (diagnostics - xray, scans, Social Care and community services). Urgent care centre staff will be able to access key historical medical history, medication and care plans, to ensure that the patient receives the most appropriate care. We will ensure a wide range of professionals can access appropriate advice and guidance to reduce the need to enter into the urgent and emergency care system.
3. Providing a highly responsive urgent care service outside of hospital so that people no longer have to queue in A&E. – By integrating the Urgent and Emergency Care Centre, patients will have access to various levels of clinical advice and input. They will be signposted to the appropriate part of the system based on clinical need. This will reduce the levels of primary care type activity that adds to the delays in care in our A&E department. This will be supported by the development of a Primary Care Strategy which will include harnessing the minor ailment scheme for pharmacies.
4. Ensuring that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise – We will work with the Black Country network and wider West Midlands engagement, the local acute trust, WMAS and to ensure, where appropriate, patients have access to right emergency care provider that best meets their needs. A particular focus for ensuring this will be emergency planning/mass casualty and the critical care network engagement.
5. Implement the findings of the NHS services 7 days a week forum – We have implemented pilots during winter 13/14 with practices across the city to deliver extended access. This varies from extending appointments at traditionally busy times (Monday mornings) to additional evening clinics, Saturday and Sunday opening. In addition there is already a strong focus on 7 day working across health and social care within the urgent care system. We will expand and strengthen the intermediate care system developing alternatives to A&E/UC and in doing so further strengthen the availability of 7 day service provision.
6. Connecting the whole urgent and emergency care system together through networks – The CCG will work through local, regional and national networks, involving both commissioners and providers in order to ensure that the local configuration of services integrates effectively with the west midlands footprint. A key aspect of this will be the implementation of the Keogh Review whereby the national number of major emergency and urgent care centres will be rationalised to between 40 and 70, supported by networks of emergency and urgent care centres. We will work through the Urgent Care Working Group, the Black Country Network and the Area Team in order to agree local and regional plans, engage with patients and the public and sign-off development and implementation plans.

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Local resilience planning continue through UCWG delivered refreshed plans by summer 2014, detailing the use of retained 70% from marginal	Urgent care Centre opened Implementation phase for Emergency care Review commenced	Urgent Care Hub implemented, integrated with primary Care, incorporating telephone/111 access and a home visiting service	Electronic patient Record implemented, shared across the local health community Fully developed	

tariff. Wolverhampton Urgent Care Centre & Out of Hours Service implemented Stakeholder engagement and local implementation plan developed	40 to 70 Urgent and Emergency Care centres, supported by emergency centres and urgent care facilities.		local clinical network established Evaluation phase for Emergency Care Review commenced	

Expected outcomes:

- Implementation of the Wolverhampton Urgent Care Centre;
- Reduced emergency attendances in A/E;
- Shorter waiting times in A/E;
- Increased access in primary care.

The specification for the Urgent Care Centre will include:

- Redesigned pathway for A/E activity;
- Out of Hours Service;
- Care Home Support Service;
- GP Home Visiting Service;
- NHS 111;
- Social care support (linked to BCF).

Progress will be monitored through the following KPIs: A/E attendances, A/E waiting times, Patient experience and feedback, Access rates in primary care.

In order to support the delivery of an effective urgent and emergency care system, we recognise that it is important to improve the range, flexibility, capacity and access to primary care. Feedback from the public on the Urgent and Emergency Care Strategy indicated that pressure on urgent care services could be alleviated by improving access to primary care services throughout the day as well as outside of normal working hours. The delivery of our Primary Care Development Strategy will be a contributor to improvement across the urgent care system.

4.6 Community services development

As part of the delivery of our Operating Plan, we will undertake a review and commence the process of redesign and transformation of community based services. This will initially focus on Community Nursing Services but will, in the course of this Strategic plan, encompass the delivery of all healthcare services based in a community setting. As part of this work we will seek to maximise the potential for Telehealth and telecare in the delivery of personalised support to patients.

The vision is of delivering care at the right care, right time, right place, building on the momentum of the Better Care Fund to deliver seamless care and co-ordinated care. The key characteristics are:

- Central hub that anyone can contact
- Care planning
- Single IT system
- Providers that are fully engaged and involved
- Early detection and screening facilitating better prevention
- More care closer to home
- Co-ordination of medication (less wastage)
- Single budget
- One team of commissioners (local authority / health)
- Multi-disciplinary care delivery teams
- More community based clinics
- More community hubs for information, signposting and support
- Better support in mental health (walk in centres)
- Public health play a key role
- Third sector involvement (awareness, communication, provision and delivery of services)
- Same care for everyone
- Equality of access
- Outcome focused
- Better value for money (more effective)
- Co-ordinated care with a key worker
- Voluntary sector involved with CHC patients (personal health budgets).

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Phase 1: Service review, stakeholder engagement, strategy and plan development. Review West Park provision as a priority	Phase 2: Transition phase incorporating procurement planning, service transformation, commissioning intentions. Implement West Park project.	Phase 3: Implementation of Integrated Primary and Community care Nursing Services	Phase 4: Implementation Therapy Services	Phase 5: Implementation Therapy Services & Other

Expected outcomes:

- Greater productivity and efficiency
- Improved support to GP practices
- Increased integration with voluntary sector and social care
- Reduced unplanned hospitalisation
- Improved patient experience of care
- Reduced lengths of stay

- Improved patient outcomes.

Progress will be monitored through the following KPIs: delayed transfers of care; admissions to Nursing Homes; patient/user experience; proportion of older people who are still at home 91 days after discharge from hospital; and health related quality of life for people with a Long Term Condition.

Interdependencies:

This programme will require strategic leadership and oversight by the CCG and Social Care on a single vision of integrated care delivery alongside effective stakeholder communication and engagement. GP leadership of the commissioning process within CCG will be essential. The programme will be closely aligned with the primary care development strategy and the Better Care Fund plan.

4.7 Mental health strategy

The CCG's over-arching aim regarding mental health services is to commission a system that:

- Prevents people from entering secondary and tertiary services wherever possible via early intervention initiatives delivered in primary care and universal services.
- Provides an integrated system of assessment and intervention with social care partners to enable recovery, promote independence and prevent relapse within secondary and tertiary care.

The vision for all-age mental health services is that by 2018/19 we will have transformed service user and carer experience and outcomes by commissioning an evidence based system of integrated care pathways and services for people of all ages that will achieve parity of esteem and deliver:

- Using the Friends and Family test improved transparency and quality across the whole system including CAMHS;
- Integrated Access to Psychological Therapies within CAMHS and younger people's services;
- Early intervention and prevention initiatives and services including those provided for children and young people in Tier 2 CAMHS and a dedicated Young Person's service that operates a resilience building model;
- Early intervention in Psychosis services for those aged 14-35 years that meet recommendations highlighted in 'Schizophrenia the Abandoned Illness; and the relevant NICE Guidance;
- An Acute Care system that includes an integrated care pathway with social care regarding urgent mental health care using Better Care Funds;
- Local mental health crisis concordat;
- Local multi-agency suicide prevention strategy;
- Access to services and waiting times that are equitable with standards for physical health;
- Improved access to information, support and advice for people of all ages and local marketing campaigns regarding #beatbullying and #timeforchange.

Using Better Care Funds, the CCG will commission integrated care pathways for people with the highest level of need and co-morbidities / vulnerabilities including dual diagnosis, to improve quality of life and life expectancy for people with multiple long-term conditions and clinical risk factors. The CCG will commission services across the system that encourage self-management, reduce the numbers of people on sick pay and benefits, and increase the numbers of people with mental health problems receiving community support. Detailed plans are currently being developed in our revised Commissioning Strategy for Mental Health 2014. The detailed financial

model behind the strategy development will outline our intentions to re-align the CCG spend on mental health as part of QIPP plans locally to deliver system and service re-design, deliver cost efficiency savings and increase value for money. This will include:

- An integrated care pathway to deliver reablement, self-management and recovery
- Increased dementia diagnosis in primary care
- Single assessment and care planning processes for people with dementia
- Physical health care pathway for people with mental health difficulties across primary and secondary care
- Integrated care pathways for people with dual diagnosis.

The CCG will commission an integrated mental health urgent care pathway which provides 24/7 pro-active health and social care interventions and support for people of all ages including CAMHS. This will provide emergency and urgent assessment, treatment, intervention and care and support within an integrated health and social care model for adults and children with acute and severe mental health difficulties who require high levels of care and support in urgent and / or emergency situations.

The CCG will develop a local Suicide Prevention Strategy by supporting those with the highest levels of acute risk and reduce self-harm and suicide. The all age mental health urgent care pathway will include an embedded all Liaison Psychiatry Service (LPS), providing a dedicated function to the wards and departments within the Acute Hospital and primarily A&E for patients who require mental health assessment, intervention and support. In 14/15 and 15/16 the above initiatives will be developed in line with our local Better Care Fund Mental Health plans which focus on the following key outputs / success factors:

- More people in recovery
- More people with mental health problems being managed within the community
- Less use of residential & hospital care.

We will commission services and care pathways to support self-management of patients taking anti-psychotic medication and prevent relapse wherever possible. We will align these initiatives with locally developed care pathways and procedures regarding dual diagnosis to ensure that the mortality risks of people with mental illness who misuse substances such as alcohol and drugs are pro-actively managed and reduced. We will align this care pathway development and implementation with plans in 2015 / 2016 to develop Recovery Colleges as part of the Better Care Fund initiative.

- Integrated care pathways for people with a learning disability;
- Utilisation of digital technology i.e. simple Telehealth across the system.

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
• Delivery of agreed QIPP schemes as part of Operating Plan. • Development of Mental Health Strategy	• Delivery of agreed QIPP schemes as part of Operating Plan	• Implementation of Mental Health Strategy		

Note: 2 year objectives for Mental Health are identified within the Operating Plan. This includes the requirement to undertake a refresh of the Mental Health Strategy which mental health strategy will be completed by July 14. Key objectives of the strategy will be:

- Early intervention and support
- Community based services
- Integrated services.

Expected outcomes

- Delivery of early intervention which facilitate avoidance of disease progression
- Improved CAMHS
- Service integrated around the patient
- Improved quality of life
- Improved life expectancy
- Reduction in suicide rates
- Improved self-management
- Improved patient experience.

Progress will be monitored through the following KPIs: admission rates; length of stay; suicide rates; patient experience; referral rates; transfer between service tiers; usage rates of residential and hospital care; and community activity rates.

Interdependencies

We will work with local partners and key stakeholders to deliver quality improvements regarding our application of the Mental Capacity Act locally, by ensuring access to training and support, cross cutting performance management and audit initiatives across agencies and organisations. We will involve service user and carer groups in this process. We will bench mark performance standards against national prevalence and best practice data and provide annual reports vs the local safeguarding board.

4.8 Better care fund

The Better Care Fund (BCF) programme is regarded by the Local Health & Care Economy as a catalyst and microcosm of a much larger and fundamental long-term transformation strategy. To this end, key stakeholders have embarked upon an ambitious journey of whole system change. The Wolverhampton Whole System Change and Improvement Programme is focused around enabling adults in Wolverhampton to live fulfilling lives by enhancing their independence, health and quality of life through seamless, efficient action that strives to improve experiences and outcomes. This transformation project will provide the basis of the longer term Health & Care Strategy for Wolverhampton and will be a key plank in this Strategic Plan. The key partners for the Better Care Fund are: Wolverhampton Clinical Commissioning Group, Wolverhampton City Council, Black Country Partnership Foundation Trust and The Royal Wolverhampton NHS Trust.

Within 5 years, the BCF programme will have:

- A single plan or a single over-arching framework covering the necessary suite of strategic plans from each partner which will be collaborative, complementary and assist partners in the delivery of agreed common goals
- Routinely shared information, resources and facilities
- Delivered a re-configured series of integrated services with single providers where appropriate
- Embedded new ways of working ensuring that service users interact with fewer professionals, with fewer hand-offs between services, creating more seamless patient care and continuity of care
- Shifted the focus on care planning from treatment to prevention
- Moved the focus of Clinical pathways and care services to be patient / service user centred – not organisationally orientated
- Achieved clinical, financial and social outcomes which are sustainable
- Made personalisation available to all
- Kept more people well – maximising individual quality of life / independence and reduced need for unplanned care
- Many more people taking increased responsibility for their own care and managing their own health & well-being.

The Wolverhampton Health & Social Care economy have, over a series of events, developed a Better Care Fund Plan based on 4 workstreams : Mental Health De-Escalation, Intermediate (Reablement/Rehabilitation) Care, Nursing & Residential Homes and Dementia. Within each of these workstreams there are a series of projects designed to achieve the mandated National Metrics.

In order to identify the financial contributions from the CCG Commissioning Budget analysis of areas to be included in individual projects against CCG budget line has been undertaken - this has resulted in a value above the minimum requirement identified. A transitional fund of £3m (referred to as 'Call to Action' monies in the NHSE Operating Framework) has been set aside to facilitate any change in practice that requires pump-priming or double running during 2014/15.

Plan development work has included in excess of 120 stakeholders - drawn from frontline professionals (health & social care), patients, users, carers, voluntary and 3rd Sector Organisations. A number of these stakeholders have identified a wish to take part in the workstreams and projects and will form part of individual project teams going forward.

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Establish Single Assessment Process for Dementia Establish memory clinics for Dementia Establish community database Establish step-	Establish step-down facility Health and social care integration (CICT/HARP) Establish care home in-reach service	Establish Dementia Hub Introduce 7 day therapy services	Specify and develop health and social care telehealth/telecare support services	Implement health and social care telehealth/telecare support service

down framework Review CICT/HARP Establish care homes training and education Establish care homes quality standards				

Expected outcomes:

- Reduce emergency admissions
- Improve patient experience of services
- Reduce permanent admissions to residential & care homes
- Increase effectiveness of reablement services
- Reduced delayed transfers of care
- Optimise independent living post-discharge
- Maximising independence
- Avoid preventable hospital admissions
- Maintain / improve personal well-being
- Optimise GP managed care
- Support the management of Long Term Conditions in the community
- Maximise self-care
- Dramatically improve the dementia diagnosis rate
- Pooled Better Care Fund budget, in excess of the minimum requirement.

The over-arching measure of health gain will be fewer hospital bed-based interventions

4.9 Modernisation programme

The vision is to ensure patients are seen in the right place at the right time by the most appropriate healthcare professional. Also that if they do need to be seen in secondary care that their stay is not prolonged by either delays in treatment or delays in discharged. Improving productivity by 20%. For people who need episodic, elective care, access to services must be designed and managed from start to finish to remove error, maximise quality, and achieve a major step – change in productivity.

The modernisation programme is currently funded. CCG non-recurrent transitional funds will be made available to support transformational change.

Milestones				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
As per QIPP schemes outlined in Operating Plan		• Shift of activity into community settings • Implementation of enhanced recovery and discharge planning projects.		

Expected outcomes

- Reduced length of stay
- Discharge planning upon (or prior to) admission
- More care closer to home
- Near patient testing instead of attendance at community clinics leading to patient self-testing
- Increased patient choice by increasing competition into the market
- Care delivered in primary or community settings, where appropriate
- Continual review and enhancement of POLCV policy
- Continual review of pathways to ensure that patients are experiencing the most efficient pathway
- 20% improvement in productivity.

This programme will build on the collaborative working between primary and secondary care facilitated by the primary care development strategy; locality development commissioning; and our market development analysis.

4.10 Specialised commissioning

It is important for the CCG (and the local unit of planning) to align its local strategy to the direction of travel nationally for specialised services over the next five years as:

- The focus on planning across the entire patient pathway is the vital .i.e. Any changes to a patients pathway considered by the CCG/Local Authority/specialised team for a service such as Child Adolescent Mental Health Services(CAHMS) will impact on the whole pathway.
- Historically Specialised Services account for £12.2 billion per annum of the NHS allocation. Historically, the growth in cost exceeds other parts of healthcare by as much as 4% per annum. We are planning to look at how we work together with NHS England to review and achieve better value for money and improved quality is a key priority. Specialised services will be developing a robust QIPP challenge of its own and the CCG will need to work with the Area Team to understand the impact of their QIPP agenda on the local health economy.
- The national strategy being developed for specialised services is in the early stages of its development but it is clear the direction of travel is towards fewer centres concentrated in centres of excellence (around 15 to 30 centres). The CCG will need to work closely with NHS England to understand the implications of the strategy and work together on how to implement the transformational change required.
- There will be joint opportunities for maximising research and teaching opportunities to encourage innovation and change.

The CCG will therefore work with Specialised Commissioning Team over the duration of this Strategic Plan to ensure:

- Strong engagement in the development of the national strategy for specialised services through the call to action programme completing in July 2014.
- Active participation in the proposed West Midlands governance arrangements for the strategy development which will be considered and discussed at the 5th February Call to Action event.
- Identification of opportunities for joint planning and development of care across the whole patient pathway within local plans. Supporting the need for change within an agreed case for change.

- Close contract management arrangements with specialised commissioners for providers.
- Supporting the development of the local service priorities and/or reconfigurations currently being considered by the Area Team plan which include CAHMS Tier 4, Cancer services, Cardiology, Paediatric Intensive Care and High Dependency services and neuro-rehabilitation services.

4.11 Strategic enablers

4.11.1 Quality monitoring and assurance framework

We are committed to commissioning high quality services that both improve patient experience and the quality of care. We recognise that a quality agenda must be implicit in everything that we do. We believe that a robust and systematically embedded approach to safety and quality will be a key enabler in delivering our required outcomes and other associated targets. Refer to Figure X for an overview of our quality assurance framework.

The Quality & Safety Committee monitors the outcomes and recommendations made from national reviews and inquiries and will endeavour to be assured that all appropriate learning is recognised and acted upon by commissioned providers. Providers are required to submit ongoing progress reports and updates on changes and improvements made to the quality of services. Quality visits are also used to monitor practice and continuous improvement at service level. The implementation of the Quality Assurance Framework in Primary Care will identify patient safety improvement indicators focused on needs and outcomes, in particular relating to safety, experience and effectiveness. Further development of patient safety reporting in primary care via the CCGs teams will enable practice level learning and sharing of information to identify learning opportunities at practice and locality level, and reduce the likelihood of recurring incidents. Safeguarding duties are and will be discharged in all local plans and continuous assurance will be sought on this matter via CQR reports (quarterly exception reports on progress against safeguarding plans), quarterly themed reports to Quality and Safety Committee and onward reporting to the Governing Board.

Overarching approach to quality improvements		
Quality Components		**Actions**
Bring clarity to Quality	By being clear about what high quality care looks like in all specialties/services and reflecting this consistently when setting standards and quality indicators in specifications and contracts	Use National Guidelines to support setting standards for good practice. Commission for Quality and Effectiveness by ensuring clinically recognised best practice is used as the benchmark for new services. Establish defined standards and evidence based commissioning
Measure Quality	By gathering and using information that shows providers and their clinical teams where they most need to improve on key measures and enables them to track the effect of changes they implement via clinical quality review and contract monitoring	Use Clinical Audit as a key mechanism to monitor clinical performance, quality of services and demonstrate continuous quality improvement. Review and take appropriate action on the five domains from the National Outcomes Framework, including Hospital Standardised Mortality Ratio indicators, never events, HCAIs, RTT times, cancer waits, A&E waits, patient experience and ambulance quality. Monitor and performance manage providers using the CQC Essential Standards, Clinical Quality Review Groups, as part of the contracting process, use a single quality dashboard, and patient experience feedback to bring providers to account.
Publish Quality	By making data available so that patients and their carers can make better informed choices, clinical teams can benchmark, compare and improve their performance, commissioners/providers agree priorities for improvement by using information from the quality observatory and the development of quality accounts/board reporting	Use Quality Accounts in conjunction with financial accounts in order to help test compliance. Work in partnership with the Care Quality Commission to seek assurance that providers are compliant
Recognise and reward Quality	By ensuring the right incentives are in place to support quality improvement by using commissioning for quality and innovation	Develop CCG CQUIN schemes to incentivise improvement against a number of clinical practice indicators.
Raise standards through clinical	Through stronger clinical leadership and engagement in commissioning, Strategic Planning and service/pathway development, using stronger clinical engagement with	Recognise that strong clinical leadership and engagement is paramount to the process of quality improvement. GPs are engaged at every level of the commissioning process in Wolverhampton.

transformation	CCGs and through networks	
Safeguarding Quality	Through regulation of professions and services and collaboration with the SHA and regulators such as the Care Quality Commission.	The processes for monitoring and managing Serious Untoward Incidents (SUI) is part of the provider contract monitoring process.
Stay ahead	By supporting innovation to foster a pioneering NHS through the promotion of quality innovation and providing initiatives	Engage and work in partnership with Health Innovation and Education Clusters, Academic Health Science Centres and NHS Improvement Agencies to develop and implement innovation, new learning and tools and techniques within the Wolverhampton health system.

4.11.2 Commissioning locality development

The 5 year strategy is to develop the GP membership and localities in the commissioning agenda of the CCG through the creation of a supporting governance, accountability, business planning and delivery structure. Our vision is that our localities will drive the commissioning agenda, working at a local level to maximise QIPP while helping to shape the strategic direction of the CCG. The cost of this programme will be managed within existing CCG management cost envelopes.

Alongside the components of the Better Care Fund, the Primary Care Investment Scheme and the Enhanced Service for Unplanned Admissions, the CCG will task its localities to develop schemes for the frail and elderly population of Wolverhampton. These will be designed to enables the elderly population to receive maximum care and support within their own homes and/or the community, reduce the reliance on urgent and emergency care, improve their quality of life, improve their experience of care and maximise the integration of health and social care services.

It is expected that the CCG will adopt a co-production approach with localities to deliver on CCG system objectives and QIPP targets. A key benefit will be enhanced patient and public engagement through practices and patients working at a local level on service improvement.

4.11.3 Whole system approach to community based prevention

The CCG is a partner in a successful bid to the Public Health Transformation Fund, to develop a whole systems approach to community based prevention. This project seeks to make a step change in the delivery of preventative activity and services and to refocus efforts around the delivery of health and social care away from acute care and towards preventative and early intervention services which have been identified as priorities in the City Strategy (http://wolverhamptoncityboard.org.uk/UserFiles/File/WCC%20101%20Full%20City%20Strategy%20a.pdf) following extensive engagement. This will be achieved by:

- Bringing together representatives from the Clinical Commissioning Group, The Royal Hospital Trust, the Council (including Public Health) and the community and voluntary sector to map current provision and how it could be delivered differently.
- Supporting and promoting localised provision by piloting new ways of commissioning and supporting services which enable grass roots delivery of services within local communities to grow and sustain. This will build on these emerging foundations outlined above whilst also seeking to open up the market in terms of personalisation services to grass roots providers.
- Ensuring that any developments are informed by community networks

In the long term, the project will result in:

- Improved outcomes for local people i.e. less illness;
- Better value for public money through a whole systems approach;
- An increase in community based preventative services in the city e.g. walking programmes designed to address obesity and lifestyle programmes designed to address coronary heart disease incorporating nutritional advice, exercise and smoking cessation;
- A strategy for sustaining these activities beyond the life of the project funding through mainstream funding.

4.11.4 Reshaping the secondary and tertiary hospital sector in the West Midlands

As described in several sections of the Strategic Plan (section 2.4 Characteristics of high quality and sustainable services models, and section 4 Strategic Programmes) to achieve the vision there are a number of drivers both national and local, which will change the nature and scale of the hospital sector throughout the West Midlands. Some of the most important of these factors are described below:

'Keogh' Review of the urgent and emergency care: this will bring greater standardisation and clarity for patients, public and staff concerning the provision of the urgent and emergency care provided by networks of providers, which can deal with the minor illnesses/accidents up to the most complex and life threatening conditions which require highly specialist interventions;

Review of stroke services throughout the Black Country and Birmingham and Solihull: this review involves all seven CCGs and six provider trusts in examining the best way to provide the whole continuum of care to people on the stroke pathway. One component of the review is to determine which trusts should provide the immediate interventions in Hyper Acute Stroke Units (HASU). Depending on the outcome of this review there may be significant implications for both patient flows and capacity required at different trusts.

Specialised services review: this is a national review being undertaken by NHS England and the timescales are not yet fixed. The basic driver of the review has been to achieve a range of benefits from greater concentration of these specialised services. Royal Wolverhampton NHS Trust provides specialised services therefore could be significantly affected by the outcome of the review.

15 % reduction in emergency activity: nationally there has been a drive to support integrated care outside of hospital s to help prevent patients having crises which lead to attendance at A&E and admission to hospital on an emergency basis, as well as promoting a timely return to the community as soon as an acute episode of care is completed. The 15% reduction in emergency activity is therefore a national norm which underpins the scale of resources which is expected to be invested in alternative services. Over time therefore the hospital sector will restructure its provision and costs to reflect lower levels of emergency activity.

Seven day working: there are major benefits to the whole health and social care system operating on a seven-day basis. Within the acute sector there are safety and quality gains to be made however the costs incurred in providing different services on a seven-day basis requires Trusts to restructure their services to ensure that they are clinically and financially sustainable in the long term.

All health and social care economies are considering these factors in the strategic planning. The scale of the implications goes beyond Wolverhampton and we are particularly affected by potential service reconfiguration in neighbouring areas. We will be active in making links with different decision-making groups but in particular the following are important:

- CCG Accountable Officers group in the Black Country
- CEO forum for the Unit of Planning in Birmingham, Black Country
- the West Midlands clinical Senate and Strategic Clinical Networks
- all relevant local clinical Senates

The potential strategic service changes, many of which are linked to the main driver is described above, may have implications locally:

- the dissolution of Mid Staffordshire Hospitals Foundation Trust, and the development of elective services at Cannock Hospital under the management of Royal Wolverhampton hospitals NHS trust
- Future Fit plans for the restructuring of the acute hospital and community hospitals provision in Shropshire and Telford; depending on the outcome for services in Telford, there may be implications for patient flows between the Black Country and Telford
- across the Black Country, Birmingham and Solihull, the Stroke services review, the Keogh review on urgent and emergency care, and specialised services, require a mechanism for coordinating planning.

It has to be recognised that if the outcome of these different reviews, and work streams leads to the planning of significant service change, there will need to be appropriate levels of engagement with patients and public ultimately leading to public consultation. The geographical areas covered by such public consultation, will need to be determined as part of the planning process given that this may be much wider, than Wolverhampton; it is the case however that the CCG would play a key role in the engagement and consultation on behalf of its population.

4.11.5 Market management

The provider market within the Primary, Integrated, Urgent and Hospital models of care are relatively rigid, characterised by large single providers in respect of integrated, urgent and hospital based care in mental health and acute care, and small, isolated providers within a rigidly controlled market in the case of primary care. It is likely that primary care will need to be able to develop economies of scale within the context of a federated approach to service delivery in order to respond to the challenge of increasing demand. In respect of hospital, urgent and integrated care there are both advantages and disadvantages in relation to the current configuration of providers which the CCG will need to resolve through the development of an effective market plan within each of these models of care in order to effectively address demand and the needs of the population.

As part of the delivery of this plan, the CCG will implement a process for analysing in detail our provider markets within each of the 6 models of care. The output of that analysis will then inform a market strategy and development plan that supports the delivery of our strategic objectives.

In order to deliver our strategic objectives we will need to develop the right mix of providers, market conditions and management plans in order to ensure that care is integrated, of sufficient capacity, of the highest quality and delivered in the most effective and efficient way. It is likely that this will require investment in the development and capacity of providers, the involvement of new entrants into healthcare markets and the greater involvement of the voluntary and third sector organisations. We will also need to ensure that we performance manage our existing contracts in order to maximise the quality and value that is delivered by those providers. We will need to undertake this work in close collaboration with the local authority, particularly in relation to the Better Care Fund and in such a ways to ensure that care remains co-ordinated and integrated. In 5 years we aim to have developed a health market whereby the appropriate levels of competition, choice and performance management are deployed in order to maximise care outside of hospital, ensure that the experience of care is positive, integrated and co-ordinated and that we ensure that maximum value and quality is gained from our commissioning budgets.

During 2014/15, a detailed market assessment will be undertaken to inform the development of a market plan, which will set out the detailed plans for 2015 onwards.

4.11.6 Contracting and procurement

It is nationally stipulated that the NHS Standard Contract must be used by CCGs for all their clinical services contracts, it is through the use of NHS Standard Contract a key lever for commissioners to secure improvements in the quality and cost-effectiveness of the clinical services they commission.

The fundamental aim of for 2014/15 has been to create greater flexibility for commissioners to vary, by local agreement, national rules which were sometimes seen as obstacles to major service redesign and improvement. So, for 2014/15, the CCG has greater flexibility to:

- determine the duration of the contract they wish to offer, within the framework of national guidelines and regulations on procurement, choice and competition, with the option of longer contract terms than previously;
- move away, by agreement with providers, from rigid national prices, using the Local Variation flexibility set out in the National Tariff guidance, potentially developing different payment models based more on quality and outcomes and less on activity; and
- utilise innovative contracting models such as the prime provider approach

Together, these new flexibilities should enable the CCG to be equipped with the tools to employ longer-term, transformational, outcomes-based commissioning approaches.

This in conjunction with the principles for Cooperation and Competition offer a variety of procurement options which ensure fair and transparent cooperation and competition to obtain best value for money, encourage innovation and promote patient choice

4.11.7 Primary care investment scheme

The Primary care investment scheme is a scheme for investment in GP provider services in order to facilitate development within primary care providers in Wolverhampton, working in conjunction with the Avoiding unplanned admissions enhanced service, and supporting the delivery of the objectives stated within The Mandate. This will:

- Enable personalised care planning for patients that have a long term condition that is not already provided through QOF or an Enhanced Service
- The facilitation of practice development in relation to the management of patients with a long term condition.
- Enable locality engagement to recommend how the population can be efficiently and effectively targeted
- Enable Locality Management to develop business plans in order to facilitate:
    - Ownership and delivery of QIPP
    - Delivery of reduction in unplanned admissions.

In the longer term we will evolve the scheme from a disease modification to a risk modification focus in order to support our approach to tackling health inequalities, ill-health prevention and improving health outcomes.

There will be a new enhanced service to improve services for patients with complex health and care needs and to help reduce avoidable emergency admissions. This will replace the Quality and Outcomes Framework (QOF) quality and productivity domain and the current enhanced service for risk profiling and care management and

will be funded from the resources released from these two current schemes. The key features of the scheme will be for GP practices to:

- Improve practice availability, including same-day telephone consultations, for all patients at risk of unplanned hospital admission
- Ensure that other clinicians and providers (eg A&E clinicians, ambulance services) can easily contact the GP practice by telephone to support decisions relating to hospital transfers or admissions
- Carry out regular risk profiling, with a view to identifying at least two per cent of adult patients – and any children with complex needs – who are at high risk of emergency admissions and who will benefit from more proactive care management
- Provide proactive care and support for at-risk patients through developing, sharing and regularly reviewing personalised care plans and by ensuring they have a named accountable GP and care coordinator
- work with hospitals to review and improve discharge processes
- undertake internal reviews of unplanned admissions/readmissions.

4.11.8 Clinical Research Network

Following the reorganisation of Topic specific and Comprehensive Local Research Networks across England, from 1st April 2014 Royal Wolverhampton NHS Trust (RWT) became host to the Clinical Research Network: West Midlands. This provides an excellent opportunity for Wolverhampton CCG and primary care to ensure clinical research becomes embedded as a standard treatment option.

As Commissioners we will ensure organisations are active in delivering National Institute for Health Research (NIHR) trials, supporting translation into practice, designing patient pathways and working with primary care where appropriate. We will support the CRN: WM promoting research and harnessing enthusiasm in the community through encouraging engagement with member practices and the Research teams at neighbouring Trusts. Within the next two years we will look to expand the number of research-active GPs and increase the number of patients actively recruited into trials; our patients should be offered the opportunity to be part of research. We will be actively engaged with the CRN: primary care speciality and will support the national 'Ok to Ask' campaign so that our citizens are able to choose to take part in research. Within 3-5 years we would expect to see clinical research offered in primary care as a standard treatment option.

5. Governance: how all partners will ensure this happens

All partners have participated in the process of debating the major issues encapsulated in the Five Year Strategic Plan for the Wolverhampton health and social care economy. There is sign up to the vision, values/principles, and the work programmes which have to be implemented to achieve our objectives. The dialogue concerning the development of the Strategic Plan has occurred within the formal structures of the main providers as well as the Health and Wellbeing Board as initiated by development of the BCF. The formal sign off of the Strategic Plan is scheduled for July when there will be a formal board to board between the Royal Wolverhampton NHS Trust and the CCG, and final approval will be sought from the Health and Wellbeing Board. It is acknowledged that further work is required on the Strategic plan, including taking into account the feedback from NHS England planned for 14 July, therefore further iterations of the plan, will be submitted for approval.

The existing accountability structure for the BCF is being used for the oversight of the Strategic Plan.

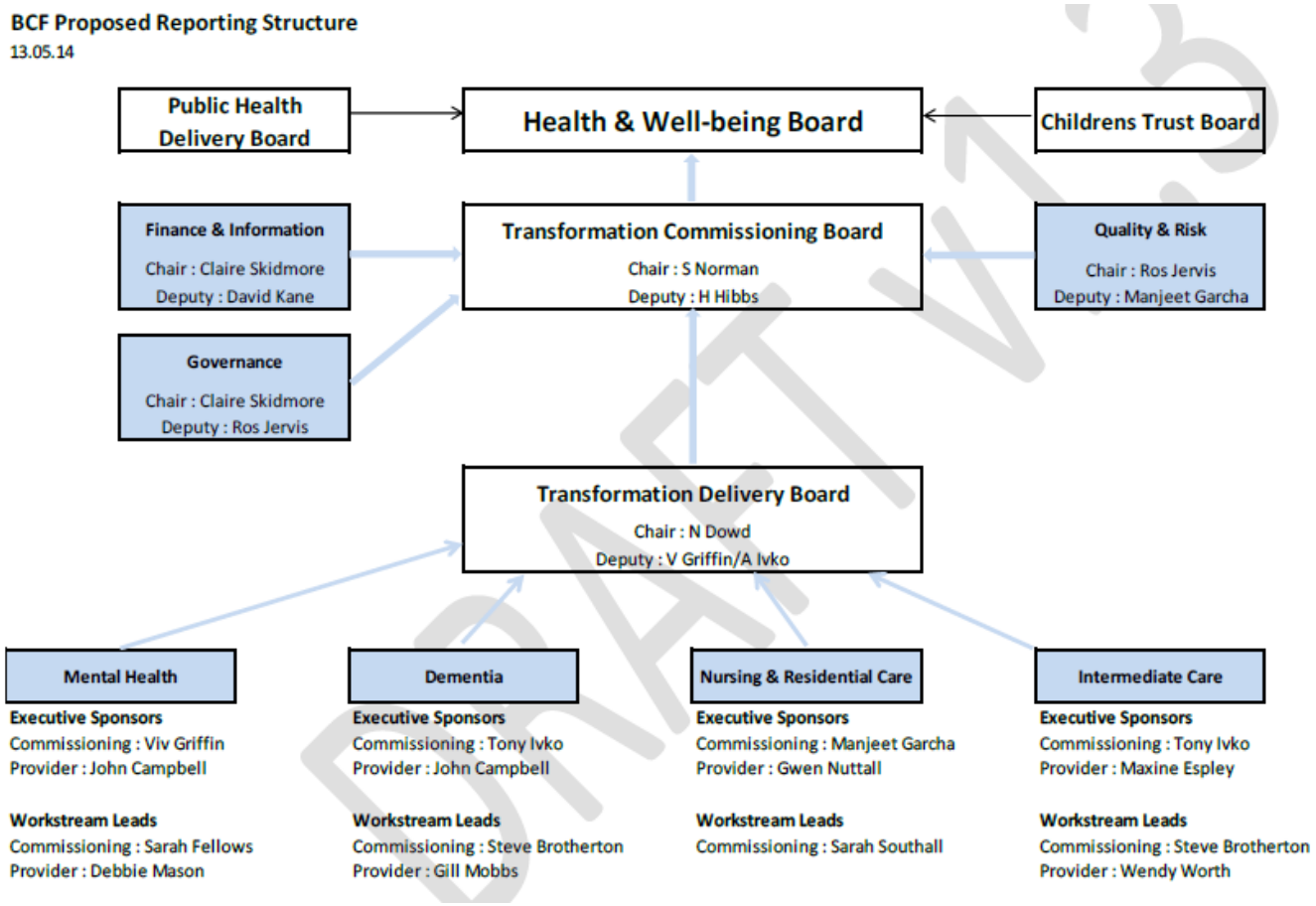


Figure 10: BCF Proposed Reporting Structure

This governance structure is in place to ensure partners sustain their commitment to the Strategic Plan and ensure delivery. The health and well being governance structure will provide system oversight of the plan and the CCG delivery board structure is clinically driven and designed so that clinical expertise and decision-making can be combined with the rigour of Programme Management using a commissioning cycle approach to the improved health outcome for the Wolverhampton CCG population.

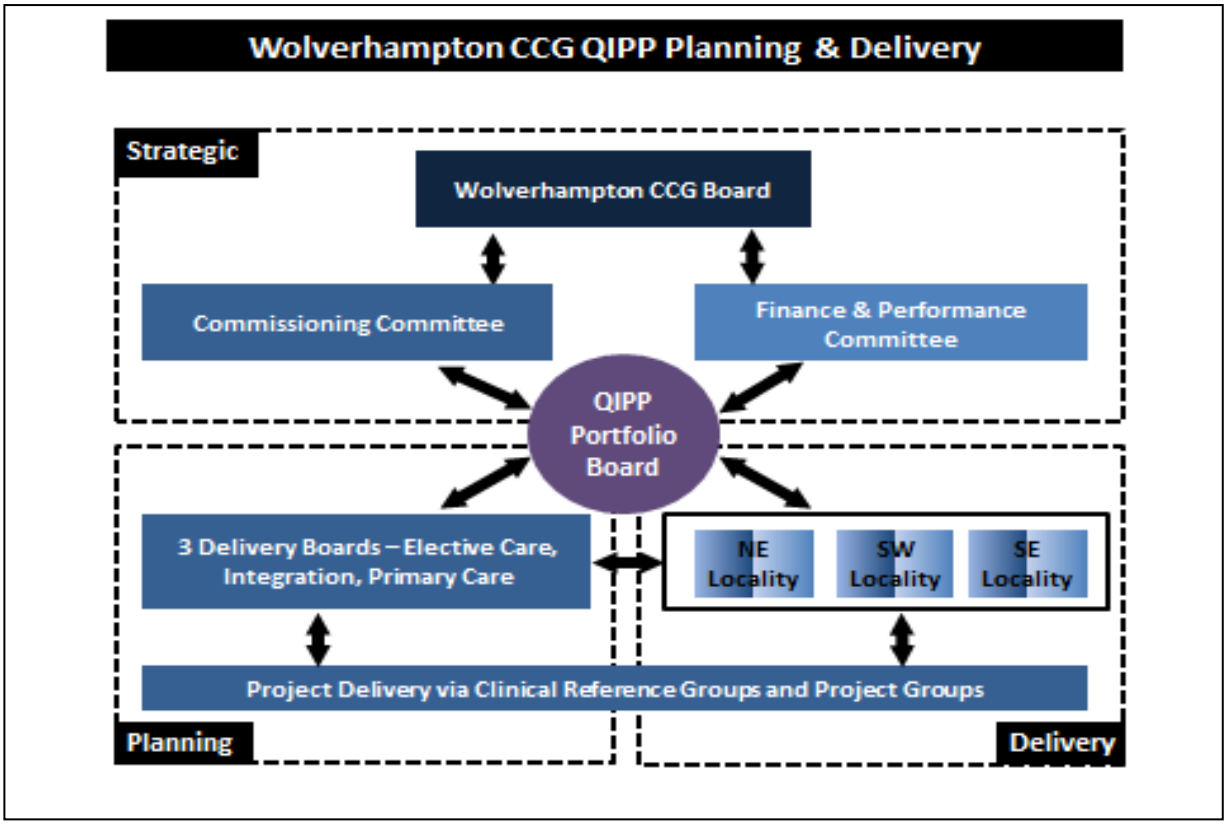


Figure 11: Planning and Business Delivery Structure

Note: Elective Care delivery board above is now the Modernisation and Medicine Optimisation Delivery Board

Local ownership and accountability

The Business Planning Framework is informed by and developed within the context of the CCG's Strategic Plan. The Strategic Plan identifies how the organisation intends to shape the commissioning and provision of health care for the Wolverhampton population over the next 5 years in order to improve health outcome.

The role of the CCG localities within this planning and delivery framework is two-fold. Firstly, localities are required to work with Delivery Boards to design service transformation, integration and quality improvement strategies and plans. Secondly, localities will have delegated responsibility for delivering QIPP benefits for the segment of the Wolverhampton population for which they are responsible. This will involve an operational business planning process whereby individual localities will agree the most appropriate way (for its constituent practices), to deliver against QIPP benefits targets which contribute to improved health outcome.

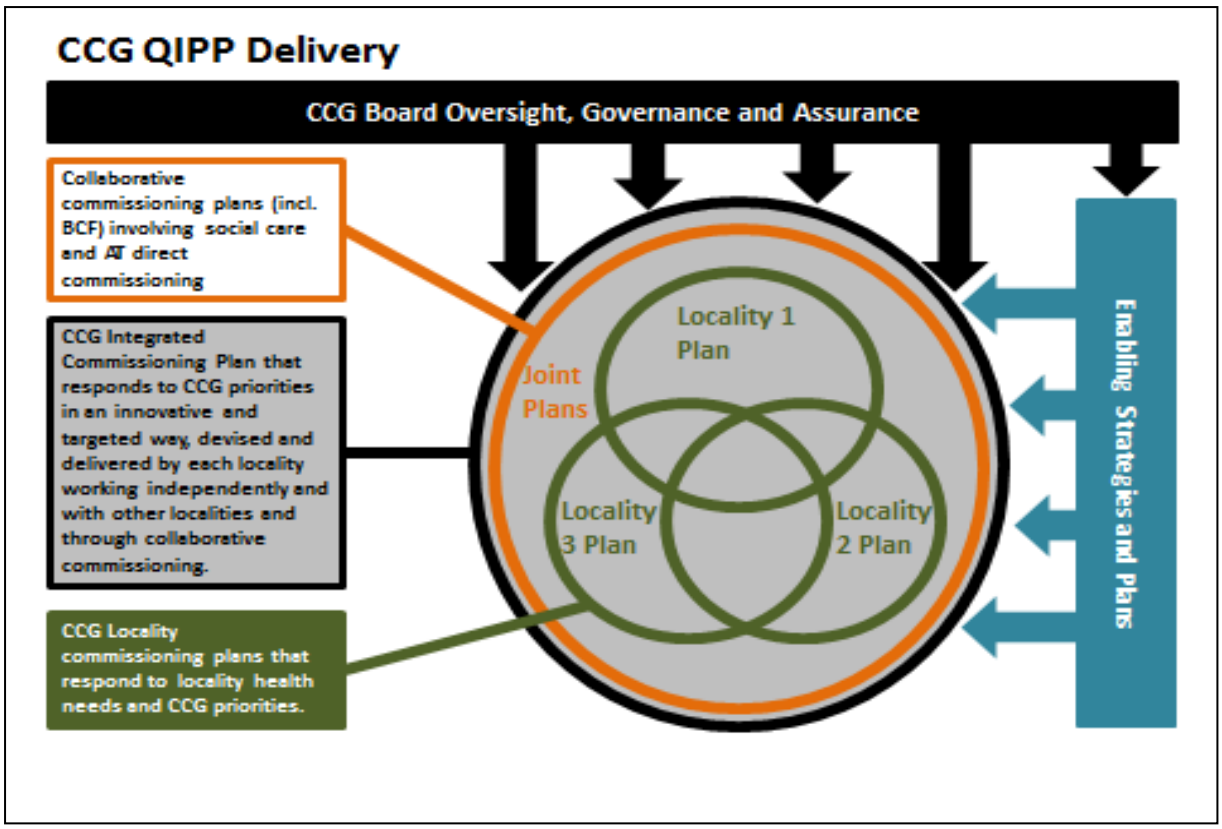


Figure 12: Integrated Planning and Delivery

Commissioning Committee

The delivery of the CCG's Commissioning Strategy plan is overseen by the Commissioning Committee which has a strategic, governance and assurance remit and is composed of the senior managerial and clinical leadership of the CCG. The Commissioning Committee is a decision-making body which is supported by the CCG's programme management structure. It will oversee the development of the CCG Strategic Plan, ensure all commission plans – Operating Plan, Locality plans and Better Care Fund plans - are aligned to the strategic objectives of the CCG.

The Finance & Performance Committee (FPC)

The FPC is accountable to the governing body and its remit is to provide the governing body with assurance on issues related to the finances and the achievement of performance objectives and targets.

QIPP Portfolio Board

The role of the QIPP Portfolio Board is to oversee and co-ordinate the activities of the Delivery Boards in order to maximise impact through integrated working. The QIPP Portfolio Board is chiefly concerned with how the benefits and outcomes for each of the Delivery Boards are to be achieved over time and in a co-ordinated way.

Delivery Boards

Delivery Boards are the key mechanism for clinical discussion and agreement regarding the delivery of effective and efficient care which improves health outcomes across the local health community. They are key engagement mechanisms for local stakeholders, clinical or otherwise and are chiefly concerned with how the benefits and outcomes for their portfolios are to be achieved, and will act as the key decision-making bodies for their sector of care. They will include primary and secondary care clinicians in agreeing optimum means by which improvement in health outcomes can be met. The Delivery Boards are chiefly concerned with the development and evaluation of strategies and plans that are delivered through localities.

Locality Plans

Locality plans are the responsibility of each of the CCG constituent localities. The locality plan will be the key delivery mechanism for QIPP. It will identify how the locality intends to achieve QIPP benefits and contribute to the strategic objectives of the CCG and improve health outcomes for locality populations.

6. Next steps

We are clear about the major transformational programmes of work which are needed to achieve the vision and we will drive the implementation now.

There are areas of work which need further development:

Within Wolverhampton for the whole system planning including clarity of financial projections of income and expenditure across all of the partners is needed given the range of scenarios based on different assumptions (optimistic/pessimistic). This will inevitably lead to the reprofiling of investment in the 3 years 2016/17 to 2018/19.

The reshaping of the health and social care system which relies less on bedded care, means that there will be a reshaping of the hospital sector. As described in this plan, the reshaping of the hospital sector is to take into account the following:

- the Keogh review on urgent and emergency care
- NHS England's review of specialised services
- the outcome of the stroke review including the designation of hyper acute stroke units
- the impact of a 15% reduction in emergency activity
- seven day working
- improvements the productivity of elective care

This cannot be achieved within Wolverhampton alone therefore we will use the available collaborative structures to develop an agreed approach across our borders in the following way:

- the Black Country meeting of CCG Accountable Officers
- Linking with the leaders forum for the Unit of Planning covering Sandwell, Birmingham and Solihull.
- Continued dialogue with the Staffordshire CCGs and Royal Wolverhampton NHS Trust concerning both the development of Cannock hospital and the future patient flows into and out of Wolverhampton.

Although there is important work to be undertaken on the most intensive part of the health and social care system in terms of bedded care in the secondary and tertiary centre, our main focus will continue to be transforming services outside of hospital, based in the community with primary care transformation at its core. It is only by achieving this transformation that the whole of the health and social care system can provide and sustain, safe and high quality services, which improve people's experiences of services and produce the health outcomes our population deserves.