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## **STRATEGIC SERVICE DEVELOPMENT PLAN 2007**

# Wolverhampton City Primary Care Trust

## Mission Statement

*Improved health for the people of  
Wolverhampton and a future where there is less  
deprivation and disadvantage.*

*Providing good quality services that are equitable,  
speedy, convenient and treat people with dignity.*

### **Statement from the Chairman and the Chief Executive Wolverhampton City PCT**

*“The aspirations laid out in this SSDP are not new. We have been working on their development for almost ten years, and the PCT remains committed to working in partnership and commissioning the best possible care for local people, and to providing care in buildings that are modern, clean and fit for purpose.*

*We genuinely believe that the plans we have developed will not only bring about services that are high quality, patient focussed, effective and affordable, but that the impact of these plans will have a wider, positive impact on the development of our city into the 21<sup>st</sup> Century. “*

**Barry Picken**

Chairman

**Wolverhampton City PCT**

**Jon Crockett**

Chief Executive

**Wolverhampton City PCT**

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## **1.0 Introduction**

All NHS Primary Care Trusts (PCTs) are required to produce a Strategic Service Development Plan (SSDP) which details their strategy for service development together with the supporting infrastructure investments over a five year rolling programme.

In constructing the Wolverhampton City PCT SSDP the PCT is responding to the challenges laid down in 'Our Health, Our Care, Our Say', Commissioning for a Patient Led NHS, the Commissioning Framework<sup>1</sup>, and Investing for Health, A Strategic Framework for the West Midlands<sup>2</sup> and sets out the service model to deliver care closer to home which is being developed across the city. It does not limit itself to the proposals which form part of the city's LIFT programme, but outlines all of the PCT's plans to modernise and improve how and where services are provided. It is also fully integrated with the development of the City Council's Every Adult Matters Strategy and Outline Business Case.

This document begins with a description of Wolverhampton City PCT then progresses in section 3 to consider the constraints and factors that have needed to be taken into account when shaping the SSDP.

Section 4 then describes the service strategies being taken forward for Primary Care, Mental Health, Rehabilitation and Community services and outreach outpatient services..

Section 5 takes the service strategies referred to in section 4 and describes how in responding to these strategies this impacts upon the PCT owned and Primary Care Estate, IT, Finances and Workforce.

Section 6 defines the management arrangements being put in place to enable this Project to be effectively managed.

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<sup>1</sup> Commissioning Framework.....

<sup>2</sup> Investing for Health, A Strategic Framework for the West Midlands, NHS West Midlands 2007,

The main vehicle, through which it is anticipated the SSDP will use to deliver its new facilities, is the established Wolverhampton and Walsall LIFT Company. Section 7 provides a brief description of the LIFT arrangements as they relate to Wolverhampton.

The complexity and scale of the changes as proposed within the delivery of this SSDP inevitably bring risks that need to be addressed. Section 8 describes the key risks of the SSDP and the actions being taken to mitigate these risks.

Section 9 then concludes by describing the tangible outcomes that emerge to the Wolverhampton Health Economy from the implementation of the SSDP.

## **2.0 Background to Wolverhampton City PCT**

In taking forward the Strategic Service Development Plan for Wolverhampton City PCT it is necessary to understand:

- The unique demographics and challenges presented through the demographics and profiles of the localities,
- The nature of Partnership working,
- The underlying financial circumstances as they relate to the PCT,
- The characteristics of the PCT owned and Primary Care owned estate,
- The underlying issues as they relate to the delivery of Primary Care, Mental Health, Rehabilitation and Community Services; and
- The Profile of service access across the three localities of Wolverhampton.

### **Demographics**

Wolverhampton is a vibrant and multi cultural community and one of the most densely populated areas in the country. Ranked as the 35<sup>th</sup> most deprived area in England. 12% of the population describe their general health, as not good, 35% of households do not own a car and 21% of the population claim income support. Wolverhampton has the 18<sup>th</sup> highest rate of teenage pregnancy and the 19<sup>th</sup> highest rate of stroke in under the 75s. More specifically

- The City has a resident population of 239,100 (2005 mid year)
- 22.2% of the population are from Black/Ethnic Minority (BME) groups<sup>3</sup>
- There has been a population decrease of almost 5% over the past 30 years (12,000 residents) - the highest in the West Midlands
- There are growing numbers of very young people, lone parents and elders

### **The three Localities of Wolverhampton**

In describing Wolverhampton to gain a full understanding it is necessary to consider the city as one that is differentiated into three locality groupings which are consistent with the three parliamentary constituencies.

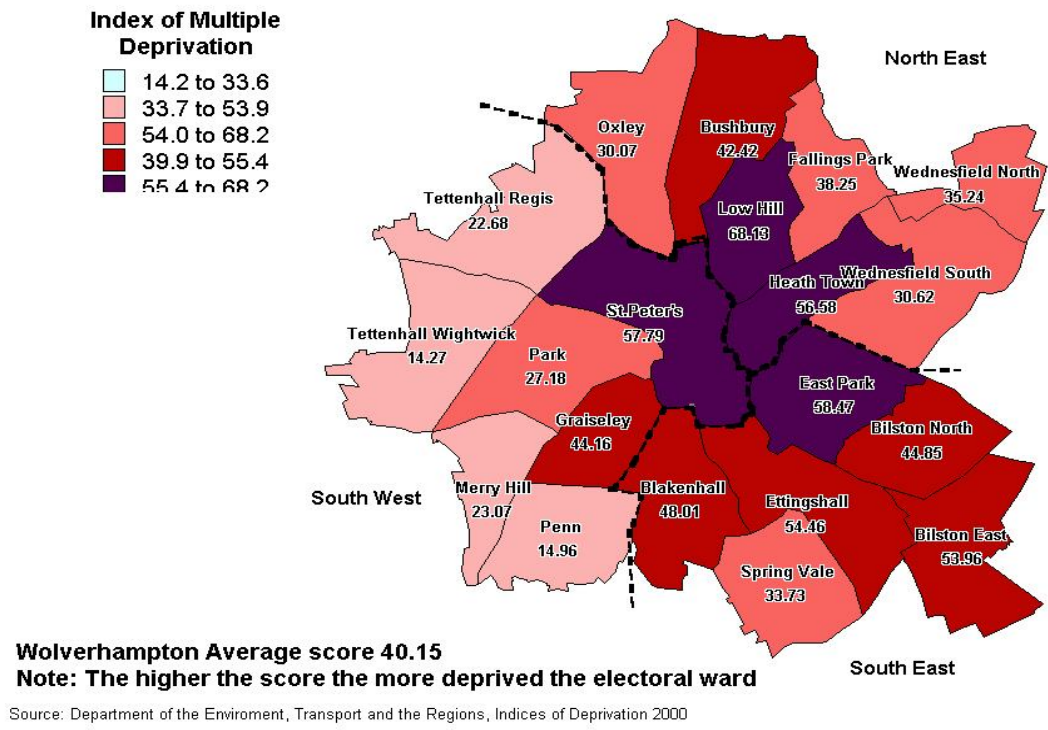
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<sup>3</sup> 2001 Census

The south west constituency takes in the city centre and the population centre close to West Park. The south east constituency covers the Bilston population centre, and the north east constituency covers the Lowhill population centre and the New Cross Hospital.

The diagram below summarises the level of deprivation, as it exists across the three localities.

**Index of multiple deprivation for Wolverhampton by electoral ward (2000)**



As can be seen high levels of deprivation exist at the core of the City and extends outwards particularly into the South East and North East Localities. However each locality has a range of characteristics which impact on the delivery of health and social care services, as can be demonstrated in the table below:

Table 1 – Locality characteristics

Locality Characteristics		
South West	South East	North East
<ul style="list-style-type: none"> <li>• Population: 81,705 (35% of total Wolverhampton population)</li> <li>• 49% males</li> <li>• 51% females</li> <li>• 7 wards</li> <li>• Highest proportion of elderly residents</li> <li>• Affluent wards predominate but pockets of deprivation</li> <li>• Highest admission rates for stroke</li> <li>• Higher mortality rates for CHD in deprived wards</li> </ul>	<ul style="list-style-type: none"> <li>• Population: 70,792 (30% of total Wolverhampton population)</li> <li>• 49% males</li> <li>• 51% females</li> <li>• 6 wards</li> <li>• ABCD Regeneration Area</li> <li>• Significant deprivation</li> <li>• High rates of teenage conceptions</li> <li>• High rates of induced abortions in 15 to 44 year old women</li> <li>• Ettingshall has the highest death rate from CHD in the city</li> </ul>	<ul style="list-style-type: none"> <li>• Population: 81,050 (35% of total Wolverhampton population)</li> <li>• 48% males</li> <li>• 52% females</li> <li>• 7 wards</li> <li>• Significant areas of deprivation</li> <li>• Highest rates of teenage births</li> <li>• Low Hill has the highest death rate from lung cancer in the city reflecting smoking patterns</li> </ul>

### **The Nature of Partnership**

Partnership working within Wolverhampton, particularly between the PCT, the Local Authority and RWHT is well developed within the City. The recent PCT fitness for purpose review by Mckinsey Management Consultants referenced the strong working relationships between the PCT and the Council whilst The Department of Health National Support Team review into the management of Health Inequalities in Wolverhampton recently commented that there existed a “Strong, Shared commitment of PCT, Local Authority and other statutory sector partners to tackling inequalities and sustainable regeneration”. Further, the Children’s Services Joint Annual Review conducted in 2007 commended the excellent working relationships and partnership outcomes that existed between the whole health and social care economy in Wolverhampton.

The PCT has been an active force in the development of partnerships across the city, as evidenced by involvement in the Local Strategic Partnership, the PCT’s development as a first wave Local Area Agreement pilot site, and the formal agreement between the PCT and the City Council described in the Framework

Partnership Agreement resulting in the integration of mental health, community equipment, community intermediate care team, and learning disability services. Further these services are jointly commissioned through a jointly established PCT /Council Commissioning Unit financed through the existence of Pooled PCT/ Council budgets.

### **The financial Position of Wolverhampton City PCT**

In constructing the Strategic Service Development Plan the PCT has been able to do so from a position of financial strength. In the recent Audit Local Evaluation, the PCT scored an overall level 3 and in respect of the financial standing criteria was classified as level 4.

The PCT finances are summarized in the table below, covering a five-year period from 2007/8 to 2011/12. In developing this plan the PCT has assumed that a sharp reduction in the level of growth funding (after allowing for inflation) occurs from the year 2008/9 onwards. In doing so the level of growth money received by the PCT in the years 2008/9 to 2011/12 amounts to 1.0 per cent in each year.

**Table 2 – Five year Financial Plan**

		Planned Forecast outturn (if growth 1%) £000's
<b>2007/8</b>	Recurrent	4,977
	Non Recurrent	15,033
	<b>Total</b>	<b>20,010</b>
<b>2008/9</b>	Recurrent	3,091
	Non Recurrent	25,327
	<b>Total</b>	<b>28,418</b>
<b>2009/10</b>	Recurrent	3,839
	Non Recurrent	32,595
	<b>Total</b>	<b>36,434</b>
<b>2010/11</b>	Recurrent	939
	Non Recurrent	36,842
	<b>Total</b>	<b>37,781</b>
<b>2011/12</b>	Recurrent	(961)
	Non Recurrent	37,281
	<b>Total</b>	<b>36,320</b>

## Estate characteristics

A comprehensive review of the PCT owned estate and Primary Care estate has been completed. Using the Department of Health five-facet methodology this review concluded that the following number of premises could be regarded as meeting a level that was either excellent or good across the five categories. (Classified as either A or B, or 3 in respect to space utilisation)

Table 3 – Five facet survey – PCT Owned and Primary Care Premises.

	<b>Total Number of Premises</b>	Physical Condition (A,B)	Energy Perform. (A,B)	Statutory Standards compliance (A,B)	Functional suitability (A,B)	Space utilisation  Score = 3
North East Locality	<b>26</b>	12	15	16	11	16
South East Locality	<b>18</b>	10	10	12	9	14
South West Locality	<b>16</b>	11	13	16	11	9
Rehabilitation	<b>1</b>	-	-	1	-	1
Mental Health	<b>4</b>	1	-	4	1	1
	<b>65</b>	<b>34 (52%)</b>	<b>38 (58%)</b>	<b>49 (75%)</b>	<b>32 (49%)</b>	<b>41 (63%)</b>

As can be seen only 52% of existing PCT / Primary Care premises could be regarded as good or better and only 49% of premises offered space that was functionally suitable for the delivery of healthcare.

Beyond the five-facet assessment, the review also considered the extent to which existing premises used by General Practitioners have the capability of being developed to provide further locality-based additional services. This review revealed the following.

Table 4 – Capacity for building development

	Total Number of Practices	Capacity to deliver additional Services
North East Locality	26	14
South East Locality	18	10
South West Locality	16	5
	<b>60</b>	<b>29 (48%)</b>

Only 48% of existing General Practices operated from facilities that were capable of being expanded to deliver additional services.

**The delivery of Primary Care, Mental Health, Rehabilitation and Community services**

- Primary Care

a. General Practice

Wolverhampton City PCT is characterised by a high incidence of single-handed General Practices. Specifically out of 60 practices 30 are single handed (50%), of these 64% work in isolation and are not housed in close proximity to other GP's or members of the Primary health care team.

Further Wolverhampton is listed as the eleventh most under doctored PCT in England. To achieve the national norm, the PCT would need to deliver an additional 26 WTE general practitioners.

The age profile of the population of General Practitioners working within Wolverhampton City PCT is also of concern. Specifically, the PCT engages the services of 125 General Practitioners of whom 44 are over the age of 55 and 3 over 70- years. It is estimated that up to 47(38%) could retire within the next 10 years giving an average loss of 4 per year.

Addressing a need to increase the General Practitioner workforce and respond to the loss of Doctors through retirement is made difficult because Wolverhampton does not have a good history of attracting new doctors to the city. To do requires:

- i. Training - One opportunity for overcoming this problem is to offer local training opportunities and by doing so retain the doctors as they qualify as General Practitioners.
- ii. Additional / Enhanced Services – Opportunity to increase available Income through the ability to deliver additional / enhanced services.

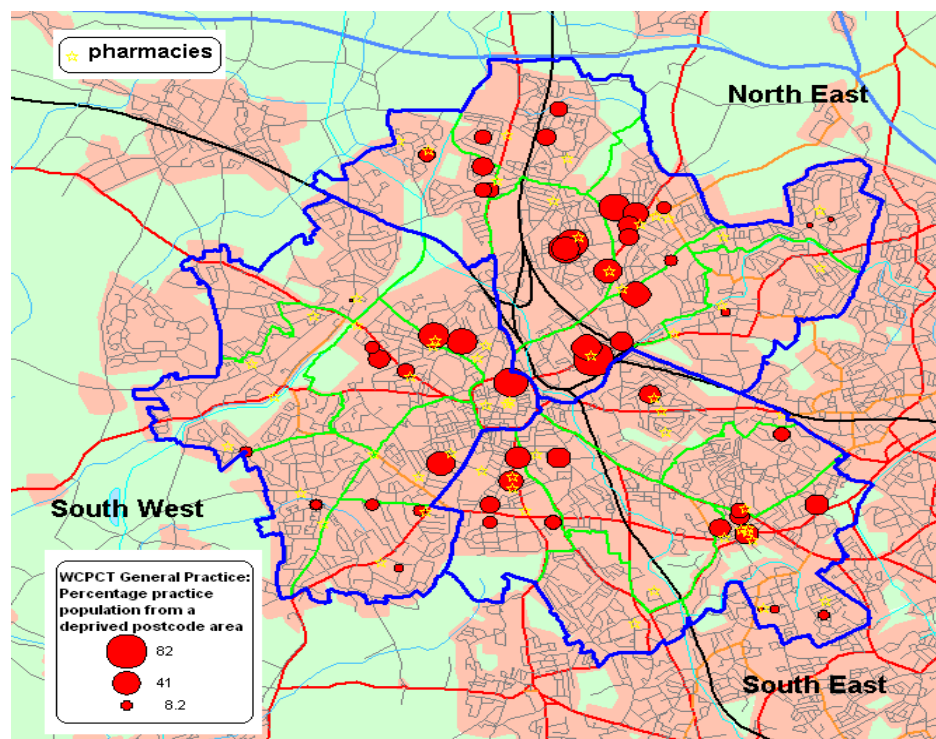
#### b. Dental

Excellent access to Dental services exists in Wolverhampton however the General Dental Practitioners committing to the completion of NHS work are disproportionately located within the South West Locality.

#### c. Pharmacy

Recent Public health needs assessment into Pharmaceutical services suggests that there are no known areas in Wolverhampton that are inadequately served by existing contractors. Most community pharmacies are located near Wolverhampton City PCT General Practices as illustrated in **(Figure 1)**. Furthermore, this map shows that the majority of general practices with over half of their registered population living in a deprived postcode area have good access to pharmacies and their services.

**(Figure 1): General Practices and Community Pharmacies in Wolverhampton**



- Mental Health services

The PCT has a well-established Mental Health Service providing Inpatient services in a recently constructed purpose built facility at Penn Hospital. In addition a diverse range of community, day and outreach services are delivered along with specialist mental health services exists across the borough, including psychotherapy, early intervention, home treatment, crisis intervention and eating disorders. The health and social care mental health service is managed by the PCT to deliver a fully integrated model of care. The service achieved an overall good rating in the recent Healthcare Commission assessment.

In addition to the statutory services delivered in Wolverhampton, excellent examples exist of mental health services being delivered in Partnership with the third sector, these include:

- Afro – Caribbean services delivered jointly with ACCI,

- Residential nursing rehabilitation services provided in association with FOCUS Housing Association; and
- An OMI Sheltered Housing service provided in conjunction with Methodist Homes for the Aged.

The PCT has however a relatively under developed Primary Care mental health service and as such challenges exist over the level of General Practice Access to Counselling, Cognitive behavioural Therapy and Psychological Interventions.

The current Mental Health Day services are delivered in each of three localities are currently under review to develop a social inclusion based model, in comparison to the more traditional based model of day care previously delivered to people with mental health needs.

- Community services

A full suite of Community services are provided, incorporating District Nursing, Health Visiting, Specialist Nursing e.g. Diabetes Care, Community Intermediate Care Team, Community Matrons, Paramedical services, Community Dentistry and a Minor Injuries Unit. All services are delivered through locality-based structures.

Joint strategies exist between the PCT and the Local Authority for the delivery of a range of community services, for example the management of Long Term Conditions, however the current services do not currently operate in a fully integrated Health and Social Care community model.

- Rehabilitation services

Uniquely the PCT operates a community based inpatient and outreach rehabilitation service. This service is consolidated around the community rehabilitation hospital located at the West Park hospital site; outreach services operate from the site but are delivered within a locality model. Three service areas delivered via the community rehabilitation service are: general elderly rehabilitation, stroke rehabilitation and neurological rehabilitation.

There are currently 94 beds at the West Park community rehabilitation hospital with an average occupancy for the site being 94% (2006/07). The average length of stay for patients on the general elderly rehabilitation wards is longer than the average across the West Midlands and was 48 days in 2006/07. This represents an increase over the past 3 years.

As stated previously the West Park hospital site is in need of a major upgrade.

### **3.0 The Factors that have determined the shape of the SSDP**

In determining how to shape the Strategic Service Development Plan, the PCT has needed to be mindful of a series of factors that need to be accommodated if the solution developed via the SSDP is to meet with National and Local Policy requirements and is capable of being delivered. This section describes the key factors that have impacted upon the construction of the Strategic Service Development Plan.

#### **Primary Care**

**Recruitment** - In describing a future for Primary Care services, particularly, General Practice it is necessary to consider how best to improve recruitment of General Practitioner and/or create capacity through the engagement of allied professionals working within Primary Care.

**Resilience** - If care within General Practice is to grow more resilient the need also exists to address the number of single handed general practitioners working across the City, the basis for doing so however depends also on the ability to encourage existing General Practitioners to work more collectively.

#### **Mental Health**

The Mental Health National Service framework and Social Inclusion strategy define new ways of working for mental health services. Specifically requiring the mainstreaming of mental health care provision into a persons broader health care needs. In delivering this approach it is necessary for mental health services therefore to be co-located within recognisable community and primary care settings.

## Community Services

The white paper your health, your care, your say outlined a range of key messages for the future delivery of health and social care services, namely:

- Delivering care closer to home – to increase the range of services delivered outside a hospital setting and to maintain an individuals independence for as long as possible.
- Integration of health and social care – maximise the potential to manage care pathways in a co-ordinated and efficient way to deliver a seamless package of community health and social care
- Shift from treatment to preventative services – support patients in the self management of their illness, increase information and health promotion activities.

Therefore in scaling the new services and associated infrastructure it is critical for these messages to be adopted.

Locally the PCT is also working with its local Secondary Care provider in creating capacity to support a reduction in facilities provided through the New Cross Hospital site.

## Rehabilitation

The effective delivery of rehabilitation services, where patients are able to return and maintain their independence within their own home requires closer alignment between health and social care services. This necessitates the delivery of such care in a variety of settings, through integrated health and social care teams, integrated care pathways and in a community based setting.

For this service to be at the same time cost effective requires an increase in the capacity and throughput of the existing bed numbers through a reduction in the average length of stay of patients in the hospital.

## Financial Envelope

The PCT in constructing its plans for the future needs to ensure that the ongoing recurrent revenue costs of the new developments remain affordable within the level of resources available.

The PCT has established a financial model to determine the affordability of the whole suite of developments as contained within the SSDP. This model allows for:

- the re-engineering of existing recurrent revenue premises funding (through the rationalization of PCT owned and GP owned premises),
- rental for space occupied by Wolverhampton City Council and the Royal Wolverhampton Hospital NHS Trust; and
- development funding as detailed within the PCT LDP

## Local Authority Business Case

Wolverhampton City Council has secured through the Department of Health PFI Credits supporting the revenue costs associated with a £30 million capital development as a result of its Outline Business Case, Every Adult Matters. This OBC describes a strategy for service delivery where adult social care, Library and Leisure Services become integrated with Health Services. In doing so the City Council's OBC<sup>4</sup> made the following commitment to the further integration of health and care services:

- the need to modernise the range of facilities for the provision of care and related services
- the drive toward integration
- the strong commitment .....to bring about a real improvement in outcomes
- the strong commitment...to improve facilities to achieve an improved service and improvement in staff facilities, and

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<sup>4</sup> Outline Business Case for Every Adult Matters, March 2006, Wolverhampton City Council

- potential to release efficiency savings through integrated PCT and Local Authority business processes, streamlined transactions and improved communications between practitioners.

The approved Outline Business Case explicitly requests the establishment of six new health and social care facilities divided evenly across the three localities. In each of these localities one such facility is required to provide dedicated mental health care.

In the event that either the service model or distribution of facilities was to be compromised this would then mean that the Local Authority would lose the available funding.

### Expectations

The PCT had in presenting its original SSDP held discussions with local communities describing future service plans and the availability of new infrastructure. In deciding to shift the SSDP from the position as had been presented it was necessary for the expectations of local communities to be handled sensitively.

### Locality

Solutions for both Service delivery and Infrastructure have to be mindful of the specific characteristics that exist within the three localities. To satisfy the requirements of the South East Locality for example it is necessary for any solution to accommodate the relatively low levels of transport and improve access to health care services as a way of improving the healthcare of that resident population.

### National and Regional Policy Drivers

#### a. NHS West Midlands Strategic framework

The draft SHA Strategic Framework acknowledges that nationally some 90% of all patient contact takes place outside of acute hospitals, in GP practices, dental surgeries, community health centres and in patients own homes.

Further the draft SHA Strategic Framework outlines four key areas of development:

- Improving the management of long-term conditions
- Improving the way we support patients at the end of life
- Supporting the development of the highest quality and most accessible primary care
- Improving the availability of excellent NHS dentistry

In constructing the integrated health and social care service models contained within the SSDP the PCT has recognised the need to respond to these four areas of development and seeks to do so through the development of modern facilities in an integrated health and social care service model.

#### b. Regeneration

The regeneration agenda for the city is significant. The Black Country Study<sup>5</sup> notes that:

- There are 100,000 fewer jobs in the Black Country today than there were in the 1970s,
- That the significant trend in net out-migration from the area needs to be reversed; with the population of the Black Country growing by 1.2 million
- Raising the income levels to 90% of the UK average from the 81% is seen today as a key local priority, and, most significantly for the SSDP,
- a proposed increase of 71,000 dwellings across the Black Country by 2031, in line with the Government's commitment to build 3,000,000 more homes by 2020.

Key regeneration projects include:

- the development of Bilston Urban Village – the redevelopment of this 101 acre site will be one of the largest regeneration projects in the Black Country, and

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<sup>5</sup> Black Country Study, Technical Executive Summary, May 2006

will include 1000 new homes and leisure facilities, as well as one of the city's three primary and community care centres.

- Wobaston Road. This development, in the north west of the city, will include high quality manufacturing, office buildings, research facilities and a hotel. The project represents significant future employment opportunities.
- Proposals for £176 million comprehensive office led scheme at Wolverhampton Interchange have been put forward by a North West based development company. The interchange will provide a new railway and remodelled bus station, a four star 150 bed hotel and 114,000 square feet of leisure facilities. It is anticipated that the scheme will result in 2,900 new jobs.

Wolverhampton City PCT in shaping and implementing its development plans continues to be committed to supporting the regeneration of the city and sees the proposals within the SSDP making a significant contribution, namely:

- through investment in construction and service industries which will support the proposed development
- through the employment of local people in community services
- through the retention of and investment in a skilled workforce, and
- through working with partners to support the strategic planning processes in the city, including public transport and the development of healthcare facilities in areas targeted within the City for regeneration.

## **4.0 Wolverhampton City PCT – A way forward – Service Strategies**

The PCT in developing a way forward has sought to establish a solution that best addresses the Primary, Mental Health, Rehabilitation and Community Service Issues raised earlier. This solution requiring both changes to the way in which existing services operate and the underpinning Infrastructure (both premises and IT) needed to enable these services to function in the future. This section provides a brief description of these service strategies.

### **The Service Implications for Primary, Community Mental Health and Rehabilitation services.**

#### **a. Primary Care**

##### **Improving Resilience**

Proposals for the Improving the resilience of General Practice is based upon reducing substantially the numbers of single handed General Practitioners working within the City. The PCT Primary Care strategy allows for a consolidation of the existing 60 practices into 34 Primary Care Clusters. Crucially In doing so, this plan does not assume that any of the existing 60 practices will formally merge, but believes that through co-locating with other practices this will enable cross working between practices to become more possible.

Table 5- Plans for Consolidation of General Practice services into larger Units

	Total Clusters (Pre SSDP)	<b>Total Clusters (Post SSDP)</b>	1 GP	2 -5 Gp's	6-10 Gp's	11+ Gp's
North East Locality	26	<b>14</b>	3	8	3	-
South East Locality	18	<b>12</b>	4	4	3	1
South West Locality	16	<b>8</b>	-	3	5	-
	60	<b>34</b>	7	15	11	1

In undertaking this consolidation exercise the problem of the number of single General Practitioners operating as Practices, without available underpinning support, becomes substantially reduced.

Table 6 – Reducing the number of Practices working in isolation

	North East Locality Pre SSDP	Post SSDP	South East Locality Pre SSDP	Post SSDP	South West Locality Pre SSDP	Post SSDP	<b>Total</b>  <b>Pre SSDP</b>	<b>Post SSDP</b>
Single handed GP' Practices – working in isolation	10	3	7	4	3	-	<b>20</b>	<b>7</b>
Non Single handed GP' Practices	16	23	11	14	13	16	<b>40</b>	<b>53</b>
Total	26	26	18	18	16	16	<b>60</b>	<b>60</b>

Beyond the proposals as contained within the SSDP, the PCT is presently working with General Practitioners, within the North East Locality to enable further reconfiguration of Practice groupings to take place. In doing so this would then reduce the number of single-handed GP's within that locality to one practice.

In the South East Locality consideration is being made as to whether a further new facility could become established within the Bradley Area, if possible this would reduce the number of single-handed practices in this locality to one practice. This new facility does not however presently feature as part of the SSDP.

The Plans for General practice as proposed within the SSDP have been shared fully with General Practitioners; all Practices impacted upon by the SSDP have indicated their support to moving into the new premises.

## Recruitment and Retention.

Whilst the existence of new purpose built facilities will undoubtedly serve to make the prospect of working as a General Practitioner more attractive, this in itself is not regarded as sufficient if the PCT is to address its recruitment difficulties.

The new PCT Primary care strategy seeks to address this problem in two ways:

- Training – To improve training opportunities it is intended to establish, in association with the University of Birmingham Medical School, five dedicated General Practice training centres. The PCT SSDP allows for two new premises to be equipped to provide this training capability.
- Income from providing Additional / Enhanced Services – The development of new facilities addresses the problem of existing Premises being unable to, or be capable of being developed, to create the capacity to provide Additional / Enhanced Services. In doing so this then enables these services to be made available more equitably across the City.

Table 7 – Impact of SSDP on increasing the capacity to deliver Additional / Enhanced services

	Total Number of Practices	Capacity to deliver additional / Enhanced Services Pre SSDP	Capacity to deliver additional Enhanced Services Post SSDP
North East Locality	26	14	25
South East Locality	18	10	17
South West Locality	16	5	16
	<b>60</b>	<b>29 (48%)</b>	<b>58 (95%)</b>

As can be seen as a result of the development programme within the SSDP, it then becomes possible for 95% of practices within Wolverhampton to undertake additional / enhanced services.

## b. Mental Health, Community and Rehabilitation services

The models of care for Mental Health, Community and Rehabilitation services have been developed by clinicians from across primary care, community services, and secondary care. These models define a future with a greater emphasis placed on opportunities to provide care directly in a patient's home environment.

Accordingly the model for each of these services describes care provided across three levels:

- **Level 1** – Care provided in the home environment – e.g. nursing support for chest and respiratory conditions, palliative care
- **Level 2** – Neighbourhood services where it is not possible to deliver the care in a person's home – e.g. specialist tissue viability clinics, diabetes outpatients, intermediate care beds; and
- **Level 3** – Borough wide services – e.g. walk in centre, audiology services and Rehabilitation beds

### Mental Health:

The service model for Wolverhampton's mental health services has been developed by clinicians and service users using the National Service Framework to:

- Meet the needs of service users with long-term and enduring mental health needs living in the City whilst further developing primary care based mental health services.
- Maximise the opportunities presented through the delivery of a fully integrated health and social care mental health service and extend access to a broader range of health and social care services, including primary care, for people with mental health needs.
- Deliver person centred services within service users own homes or in an environment, which reduces the stigma of mental health to maximise an individual's recovery, independence and social inclusion.

- Provide day services, which focus on achieving social inclusion. The service will deliver group and individual sessions in areas such as, leisure activities, living skills and confidence building, as well as building links with organisations, which offer training and employment opportunities.

To do so the SSDP rationalises the number of community based clinics from the 4 existing sites to 3 new mental health and community health centres. The new mental health and community centres serve to enable the delivery of the described model of service by:

- Co-locating primary, community and mental health services within a locality setting, maximising the opportunities for people with mental health needs to access a wider range of services in an environment which does not stigmatise mental health.
- Designing and delivering purpose built facilities, which provide an environment conducive to a social inclusion model of day services.
- Providing a co-located primary care and mental health model, increases the delivery of services such as counselling and psychological therapies to the wider practice/locality population.

For Wolverhampton the vast majority of community services will be delivered as levels 1 and 2 activity in the three centres, these include:

- Community and Primary Care Mental Health Teams
- Consultant Outpatients
- Day opportunities.

There are however a number of services which rather than having a locality base need to take a wider (level 3) city remit or offer a 24hr service and these services are to be placed in a single city centre site:

- Assertive Outreach
- Early Interventions
- Home treatment team

- Liaison Team

In shaping the services in this new format it is believed that substantial productivity gains can be realised. Specifically more effective assessment, screening and the use of evidence based research will enable the Community and Primary Care Mental health teams to increase their workload by 30%. Similarly the capacity to deliver Day Care can be expected to increase by a further 20%.

By rationalising the number of sites the PCT also addresses its known estate problems where 3 of the sites were classified as in need of major refurbishment or replacement and inadequately met the services functional requirements.

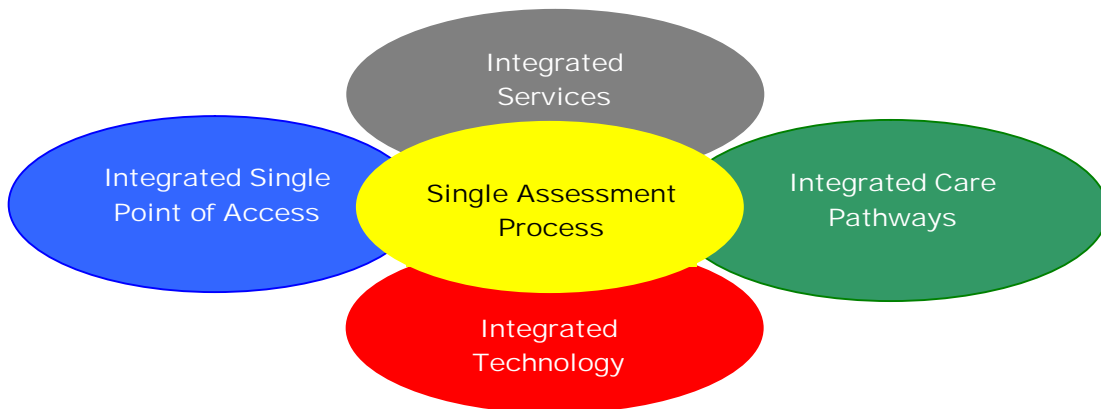
#### Community Services:

The model of care for adult community services has been developed in partnership between the PCT and the City Council and is based on the principle of supporting individuals to stay healthy for as long as possible and, when required, to manage their health and social care needs in a coordinated, integrated way.

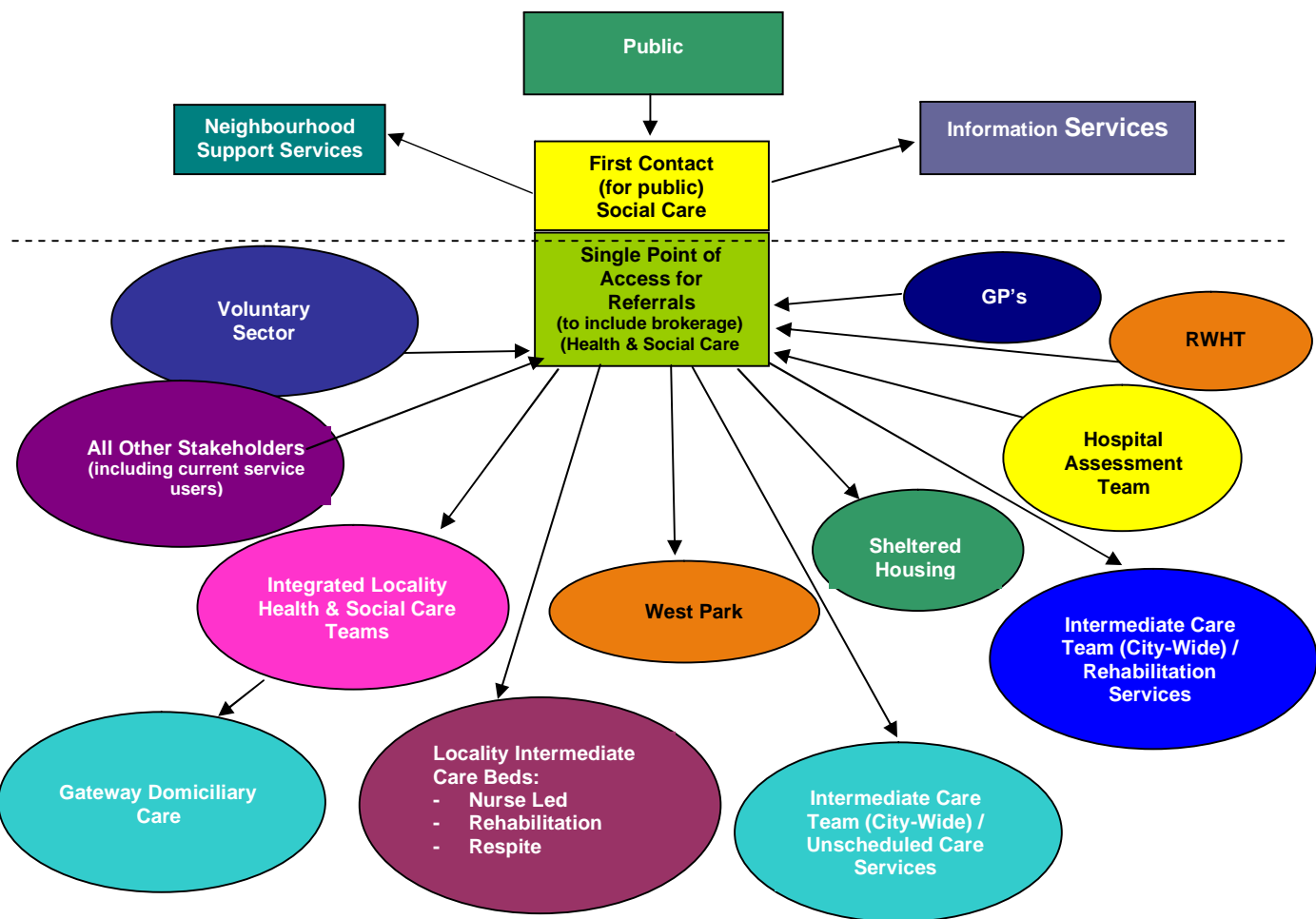
Access to services in Wolverhampton is characterised by multiple referral and access routes causing confusion to patients and inefficiency in the delivery of services. Key to the resolution of these problems will be the establishment of a 24 hour seven days a week single point of Access referral (SPAR) service.

The SPAR will be appropriately staffed with individuals qualified to carry out consistent assessment / triage process supported by the Single Assessment Process and Electronic Patient Record which will ensure referrals whether routine or urgent to be forwarded to the most appropriate service for timely response. It is anticipated that for many cases this will negate the need for patients to attend acute hospital.

# Framework for the Integrated Health & Social Care Community Service Model



## The patient pathway: access and the range of services and organisations contributing to the delivery of the community services model



The development of new Primary and Community Care Centres will enable the delivery of the described model of service by:

- Bringing together primary, community and social care services supported by the single assessment process and a single point of access to deliver an integrated model of care. (Level 1)
- Supporting a broader range of community based services which are delivered within a persons own home or as close as possible to where they live by a fully integrated team (Level 1).
- Providing a service which is co-located with and enhanced by a range of self-care initiatives, health and social care information services, health promotion services, group activities and specialist clinics (level 2).
- Improving equality of access to community services across the three localities and increases the direct access to community based paramedical services and community dental services (Level 2).
- Establishing the capacity and infrastructure to implement new community services to support the commissioners intention to reduce activity within the secondary care provider (Levels 1 and 2)

The existence of these services will undoubtedly improve the patient experience and increase the efficiency of the community service teams. A realistic estimate of the effect the new improved, integrated care pathways, supported by the single point of access referral system will have upon the community nursing service, is that once embedded this service will increase its capacity by 35%.

#### Examples of Changes to the delivery of Community Services

##### **a. Supporting Individuals with Long Term Conditions (LTC) (Levels 1 &2)**

80% of primary care consultations and 2/3 of hospital admissions involve patients with long term conditions. A key element in the model of a care is the assertive case and care management of such patients.

Supporting patients with LTC relies on a coordinated health and social care response and the ability to input appropriately during all levels of an individual's need whether proactively supporting people to stay well or supporting them through times of ill health.

Although much of this work will take place at level 1 in patients' homes, the basing of primary and community health and social care staff together in localities will bring benefits of closer working supporting integrated care. The UFT developments associated with the SSDP allows for the opportunity to develop specific resources to support people in staying well at level 2 by delivering services in local neighbourhoods, including access to diagnostics.

### **b. Improved information and support for self management (levels 1 & 2)**

The PCCC developments will include an Older People's Centre, an Information Centre and health promotion facilities enabling integrated health and social care information and health education sessions. The facilities will also provide access to community groups in support of patients, carer groups and expert patient programmes. Wolverhampton's strong link with the voluntary sector in providing support for those with LTC is part of the success of the model.

In addition community nursing services are being designed to work more proactively with patients who are defined as being in need of support to enable a shift from a traditional treatment based service to one that also includes a preventative element.

### **c. Increased input to most vulnerable (Levels 1 & 2)**

The established number of Community Matrons (CM's) employed by the PCT is to be increased by a further six posts. In doing so this will then enable a team of 12 CM's to exist to support and proactively manage the Long term Conditions of individuals identified as at most risk. Further the CMs will be based alongside the urgent care team to ensure that they are able to "pick up" relevant patients before entering an urgent care pathway if appropriate.

The managing of individuals with LTC will be supported by the continued development of the following agreed Integrated care Pathways (ICP's)

- Community COPD Exacerbation Management
- Community CHD Exacerbation Management
- Community Diabetic Care
- Specialist Wound Care Management
- Community Neurological Exacerbation Management
- Community Rheumatology Exacerbation Management
- Community Uro gynaecology clinics
- Intermediate care bed admissions

In making the decision to employ a further 6 Community Matrons the service will be able to extend its support to a further 360 individuals. By doing so the service will then be proactively managing the care provided to 720 patients.

#### **CASE STUDY 1: DELIVERING CARE CLOSER TO HOME –**

*In a routine follow-up visit the Clinical Nurse Specialist for Multiple Sclerosis assessed a patient as having evidence of a relapse in her MS.*

*Within 24 hours the nurse was able to commence the patient on the Community Intravenous Care Pathway.*

*The patient was treated in her own home allowing her to stay with her family and avoiding an hospital admission,*

*The community treatment is supported by community therapists who ensure that maximum benefit is gained from the intervention*

#### **d. Unscheduled care (Levels 1, 2 &3)**

Inevitably there will be occasions when individuals need access to unscheduled care; whether this is a minor injury, illness or exacerbation of chronic conditions.

In recognition that a significant number of people attending A&E Departments and hospital Admission Unit could be managed in community settings including their own homes (supported by local audit) the model of care develops a range of community services including city wide First Contact Practitioners and the provision of a Walk-in Centre. The PCT has adopted a walk in centre to support the South

East locality on a pilot basis since January 2007. In the six months to the period ending the 30<sup>th</sup> June 2007, this service had recorded attendances of 5,680. Once fully functioning it is believed that this service would provide the capacity to deliver 12,670 attendances in a year.

These services are supported by the development of Integrated Care Pathways which enhance the health and social care communities ability to manage patients in their own environments or as close to home as possible.

These include:

- Community Cellulites Pathway
- Community DVT pathway
- WMAS Category C diversion
- Community TIA /minor stroke pathway
- Intermediate care bed admissions

#### **CASE STUDY 2: DELIVERING CARE CLOSER TO HOME –**

*A 68 year old male who attended the Walk-in Centre with exacerbation COPD was seen and examined on arrival by an Advanced Nurse Practitioner who was able to diagnosis and treat with antibiotics and steroids.*

*This was followed up by telephone contact the following day to establish whether onward referral to other community services was necessary.*

*Evidence suggests this intervention prevented an unnecessary hospital admission*

#### **e. End of Life (Level 1)**

The current model of care in Wolverhampton provides a predominantly acute/hospital based service for patients in the terminal phase of their illness. The SSDP service model developed in Wolverhampton will:

- Develop a 24-hour, 7 day a week community team to provide an alternative for patients who wish to remain in their own home during the terminal phase of their illness.

- Provide a single point of access both in and out of hours to ensure a timely response from the community teams in a crisis.
- Ensure the co-ordination of services between the acute, GP's and third sector hospice providers and develop care pathways which deliver this
- Deliver a fully integrated health and social care end of life model to ensure the clinical and social aspects of the service are managed in the most effective and co-ordinated way
- Maximises technology to offer better care at home

The existence of this service will mean that for the first time a dedicated resource to provide end of life care will exist for the people of Wolverhampton. Once established this resource will have the capacity to support 70 patients.

#### **f. Team around the child (Level 1, 2 & 3)**

The model for services in Wolverhampton is focused on services integrated around the child, young person and family, with many teams functioning as integrated teams or delivering care around comprehensive multi agency pathways. Over the last three years ten childrens centres/ sure starts have been developed across the most deprived areas of Wolverhampton and when the SSDP programme is complete there will be a further five, giving a total of fifteen centres.

When children and young people require more comprehensive level 3 care this will be co-ordinated via the city Specialist Health and Social Care Children's Centre (The Gem Centre) which brings together services provided by Wolverhampton City Primary Care Trust and Wolverhampton City Council for children and young people up to the age of 19, including some who may have special needs and/or disabilities.

The focus for delivering services at the Gem Centre is to co-ordinate care around the child, young person or family. Where possible one appointment is offered as a single visit and clinicians work around the Childs schedule.

The Gem centre is key to the development of children and young people's services in Wolverhampton and the close working relationship with the paediatric team at Royal Wolverhampton NHS trust is critical to the success of this facility. Work is underway at identifying care currently delivered in acute hospital setting which through service redesign and new community facilities could lead to a transfer from level 3 (borough wide) to level 2 (neighbourhood) services. This close working relationship across primary and secondary care means that children and families have enhanced access to acute care facilities when required.

#### **DELIVERING CARE CLOSER TO HOME**

*For an autistic child and his family access to services to support them has been vastly improved by the provision of the Children's Centre. The Centre is able to offer a "one stop shop" approach enabling children to be seen by various professionals in one place, during one visit to a facility designed to meet their specific needs. Previously the same level of care may have involved several visits to different premises across the city.*

#### Impact of Community service changes upon Royal Wolverhampton NHS Trust

In introducing the service model, this is complementary to the objective of rescaling the existing hospital facility provided by Royal Wolverhampton NHS Trust on the New Cross site. The Community services development programme does so through initiatives that either:

- reduce admissions,
- reduce the length of stay in the hospital,
- deliver non consultant outpatient attendances in community settings; and
- deliver further services within an Individual's own home.

Confidence in the ability to deliver this programme of work has been possible through the willingness of acute, community and primary care clinicians to become engaged in the development of the new care pathways.

The financial model supporting the SSDP assumes the delivery of new community schemes to be financed through savings realised through reduced expenditure within

secondary care. Table 8 below describes the schemes to be taken forward and their financial implications. (Described in more detail in annex 1)

Table 8 – Activity transferred from Hospital into the Community

Scheme	Transferred Activity	Tariff cost savings £000's	Cost of service £000's
Walk in centre	10,000 A and E attendances	84	45
Cellulitis	84 spells	39	20
Palliative Care	70 spells	138	189
Neurological exacerbation	20 spells	34	45
Minor strokes	53 spells	59	134
COPD Exacerbation	200 spells	257	135
Walk in centre – category C diverts	520	6	
DVT	80 spells	33	22
CHD Exacerbation	300 spells	485	161
Diabetes clinics	264 new 790 follow up outpatient attendances	136	70
Tissue viability	1600 outpatient attendances	114	98
Rheumatology exacerbation	40 spells	59	46
Urogynaecology	384 new and 576 follow up attendances	97	65
INR	4000 follow up outpatient attendances	344	171
Infective endocarditis	Reduced length of stay	69	33
Intermediate care beds	478 spells	586	476
Infrastructure			97
<b>Total</b>		<b>2,540</b>	<b>1,807</b>

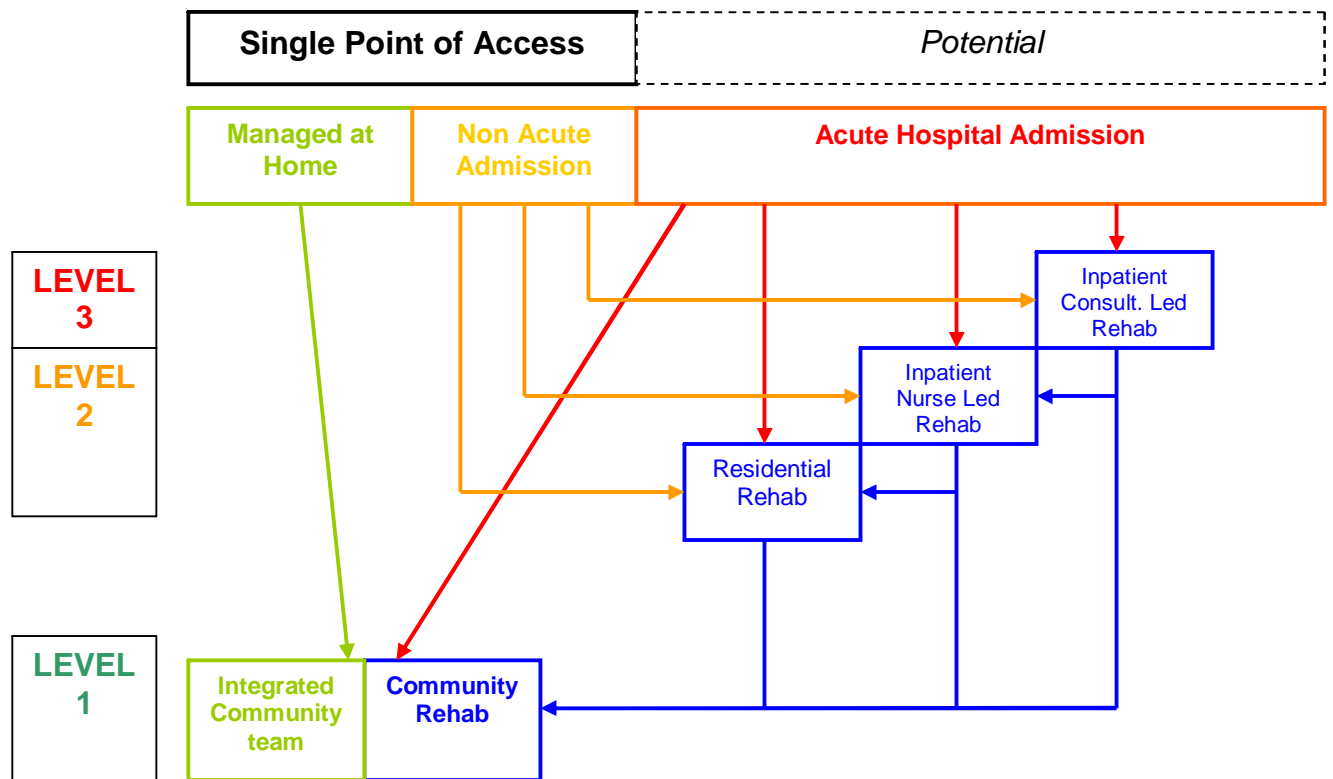
The PCT is presently finalising with RWHT further transfer of care schemes. The targeted cost ultimately of delivering these schemes is £2.2 million, supported by savings from the transfer of care from Hospital into the community amounting to £3.0 million.

### Rehabilitation Services:

The proposed service model for the delivery of community rehabilitation services has been developed in partnership with the City Council and the Acute Trust to ensure the patient pathway is developed to maximise the availability of acute, community in-patient and community outreach services.

The model of care recognises the importance of allowing individuals the opportunity to maximise their function in environments best suited to their needs. A guiding principle being that rehabilitation should take place in an environment away from an acute hospital setting.

The future service model for the delivery of rehabilitation services is described in the diagram below:



**The key characteristics of the model are:**

- Single point of access and triage for all rehabilitation patients
- Direct access via general practitioners to community based inpatients and outreach services
- Dispersal of 18 of the current general elderly community rehabilitation beds based within the West Park community hospital to the three localities, co-located with the social care resource centres.
- Increase in the range of community rehabilitation outreach services to manage more people within their own home

The development of the West Park Community Rehabilitation Hospital and the location of the community nurse-led beds within the three Primary and Community Care Centres will enable the delivery of the described model of service by:

- Providing purpose built rehabilitation facilities for neurological patients, stroke patients and the general rehabilitation of elderly patients on one main community hospital site (level 3)

- Co-locating nurse-led beds within the social care resource centres (to be established within the three PCC's), to enable patients to move closer to home and away from a hospital setting when no medical input is required but the requirement for rehabilitation is still ongoing.(level 2)
- Maximising the additional community services and co-located locality beds to reduce the length of stay within the community hospital. This will enable the rehabilitation service to develop additional capacity to meet the projected increase in demand (over 85's expected to increase by 21% by 2011) and demonstrate value for money. (level 3)
- To fully integrate the model of health and social care rehabilitation and further enhance the outreach services designed to both keep people well and support timely discharge from inpatient settings.(level 1)

In developing the new rehabilitation service model, as illustrated in the tables below the service becomes able to improve its overall level of productivity and increase its capacity to meet the growing needs anticipated as a result of:

- demographic changes, and
- Increased demand arising from the existence of an improved quality rehabilitation service.

Table 9 - Current Provision of rehabilitation services

	Inpatient Spells	Ave. Length of Stay (Days)	Occupied Bed Days	Available beds days	<b>Available Beds</b>
Neuro Rehab	61	52	3152	3650	<b>10</b>
Stroke Rehab	161	45	7185	8030	<b>22</b>
General Rehab	468	46	21528	22661	<b>62</b>

Table 10 - Projected Provision of Rehabilitation services.

	Inpatient Spells	Target Ave. Length of Stay (Days)	Require Available Bed Days (95% occ)	Total Required Available beds days	Required Beds
Neuro Rehab Level 3	71	49	3468	3650	10
Stroke Rehab Level 3	170	45	7629	8030	22
General Rehab Level 3	381	40	15260	16060	44
General Rehab Level 2	335	19	6240	6570	18

**CASE STUDY 3: DELIVERING CARE CLOSER TO HOME –**

*Following a 20ft fall resulting in a traumatic brain injury a 35 year old male was admitted to hospital where he underwent neurosurgery.*

*With the support of the specialist community rehabilitation team he was able to be discharged directly home where the integrated team provided intensive multi disciplinarily input into his own environment supporting a return to family life and ultimately work as an engineer*

c. Secondary Care Activity – Outpatient attendances

In scoping the services to be delivered through the new facilities it has been concluded that the delivery of a substantial proportion of outpatient attendances should be transferred from the existing New Cross Hospital site into a City centre facility and into each of the three localities within the borough. It is estimated that 65,750 outpatient attendances could be delivered in this way.

Table 11 – Distribution of Outpatient attendances transferred from New Cross Hospital site by location

	North East Locality	South East Locality	South West Locality	City Centre locality	<b>Total</b>
Volume of outpatient attendances transferred.	8,520	10,390	7,700	39,140	<b>65,750</b>

Table 12 – Distribution of Outpatient attendances transferred from New Cross Hospital site by speciality

	First Attendances	Review attendances	Total attendances
General Surgery	980	2,010	2,990
Urology	750	2,240	2,990
Trauma and Orthopaedics	1,370	5,700	7,070
ENT	1,630	2,820	4,450
Ophthalmology	3,500	11,660	15,160
Orthodontics	740	2,220	2,960
Dermatology	2,100	8,290	10,390
Rheumatology	710	3,250	3,960
Paediatrics	-	2,200	2,200
Gynaecology	800	1,200	2,000
Endocrinology	290	4,110	4,400
Gastroenterology	300	2,140	2,440
Thoracic Medicine	290	1,870	2,160
General Medicine	870	1,710	2,580
	14,330	51,420	65,750

## 5.0 The Estate and Information Technology implications of the SSDP

Section 4 of this document has described the service case that underpins the SSDP. In this section the document progresses to consider how in responding to these requirements, the PCT will:

- provide new improved facilities, for the services to operate from,
- provide new technologies to enable the services to be offered in a modern way,
- finance the new developments and secure value for money, and
- work with the services to secure the staff to deliver the new services.

### The Proposed developments

To support the delivery of the strategies for Primary Care, Mental Health, Rehabilitation and Community services requires the PCT has determined that there is a requirement to construct a range of new facilities, these being:

- 3 Primary and Community Care centres,
- 3 Mental Health and Community Care centres,
- 5 Primary Care Centres; and
- 1 Community Rehabilitation Centre.

Table 13 – Proposed List of Developments in the SSDP

Facilities	Estimated capital Cost £000's	Estimated Capital cost attributable to the PCT £000's	Floor area	Estimated space utilisation %
Bilston Primary and Community Care Centre	17,761	9,217	5,598	94%
Fifth Avenue Primary and Community Care Centre	12,562	4,764	4,374	94%
West Park Primary and Community Care Centre	15,216	7,834	5,587	90%
Portobello Mental Health and	3,460	2,467	1,091	69%

Community Care Centre				
Showell Circus Mental Health and Community Care Centre	3,437	2,690	1,450	69%
Whitmore Reans Mental Health and Community Care Centre	4,150	3,311	1,750	69%
Warstones Primary Care centre	3,565 (est)	3,565	1,449	Not Available
West Park Community Rehabilitation Hospital	16,228	16,228	6,067	Not Available
Heath Town Primary Care Centre	2,355(est)	2,355	942	Not Available
The Scotlands Primary Care Centre	2,240 (est)	2,240	894	Not Available
Castlecroft Primary Care centre	1,540	1,540	1,101	Not Available
The Royal Primary Care Centre	10,000 (est)	10,000	4,500	Not Available
	92,514	66,211		

The estimated Capital cost of the facilities amounts to £92.5 million, of which £66.2 million of this sum relates to area occupied by the PCT or General Practitioners.

Enclosed as annex B is a more detailed description of the services included within each of the new facilities.

As stated earlier as part of the process of determining the PCT proposals for the SSDP it has been necessary to also configure the Plan so as to safeguard the development funds available to the Local Authority through the Department of Health. The existence of:

- three new Primary and Community Care centres in each of three localities; and
- three new Mental Health and Community Care Centres in each of the localities

ensures that the Local Authority is able to meet the Department of Health requirements.

Determining and gaining acceptance of locations for the new facilities has required local communities and stakeholders to become engaged in the selection of suitable opportunities. To facilitate this a programme of non-financial option evaluations involving local people was carried out. The locations for the developments as reported in table 11 reflect the outcome of this exercise.

The non-financial option evaluation was designed in two stages:

1. a team of stakeholders were brought together to design the evaluation criteria and agree a short list of locations for the proposed developments. This team was made up of both internal and external partners including the PCTs staff side, the Local Authority representatives from Service Groups including Adults and Community, Children and Young People and Regeneration and Environment, RWHT, members of the voluntary sector, primary care contractors, along with locality, provider and commissioner staff.
2. once the first stage was complete, the option evaluation was then taken out across the City to localities to engage the views of local people, tenants and residents associations, locality health and social care staff, regeneration staff, local neighbourhood partnership staff and members, user and interest groups, and contractors. In addition, option evaluation workshops were also held for elected members of the Local Authority.

Both the engagement process and the outcomes were reported to the City's overview and scrutiny committee and the PCT board, prior to formal agreement. In

respect of the six joint developments, reports were also delivered to the City Council's Cabinet for formal agreement.

The impact upon the estate used by the PCT and Primary Care practitioners through the delivery of the SSDP is dramatic. As table 10 show the number of premises providing Primary Care and Clinical services is reduced from 65 to 43.

Table 14 – Comparison of the number of Primary Care and PCT owned Premises

	Total Number of Premises PRE SSDP	Total Number of Premises POST SSDP
North East Locality	26	17
South East Locality	18	13
South West Locality	16	8
Mental Health	4	4
Rehabilitation	1	1
	<b>65</b>	<b>43</b>

and more significantly the number of practices and clinical services operating from buildings exhibiting poor Physical condition and functionality is substantially improved

Table 15 – Physical condition and functional suitability of Premises used by GP Practices and Clinical services.

	Physical Condition PRE SSDP	<b>Physical Condition Post SSDP</b>	Functional Suitability Pre SSDP	<b>Functional Suitability Post SSDP</b>
North East Locality	46%	<b>85%</b>	42%	<b>85%</b>
South East Locality	56%	<b>85%</b>	50%	<b>85%</b>
South West Locality	69%	<b>100%</b>	69%	<b>94%</b>
Rehabilitation	0%	<b>100%</b>	0%	<b>100%</b>
Mental Health	40%	<b>100%</b>	20%	<b>80%</b>
	<b>52%</b>	<b>89%</b>	<b>49%</b>	<b>88%</b>

### Information Technology

The PCT has developed a detailed Information and Communication Technology Strategy and Development Plan with a programme of developments intended to support the implementation of the SSDP. Key streams of work include:

- New ways of working intended to support the models of care – the roll out of mobile devices for clinical staff in order to enable community staff to utilise technology away from traditional office bases. This will include the implementation of the Wide Area Network Strategy.
- Migration of Mental Health and Child Health services from the existing legacy solution to the Connecting for Health reference solution.
- The roll out of electronic access to the single assessment process across all integrated services.
- Sustained support of the e-booking and choice programme, enabling and supporting GP practices to provide additional services including dermatology and vasectomy services.
- Supporting the implementation of Clinical Assessment services, building on the orthopaedic developments to ophthalmology and ear nose and throat services.

- Supporting the rationalisation of the PCTs estate by reduced need for dedicated office space.
- Supporting the roll out of the Electronic Prescriptions Service.

Annex C provides a description of the benefits to be realised by Patients, Staff and the PCT from the IT developments.

## **Financing the SSDP and Achieving value for Money**

### **Financing the SSDP**

As commented in section 2 of this document the PCT has constructed a five-year financial plan, covering the period 2007/8 to 2011/12. This plan demonstrates the underlying financial strength of the PCT.

Table 12 below provides a Source and Applications of Funds statement in respect of Recurrent funds available to the PCT over this period. At the end of the five year period the PCT has a recurrent deficit amounting to £961,000. and has available non recurrent funds amounting to £37.28 million.

### **Tables 16 – Source and Applications of Recurrent funds over the period 2007/8 to 2011/12**

	£000's	% growth
<b>Sources</b>		
Growth Funds – including efficiency savings	35,019	
Secondary Care savings	3,000	
PCT Planned savings schemes	2,140	
Carried forward recurrent budgeted surplus in 2006/7	72	
<b>Total Sources of Recurrent Funds</b>	<b>40,231</b>	<b>10.66</b>
<b>Applications</b>		
Prescribing	(4,446)	10.73
Primary Care	(1,800)	4.02
LIFT Revenue costs	(4,008)	201.91

Secondary Care	(6,748)	4.98
High Cost Drugs and Treatments	(5,500)	64.71
Specialised Services	(8,011)	23.04
Community Services	(2,220)	4.64
Continuing Care	(3,570)	178.59
Learning Disabilities	(1,625)	16.07
Choosing Health Initiatives	(1,630)	67.66
Connecting for Health	(1,530)	127.50
Other	(104)	0.22
<b>Total Applications of Recurrent Funds</b>	<b>(41,192)</b>	<b>(10.92)</b>
<b>Recurrent deficit in 2011/12</b>	<b>(961)</b>	

During this same period the PCT generates substantial Non recurrent funds, as described in table 17.

Table 17 – Non Recurrent funds generated in the period 2007/8 – 2011/12

	£000's
<b>Non Recurrent Funds generated in the period 2007/8 – 2011/12</b>	
2006/7 Top sliced funds returned to PCT	2,940
Planned slippage on LIFT schemes	10,677
Planned slippage on High Cost Drugs and Treatments	1,100
Planned slippage on Choosing health schemes	1,631
Planned slippage on Primary Care Developments	1,180
Planned slippage on Community Service Developments	750
Planned budgeted underspending over the period	18,977
<b>Total Non recurrent funds generated in the period 2007/8 – 2011/12</b>	<b>37,255</b>
<b>Applications of Non Recurrent funds</b>	
2007/8 SHA Top slice adjustment	(3,600)
LIFT Professional and Project Management Fees	(3,020)

<b>Total Non Recurrent Applications in the period 2007/8 – 2011/12</b>	<b>(6,620)</b>
<b>Net Non Recurrent funds generated in the period 2007/8 to 2011/12</b>	<b>30,635</b>
Non Recurrent funds brought forward from 2006/7	6,645
<b><i>Total Non Recurrent funds available to the PCT at the end of 2011/12</i></b>	<b>37,280</b>

Specifically in respect of the Strategic Service Development Plan, the PCT has allowed for:

- Recurrent funding to support community developments amounting to **£2.2 million,**
- Additional recurrent and Non Recurrent monies to transform the use of Information Technology across the PCT and Primary Care – **Cost - £7.485 million**
- Recurrent funding to enable the Primary Care Medical and Non Medical workforce to be expanded – **Cost £1.8 million.**
- Additional Recurrent resources to pay for premises as contained within the SSDP - **£4.009 million;**
- Non Recurrent funds to cover Professional Advisor fees and Management Costs across the period 2007/8 to 2011/12 – **Cost £3.02 million;** and
- Recurrent financial savings from the transfer of care from hospital to community / Primary care amounting to **£3.0 million.**

#### Affording the Recurrent Revenue Costs of the new Premises

Affording the Recurrent Revenue costs new premise developments as contained within the SSDP, requires:

- the reengineering of existing recurrent revenue premises funding (through the rationalization of PCT owned and GP owned premises),

- rental for space occupied by Wolverhampton City Council and the Royal Wolverhampton Hospital NHS Trust; and
- development funding as detailed within the PCT LDP

The PCT financial model demonstrates that the collective use of these resources will fully cover the Annual revenue cost of the new developments.

Table 18 – Financing the SSDP

	£000's
Annual revenue cost of the new developments	10,576
Wolverhampton City Council contribution	(2,775)
GMS Payments – re-engineered	(555)
Outpatient facilities recharge to Royal Wolverhampton NHS Trust	(431)
PCT Capital charges	(1,125)
Reengineered PCT Premises costs	(1,681)
<b>PCT five year plan earmarked Development funding</b>	<b>(4,009)</b>

Detailed attached as annex D.

Wolverhampton City Council has available earmarked funding through the Department of Health as a result of a successful application for PFI credits. This funding is restricted being based upon the revenue costs associated with a £30 million capital development.

The Royal Wolverhampton Hospital Trust has presented information to the PCT detailing the level of outpatient attendances, and sessions it wishes to perform in the three new Primary Care centres. The full cost of constructing and operating this outpatient space is to be charged to the Trust through the PCT.

Whilst satisfied that the programme of developments is affordable, it is also necessary for the PCT to be satisfied that the charges being levied for the premises represent value for money. As a basis for securing value for money the PCT is to commission the opinion of the District Valuer so as to ensure that the respective property rentals are consistent with the rates that ordinarily should be charged for such premises. Further the PCT is also engaging independent financial advisors to undertake benchmarking exercises in respect of the charges being levied for both the premises and facility management services being offered.

Beyond the advice of the District Valuer and the completion of benchmarking exercises, affordability and value for money is also to be achieved through the adoption of competitive tendering as part of the procurement process. To this end it is envisaged that a mix of financing routes may be used to finance the development programme, thus:

	Potential developer
West Park Community Rehabilitation Centre	LIFT
West Park Primary and Community Care Centre	LIFT
Bilston Primary and Community Care centre	LIFT
Showell Park Primary and Community Care centre	LIFT
Showell Circus Mental Health and Community Care Centre	LIFT
Portobello Mental Health and Community Care Centre	LIFT
Whitmore Reans Mental Health and Community Care Centre	LIFT
Warstones Primary Care Centre	LIFT/ 3 <sup>RD</sup> party Development
Scotland Primary Care Centre	LIFT/ 3 <sup>RD</sup> party Development
Health Town Primary Care Centre	LIFT/ 3 <sup>RD</sup> party Development
Castlecroft Primary Care Centre	3 <sup>RD</sup> party Development
Royal Primary Care Centre	Private Developer

The health centre developments, with the exception of the Royal Health centre, are to be procured through a competitive process involving the LIFT Company and any

other potential Third party development companies. This being possible because such developments relate purely to the reprovision of general practice services and in such cases it may be possible for the “exclusivity agreement” with the LIFT Company to be waived. To do so would however require any leases to be held directly with the General Practices as opposed to being with the PCT.

### **Workforce implications from the SSDP**

Ensuring the PCT workforce develops in line with the proposed models of care represents a significant challenge, and it is imperative that the skills competencies and knowledge required for the future are developed in a co-ordinated sustainable way over the life of the plan. The PCT proposes to complete this work using a population centered workforce planning approach working collaboratively with key partners to ensure consistency. This will enable the PCT to match activity with skills, and ultimately, inform workforce plans.

Table 19 below, details the initial proposal for the workforce requirements as they relate to the Transfer of Care Projects described earlier

**Table 19 -Transfer of Care Projects- Proposed workforce**

		Transfer of Acute Activity		New Workforce Plan (Agenda for Change Banding)					
		Admissions	Attendances	2	3	5	6	7	8a
B	Walk in Centre		1000	0.5	2				
	Cellulitis	84							0.25
B	Palliative Care	70			10.8			1	
	Neur Exacerbations	20				0.5	0.5		0.25
	TIA/Minor Stroke	53					0.5	3	
	COPD	200						3	
	CAT C Diverts		520						
	DVT	80							0.25
B	CHD Exacerbation	300				1		3	
	Diabetes		1056	1	1		1		
	Tissue Viability		1620		2.67				1
	Rheum. Exacerbation	40				0.5	0.5		0.25
	Continenence Services		960		2	1			
	INR Services		4000		2	1		1	
	Int. Care Beds	478			1	1	0.5	4	
B	Infective Endocarditis	10				1			
	<b>Total</b>	<b>1335</b>	<b>9156</b>	<b>1.5</b>	<b>21.47</b>	<b>6</b>	<b>3</b>	<b>15</b>	<b>2</b>

The health economy has already evidenced its commitment to its workforce by developing a programme of supporting staff at risk of redundancy at The Royal Wolverhampton Hospital NHS Trust in finding suitable alternative employment within the PCT and providing a comprehensive induction and development programme, and this programme will be sustained over the life of the SSDP to ensure that key skill are retained within the NHS and care workforce.

In addition, the PCT has introduced an Accelerated Development Programme which is a learning programme aimed to create a specialist support worker role which crosses the traditional nursing, therapy and social care boundaries. It was developed to respond to specific staffing needs within integrated teams across the city, and also provides a skills accelerator for local people who would like to access careers within the health and social care sector and are unable to pursue more traditional routes. The PCT is also in the process of developing other support worker roles in other areas, based on the principles outlined above.

These posts will underpin the PCTs commitment to actively contribute more widely to the regeneration of the city, to increase the skill and competency base of local people in general, and to support the development of the staff within the organisation and in partner organisations.

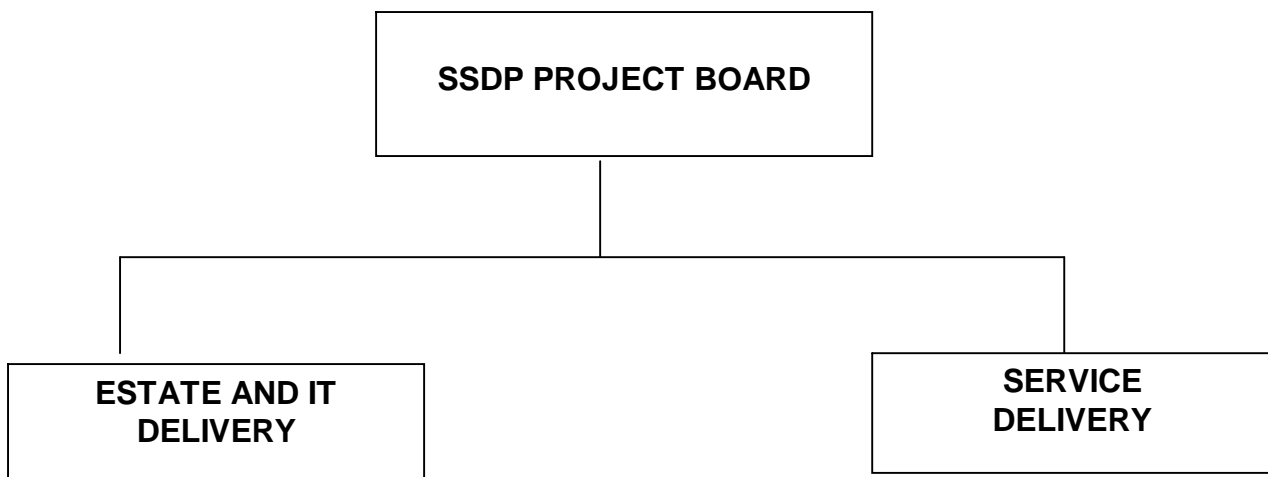
Staff are our biggest asset and Programmes are in place and are being developed to help to:

- develop skills and competencies needed to deliver changing service requirements
- recruit and retain expert, skilled staff
- develop leadership skills
- improve productivity, efficiency and effectiveness
- provide employment opportunities for local people. (especially those from disadvantaged, socially excluded groups)

## **6.0 Managing the implementation of the SSDP**

The PCT has not sought to define the reconfiguration of its estate in isolation from service changes. Whilst this is the correct approach, it means that within the project ‘delivering the SSDP’ what is really required is the implementation of two inter-related projects. The governance arrangements therefore have been developed to reflect this situation.

Notwithstanding the partnership elements of the SSDP that need to exist between the PCT and the Local Authority, the SSDP project requires a transformation of the way in which healthcare services are provided by the PCT and commissioned from Primary Care. For this reason, if the PCT is to maintain tight controls over its performance and management of financial resources, the SSDP project arrangements have needed to allow for tight controls to be exercised “within the PCT”. These PCT project governance arrangements do, by necessity need also to be capable of co-existing with the governance arrangements that the Local Authority have put in place and the formally defined Wolverhampton and Walsall LIFT company structure and in particular the “Strategic Partnership Board”.



### **SSDP Project Board**

To ensure that the two sub projects are delivered in a common, integrated manner, the project board has developed a project plan where the inter-dependencies of the

estate and service delivery changes are recognised, scheduled and performance managed over the duration of the project. A further important role of the project board is to potentially arbitrate in circumstances surrounding the two projects.

### **Service Delivery Board**

The service delivery project board takes full responsibility for the management of service changes that drive the development of the new facilities, in response to service models defined and determined by commissioning strategies. Separate working groups exist for each area of service impacted upon by the SSDP. These groups are:-

- Mental Health Services
- Learning Disability Services
- Community Nursing Services
- Allied Health Professionals
- Rehabilitation Services
- Children's and Families Services
- Older Peoples Services
- Physical and Sensory Disabilities

The product of these workstreams is to:-

- i. Define the service profiles and specification delivered within the care model;
- ii. Determine the operational characteristics of the individual service areas;
- iii. Construct care pathways, that define the roles/responsibilities of secondary care, primary care, social care and community care, within the pathway;
- iv. Specify the operational requirements to be delivered through the new developments;

### **Estate and IT Delivery Board**

The Estate and IT delivery board has responsibility for developing and implementing essential infrastructure to support the new working practices emerging through the clinical service delivery board. Specifically these include the development of:-

- i. New or refurbished premises; and
- ii. IT systems.

#### **- Premises Development**

In taking forward premises development the responsibility of the Estate and IT development board is to:-

- i. Construct outline and full business cases to support the new premises developments;
- ii. Engage and negotiate with third party developers and NHS LIFT to ensure value for money;
- iii. Agree with developers (in conjunction with clinicians) the design, styling layout and functional content of the new premises;
- iv. Negotiation with other parties e. independant, contractors, pharmacists, dental practitioners where such partners are making use of the premises; and
- v. Commission the new buildings and manage the transfer of services into the new premises

#### **- IT Development**

The successful delivery of a model of care where greater emphasis is to be placed upon: the delivery of care within a patient's home, or from secondary care to primary care requires in addition to new working methods a use of more sophisticated IT technologies to facilitate these new working practices. The role of the IT development group is to:-

- i. Construct viable IT strategies to meet the changed working practices as defined by the service delivery board;
- ii. Ensure that the new IT strategies are implemented in accordance with the timescales as defined by the service delivery board.

## **Professional Advisers and Management Support**

The delivery of a project involving the development of twelve new services at a cost of £92 million and new community services with a revenue cost of £2.2 million per annum, is clearly a complex project and if it is to be delivered on time needs to be supported by dedicated project management and professional advice and support. To this end, the PCT is to:-

1. Employ for the duration of the project, a dedicated SSDP Programme manager, who would act as project support to both the Estate and IT delivery boards and the Service Delivery Board. The SSDP Programme Manager has the overall responsibility for managing the delivery of the SSDP project to budget, and within the agreed timescales. In exercising this role the Programme Manager will be supported by dedicated Project Managers and Financial Management support and skilled externally appointed professional advisors.
  
2. Engage professional advisers to:-
  - (i) help test the validity and appropriateness of solutions presented by developers (both financial and non financial);
  - (ii) provide appropriate levels of legal advice and support; and
  - (iii) ensure that the governance requirements, e.g. audit opinions, are followed.

## **Resources**

A budget for professional advisers has been incorporated within the PCT financial plan for the year 2006/7 to 2008/9, and amounts to:-

2007/8	£770,000
2008/9	£250,000
2009/10	£250,000

2010/11	£250,000
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2011/12	£250,000
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Additionally the PCT has allowed for a further £250,000 per year to be able to support the cost of its dedicated in house team across the financial years 2007/8 to 2011/12.

## **7.0 Wolverhampton and Walsall LIFT Company**

This section deals with the management of premises development through the LIFT mechanism and the arrangements that are in place to ensure the successful operation of the local LIFTCo (the public-private Joint Venture entity). LIFT is different to the conventional way of funding public buildings through private finance because the public sector participants are an integral part of a joint venture. Public sector partners can be shareholders in the company and two of the company directors are public sector/*Partnerships for Health* appointments.

Following a formal tendering process initiated in 2002, *Healthcare Improvement LIFT Partnership* was selected to work with public sector partners in Wolverhampton and Walsall. The joint venture *Wolverhampton City and Walsall Ltd (W & W)* was established on 11<sup>th</sup> November 2004, following financial close on the first schemes.

### **The LIFT structure and agreements**

The governance for the W & W LIFT is underpinned by a number of agreements and a formally constituted governing body in accordance with Department of Health guidance.

Details are given in the following subsections.

#### ***Strategic Partnering Agreement (SPA)***

The Strategic Partnering Agreement (SPA) is the agreement which sets out the framework for long-term collaboration and is entered into by *LIFTCo* and local health and social care stakeholders. This is a long term agreement for at least 25 years.

The public sector partners in W & W clearly have an interest with *LIFTCo* in making the SPA work to achieve the W & W LIFT objectives. Both Wolverhampton City Primary Care Trust and Walsall Teaching Primary Care Trust have voting rights under the terms of the SPA. Wolverhampton City Council has signed up to the SPA and is represented as a non – voting stakeholder.

Under the SPA, the W & W PCT's have given *LIFTCo* through an exclusivity agreement the right to carry any PCT-led capital works or developments as contained within the Strategic Service Development Plans of Wolverhampton City PCT and Walsall Teaching Primary Care Trust. This right is only exercisable if the *LIFTCo* is able to demonstrate that their costed plans for completing capital work can be shown to represent value for money.

*LIFTCo* will deliver services through a supply chain of organisations, each of which brings specialist expertise.

The SPA also sets out the *Partnering Services* to be provided by *LIFTCo* (or its supply chain) which may include:

- Assistance with service planning.
- Estate and facilities management.
- Estate planning services.
- Property acquisition and disposal.
- Property development.
- Regeneration and community involvement.

### ***Strategic Partnering Board (SPB)***

Representatives of SPA signatories, both voting and non voting and a representative of *LIFTCo*, make up the Strategic Partnering Board (SPB). There is an independent Chair. The SPB oversees the strategic direction of LIFT locally and is responsible for:

- -Approving the annual SSDP,
- Approving *New Project Proposals* which have been developed by *LIFTCo* in conjunction with the relevant public sector partners and which are in accordance with strategies set out in the SSDP and are affordable and represent value for money.
- -Reviewing the financial and operating performance of *LIFTCo*.

### ***LIFTCo Board***

The *LIFTCo* Board is responsible for the operation of *LIFTCo*. Its structure reflects the relative shareholdings of the partners (as defined nationally by *Partnerships for Health* and reflected in the Shareholders' Agreement). There are three Healthcare Improvement LIFT Partnership Directors, one *Partnership for Health* Director, a PCT-appointed Director and an independent Chair.

PCT's will fund their equity in *LIFTCo* through capital obtained from selling sites. Future schemes will increase the total amount that will need to be borrowed and will require shareholders including the PCT's to make additional purchases of equity. It is likely that future PCT investments will also be funded through the land sales linked to the schemes.

### ***Lease-Plus Agreements (LPA)***

*LIFTCo* will obtain its income from rental of premises to the organisations occupying the buildings. This currently includes the PCT's, GPs and Local Authorities, but in future may also include community pharmacists, opticians or other retail/service outlets or other organizations providing primary care and secondary care services.

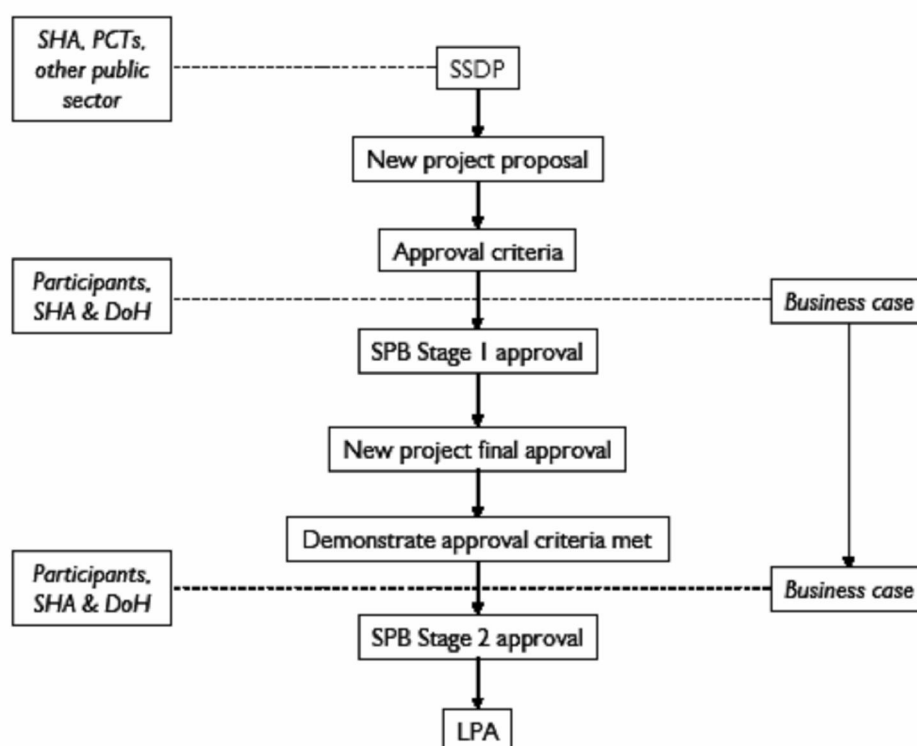
*Lease Plus Agreements (LPA)* are tenancy arrangements made between *LIFTCo* and the relevant public sector tenants. These impose more obligations on the landlord than in a conventional commercial lease providing the necessary security that is needed for delivering modern reliable services in the public sector. Under the current arrangements for public sector funded health services, PCT's take a head

lease from *LIFTCo* and sub lease premises to organizations commissioned by the PCT to provide services.

## Approval process

The process for approving new LIFT projects is set out in the diagram below. Inclusion of a scheme in the SSDP is a statement of intent only. The firm commitment comes when the SPB approves a Stage 1 proposal (see diagram).

Figure 1: Stages in approval for LIFT schemes



As this diagram shows, the Strategic Service Development Plan (SSDP) sets the broad strategic context for investments and short, medium and longer term objectives. The *New Project Proposal* gives the NHS participants sufficient information about the proposed scheme to enable them to make a properly informed decision against agreed criteria by which the scheme can be accepted in terms of:

- Service delivery (in line with the SSDP).
- Affordability.
- Value-for-money.

At the same time as a *New Project Proposal* is prepared for approval by the *Strategic Partnering Board*, a business case is developed by the PCT for approval by the Strategic Health Authority.

## **8.0 Risk Assessment**

The Wolverhampton City PCT Strategic Service Development Plan is a complex project requiring a transformation in the way that Primary, Community and secondary healthcare is provided for the residents of Wolverhampton. To be delivered the plan necessitates that a number of organisations from within the Public Sector and Private Sector work successfully together. For Wolverhampton City PCT the management of the SSDP requires first an understanding and recognition of the risks implicit in the project and a set of actions to address these risks. Accordingly, this section of the SSDP document provides a brief description of the key risks impacting upon the project and the actions being prescribed to handle these risks.

### **Partnership working between the PCT and the Local Authority**

Contained within the SSDP are six developments being taken forward jointly between the PCT and the Local Authority. For these six schemes to progress effectively there needs to exist within each organisation an understanding of the differing decision making processes of the two organisations and their associated authorisation / approval processes.

To facilitate this understanding the SSDP has established a joint PCT / Local Authority project management structure as described in section 6 of this document. This project management structure allows for the existence of Joint Estates and IT and Service Delivery Boards. Both boards report into a joint SSDP board, charged with the task of arbitrating in circumstances of disagreements and progress managing the SSDP project plan. Beyond these mechanisms the PCT / Local Authority officers provide regular updates to Local Authority members through the Local Authority Special Advisory Group and Health Scrutiny committee and to PCT Non executives through its PCT Board.

### **Affordability**

The PCT needs to ensure that in committing to the SSDP that it has an available level of resources to meet the revenue costs arising from the development. Further the PCT needs to be satisfied that the costs associated with the construction of the new facilities and the ongoing running costs will allow for the PCT to be provided with new facilities that meet fully its requirements.

Whilst the level one LIFT approval stage process affords the PCT protection of an agreed affordability cap to take forward into final contractual negotiations, the PCT has also at this stage constructed a Public sector comparator of the construction costs and committed to undertaking a comprehensive financial review of the lifecycle costs, facilities management costs and the structure of the financial deal. Through these exercises the PCT is then able to determine whether the proposition made through the LIFT Company is robust and sustainable. This work is being handled for the PCT through external advisors, selected from a nationally approved list, though subjected to a local tendering process.

### **Staff Recruitment**

The expansion of community services to enable the models of care for Community, Mental Health and Rehabilitation services requires the PCT to recruit a further 48.97 whole time equivalent staff.

To enable these staff to be recruited the PCT has established a dedicated Human Resource team working across both the PCT and the City Council to develop workforce plans, handle the recruitment process and construct and deliver the new Accelerated Development Programme. It is recognised that the new models of care delivery will impact directly upon the local Secondary care provider RWHT. Through proactive Human Resource management it is intended to secure a substantial portion of the PCT's increased community service workforce through the retraining of staff within the Wolverhampton Health economy.

### **General Practitioners support**

Key to the delivery of the PCT is the grouping of existing General Practitioners practices into larger General practice Units, this provides for greater resilience in the delivery of primary care and allows for resources to be recycled to help pay for the new developments.

In developing these plans the PCT has actively engaged with General Practices, sharing knowledge of the locations for new developments and significantly how the individual practices are to be consolidated into larger collective units. At the stage one LIFT process General Practitioners affected by the changes have been required to formally express their support. Full support has been obtained in all cases.

Beyond stage one the PCT has committed to engaging General Practitioners fully in the operational arrangements of the new developments, and the design of the buildings.

### **Negative equity**

It is recognised that where General Practitioners would be required to transfer their practices into the new facilities, there may exist for some practices a difference between the valuation placed upon their premises by the District Valuer and the value presented by a commercial Valuer, basing their value of the practice as an ongoing business.

A comprehensive review of the facilities affected by the SSDP has been undertaken, which has categorised practice buildings into those where:

- the practice is a sub tenant of a PCT owned building,
- the practice operates from a building that is easily able to be converted into an alternative use (most often residential dwelling) ; and
- the practice operates from a building that is not easily able to be converted.

From the review only two practices affected by the SSDP could be classified as operating from a building where conversion was not possible and hence negative equity could become a recognisable problem.

A potential negative equity value of £500,000 has been placed upon these two practices. The PCT is presently maintaining a reserve to cover such a cost.

### **Transfer of Care savings**

The PCT is funding new community services amounting to £2.2 million across the two years 2007/8 and 2008/9 funded through savings realised from reduced activity performed within the Royal Wolverhampton NHS Trust. A potential risk is that the level of savings needed to support these new developments may not be sufficient.

The PCT has handled the Transfer of care savings risk through:

- Validating its level of savings independently through the RWHT. This exercise determined that based upon the new community schemes being established RWHT believed that the level of reduced Income would be £3.06 million, a difference of £60,000,
- In determining the level of savings the PCT has deliberately adopted a prudent approach to determining the level of impact upon RWHT,
- The PCT has recognised that a lag will exist between the implementation of the new community services, and the savings being generated from RWHT. The PCT financial plan assumes that savings will commence in the 2008/9 financial year, but will not flow through in full until the 2009/10 financial year,
- Establishing a transfer of care project board comprising of clinicians from Primary / Community care and secondary care, to plan and develop sustainable new care pathways,
- Engaging with Practice Based Commissioners to ensure that the newly developed community services are consistent with the plans being developed by Locality commissioners.

### **Land Availability**

The PCT in developing its SSDP determined the location for new facilities based upon a consultation exercise with key stakeholders in each of the three City

localities. This exercise deliberately requested stakeholders to indicate their preferences for locations without reference to site availability, giving the PCT or its developers the task of responding to the wishes of the local community. A risk to the PCT is that it becomes impossible to identify land to support the developments in the areas as requested.

Contained within the SSDP are twelve new developments, at the time of writing this document, the PCT has been able to secure land to support ten of these developments. Land is therefore still being sought for developments within the Scotlands and at Warstones. The PCT is now a member of the Capital Asset Management Group (CAMG) of the local Authority. CAMG acts as the consultation and contact point for the advancement of improved asset management within the Council. This group is also responsible for the management and implementation of the Council's Asset Management Plan and Capital Strategy, which will work with the Local Strategic Partnership in identifying partner's asset management aspirations.

### **Operational Capacity / Programme of Developments**

The PCT is still developing its programme of developments and as such has requested that the LIFT Company provide its costed proposals on the assumption that all developments occur on an individual basis. That said the initial plans as produced by LIFT Co would have a development programme where all twelve new developments were being implemented over a five year period from 2008/9 to 2012/13. At its peak this would then mean that in the year 2010/11 all twelve developments would be at a state of construction.

In agreeing to a final programme of work for the SSDP the PCT recognises that it is necessary for the development programme to progress without hindering the continued delivery of community and Primary care services. This being so, the PCT is developing decant proposals potentially involving the use of accommodation available through RWHT at its New Cross Hospital site, Independent contractors and spare capacity within the PCT owned asset base.

### **Volume of activity (Scaleability)**

In developing the SSDP to support the provision of healthcare into the future, it is clearly necessary for any such proposals to be able to respond to changes impacting in the future that are not capable of being quantified with certainty today. More specifically the proposals need to be capable of responding to changes in the activity volumes being delivered and in the types of activity being delivered.

In respect of Community, Mental Health and Rehabilitation services the establishment of a model of services based upon three tiers means, as described in section 4, suggests that for these services any future expansion in the volume of activity is likely to require the service to respond by providing more care at the level 1 level, in a person's home environment. As a result whilst this could be expected to create challenges for the services in the direct recruitment of staff, it is not believed that this would necessitate an expansion in the level of physical accommodation required to deliver care at levels 2 and 3. (Indeed, as part of re-shaping these three services into these categories, the SSDP now requires less accommodation to be available to support the delivery of care than is presently the case).

For Primary Care, the increased opportunity to deliver care locally as opposed to in a hospital setting into the future, reinforces the requirement for the new developments when in place to be constructed in a form that is easily capable of modification. The design brief therefore for all such buildings will be to ensure that the structure of the buildings does not compromise the services' ability to respond to new opportunities. It will be the role of the PCT Technical advisors in agreeing to any plans as presented by the developers to ensure that this is the case.

### **Project Management**

As stated previously the SSDP is a complex project. The governance processes as they exist for the project and the ongoing management arrangements are described in section 6. Clearly in such a project, over its duration new and unexpected

challenges and opportunities will emerge and will need to be responded to. The PCT recognises however that if the project is to be managed in a controlled manner, then it needs to do so by reference to a tried and tested Project Management Methodology. For this reason the PCT will be endorsing the application of PRINCE 2 as its preferred project management Tool.

## **9.0 The Product of the Strategic Service Development Plan**

In taking forward this SSDP, the PCT is then able to;

- **Primary Care Resilience** – Introduce greater resilience into the operational delivery of Primary Care services, through grouping the existing practice base into larger units. In doing so this reduces the number of single handed General Practitioners working in the city from 20 to 7.
- **Primary Care Training** – Deliver training programmes through two new facilities to enable the PCT to be able to better secure a Primary Care Clinical and non clinical workforce for the future.
- **Advanced / Enhanced services** – Provide facilities to enable Advanced and Enhanced services to be provided more consistently across three localities.
- **Mental Health National Service framework** – Deliver against the Mental Health National Service framework and Social Inclusion strategy, through the co-location of mental health, community and primary care services.
- **Preventative Mental health care** – Establish capacity within mental health services to enable the needs of mental health patients to be contained more effectively within Primary care
- **Closer to home** – Support the PCT strategy of shifting the delivery of care closer to a patients home environment.
- **Integrated health and Social Care** – Bring together primary, community and social care services supported by the single assessment process and single point of access to deliver more closely integrated services

- **Preventative measures** – Assist patients in better understanding and managing their care through the co-location of health and social care information services and a range of health promotion services
- **Rescaling of New Cross Hospital** – Complement the work undertaken by the Royal Wolverhampton NHS Trust in reducing the number of beds on the New Cross Hospital site, through the provision of capacity to enable the re-provision of clinical activity by Primary Care and Community services.
- **Community Rehabilitation** - Improve the delivery of Rehabilitation services provided for stroke, elderly and neurological patients by providing Facilities to provide a new care Pathway delivered through Integrated health and Social care services,
- **Future sizing** – Improve the efficiency of the existing Community Hospital and in so doing increases the capacity of the Rehabilitation service to meet the growing demands being placed on the service.
- **Affordability** – Achieve the improvements in Primary Care, Mental health and Community services and facilities within an envelope of resources that is affordable to the PCT., and safeguards the new resources being made available to the Local Authority.
- **Estate Infrastructure** – Dramatically improve the Physical environment through which Primary Care, Mental Health, Community and Rehabilitation services are provided in Wolverhampton.
- **New ways of working** – Equip clinical staff to be provided with the access to new Information Technology needed to enable fast, responsive and flexible care to be provided in the 21<sup>st</sup> Century.
- **Human Resources** – Through the careful management of workforce across the health economy allow for the repatriation of staff from the acute sector into the new opportunities being afforded within the new services provided in Primary and Community care.

- **Regeneration** – Support the broader regeneration objectives for the city of Wolverhampton through investing in local construction and service industries and developing new facilities in targeted areas for regeneration.

**SSDP – Transfer of Care Proposals – Phase One, Three Year Programme**

	Condition	Scheme	Community Delivery	Admissions/ Attendances	Tariff Cost	Transfer Costs	Savings
<b>YEAR 1 2006/2007</b>	<b>WALK-IN-CENTRE</b>	Reduces A&E attendances	Phoenix Health Centre	1. 40-per day 2. Extended hours = TBD	£84,240	£45,129	£39,111
<b>YEAR 1 2006/2007</b>	<b>INFRASTRUCTURE</b>	Single Point of Access (Extension)				£0	£0
<b>YEAR 2 2007/2008</b>	<b>CELLULITIS Uncomplicated</b>	Prevents in-patient admission	Patient's Home	84-per year	£39,060	£19,850	£19,210
<b>YEAR 2 2007/2008</b>	<b>PALLIATIVE CARE</b>	Prevents in-patient admission (EAU) and reduces length of stay	Patient's home	70-per year	£137,708	£188,899	-£51,191
<b>YEAR 2 2007/2008</b>	<b>NEUROLOGICAL EXACERBATION (IV STEROIDS/P HYSIOTHERAPY) Multiple Sclerosis</b>	Prevents in-patient admissions	Patient's Home	20-per year	£34,356	£44,717	-£10,361
<b>YEAR 2 2007/2008</b>	<b>TIA / MINOR STROKES COMMUNITY STROKE SERVICE</b>	Prevents in-patient admissions  Supports the stroke community service and completes stroke ICP  Supports implementation of NSF older people and sentinel audit	Patient's home (requires direct access diagnostics)	53 per year	£58,645	£133,936	-£75,291

<b>YEAR 2 2007/2008</b>	<b>COPD Exacerbation</b> Uncomplicated	Prevents in-patient admission – management of long term condition	Patient's Home	200 per year	£257,000	£134,996	£122,004
	<b>Condition</b>	<b>Scheme</b>	<b>Community Delivery</b>	<b>Admissions/ Attendances</b>	<b>Tariff Cost</b>	<b>Transfer Costs</b>	<b>Savings</b>
<b>YEAR 2 2007/2008</b>	<b>WALK-IN-CENTRE</b>	Diverts Category C "999" calls	Phoenix Health Centre	Category C diverts 2 per day = 520pa	£5616	£0	£5616
<b>YEAR 2 2007/2008</b>	<b>INFRASTRUCTURE</b>	Clinical Skills Facilitators					

	<b>Condition</b>	<b>Scheme</b>	<b>Community Delivery</b>	<b>Admissions/ Attendances</b>	<b>Tariff Cost</b>	<b>Transfer Costs</b>	<b>Savings</b>
<b>YEAR 3 2008/2009</b>	<b>DVT</b> Uncomplicated without diabetes	Prevents in-patient admission	Patient's Home	80-per year	£33,200	£21,850	£11,350
<b>YEAR 3 2008/2009</b>	<b>CHD Exacerbation</b> - Heart Failure - Unstable Angina	Prevents in-patient admission – management of long term condition	Patient's Home	300-per year	£484,822	£161,234	£323,588
<b>YEAR 3 2008/2009</b>	<b>DIABETES CLINICS</b> Out-patient, uncomplicated IDDM	Prevents out-patients (New & Review)  Supports model of care for diabetes	Community Clinics	264 new per year 792 follow up per year	£136,488	£70,215	£66,273

<b>YEAR 3 2008/2009</b>	<b>TISSUE VIABILITY SERVICES (Derms / Vascular)</b> Dermatology Vascular Out-Patients	Prevents out-patients attendances reviews	Community Clinics	900 per year (Dermatology)  720 per year (Vascular)	£113,940	£98,046	£15,894
<b>YEAR 3 2008/2009</b>	<b>RHEUMATOLOGY EXACERBATION (IV STEROIDS / PHYSIOTHERAPY)</b> - Rheumatoid arthritis - Osteoarthritis	Prevents in-patient admissions	Patient's Home	40-per year	£58,916	£45,717	£13,199
<b>YEAR 3 2008/2009</b>	<b>OUTPATIENTS UROGYNAE FOR CONTINENCE ISSUES</b>	Prevents unnecessary out-patients	Community Clinics	384 New 576 Follow up	£96,768	£65,426	£31,342
	<b>Condition</b>	<b>Scheme</b>	<b>Community Delivery</b>	<b>Admissions/ Attendances</b>	<b>Tariff Cost</b>	<b>Transfer Costs</b>	<b>Savings</b>
<b>YEAR 3 2008/2009</b>	<b>INR SERVICES</b>	Prevents Ward Attendances  Supports existing community based model of care	Community Clinics & patient's homes	4000 follow up attendances	£344,000	£171,091	£172,909
<b>YEAR 4 2009/2010</b>	<b>INFECTIVE ENDOCARDITIS (IV Therapy)</b>	Reduces length of stay	Patient's home	10-per year	£68,620	£32,738	£35,882
<b>YEAR 4 2009/2010</b>	<b>INTERMEDIATE CARE BEDS AND NURSING HOME HOSPITAL AVOIDANCE</b> - UTI's - Chest Infection	Prevents EAU/general elderly admissions (UTI's, chest infections, falls)	Re-distribution of beds – to include nurse-led	UTI 119 per year Chest Infection 131 pa Falls 228 pa	£586,097	£476,396	£109,701

	- Falls						
<b>GRAND TOTAL</b>					<b>£2,539,476</b>	<b>£1,710,240</b>	<b>£829,236</b>

## SERVICE LOCATION BY DEVELOPMENT

Annex 2

### SOUTH WEST LOCALITY

#### West Park Primary and Community Care Centre

GP Practices	Team Base	Direct Access	Clinics	Bookable Rooms	PT Education	Resource Centre	PCT Rehab
X 4	SW DN Team Base	Dental Wheelchair Access	TV Clinics	Addiction Services	Foot Health	18 IC Beds	6 Nurse Beds
	Domiciliary Gatekeeping	Foot Health	Cont Clinics		Audiology	10 Respite Beds	
	Access and Care Man Teams		Diab Clinics			Day Centre	
			CAMH Clinic			Info Shop	
			Com Paeds Clinic			Carers Support	
			Older People OP				
			Rehab Outpatients				

#### Whitmore Reans Mental Health Resource Centre and Community Health Centre

GP Practices	Team Base	Direct Access	Clinics	Book Rooms	PT Education	MH Services
X 3	Phleb INR Team Base		Phleb	Addiction Services	Foot Health	Adult CMHT
	Health Visitors		INR		Audiology	Adult Day Services
	School Nursing		School Nursing			Adult Out Pt
						Older People CMHT
						Carers Support

### Warstones Health Centre

<b>GP Practices</b>	<b>Team Base</b>	<b>Direct Access</b>	<b>Clinics</b>	<b>Book Rooms</b>
X 2	SW DN Man Base	Physio MSK	Cont Clinics	Audiology Vol Clinic
	Health Visitor	Foot Health	Diab Clinics	SLT
	School Nursing		Phleb	
			INR	
			Com Paeds Clinic	
			School Nursing	

Annex B

**SOUTH EAST LOCALITY**

**Bilston Urban Village Primary and Community Care Centre**

<b>GP practices</b>	<b>Team Base</b>	<b>Direct Access</b>	<b>Clinics</b>	<b>Bookable Rooms</b>	<b>PT Education</b>	<b>Resource Centre</b>	<b>PCT Rehab</b>
X 7	SE DN Team Base	Dental	TV Clinics	Addiction Services	Foot Health	18 IC Beds	6 Beds
	Dom Gatekeeping	Foot Health	Cont Clinics	Audiology Vol Clinic	Audiology	10 Respite Beds	
	Access and Care Man Teams	Physio MSK	Diab Clinics	SLT		Older People Centre	
	Health Visitors		INR Clinic	TPU		Info Shop	
	School Nursing		School Nurse Clinics			Carers Support	
			Older People OP				
			CAMH Clinic				
			Com Paeds Clinic				

**Portobello Mental Health Resource Centre and Community Health Centre**

<b>GP Practices</b>	<b>Team Base</b>	<b>Direct Access</b>	<b>Clinics</b>	<b>Book Rooms</b>	<b>PT Education</b>	<b>MH Services</b>
X 1			Diabetic Clinic	Addiction Services		Adult CMHT
						Adult Day Services
						Adult Out Pt
						Older People CMHT
						Carers Support

**NORTH EAST LOCALITY**

**Fifth Avenue, Showell Park Primary and Community Care Centre**

<b>GP practices</b>	<b>Team Base</b>	<b>Direct Access</b>	<b>Clinics</b>	<b>Bookable Rooms</b>	<b>PT Education</b>	<b>Resource Centre</b>	<b>PCT Rehab</b>
-	NE DN Team Base	Dental	TV Clinics	Addiction Services	Foot Health	18 IC Beds	6 Beds
	Dom Gatekeeping	Foot Health	Cont Clinics	Audiology Vol Clinic	Audiology	10 Respite Beds	
	Access and Care Man Teams	Physio MSK	Diab Clinics	SLT		Day Centre	
			INR Clinic			Info Shop	
			School Nurse Clinics			Carers Support	
			Older People OP				
			CAMH Clinic				
			Com Paeds Clinic				

**Showell Circus Mental Health Resource Centre & Community Health Centre**

<b>GP practices</b>	<b>Team Base</b>	<b>Direct Access</b>	<b>Clinics</b>	<b>Book Rooms</b>	<b>PT Education</b>	<b>MH Services</b>
X 4				Addiction Services		Adult CMHT
						Adult Day Services
						Adult Out Pt
						Older People CMHT
						Carers Support

### Heathtown Community Health Centre

<b>GP practices</b>	<b>Team Base</b>	<b>Direct Access</b>	<b>Clinics</b>	<b>Book Rooms</b>
X 3	Health Visitors		Phleb	Audiology Vol Clinic
			Comms Paeds Clinic	TPU

### Scotlands Medical Centre

<b>GP practices</b>	<b>Team Base</b>	<b>Direct Access</b>	<b>Clinics</b>	<b>Book Rooms</b>
X 4		Physio MSK	CAMH Clinic	SLT
			Comms Paeds Clinic	Addiction Services

## CITY WIDE SERVICES

### West Park Hospital

Services	
Neuro Rehab Beds	Direct Access single use
Stroke Beds	Physio MSK, OCAS
General Rehab Beds	
AHP Outpatients Rehab	
Specialist Rehab Teams	

## Annex C

### Benefits Realised through the Delivery of the IT strategy.

Area	What	How	When
<b>Patient</b>	<ul style="list-style-type: none"> <li>• Improved provision of care</li>   <li>• Timely receipt of clinical correspondence, e.g. appointment letters</li> </ul>	<ul style="list-style-type: none"> <li>• Better access to information relating to clinical interventions made by other services</li> <li>• Co-ordination of appointments across services through structured clinics and diary management functionality</li>   <li>• P1R1 is linked to the national demographics service providing reliable demographic details (including NHS Number, GP details and address)</li> <li>• Reduction in misdirected clinical correspondence by 5% (based on estimates of invalid GP Practice Code on patient records)</li> <li>• Electronically managed clinics will increase from 1 to 5 improving the time taken for appointments letters to be produced and sent</li> </ul>	<p>Q2 2007 (onwards)</p> <p>Q2 2007 (onwards)</p>
<b>Staff</b>	<ul style="list-style-type: none"> <li>• Improved quality of deployed PCs, e.g. modern PCs replacing out-dated PCs</li>   <li>• Improved access to information, e.g. the ability to view all clinical interventions by PCT staff with the patient</li>   <li>• Improved administrative processes to support the delivery of care, e.g. diary / clinic management</li>   <li>• Improved staff IT literacy</li>   <li>• Reduced duplication of electronic patient records</li> </ul>	<ul style="list-style-type: none"> <li>• Baseline specification of existing PCs (An estimation of 300 PCs will meet modern specifications for this deployment)</li> <li>• Faster system response times, typically screen refresh times are 10 seconds+, modern PCs will reduce this to 5 seconds or less</li>   <li>• Through improved data capture processes and reporting tools, PCT staff will have access to this "holistic" view of patient activity and treatment</li>   <li>• Through improved data capture processes and reporting tools, the count of services currently electronically managed clinics will increase from 1 (Foot Health) to 5.</li>   <li>• All potential user's to be at, or have completed basic IT training module (3 hours) – count of the number of certificates issued</li> <li>• 15% of end user's to have completed ECDL Part 1</li>   <li>• NHS No. currently at 59% on existing community system (HMT),</li> </ul>	<p>Q2 2007 (onwards)</p> <p>Q2 2007 (onwards)</p> <p>Q2 2007 (onwards)</p> <p>Q2 2007 (onwards)</p>

	<p>through a centralised strategic approach to community information systems</p> <ul style="list-style-type: none"> <li>• Improved use of clinical staff time</li> <li>• Access to a single patient record incorporating all historic paper-based documentation through a single system</li> </ul>	<p>number to be increased to 95% to support a single electronic record per patient</p> <ul style="list-style-type: none"> <li>• Reduction in DNA rates for clinic-based community appointments</li> <li>• Reduction in the number of “failed” home-visits</li> </ul> <p><i>(Data to support both these metrics is currently not collected – to demonstrate, a baseline assessment using the existing systems will need to happen and then compared with the new system)</i></p> <ul style="list-style-type: none"> <li>• Centralised electronic document management (EDM) will allow traditional paper-based documentation (e.g. case notes or referral letters) to be scanned and attached / accessed through a single system</li> </ul> <p><i>(An options appraisal exercise will need to be completed to select the most appropriate and affordable solution available)</i></p>	<p>Q2 2007 (onwards)</p> <p>Q2 2007 (onwards)</p>
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<p><b>Organisation</b></p>	<ul style="list-style-type: none"> <li>• Better use of staff time</li>   <li>• improved reporting and timely information to support caseload and clinic management</li>   <li>• provide a foundation electronic care records and reducing paper flows through the organisation</li>   <li>• able to review workforce resources / caseload management</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in DNA rates for clinic-based community appointments</li> <li>• Reduction in the number of “failed” home-visits</li> </ul> <p><i>(Data to support both these metrics is currently not collected – to demonstrate, a baseline assessment using the existing systems will need to happen and then compared with the new system)</i></p> <ul style="list-style-type: none"> <li>• Improved data capture processes and reporting tools will minimise the number of occurrences where multiple appointments are booked concurrently</li>   <li>• Provide a mechanism to capture activity and caseload management information which can then be reported as required</li>   <li>• Centralised electronic document management (EDM) will allow traditional paper-based documentation (e.g. case notes or referral letters) to be scanned and attached / accessed through a single system</li>   <li>• Access to the existing caseload management information for managers is manual, by providing access to computers and training, managers will be able to access this information electronically. 50% in year 1, increasing to 90% year 2</li> </ul>	<p>Q2 2007 (onwards)</p> <p>Q2 2007 (onwards)</p> <p>Q2 2007 (onwards)</p> <p>Q2 2007 (onwards)</p>
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**Annex D**

**Funding of Properties in SSDP**

	Total Revenue Cost £000's	Wolverhampton City Council £000's	Outpatient Recharge £000's	Savings from Current Properties £000's	LDP Identified Funding £000's
Fifth Avenue Primary and Community Care Centre	1,293	805	89	-	399
Bilston Primary and Community Care Centre	1,650	798	73	269	510
West Park Primary and Community Care Centre	1,752	856	64	82	750
Showell Circus Mental Health and Community Care Centre	422	92		239	91
Portobello Mental Health and Community Care Centre	388	111		110	167
Whitmore Reans Mental Health and Community Care Centre	560	113		227	220
West Park Community Rehabilitation Centre	2,223			1,450	773
Warstones Primary Care Centre	487			148	339
Scotlands Primary Care Centre	300			149	151
Heath Town Primary Care Centre	317			97	220
Royal Primary Care Centre	959		205	543	211
Castlecroft Primary Care Centre	226			48	178
	<b>10,576</b>	<b>2,775</b>	<b>431</b>	<b>3,362</b>	<b>4,009</b>