NHS
Wolverhampton
Clinical Commissioning Group

Primary Care Commissioning Committee (PUBLIC)

Tuesday 3rd September 2019 – 1:30pm to 3.30pm

PA125 Stephenson Room, 1st Floor, Technology Centre, Wolverhampton Science Park WV10 9RU

A G E N D A

1.	*Welcome and Introductions*		*Chair*	*Verbal*
2.	*Apologies*		*Chair*	*Verbal*
3.	*Declarations of Interest*		*Chair*	*Verbal*
4.	*Minutes of Previous Meeting 2nd July 2019*		*All*	*Enc 4*
5.	*Matters Arising From Previous Minutes*		*Chair*	Verbal
6.	*Committee Action Points*		*Chair*	Enc 6
7.	***Primary Care Update Reports***			
7a	*Q1 Finance Report Apr-Jun 2019*	*A*	*Tony Gallagher*	*Enc 7a*
7b	*Primary Care Quality Report*	*A*	*Liz Corrigan*	*Enc 7b*
7c.	*Primary Care Operational Management Group Update*	*A*	*Mike Hastings*	*Enc 7c*
7d	*Primary Care Contracting Update*	*A*	*Gill Shelley*	*Enc 7d*
7e	*Merger of Parkfields Medical Centre with Grove Medical Centre (Health & Beyond Partnership)*	*D*	*Gill Shelley*	*Enc 7e*
7f	*Quarterly Primary Care Assurance Report*	*D*	*Sarah Southall*	*Enc 7f*
7g	*STP Primary Care Strategy*	*D*	*Sarah Southall*	*Enc 7g*
7h	*STP GP Forward View Programme Board update*	*A*	*Sarah Southall*	*Verbal*
8.	***Any Other Business***			

Date of Next Meeting:

To be confirmed

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WOLVERHAMPTON CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Minutes of the Primary Care Commissioning Committee (PUBLIC)
Tuesday 2 July 2019 at 2.00pm
PA125 Stephenson Room, Technology Centre, Wolverhampton Science Park WV10 9RU

MEMBERS ~

Wolverhampton CCG ~

Name	Position	Present
Sue McKie	Chair (voting)	Yes
Les Trigg	Lay Member (Vice Chair) (voting)	Yes
Steven Marshall	Director of Strategy & Transformation (voting)	Yes
Sally Roberts	Chief Nurse & Director of Quality (voting)	No
Dr Salma Reehana	Clinical Chair of the Governing Body (non-voting)	No
Dr David Bush	Locality Chair / GP (non-voting)	No
Dr Manjit Kainth	Locality Chair / GP (non-voting)	No

NHS England ~

Bal Dhami	Senior Contracts Manager – Primary Care, NHSE	Yes

Non-Voting Observers ~

Tracy Cresswell	Wolverhampton Healthwatch Representative	No
John Denley	Director of Public Health	No
Dr B Mehta	Wolverhampton LMC	No
Jeff Blankley	Chair of Wolverhampton LPC	No

In attendance ~

Helen Hibbs	Chief Officer (WCCG)	Yes
Liz Corrigan	Primary Care Quality Assurance Co-ordinator	Yes
Mike Hastings	Director of Operations (WCCG)	Yes
Peter McKenzie	Corporate Operations Manager (WCCG)	Yes
Claire Morrissey	Strategic Transformation Manager (WCCG)	Yes
Sarah Southall	Head of Primary Care (WCCG)	Yes
Gill Shelley	Primary Care Contracts Manager (WCCG)	Yes
Awa Jallow	Work Experience Student (Observer)	Yes

Welcome and Introductions

WPCC530 The Chair welcomed attendees to the meeting and introduced Awa Jallow who was shadowing Ms Corrigan as part of her work experience placement with the CCG.

Apologies

WPCC531 Apologies were received from Sally Roberts, John Denley and Dr Ankush Mittal (who was due to attend on John Denley's behalf), Jeff Blankley and Drs Bush, Reehana and Mehta.

Declarations of Interest

WPCC532 The Chair declared that she had an interest in items relating to Primary Care in her role with the Child Death Overview Panel for Walsall and Wolverhampton. As this did not constitute a Conflict of Interest, she remained in the meeting.

Minutes of the Meeting held on the 4th June 2019

WPCC533 The minutes of the meeting held on 4 June 2019 were agreed as an accurate record.

RESOLVED: That the above was noted.

Matters Arising from Previous Minutes

WPCC534 There were no matters arising from the previous minutes.

RESOLVED: That the above was noted.

Committee Action Points

WPCC535 **Action 37 (Minute No: WPCC525) – Wolverhampton Primary Care Strategy update**
An update to be provided to committee in Sept (as Aug meeting cancelled)

Action 38 (Minute No: WPCC526) – STP Primary Care Strategy Update
An update had been provided to committee members. Further update due at Sept meeting.

Action 39 (Minute No: WPCC481) – Tettenhall Medical Practice – Wood Road Branch Closure
This had been transferred from the Private meeting and an update was due to be provided at the meeting in September.

RESOLVED: That the above was noted.

Primary Care Update Reports:

Primary Care Quality Report

WPCC536 Ms Corrigan presented the report, highlighting the following key points:-

- The Serious incident reported to NHS England's Practice Performer Intelligence Gathering Group (PPIGG) had been closed with no further action.
- Four issues raised through Quality Matters were being referred to PPIGG but no significant action was anticipated.
- The annual programme of Infection Prevention Audits was due to commence, further details, including exact dates, were awaited.
- Uptake of Friends and Family Test (FFT) continued to outperform regional and national benchmarks.
- The programme of collaborative contracting visits to practices was due to be completed by the end of July.
- The STP Practice Nurse strategy approved by the committee had been endorsed by the STP Clinical Leadership Group and was being considered by the other CCGs' Primary Care Commissioning Committees.

In response to a query around the timescale for approval of the Practice Nurse strategy, Ms Corrigan confirmed that, following agreement at the STP clinical leadership group, the other CCGs were developing timescales for approval to allow consultation with appropriate stakeholders, including local medical councils.

RESOLVED: That the report and highlights above were noted.

Ms Corrigan and Ms Jallow left the meeting.

Primary Care Operational Management Group Update

WPCC537 Mr Hastings presented the report, highlighting the following key areas of discussion at the June meeting of the group:-

- Patient feedback from the consultation on the proposed closure of the Wood Road branch surgery of Tettenhall Medical Practice continued to be gathered. The local MP had arranged a public meeting at which the CCG would be represented.
- The planned IT system migration for Bilston Urban Village had been pushed back in agreement with the new providers.
- Estates work funded through the NHS England Estates and Technology Fund (ETTF) had been completed at Newbridge Surgery and work at East Park was almost complete. Discussions around potential rationalisation of estate in the Oxley area was underway with the local GPs.

RESOLVED: That the update was noted.

Primary Care Networks Update

WPCC538 Ms Southall presented the report, which provided an update on the development of Primary Care Networks (PCNs), including a request from the Royal Wolverhampton Trust network for approval to change their designated clinical director.

The report highlighted work by the Primary Care and Finance teams to ensure that appropriate payments related to the new network Directed Enhanced Service (DES) would be made in line with requirements. These payments included reimbursement for Clinical Director time and new roles including Social Prescribing Link Workers and Clinical Pharmacists. The PCNs had agreed that provision for Social Prescribing should link in with the existing service provided by Wolverhampton Voluntary Sector Council and a Service Level Agreement was being developed to support this.

In response to questions in relation to social prescribing, Ms Southall confirmed that the funding available was to employ link workers for each PCN in addition to those employed through the existing service. She highlighted that the long term plan would require additional link workers to be in place in future years and the PCNs were working with the Voluntary Sector Council to understand how this would be implemented in a complementary way to existing provision.

The report also highlighted the offer available to PCNs, in line with a self-assessment of their maturity, for support with their development. A national prospectus provided eight modules across a range of issues that would support the development of mature PCNs. In response to a question, Ms Southall confirmed that PCNs would have flexibility in which modules they took up, based on the needs identified through the maturity matrix self-assessment. The CCG's Primary Care Group Managers were working with PCNs to identify areas where they would benefit from the development offer available. In response to further questions, she also confirmed that PCNs were working to understand their population health needs to identify service requirements and that, in line with on-going assurance processes and measures identified in the NHS Long Term Plan implementation Framework, measures of success would continue to be developed.

The Chair highlighted the importance of continued patient engagement as PCNs matured and it was noted that PCNs were being supported in meeting their responsibilities in these areas. In response to a question around the identification of risks associated with the development of PCNs, Ms Southall confirmed that, as networks matured and the STP and CCG Primary Care priorities crystallised, risks would be identified and assessed.

The Committee were informed that, when the Royal Wolverhampton

Trust PCN had submitted their network application they had not completed the process of identifying a substantive Clinical Director and had named Dr Julian Parkes as an interim Clinical Director. Following the conclusion of the process, Dr John Burrell was now nominated as the Clinical Director and the committee were asked to approve this change.

RESOLVED:

1) **That approval be given to the change of Clinical Director for the Royal Wolverhampton Trust Primary Care Network to Dr John Burrell.**
2) **That the update was noted.**

Primary Care Training Hub Proposal

WPCC539 Ms Southall advised the committee that a proposal for the Primary Care Training Hub provision for Wolverhampton had been developed but that, due to commercial confidentiality, would be discussed during the private part of the agenda.

Quality Assured Spirometry Business Case (revised costs)

WPCC540 Ms Morrissey presented the report, which advised the committee that, following discussion with Clinical Directors, the costs associated with the development of a Primary Care Spirometry service had increased. The Business case for the proposal had been revised and the committee's attention was drawn to the revised costs which were now calculated to be £62,440 for 2019/20 and around £126,500 in future years.

Ms Morrissey also advised that each of the Primary Care Networks (PCNs) had been asked to develop an implementation plan for the service and that not all networks would be in a position to commence the service until Quarter 4. In response to a question about the activity and costing levels outlined in the report, she highlighted that they were projections, there was likely to be an element of season variation and that data suggested current patient registers did not match with expected prevalence. It was noted that, whilst this meant that the cost for Spirometry could therefore be higher, investment in earlier diagnosis would lead to savings through preventative measures across the broader pathway. In response to a further question about arrangements in the Royal Wolverhampton Trust PCN, it was confirmed that discussions continued with all PCNs to develop their implementation plan.

The Chair raised a query in relation to the uptake of training for practice nurses and Ms Southall confirmed that one date had been cancelled as, whilst practices were working on their implementation plan, they needed to clarify their workforce requirements as a number of nurses had already been trained. The committee asked that an update on the implementation of the service be provided in October 2019.

RESOLVED:

1) **That the revised costs for the Quality Assured Spirometry Service in Primary Care be noted.**
2) **That an update on the implementation of the service be provided in October 2019.**

Any Other Business

WPCC541 **Practice Resilience Funding**

Ms Southall advised that the STP GP Forward View programme board received funding to support practice resilience and had asked each CCG to consider how this might be used in each area. The Operational Management Group was due to discuss potential funding requirements for Wolverhampton and a proposal would be circulated for virtual approval by the committee prior to its next meeting.

Committee Meeting Frequency

The Committee agreed to cancel the August 2019 meeting and consider whether a Bi-monthly programme of meetings would be possible.

Date of Next Meeting

WPCC542 **Tuesday 3 September at 1.30pm in PA125 Stephenson Room, 1st Floor, Technology Centre, University of Wolverhampton Science Park WV10 9RU**

Primary Care Commissioning Committee Actions Log (Public)

Action No	Date of meeting	Minute Number	Item Title	Item	By When	By Whom	Action Update
37	04 June 2019	WPCC525	Wolverhampton Primary Care Strategy update	The next iteration of the Wolverhampton Primary Care Strategy to be presented to the Aug 19 meeting	Aug-19	Sarah Southall	**02/07/19: An update to be provided to committee in Sept (Aug meeting cancelled)** 04/06/19: Next iteration to be presented to the Aug meeting.
38	04 June 2019	WPCC526	STP Primary Care Strategy update	Further update to be provided to committee members following submission deadline of 20th June and before next meeting 2nd July	Jul-19	Sarah Southall	**02/07/2019: An update on PCN's generally was provided to the Jul meeting. Further update to follow in Sept.** 04/06/19: Further update to committee due before Jul meeting and following 20th June NHS England deadline.
39	05/03/2019 moved from private to public actions 04/06/19	WPCC481	Tettenhall Medical Practice - Wood Road Branch Closure	An Update to be provided at the conclusion of the consultation period	Sep-19	Gill Shelley	**04/06/19 Action inherited from Private action Log. Update to be provided at conclusion of consultation. Consultation ends Aug, report to be presented to committee in Sept.** 07.05.19 It was confirmed that the consultation on the closure of Tettenhall Medical Practice, Wood Road branch commenced today 07.05.19. 02.04.19 Arden & GEM CSU to support Tettenhall Medical Practice with the 90 day consultation period. Findings to be presented to Sept committee.
40	02 July 2019	WPCC540	Quality Assured Spirometry Business Case	An update on Spirometry service implementation to be provided to the **Oct/Nov** committee (dependant on if meetings go forward bi-monthly)	Oct-19	Claire Morrissey	
41	02 July 2019	WPCC541	Practice Resilience Funding	The Operational Management Group was due to discuss potential funding requirements for Wolverhampton and a proposal would be circulated to PCCC committee for virtual approval prior to its next meeting.	Sep-19	Sarah Southall	

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NHS
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Clinical Commissioning Group

WOLVERHAMPTON CCG

Public Primary Care Commissioning Committee
3rd September 19

TITLE OF REPORT:	Primary Care- Financial Position as at Month 3, June 2019
AUTHOR(s) OF REPORT:	Sunita Chhokar - Senior Finance manager
MANAGEMENT LEAD:	Tony Gallagher, Chief Finance Officer
PURPOSE OF REPORT:	To report the CCG financial position at Month 3, June 2019
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• Financial metrics being met • Additional allocations
RECOMMENDATION:	The Committee note the content of the report
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	<u>Ensure on-going safety and performance in the system</u> Continually check, monitor and encourage providers to improve the value for money of patient services, ensuring that patients are always at the centre of all our commissioning decisions to ensure the right care is provided at the right time in the right place.
2. Reducing Health Inequalities in Wolverhampton	<u>Improve and develop primary care in Wolverhampton</u> – Delivering a robust financial management service to support our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical

	groupings and fostering strong local partnerships to achieve this. <u>Support the delivery of the new models of care that support care closer to home and improve management of Long Term Conditions</u> by developing robust financial modelling and monitoring in a flexible way to meet the needs of the emerging New Models of Care.
3. System effectiveness delivered within our financial envelope	<u>Continue to meet our Statutory Duties and responsibilities</u> Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework. <u>Deliver improvements in the infrastructure for health and care across Wolverhampton</u> The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.

Performance against budget

The following table pulls together all area of primary care spend within the CCG and analyses expenditure and forecast outturn as at M03 across the various areas for Primary Care:

	Budget YTD	Actual YTD	YTD Variance	Annual Budget	FOT	FOT Variance
	£'000	£'000	£'000	£'000	£'000	£'000
General Practice GMS	5,960	5,644	(316)	23,842	23,842	0
General Practice PMS	724	363	(361)	2,895	2,895	0
Other List Based Services APMS incl	383	587	205	1,531	1,531	0
Premises	626	601	(25)	2,505	2,505	0
Premises Other	16	30	13	65	65	0
Enhanced services Delegated	189	432	243	758	758	0
QOF	938	918	(20)	3,751	3,751	0
Other GP Services	557	960	404	2,226	2,226	0
Delegated Contingency reserve 0.5%	48	0	(48)	191	191	0
Delegated Primary Care 1% reserve	95	0	(95)	381	381	0
Sub total Delegated Commissioning	**9,536**	**9,536**	**0**	**38,145**	**38,145**	**0**
Locally Commissioned Services	195	195	0	781	781	0
GP Transformation Fund	110	110	0	441	441	0
	305	**305**	**0**	**1,222**	**1,222**	**0**
GP Forward View						
Allocated to date						
Reception & Clerical Training	62	62	0	246	246	0
Online consultion software	100	100	0	400	400	0
Access	436	436	0	1,744	1,744	0
Practice Resilience	50	50	0	202	202	0
GP Retention	80	80	0	320	320	0
Primary care Networks	276	276	0	1,104	1,104	0
	1,004	**1,004**	**0**	**4,016**	**4,016**	**0**
Primary Care Commissioning						
Commissioning Schemes	500	500	0	2,001	2,001	0
GP IM&T	191	191	0	788	763	(25)
NHS 111	224	224	(0)	897	897	0
Out of Hours	643	643	0	2,572	2,572	0
Prescribing Incentive Scheme	113	113	0	450	450	0
Prescribing	11,736	11,585	(151)	46,944	46,344	(600)
Sub total	**13,407**	**13,256**	**(151)**	**53,652**	**53,027**	**(625)**
Subtotal Primary Care Commissioning	**14,717**	**14,565**	**(151)**	**58,890**	**58,265**	**(625)**
TOTAL FORECAST 2019-20	**24,253**	**24,101**	**(151)**	**97,035**	**96,410**	**(625)**

It is early in the financial year to provide a robust forecast outturn (FOT). However, working closely with the key budget holders the FOT will be refined as the year progresses.

Delegated Primary Care

Delegated Primary Care allocations for 2019/20 as at M3 are £38.145m. The forecast outturn is £38.145m delivering a breakeven position.

The CCG planning metrics for 2019/20 are as follows;

- Contingency delivered across all expenditure areas of 0.5%
- Non Recurrent Transformation Fund of 1%. The CCG is not required to deliver a surplus of 1% on their GP Services Allocations.

The 0.5% contingency and 1% reserves are showing an underspend year to date with expenditure being fully utilised on “other GP Services” line. In line with NHSE planning metrics no expenditure should be shown on the 0.5% contingency and 1% reserves but recorded against the appropriate lines.

Locally Commissioned Services

The table above shows an breakeven position. Practices submit a monthly claim form and payments are made accordingly. The CCG is assuming a continuation of the current level of claims in delivering a FOT. A final reconcilation will be completed once March claims have been processed. These services relate to Minor Injury, High Risk Drugs, Simple and Complex dressings, Testosterone, Denosumab, Ear Syringing, Suture Clip Removals etc.

Variations in claims and between practices form part of the management of the Local Commissioned Services budget by the Primary Care team.

GP Transformation Fund

The transformation fund is funded by the CCG based on practices joining a network. The practice will be paid £1.50 based on weighted list size. This will be a monthly payment made to the network. The CCG antipicates the FOT will be breakeven.

GPFV

GPFV schemes are funded from national monies provided by NHSE to deliver schemes in line with STP GP Forward View and comprise of:

- Reception & Clerical
- Online Consultation
- Access
- Practice Resilience
- GP Retention
- Primary Care Networks

As at M3, the position is reported as breakeven. Plans will need to be signed off by the STP board in terms of how the money will be spent.

GP Access is a CCG scheme which is paid directly to the practice's in line with the Service Specification.

Primary Care Commissioning

For CCG core commissioning budgets, there is an underspend on prescribing of £151k to date and forecast outturn and is based upon the limited data available at this point in the financial year. The following tables represent 2 months accruals based on 19/20 budget, as there is a two month delay in prescribing information being available from NHSBSA.

The table below provides, for information, the drug item volumes and value for the 12 months of 2018/19 and month 1 of 2019/20:

Drugs Volume	April	May	June	July	August	September	October	November	December	January	February	March
2018/19	437,361	478,614	477,699	468,043	463,317	479,940	497,784	497,785	472,139	487,166	435,162	463,833
2019/20	456,948											
Volume % Change	4.48%											

Drugs Value	April	May	June	July	August	September	October	November	December	January	February	March
2018/19	3,501,986	3,751,089	3,648,409	3,628,971	3,832,570	3,519,622	3,747,521	3,636,772	3,538,689	3,709,440	3,313,291	3,610,758
2019/20	3,548,555											
Value % Change	1.33%											

There a small underspend on GP & IMT FOT due to a member of staff going on maternity leave.

Conclusion/ Recommendations

The Committee is asked to:

- Note the contents of this report.
- The CCG is proposing a non recurrent development reserve of c.£1m for new shemes which will ensure the resource is fully committed
- The current schemes are fully operational to mitaigate any risks in slippage

Name: Sunita Chhokar
Job Title: Senior Finance Manager
Date: 18/07/19

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	NA	
Public/ Patient View	NA	
Finance Implications discussed with Finance Team	**Sunita Chhokar**	**18/07/19**
Quality Implications discussed with Quality and Risk Team	NA	
Equality Implications discussed with CSU Equality and Inclusion Service	NA	
Information Governance implications discussed with IG Support Officer	NA	
Legal/ Policy implications discussed with Corporate Operations Manager	NA	
Other Implications (Medicines management, estates, HR, IM&T etc.)	NA	
Any relevant data requirements discussed with CSU Business Intelligence	NA	
Signed off by Report Owner (Must be completed)	**Lesley Sawrey**	**24/07/19**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

PRIMARY CARE COMMISSIONING COMMITTEE
6TH August 2019

TITLE OF REPORT:	Primary Care Report
AUTHOR(s) OF REPORT:	Liz Corrigan
MANAGEMENT LEAD:	Yvonne Higgins
PURPOSE OF REPORT:	To provide an overview of activity in primary care, and assurances around mitigation and actions taken where issues have arisen.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain.
KEY POINTS:	Overview of Primary Care Activity
RECOMMENDATION:	Assurance only
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Providing information around activity in primary care and highlighting actions taken around management and mitigation of risks
2. Reducing Health Inequalities in Wolverhampton	
3. System effectiveness delivered within our financial envelope	

1. BACKGROUND AND CURRENT SITUATION

PRIMARY CARE QUALITY DASHBOARD

RAG Ratings: 1a Business as usual; 1b Monitoring; 2 Recovery Action Plan in place; 3 RAP and escalation

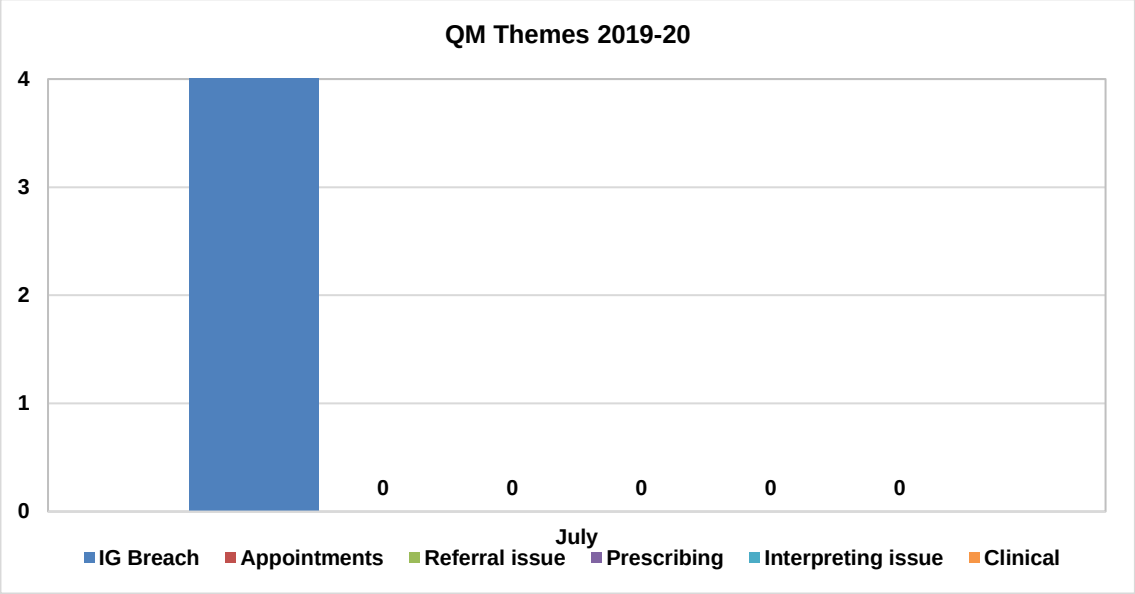
Issue	Comments	Highlights for June 2019	Mitigation for July 2019	Date of expected achievement of performance	RAG rating
Serious Incidents	All RCAs are reviewed at SISG and escalated to PPIGG if appropriate.	Serious incident escalated to PPIGG – closed no further actions as it had already been reviewed by PAG	Four further incidents reported to PPIGG	Awaiting outcomes	1b
Quality Matters	All issues being addressed by appropriate teams at the CCG and trust that has raised the issue. For review at PPIGG as relevant	Currently up to date • 4 open • 8 closed	Six incidents are open all relating to IG breaches re: blood forms	Five due for response in July and one in August	1a
Escalation to NHSE	Four incidents due to be reviewed at PPIGG from Quality Matters	Four incidents referred into PPIGG with four more pending review this month	Four incidents referred to PPIGG this month.	Expected completion by end of July 2019	1a
Infection Prevention	IP audit cycle has recommenced for 2019/20	No issues at present	New audit cycle has commenced	No further actions at present Training to be completed by end of November	1a
Flu Programme	Flu planning meetings have recommenced for 2019/20 flu season	No issues at present	All practices have active orders for all vaccines. It has been noted nationally that there will be a delay in delivery of QIV – NHSE and flu planning group to support practices with contingency	Risk identified and added to register. Flu planning group will meet at least monthly from now until March 2020	1b
Vaccination Programme	Vaccination programmes continue to be monitored	Wolverhampton continue to have low uptake for some vaccines	NHSE/PHE meeting identified issues with MMR uptake and susceptibility.	Ongoing issue at present, to review in 3 months	1a

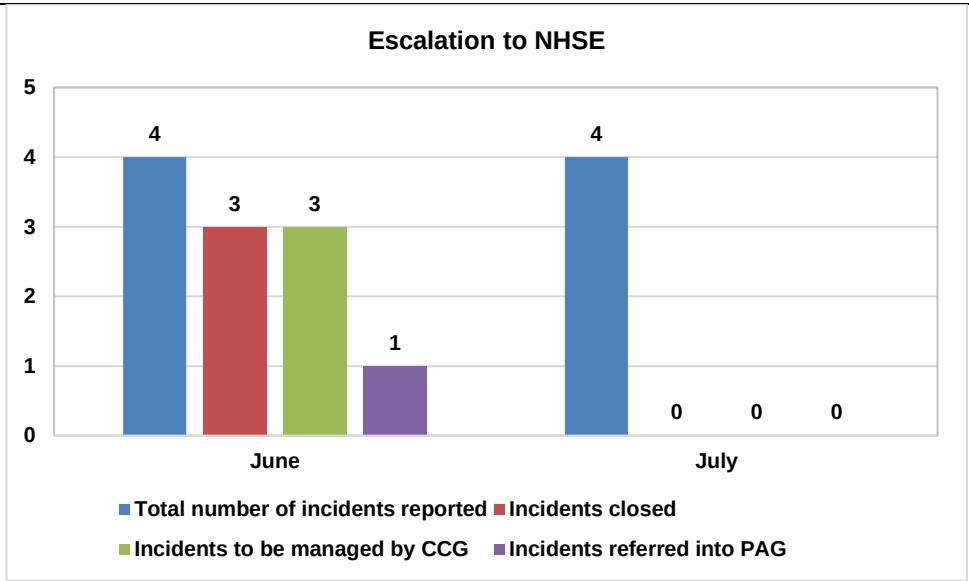
			Risk identified to discuss and consider adding to risk register. Continue to work with colleagues in PH and other CCGs		
Sepsis	Planning continues around training for practices in reduction of gram negative infection – collaboration with IP team, prescribing and continence teams. Some practices have still not identified a sepsis lead and this is being chased.	Awaiting commencement of new IP audit cycle Training for practice nurses arranged for November	Continue to work with Medicines Optimisation and IP teams	No further actions at present Training to be completed by end of November	
MHRA	No issues at present.	No further update	No further update	No further actions at present	1a
Complaints	No issues at present – quarterly report due July 2019	Quarter 4 complaints data not yet available	No further update – awaiting NHSE data	No further actions at present	1a
FFT	Quarterly full report due in July 2019 Practices who were unable to submit via CQRS or who had submitted but data was not showing on NHSE return have had their data added manually	In May 2019 • 5 practices did not submit – there appeared to be an issue with CQRS in some sites and one has submitted late • 1 practice submitted fewer than 5 responses • Uptake was 1.8% compared to 0.8% regionally and 0.6% nationally	In June 2019 • 2 practices did not submit • 1 submitted fewer than 5 responses • Uptake was 2.5% compared with 0.8% regionally and 0.6% nationally.	No further actions at present	1a
NICE Assurance	No actions at present – next NICE meeting in August 2019	New NICE guidance for primary care discussed in May 2019 – available to providers	Next meeting in August	No further actions at present	1a
Collaborative contracting visits	11 practice visits are outstanding, this will be completed by late summer in line with recent audit.	Visit schedule now available with all practices allocated a visit	As of 23rd July 2019 two practices are outstanding in this visit cycle – due to restart in September	Expected completion by end of July 2019	1b

CQC	No issues at present	One practice identified as being requires improvement – meeting arranged with practice and CCG to discuss action plan	Practices now undergoing their annual reviews by telephone. CQC reporting issues as they occur.	On-going process	1b
Workforce Activity	Work continues to promote primary care as a desirable place to work and to promote current programmes	Awaiting approval of GPN strategy in Dudley and Sandwell and then to arrange launch	GPN strategy launch booked for 6th October 2019 at Science Park Retention and apprenticeship programmes continue. Regional GPN meeting now set up with rolling chair	On-going	1a
Workforce Numbers	Awaiting NHS Digital workforce data release.	Workforce figures are still pending due to changes in data collection	No change to status	Awaiting further information	1b
Training and Development	None flagged at present	Training continues across the workforce for: GPs – retention work GPNs – strategy launch and retention work, flu training ARTP spirometry and diabetes training Other professions – pharmacy network meetings and PA Fellowships to commence Practice manager update sessions planned	Training continues across the workforce for: GPs – retention work GPNs – strategy launch and retention steering group Flu and spirometry training Pharmacy network meetings Practice manager update sessions Medical assistant training	To continue planning GPN retention and strategy launches Complete by October 2019	1a
Training Hub/HEE/HEI update	To continue monitoring, risk remains open.	Work to reconfigure the Training Hub provision continues. Primary Care Board due to meet in June 2019 to discuss the work plan for hubs and PCNs	Training Hub cover now identified to continue with work as planned	This action is on-going and will be updated as new information is available.	1b

2. PRIMARY CARE QUALITY REPORT

2.1. PATIENT SAFETY

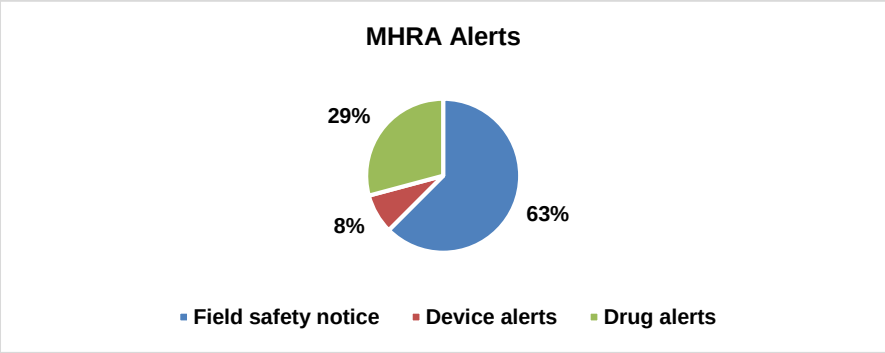
Measure	Trend	Assurance/Analysis
Serious Incidents	N/A – not enough data to display a graph/trend	**Incidents:** • No serious incidents at present. • All incidents are reviewed by serious incident scrutiny group • Incidents are also reviewed by NHSE PPIGG group
Quality Matters		• There are currently 6 open Quality Matters (QM) all IG breaches due to incorrect blood forms being given out • No Quality Matters were closed in July – some are pending at the end of the month • Four incidents have been referred into PPIGG – PSD incident, two prescribing incidents and a referral delay

	<table><tr><th>Monthly Variance</th><th>June</th><th>July</th><th>Percentage</th></tr><tr><td>New issues</td><td>7</td><td>0</td><td>23%</td></tr><tr><td>Open issues</td><td>6</td><td>6</td><td>39%</td></tr><tr><td>Overdue issues</td><td>0</td><td>0</td><td>0%</td></tr><tr><td>Closed issues</td><td>8</td><td>0</td><td>29%</td></tr></table>	
Practice Issues	N/A	No issues noted at present
Escalation to NHS England		• Four incidents reported to PPIGG: ○ Delayed prescription x 2 ○ Non-prescriber signed PSD ○ Delayed referral

2.2. INFECTION PREVENTION

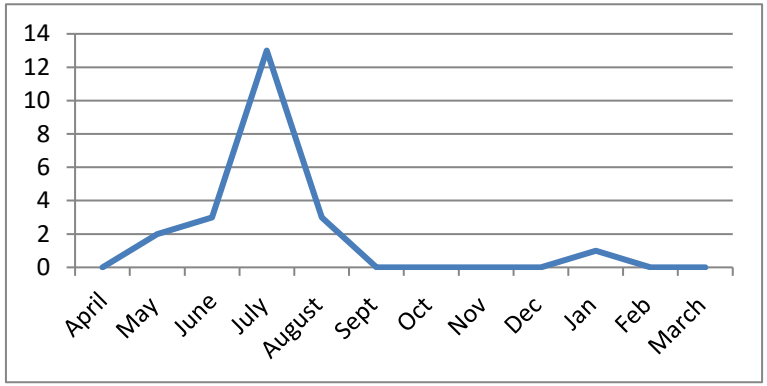
IP Audits	New audit cycle commenced – please see attached IP audit report with proposed dates (Appendix 1). Main themes: • Replace sinks with recommended ones	• **IP Audit Ratings:** Gold 97-100%; Silver 91-96%; Bronze 85-90%; No rating ≤84%. • Work will continue with RWT IP team around assurances.
MRSA Bacteraemia	Two community cases identified but no indication of origin e.g. GP in data.	• Unclear origin of MRSA • No other areas of concern to report.
Influenza vaccination programme	There will be a delay in QIV (under 65) flu vaccine this season with deliveries expected in late October and early November. Risk identified and recorded on register Flu season in Australia is currently earlier than usual with more cases identified. Local plans currently being developed around marketing, delivery and monitoring of vaccinations.	• Flu planning group met on July 2nd. • Training is booked from Black Country Training Hub in July 2019 • Flu Fighters comics to be shared across the Black Country • Work to make delivery across PCNs being developed by NHSE.
MMR vaccination programme	MMR uptake and susceptibility data was shared at the regional immunisation meeting – Wolverhampton has lower update compared with neighbours. Data report is attached (Appendix 2).	• To continue to work with PH around uptake. • To work with colleagues across the Black Country (particularly Dudley who have a very good uptake) to share good practice. • To feedback and receive data from regional screening and immunisation board.
Sepsis	No data at present	• Training for practice nurses is arranged for November 2019.

2.2. MHRA Alerts

Measure	Trend	Assurance/Analysis
MHRA Alerts		No concerns to report at present

	June	July	Total	Percentage
Field safety notice	1	3	15	63%
Device alerts	0	0	2	8%
Drug alerts	1	0	7	29%
			24	

2.3. PATIENT EXPERIENCE

<table>
<tr><th>Measure</th><th>Trend</th><th>Assurance/Analysis</th></tr>
<tr><td>Complaints</td><td> 
</td><td>Complaints Numbers and Themes:
2018/2019 Data

Quarter 1 data not received from NHS England as yet.</td></tr>
<tr><td>Friends and Family Test</td><td>
<table>
<tr><th>Percentage</th><th>April</th><th>May</th><th>West Midlands</th><th>England</th></tr>
<tr><td>Total number of practices</td><td>40</td><td>40</td><td>2066</td><td>7001</td></tr>
<tr><td rowspan="2">Practices responded</td><td>85.0%</td><td>95.0%</td><td rowspan="2">64.8%</td><td rowspan="2">63.4%</td></tr>
<tr><td>34</td><td>38</td></tr>
<tr><td rowspan="2">No submission</td><td>12.5%</td><td>5.0%</td><td rowspan="2">35.2%</td><td rowspan="2">36.6%</td></tr>
<tr><td>5</td><td>2</td></tr>
<tr><td rowspan="2">Zero submission (zero value submitted)</td><td>0.0%</td><td>0.0%</td><td rowspan="2">N/A</td><td rowspan="2">N/A</td></tr>
<tr><td>0</td><td>0</td></tr>
<tr><td rowspan="2">Suppressed data (1-4 responses submitted)</td><td>2.5%</td><td>2.5%</td><td rowspan="2">6.4%</td><td rowspan="2">7.8%</td></tr>
<tr><td>1</td><td>1</td></tr>
<tr><td rowspan="2">Total number with no data (no/zero submission and supressed data)</td><td>15.0%</td><td>7.5%</td><td rowspan="2">41.6%</td><td rowspan="2">44.4%</td></tr>
<tr><td>6</td><td>3</td></tr>
<tr><td>Response rate</td><td>1.8%</td><td>2.5%</td><td>0.8%</td><td>0.6%</td></tr>
</table>
</td><td>

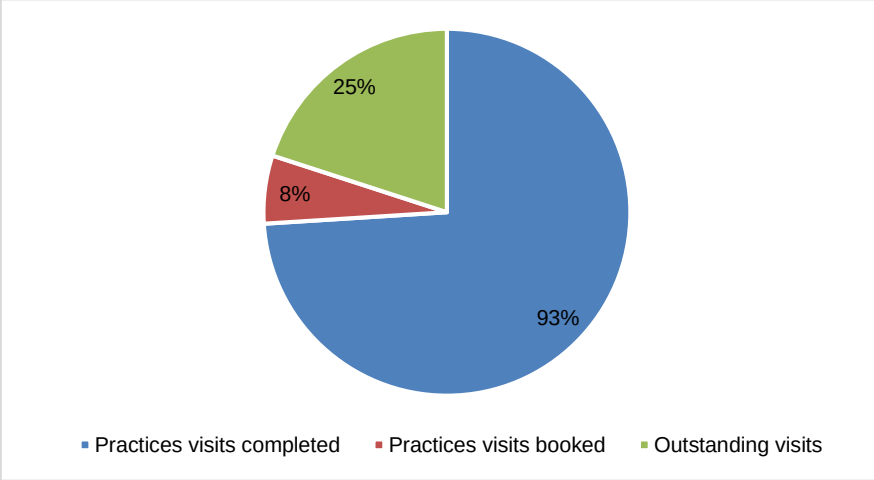
Uptake remains significantly higher than regional and national uptake.
Total non-responders 3 practices (no data, zero data or supressed data) – lower than regional and national average. All practices have been contacted.
Uptake is reviewed on a monthly basis by the Quality Team and Primary Care Contract Manager.
For highest and lowest uptake the locality managers have been advised.

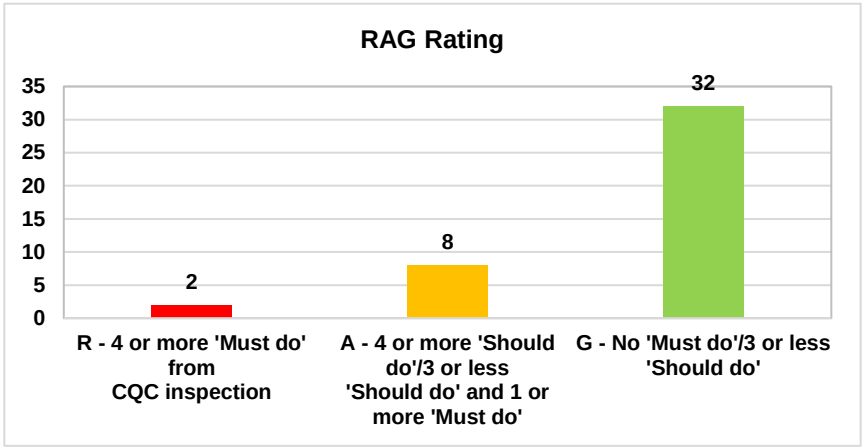
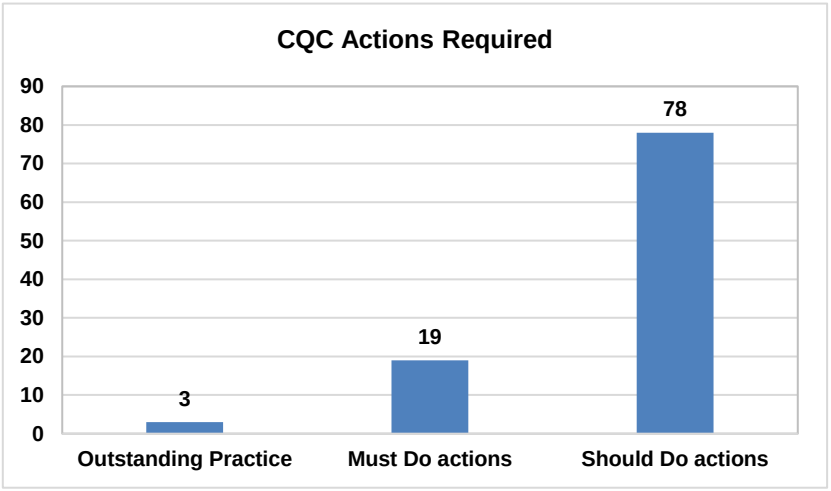
</td></tr>
</table>

	Key (compared to WM) | Lower performance | Higher performance | Same performance	

2.4. CLINICAL EFFECTIVENESS

NICE Assurance – Updated Quarterly (next due August 2019)

Measure	Trend	Assurance/Analysis
Collaborative Contracting visits		Visit schedule for this cycle is now almost complete with all practices to be visited by 31st July 2019. Themes from visits identified are: • Policies needing updating or amending e.g. version control, update date or author • Complaints procedure needs to be amended to ensure that the practice and NHS England details are given and not CCG • Mandatory training gaps – particularly safeguarding training. • Missing certificates e.g. training and insurance – cover is available but the certificates are not.

CQC ratings	 	CQC continue to liaise with CCG to support the inspection process. One practice has recently had a requires improvement rating – four in total for Wolverhampton and a meeting has been held with the practice and assurances provided. Outstanding actions are managed by inspectors via 3 monthly virtual or face to face review. Inspections by year: 2015 – 3 2016 – 12 2017 – 14 2018 – 11 2019 – 4 Several practices are due an inspection due to changes in provider.

CQC Ratings by Domain	Overall	Safe	Effective	Caring	Responsive	Well-led	People with long term conditions	Families, children and young people	Older people	Working age people (including those recently retired and students)	People experiencing poor mental health (including people with dementia)	People whose circumstances may make them vulnerable
Outstanding	0	0	0	0	0	0	0	0	0	0	0	0
Good	38	35	40	41	41	38	38	39	39	39	39	39
Requires Improvement	4	7	2	1	1	3	4	3	3	3	3	3
Inadequate	0	0	0	0	0	1	0	0	0	0	0	0
	42	42	42	42	42	42	42	42	42	42	42	42

2.5. WORKFORCE DEVELOPMENT

2.5.1. Workforce Activity

Measure	Assurance/Analysis
Recruitment and retention	• STP lead is currently identifying and raising risks around this • STP Primary Care Strategy final draft has been sent to NHSE for approval • STP project manager and project support have been recruited to support GP and GPN retention programme alongside other workforce work streams • GP retention programme continues. • The practice nurse retention programme planning now complete – for launch with GPN strategy. • HCA apprenticeship programme has 5 staff who have commenced or due to commence and one practice who is interested in larger scale HCA training and the employment of business and administration apprentices and upskilling HCAs to NAs. • Work experience pilot took place w/c 1st July with a local school – feedback from placement sites, students and teachers has been excellent, to evaluate for September QSC and feedback

	• A proposal has been made to create a GPN training and retention tracker across the STP – local information will be used to help populate this
GPN 10 Point Action Plan	• Wolverhampton Activity: • Action 1, 2, 4, 5, 7, 8, 9 and 10: GPN strategy has been approved launch currently being arranged. This now forms part of STP Primary Care Strategy. • Action 1: Work experience pilot ran between 1st and 5th July with good feedback from all parties, to evaluate and extend next year. • Action 2, 4 and 10: Digital Clinical Supervision pilot, has now finished but the sessions are continuing in Wolverhampton face to face and via Skype with technical problems persisting. • Action 4: GPN Strategy supports GPN involvement in PCN boards at strategic level. • Action 3: there are currently 17 practices and the CCG itself offering student nurse placements with another one expressing an interest, but there is some movement of mentors due to job changes. • Action 4: The GPN fast track programme continues with Wolverhampton nurses attending – nurses are also undertaking Fundamentals of General Practice Nursing with an additional candidate for September at BCU. • Action 5: Further work is being developed to promote the Return to Practice programme via Futureproof. • Action 7: Nurse Education forum continues on a monthly basis with plans to develop this further next year to include HCAs - a change in venue should be noted due to increased costs at current venue. Planned sessions include Immunisations, Cytology, Frailty and hydration, COPD and pain management. • Action 9: The CCG can support 3 Nursing Associate apprenticeships with backfill in primary care, comms have been developed and circulated - no candidates at present. • Action 9: HCA apprenticeships programme has commenced with two candidates started in April and 4 further candidates identified as part of a pipeline programme in one practice. • Action 10: The Nurse Retention plan has now been collated with work streams being planned as part of the GPN Strategy – task and finish group under development

2.5.2. Workforce Numbers

Measure	Trend	Assurance/Analysis
Workforce Numbers	No data at present – awaiting figures from NHS Digital	Figures taken from NHS Digital data are for September 2018 with the next update due imminently. Local figures are monitored.

2.5.3. Training and Development

Measure	Assurance/Analysis
GP	• 270 GP trainees within STP areas – work to commence to convert these to full time GP posts – approximately 75 due to complete this year to work with these individuals to identify them and what they will need to get them to stay

	• TPDs identified to discuss retention of trainees • GP retention programme to continue
Nurse/HCA/Nursing Associate	• CCG GPN Leads meeting now being hosted by Wolverhampton CCG with rolling chair (currently with Worcestershire CCG) • Practice Makes Perfect continues. • MERIT diabetes course will be available from September 2019 funded by Novo Nordisk – this has been arranged in conjunction with Wolverhampton Diabetes Centre • Flu training is booked for 24th July 2019 with additional mop up sessions • Cytology training arranged for October in collaboration with CRUK, RWT and PHE • Apprenticeship programmes are up and running • Spirometry training is arranged for September and December 2019 – awaiting final figures • Retention group will meet in August in Dudley.
Other professionals	• HEE have JDs available for all new primary care roles • There are varied models of employing new roles within PCNs being proposed from maintaining current provision and buying cover, to direct employment to a proposed social enterprise model • Pharmacist networks under development. • One Physicians Associate in post with a second to follow.
Non-clinical staff	• GPFV training continues • Practice resilience training is available at STP level. • PMs have requested their own forum be developed

2.5.4. Training Hub Update

	Exceptions and assurance
Black Country Training Hub	• Sandwell TH now providing cover for Wolverhampton and Walsall CCGs • Training Hubs to work with PCNs to identify workforce and training needs • Training Hubs are continuing with business as usual – training and updates booked in Dudley • Digital Nurse Champion project continues • HCAs and new to GPN being supported by Sandwell • Evaluations due on Sandwell projects including admin into HCAs, NMPs
LWAB/HEE	• HEE exploring group consultations. • Development around training hubs continues. • Work around digital leadership and nurse champions continues.
Higher/Further Education	• Fundamentals starting in January in Wolverhampton and September in BCU • SP degree starting in September

3. CLINICAL VIEW

N/A

4. PATIENT AND PUBLIC VIEW

N/A

5. KEY RISKS AND MITIGATIONS

All risks addressed through Quality and Safety, Primary Care and Workforce Risk registers.

6. IMPACT ASSESSMENT

6.1. Financial and Resource Implications

N/A

6.2. Quality and Safety Implications

Report is also delivered to Quality and Safety Committee – quality implications are addressed via this group.

6.3. Equality Implications

N/A

6.4. Legal and Policy Implications

N/A

6.5. Other Implications

N/A

Name: Liz Corrigan
Job Title: Primary Care Quality Assurance Coordinator
Date: 23/07/2019

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View	**N/A**	
Public/ Patient View	**N/A**	
Finance Implications discussed with Finance Team	**N/A**	
Quality Implications discussed with Quality and Risk Team	**N/A**	
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	
Information Governance implications discussed with IG Support Officer	**N/A**	
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)	**Yvonne Higgins**	**23/07/2019**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG
PRIMARY CARE COMMISSIONING COMMITTEE
3rd September 2019

TITLE OF REPORT:	Primary Care Operational Management Group Update
AUTHOR(s) OF REPORT:	Mike Hastings, Director of Operations
MANAGEMENT LEAD:	Mike Hastings, Director of Operations
PURPOSE OF REPORT:	To provide the Committee with an update on the Primary Care Operational Management Group.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This report is intended for the public domain.
KEY POINTS:	• The CCG continues to support Tettenhall Medical Practice with their patient consultation regarding their intention to close their Wood Road branch to ensure the patient's voices are heard. The consultation period has been extended to the end of August. • NE Locality workshop planned for a hub. All stakeholders invited. • 7 CQC Annual Reviews have been completed in this period. • NHSE support for primary care to remain as is until the end of the calendar year. 4 local Primary Care Contract visits tool place this month.
RECOMMENDATION:	To provide the Committee with an update on the Primary Care Operational Management Group.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	The Primary Care Operational Management Group monitors the quality and safety of General Practice.
2. Reducing Health Inequalities in Wolverhampton	The Primary Care Operational Management Group work with clinical groups within Primary Care to transform delivery.
3. System effectiveness delivered within our financial envelope	Operational issues are managed to enable Primary Care Strategy delivery.

1. BACKGROUND AND CURRENT SITUATION

1.1. Notes from the last Primary Care Operational Management Group are set out below.

Primary Care Operational Management Group
Wednesday 3rd July 2019 at 1.00pm
CCG Main Meeting Room, Wolverhampton Science Park, WV10 9RU

Present

Tally Kalea	(TK)	WCCG Commissioning Operations Manager
Jo Reynolds	(JR)	WCCG Primary Care Transformation Manager
Mandy Sarai	(MS)	WCCG Business Support Officer
Jane Worton	(JW)	WCCG Primary Care Liaison Manager
Yvette Delaney	(YD)	Inspector for Primary Medical Services Care Quality Commission (Central West)
Bal Dhami	(BD)	Senior Contracts Manager (Primary Care) NHS England
Liz Corrigan	(LC)	WCCG Primary Care Quality Assurance Coordinator
Peter McKenzie	(PMck)	WCCG Corporate Operations Manager

Item		
1.	**Welcome and Introductions**	
2.	**Apologies** Apologies for absence were received from: Tracey Cresswell; Mike Hastings; Gill Shelley and Ramsey Singh	
3.	**Declarations of Interest** There were no declarations of interest.	
4. **4.1** **4.2**	**Primary Care Operational Management Group Minutes** <u>Notes from Wednesday 12th June 2019</u> The minutes taken from the meeting on Wednesday 12th June 2019 were signed off and recorded as an accurate record. <u>Action Log</u> Items on the action log were discussed.	
5. **5.1**	**Notes of the Clinical Reference Group Meeting** <u>Clinical Reference Notes</u> The Clinical Reference Group did not take place last month.	
6. **6.1**	**Risk Profile** <u>Risk Register</u> New risk raised by GS for Vocare and Team W. <u>Whitmore Reans</u> Review due for Whitmore Reans Practice. <u>Primary Care Hub 2</u> Review due for Primary Care hub 2	

	Doc man Review due for Doc man due this week. There are 3 practices left to migrate for Docman 10. Protected Learning Time Risk assessment needs finalising.	
7.	**Matters Arising** There were no matters arising.	
8.	**Primary Care Updates**	
8.1	Review of Primary Care Matrix JW gave an update around the Wood Road consultation which is still ongoing To date there has been 742 survey responses which the Comms team are involved with as part of the Consultation process. Additional drop- in sessions have been put in place for the public to meet with representatives from the practice and CCG. A letter has been received from Eleanor Smith MP raising some concerns. As a result of this, a meeting is due to take place on Thursday 11th July. NHS PS have been invited to the meeting. The practice staff, public and SM (Steven Marshall) will be attending. Another session will be held at the end of July. The report with the options will go to the Primary Care Commissioning Committee in September. The Practice have been invited to attend to present their business case. APMS Mobilisation is now complete. The actions are closed.	
8.2	Forward Plan for Practice System Migrations Mergers and Closures TK gave an update on behalf of RS. Migrating systems have had issues merging onto the new systems. This could take a couple of weeks for it to resolve.	
8.3	Estates Update/LEF TK mentioned that Oxley which is based in the north east locality is looking at having a workshop for hub working and co locating practices as well as social care and other health providers. This is planned for the end of July. The site being looked at is where Dr Mittal's Practice is based. This property is part owned by NHS Properties and part owned by Accord. They are looking at acquiring the plot of land for development. A number of GP's have been invited from the area that may have an interest in moving into a co-located surgery. Newbridge have completed building works. Internal works are well under the way for East Park and should be completed by the end of the Financial year. Estates are working with PS regarding void space, consolidating practice debt and trying to consolidate debts for practices and get a plan in place for them. A meeting took place with Property Services, TK and the Estates development team who have discussed getting together to discuss Primary Care Networks.	

8.4	Primary Care Networks (PCN) Primary Care Networks- contractual arrangements are in place. DES sign up and contract variations are in place, with payments schedules agreed. Developments plans are being drawn up by each network, along with assurance that services are being provided. CD meetings are scheduled with an associated TOR agreed. Resilience funding is available, Wolverhampton to submit a number of bids to be clarified with JW and JR away from this meeting.	
8.5	Primary Care STP Update GPRISS funding has now come to an end, the programmes of work have been evaluated and will now form part of the STP programme of work.	
8.6	Care Quality Commission Update YD gave an update; The annual reviews are going well. Those completed are: • Ashmore Park Health Centre – Outcome inspection due to previous breach of regulations at previous inspection in 2018. • Cannock Road Medical Practice, • Dr Davis Mackenzie Bush, • East Park Medical Practice, • Dr Kewal Krishan, • Bilston Family Practice, • Prestwood Road West Surgery Some registration issues with some services have been identified. IH Medical - YD has met with Dr Ahmed. Has commenced the process to register as a new partnership. Advised to register the partnership with the two existing partners and Dr Sharma can be registered later when he has completed his due diligence. Health and Beyond – Registration not fully completed. All in hand. Property Services – Issues identified at inspections where GP practices are located in health care premises managed by property services. The outcome of health and safety risk assessments, maintenance, safety and security not shared or accessed by practice staff. Need to be available at inspections.	
8.7	NHS England Update Head of Primary Care Meeting will take place next week which informs feedback to all CCG's. Currently in the process of coming together for NHSE and NHSi. Bringing together regions. This will then impact on the individual teams that provide service to the CCGs. Service will continue as normal up to the end of the financial year.	
9.	**Primary Care Quality Update**	

9.1	Primary Care Quality Report • Serious Incident – has now been closed and went to PIGG. This related to a death of a patient. • Quality Matters – all ok • Infection Prevention –waiting for Mike to start the audit cycle. • Complaints Data -still waiting for results. • Friends & Family – all ok. • CQC –Ashfield Road,requires improvement. Practice is working through their actions. • Spirometry Training – is due for September. • Training hub –Going forward it will be up to Health Education England to develop this with a view to develop a Primary Care training academy.	
9.2	Collaborative Working Model: Practice Issues and Communication Log No issues noted.	
10. **10.1** **10.2**	**Primary Care Contracting** Collaborative Contract Review Programme This item was not discussed. Primary Care Contracting Update Newbridge – a good visit. Saw the new build. Small issues around vaccines, but overall went really well. Dr Mudigonda's – 13 actions outstanding around CQC registration. There was also a serious issue with the practice fridge. This had been escalated to screening and immunisation team. Complaints polices are out of date. Keats Grove – few issues around GP earnings not been made available and a couple of issues around safeguarding training certificates. Cannock Road surgery - few issues around safeguarding training. Face to face training had been arranged, which was cancelled. Online training has been made available. The complaints leaflets need to be updated.	
11. **11.1**	**Discussion Items** No items discussed.	
12.	**Any other Business** It was suggested that it would be useful to have a CCG contact for Annual Reviews. JW asked her name be put forward for a named contact person at the CCG.	
13.	**Date and time of Next Meeting – Wednesday 14th August 2019 at 13:00-14:30 in the Meeting Room 1**	

2. CLINICAL VIEW

2.1. A clinical representative from LMC attends the meetings and gives views on all discussions.

3. PATIENT AND PUBLIC VIEW

3.1. Patient and public views are sought as required**.**

4. KEY RISKS AND MITIGATIONS

4.1. Project risks are reviewed as escalated from the programme.

5. IMPACT ASSESSMENT

Financial and Resource Implications

5.1. The group has no authority to make decisions regarding Finance.

Quality and Safety Implications

5.2. A quality representative is a member of the Group.

Equality Implications

5.3. Equality and Inclusion views are sought as required.

Legal and Policy Implications

5.4. Governance views are sought as required.

Other Implications

5.5. Medicines Management, Estates, HR and IM&T views are sought as required.

Name: Mike Hastings
Job Title: Director of Operations
Date: 29.7.19

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.	**Details/ Name**	**Date**
Clinical View	N/A	
Public/ Patient View	N/A	
Finance Implications discussed with Finance Team	N/A	
Quality Implications discussed with Quality and Risk Team	N/A	
Equality Implications discussed with CSU Equality and Inclusion Service	N/A	
Information Governance implications discussed with IG Support Officer	N/A	
Legal/ Policy implications discussed with Corporate Operations Manager	N/A	
Other Implications (Medicines management, estates, HR, IM&T etc.)	N/A	
Any relevant data requirements discussed with CSU Business Intelligence	N/A	
Signed off by Report Owner (Must be completed)	**Mike Hastings**	**27.7.19**

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Primary Care Commissioning Committee
Tuesday 3rd September

TITLE OF REPORT:	Primary Care Contracting: Update to Committee
AUTHOR(s) OF REPORT:	Gill Shelley
MANAGEMENT LEAD:	Sarah Southall
PURPOSE OF REPORT:	Information to committee
ACTION REQUIRED:	☒ **For Information Only**
PUBLIC OR PRIVATE:	This report is for public committee
KEY POINTS:	• To provide update information to the primary care committee on primary medical services
RECOMMENDATION:	That the committee note the information provided
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Maintenance of quality of services for patients by continuing to offer appropriate access to primary care medical services and in offering a full range of enhanced services delivered by an appropriately skilled workforce and improving patient choice of GP
2. Reducing Health Inequalities in Wolverhampton	The CCG Primary Care Strategy is supported in transforming how local health care is delivered
3. System effectiveness delivered within our financial envelope	Collaborative working and working at acale allows for delivery of primary medical services at scale effectively reducing organisation workload and increasing clinical input at no extra cost

1. GMS Contract Variations 1st April 2019 –31st July 2019

For the committee to note the variations to GMS contracts during the above period.

Practice	Practice No	Contract variation	Variation to contract	Date of CVO
Alfred Squire Road	M92013	Removal from contract	Dr Parkes removed	31/6/19
Castlecroft Medical Practice	M92008	Removal from contract	Dr Wagstaff removed	1/4/19
Castlecroft Medical Practice	M92008	Addition to contract	Dr Negrine added	1/4/19
East Park Medical Centre	M92630	Removal from contract	Dr Majid removed	1/4/19
IH Practice	M92015	Removal from contract	Mr Greg Moorhouse removed	30/6/19
Mayfield medical centre	M92040	Addition to contract	Dr S Krishan added	1/6/19

2. **Tettenhall Medical Practice: update on consultation process on application to close Wood Road Surgery, branch site.**

   The consultation process was due to end 31st July 2019 however this has been extended to September15th 2019 to allow for a further consultation session with the patients and public on September 11th and for comments from the Local Authority Health Overview and Scrutiny Committee taking place on 12th September 2019 to be fed into the consultation process.

   A Public Meeting outside of the CCG/practice consultation was held by the local community and was chaired by Eleanor Smith MP. This was very well attended with around 180 attendees.

   The application to close Wood Road Surgery will be presented to PCCC for committee decision in due course .

3. **Primary Care Networks: Spirometry Enhanced Service**

   Wolverhampton Total Health PCN (already competent to deliver the service) and Wolverhampton South East PCN (due to commence training) have signed up to deliver the Spirometry Enhance Service and are te only 2 PCN's delivering the service at Network level.

   The following PCN,s hace chosen not to sign up to the service and will continue to refet to RWT

   - Unity East
   - Unity West
   - North Network
   - RWT

   The CCG will therefore need to double run with RWT in 20/21 and agree how the current waiting list will be cleared at RWT as well.

4. **CLINICAL VIEW**

   Not applicable

5. PATIENT AND PUBLIC VIEW

Not applicable

6. KEY RISKS AND MITIGATIONS

Not applicable

7. IMPACT ASSESSMENT

Financial and Resource Implications

Not applicable

Quality and Safety Implications

Not applicable

Equality Implications

Not applicable

Legal and Policy Implications

Not applicable

8. RECOMMENDATIONS

It is recommended that the committee note the contents of this report for their information

Name **Gill Shelley**
Job Title **Primary Care Contracts Manager**
Date: **3/9/19**

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date

Clinical View	**N/A**	**3/9/19**
Public/ Patient View	**N/A**	**3/9/19**
Finance Implications discussed with Finance Team	**N/A**	**3/9/19**
Quality Implications discussed with Quality and Risk Team	**N/A**	**3/9/19**
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	**3/9/19**
Information Governance implications discussed with IG Support Officer	**N/A**	**3/9/19**
Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	**3/9/19**
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	**3/9/19**
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	**3/9/19**
Signed off by Report Owner (Must be completed)	**G Shelley**	**3/9/19**

NHS
Wolverhampton
Clinical Commissioning Group

BOARD ASSURANCE FRAMEWORK NOTES

(Please **DELETE** before submission)

Following a review of the BAF, it will now be based on the risks associated with the CCG achieving its strategic aims and objectives as follows:-

Strategic Aims	Strategic Objectives
1. Improving the quality and safety of the services we commission	a. Ensure on-going safety and performance in the system Continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions
2. Reducing health inequalities in Wolverhampton	a. Improve and develop primary care in Wolverhampton – Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this b. Deliver new models of care that support care closer to home and improve management of Long Term Conditions Supporting the development of Multi-Speciality Community Provider and Primary and Acute Care Systems to deliver more integrated services in Primary Care and Community settings
3. System effectiveness delivered within our financial envelope	a. Proactively drive our contribution to the Black Country STP Play a leading role in the development and delivery of the Black Country STP to support material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country footprint. b. Greater integration of health and social care services across Wolverhampton Work with partners across the City to support the development and delivery of the emerging vision for transformation; including exploring the potential for an 'Accountable Care System.' c. Continue to meet our Statutory Duties and responsibilities Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework d. Deliver improvements in the infrastructure for health and care across Wolverhampton The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.

NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Primary Care Committee
Tuesday 3rd September 2019

TITLE OF REPORT:	Application for the merger of Parkfields Medical Centre, with Grove Medical Practice
AUTHOR(s) OF REPORT:	Gill Shelley, Primary Care Contracts Manager
MANAGEMENT LEAD:	Sarah Southall
PURPOSE OF REPORT:	To inform the committee of the request to merge the 2 practices and to gain committee approval for this to go ahead
ACTION REQUIRED:	☒ **Decision** ☐ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the private domain
KEY POINTS:	• Application received to merge 2 practices with GMS contracts
RECOMMENDATION:	For the committee to review the information submitted to make a decision with regard to the application. For the committee to approve the application
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Improved quality of services for patients by increasing access to primary care medical services and in offering a full range of enhanced services delivered by an appropriately skilled workforce.
2. Reducing Health Inequalities in Wolverhampton	The planned merger supports the CCG Primary Care Strategy in transforming how local health care is delivered
3. System effectiveness delivered within our financial envelope	Collaborative working allows for delivery of primary medical services at scale effectively reducing organisation workload and increasing clinical input at no extra cost.

1. BACKGROUND AND CURRENT SITUATION

1.1 The following practices have submitted a business case (**appendix 1**) to the CCG for the merger of Parkfields Medical Centre (M92024) with Grove Medical Centre (M92612)

1.2 Parkfields Medical Centre

1.3 Parkfields Medical Centre has a main surgery at 255, Parkfield, Parkfields, and a branch surgery at Woodcross Medical Centre Coseley. The GMS contract is currently held by the following partners

- Dr Alison Johnson
- Dr Akinwumi Latunji
- Dr Neja Hussian

1.4 The number of patients registered at this practice is c.13680.

1.5 Grove Medical Centre

Grove Medical Centre has a main surgery at 175, Steelhouse Lane with the following branch surgeries at:

- All Saints Medical Centre, All Saints Road, Wolverhampton
- RoseVillas Surgery, Shale Street, Bilston
- Caerleon Surgery, Dover Street Bilston
- Church Street Surgery, Bilston
- Bradley Medical Centre, Hall Green Street, Bradley Bilston

1.6 Grove Medical Practice currently provides medical services to a population of c23,700 patient population

2. Key issues

The proposal as detailed in the business case is to merge these 2 GMS practices

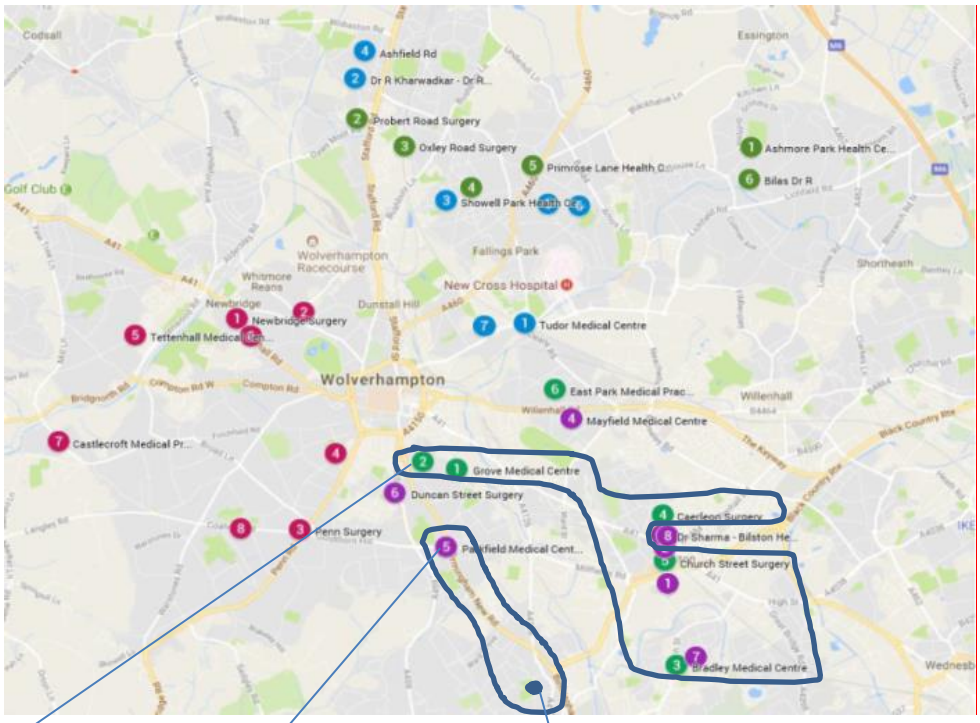
The merged practices will use the current practice code for Grove Medical Centre: M92612.

3 Premises and Location of practices.

All current practices are located in the South East Locality of Wolverhampton. Grove Medical Centre is the main surgery in this hub.
The distance between Grove Medical Centre and Parkfields Medical Centre is 0.8 miles and 2.1 miles between Grove Medical Centre and Wood Cross Medical Centre

3.1 The business case provides considerable detail on the current premises occupied by the practices.

3.2 The map below shows where the Grove Medical Practices are located in relation to practice of the proposed merger.



4. Timescales

4.1 The merger is dependent on the merging of clinical systems but will be completed by December 2019

5. Benefits to Patients

5.1 The business case provides full details of benefits to patients but included are:

- Increased access through increased opening hours, the practice will be open full core hours with no half day closing and will offer extended opening via the Directed Enhances Service and the Local Incentive Scheme.
- Patient choice of clinician will be improved along with continuing access to a female GP and a range of other clinicians and specialist skills.
- All patients will have access to a full range of enhanced services.
- Patients can be seen at any practice site.

6 Patient Engagement

6.1 A varied communication process has been implemented including:

- Leaflets/notices in the practice
- Messages added to prescriptions
- Use of local pharmacist
- Statement on practice website
- One to one discussions with patients
- Practice meeting with patients
- PPG
- Letters to patients

So far feedback from patients appears to be positive with patients keen to make use the increased patient access and the wider range of health care professionals.

7. CLINICAL VIEW

7.1 The view of the clinical partners involved in this scheme is that a larger practice along with a more corporate business structure will allow for the multiple benefits a larger organisation can offer and is detailed in the business case.

8. PATIENT AND PUBLIC VIEW

8.1 To date the views of the patients have been positive. Further events for patients are being arranged through August and September

9. KEY RISKS AND MITIGATIONS

9.1 There are risks relating to IT/System mergers and data collection issues (QOF) should this merger not be planned within appropriate timescales. To mitigate this risk the merger will be planned to go ahead before December 2019.

9.2 The timescales allow for adequate and appropriate planning for the systems merger.

10. IMPACT ASSESSMENT

Financial and Resource Implications

10.1. There are no adverse financial implications to this process

There are resource and finance implications attached to the merger of the clinical systems. The IT team are aware of the proposals and have plans in place and to meet the requirements.

Quality and Safety Implications

10.2 There are no implications for Quality and Safety as long as the planning stages are completed and the merger takes place within the planned timescales

Equality Implications

10.3 See appendix 2 EIA

Legal and Policy Implications

10.4 There are no legal and policy implications

Other Implications

10.5 The partners are consulting/engaging with all staff and there are no plans for any reduction in staff numbers and no redundancies are anticipated.

11. Recommendation

11.1 The recommendation is that approval is given for this merger, dependent on assurance that the merger is well planned, timescales are in line with IT workload and can be managed safely and there is no detriment to patient care during this process.

Name **Gill Shelley**
Job Title **Primary Care Contracts Manager**
Date: **September 3rd 2019**

ATTACHED:
Business Case health and Beyond Partnership
Finance spreadsheet

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	**Date**
Clinical View	As per business plan	
Public/ Patient View	As per business plan	
Finance Implications discussed with Finance Team	Sunita Chhokar	3/9/19
Quality Implications discussed with Quality and Risk Team	N/A	
Equality Implications discussed with CSU Equality and Inclusion Service	David King	13/8/19
Information Governance implications discussed with IG Support Officer	N/A	
Legal/ Policy implications discussed with Corporate Operations Manager	N/A	
Other Implications (Medicines management, estates, HR, IM&T etc.)	IT – Ramsay Singh	3/9/19
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	
Signed off by Report Owner (Must be completed)	**G Shelley**	N/A

NHS
Wolverhampton
Clinical Commissioning Group

BOARD ASSURANCE FRAMEWORK NOTES

(Please **DELETE** before submission)

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2019

Business Case: Merger of Health and Beyond with Parkfields Medical Centre (including Woodcross Medical Centre)

VERSION 2.0

AUTHOR : DR. RAJ MOHINDROO, JOHN SEYMOUR

Introduction

Health & Beyond is a corporate body has GMS and APMS contracts within the Locality of South East of Wolverhampton. The GMS contracts are held by Health and Beyond partnership and APMS contracts by Health and Beyond Limited.

The GMS sites which are All Saints Medical Practice, Grove Medical Centre, Caerleon Surgery, Church Street Surgery and Bradley Medical Centre, the three are Ettingshall Medical Practice, Bilston Urban Village and Pennfields Medical Centre.

Historically, existing GMS practices merged together to create this corporate body. Together they have agreed to work together to improve patient experience and to deliver more efficient, effective high-quality services by using the available resources to its optimum.

The aim of these GMS merger was to help patients but also to introduce modern digital practices, patient services and procedures as this will be beneficial to all of the stakeholders of this corporate body. It will benefit the stakeholders in a several ways i.e. enhance the efficiency, enable them to compete and continue in the challenging environment this health-care industry.

Since November 2017, the corporate body has created a total list size of 38,500 across the 5 GMC sites and 3 AMPS practices. This figure is the latest figure up till April 2019. This has been a massive achievement within a space of 17 months. The corporate body has progressed immensely and will continue to so.

This initial document helps to summaries the recommendations and key proposals that can be used for due diligence of the proposed merger of Parkfields Medical Practice and Woodcross Medical Centre these are currently held under one contract in the name of Parkfields and the merger into Health and Beyond Partnership.

1.1 Goal, Vision, Principles

Our Vision is to develop a “corporate general practice”, merging our GMS Contracts and assimilating our APMS contracts to form a larger, more corporate business structure, allowing us and our patients to benefit from the resources, economies and efficiencies of a larger organisation to survive, compete and prosper in the new and evolving competitive landscape, including the newly formed Wolverhampton South East Collaboration (WSEC), which has the majority of the patient list for that group.

Our aim is to develop cost-effective community solutions by working closely with social care and other community and voluntary sector assets to manage and deliver holistic health and social care. Creating an integrated health and social care ecosystem within Health and Beyond and sharing it within the WSEC.

We have the vision to work with mental health services to create a corporate and business solutions, legal, HR solutions for Primary Care Networks, Dental, Mental Health and Transport.

The company holds its current properties portfolio in its H&B properties company, with Parkfields premises added to that portfolios ,while Woodcross will continue as a leased premises from NHS property services.

It is also working closely with universities and research teams to expand and form Health and Beyond digital healthcare space.

1.1.1 Core principle

Our core principle is to continue to nurture and preserve all the excellence of traditional GP services. We want local GPs leading and working in local surgeries to provide long-term doctor/patient relationships based on the established values of trust and personalised care, enabling us to improve the range and quality of patient services, access, patient responsiveness and organisational learning.

1.2 Background

This document details the merger of the following stated practices into a partnership called Health and Beyond, the current locations are, All Saints, Grove Medical Centre, Caerleon Surgery, Church Street Surgery, Bradley Medical Centre and the proposed new practices of Parkfields (including Woodcross) the initial merger took place in November 2017).

The appetite for transformational change and integration is strong within the region of Wolverhampton. There is clear recognition to move from traditional, fixed models of delivery to ones which are flexible and responsive, and focused on early proactive intervention and integration, therefore, we need to maximise the synergies and opportunities we have available to us across the health and social care commissioning and provider communities, particularly enhancing those which exist between primary and community care.

As part of our journey, we have agreed to come together to develop a Super-Partnership Model to continue to enable GP practices to work together to pool their clinical skills and financial resources whilst being able continue to deliver outstanding primary care to the patients to the South East Location of the Wolverhampton CCG. This in turn would extend the patients numbers to 52,168 across Wolverhampton CCG, with only the Pennfields site sitting outside the South East Locality.

Currently Parkfields and Woodcross, has a strong, well balance workforce, 5 GP's, 2 AP's, 4 Nurses, 3 Healthcare Assistants, 1 Practice Manager, 8 Admin Staff , 12 Receptionists, 1 Apprentice, 1 Physicians Associate, 1 Pharmacist, and 3 non employed GP Registrars who have been involved in a number of engagement meetings, which have had positive feedback. The meetings have included information around processes should the merger be agreed and their positions moving forward in relation to TUPE and ongoing employment. Three of the current GP's will be offered partnerships within Health and Beyond Partnership, which they have agreed to. There has also been engagement meetings with the PPG and open public meetings, again these have been positive towards the proposed merger, and the PPG openly supporting the merger as the solutions to the practices moving forward in a positive and sustainable way.

Parkfields Medical Centre is owned by the doctors, with the Woodcross Practice being leased from NHSE. Health and Beyond are looking at purchasing the Parkfields Medical Centre property.

The current Parkfields Partners, are looking to secure the practices in the longer term in a progressive and organic way, with two of the partners due to retire in early 2022.

Partner Doctors:

Dr Alison Johnson (f) Joint Property Owner

Dr Akinwumi Adewale Latunji (m) Joint Property Owner

Dr Nejla Hussain (f)

(Dr Helen Hibbs Joint Property Owner)

The new merger plans will mean that Parkfield and Woodcross will form part of a fourth hub in relation to administration options but will retain its own clinical identity, however, in line with the Equality Impact Assessment we undertook, the merger will increase patients' access across the partnership to a female doctor, and this has been restricted in the past. All four Hubs are within 2.2 miles of each other.

Within the Parkfield merger we have already performed a due diligence equality impact exercise, which highlights that an improved mix of clinicians will deliver greater equality. There will be more managerial and administration support in the Group to offset the increase in patient numbers.

Currently the Health and Beyond 7 GMS sites are under one M code and the 3 APMS under individual contracts.

Parkfield will also be integrated into the single M Code. Clinical service delivery will remain unchanged and reflect the current services in each of the sites; patients will experience no changes to the traditional practice mechanism and the future proofing of their practice, or a change of name.

In an ever evolving NHS that is focused on delivering primary care at scale, the partners within the sites feel it was still a good idea to work together and develop clinical services which will benefit the patients. This still remains the same concept that led to the idea of a mergers between the original three practices, and in the long- term, delivering scaled up primary care services for our patients, which will make Health and Beyond more resilient in the longer term. This business case details the scope and benefits of the merger in detail.

There will be NO IMMEDIATE CHANGE to service delivery.

In the City of Wolverhampton, we have three models outside Health and Beyond:

1) GP Chambers Model-Unity – this is a loose collaboration of GP practices working together on common issues;

2) Vertical Integration Model- this is a salaried model for GPs and lead by the Acute Trust.

3) Primary Care Networks - Super practice GMS with APMS contracts working together as a Network as the lead provider of services and employer in the Wolverhampton South East of Collaboration:

Health and Beyond practices working together on common issues with two further practices.

The above baseline models are all aiming the deliver primary care at scale however, the first one are still unable to achieve a financial assimilation of assets, hence why it difficult for these models to work with Partner Organisation's such as: Social Care and Mental Health Trusts. Furthermore, as they are incapable of managing their finances, this still have not yet become business organisation's because they will not have the ability to hold capitated budgets. For these reasons, the VI Model is the most viable option in the current settings, after Health and Beyond, although this is not a preferred model by most GPs in the City of Wolverhampton.

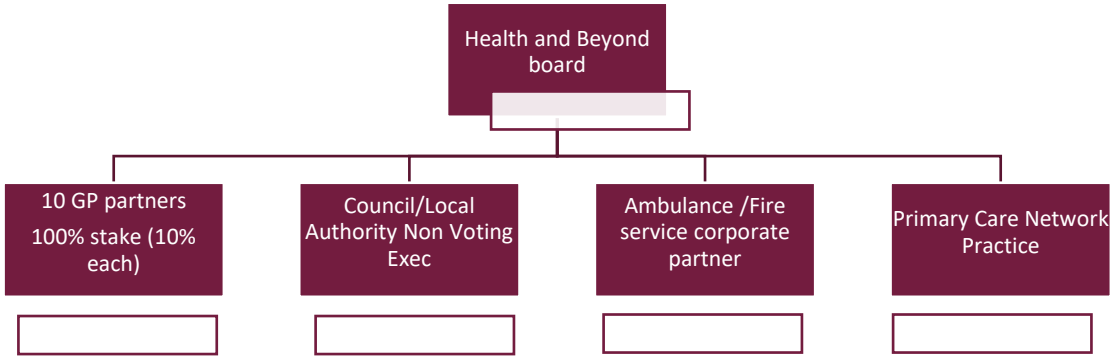
3) Health and Beyond has the Aspiration to become a lead provider for the PCN.

This document details the merger of the following practices into a super-partnership called Health and Beyond

1. All-Saints Medical Practice
2. Grove Medical Centre
3. Caerleon Surgery
4. Church Street Surgery
5. Bradley Medical Centre
6. Pennfield's Medical Centre
7. Ettingshall Medical Centre
8. Bilston Urban Village Medical Centre
9. Parkfields (Merger Proposed)
10. Woodcross (Merger Proposed)

(The AMPS sites are not merge, therefore they are separate, but they are part of H&B Ltd).

1.3 Partnership Model



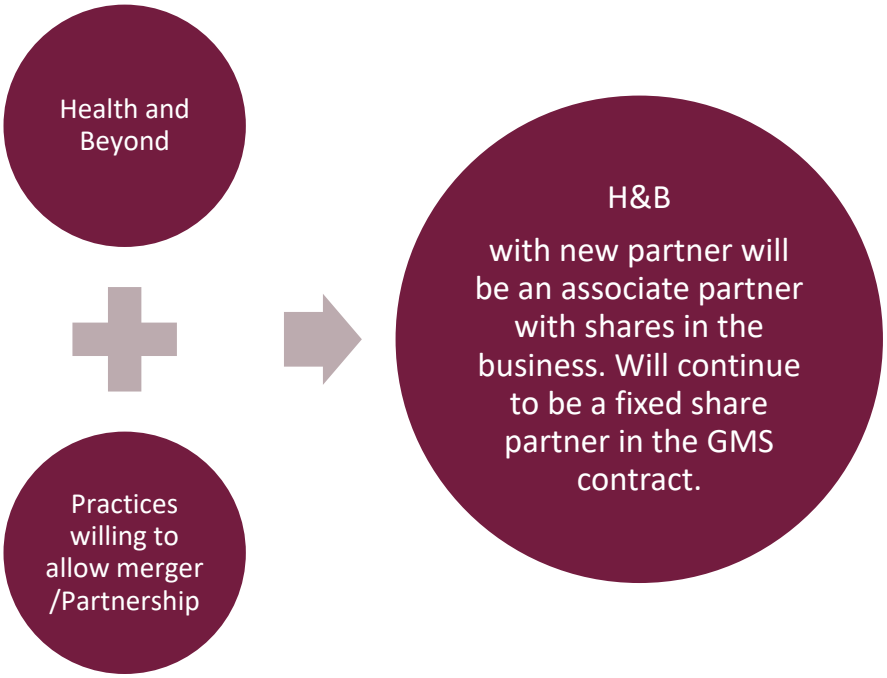
Our Future Business Model:

- All the models detailed below will be used till H&B reaches a 50,000 list size.
- Similarly, the operational team will look for potential practices who are up for acquisition to create the model in another city.
- Our aim is to create third sector partners.
- Originally, our vision was to create a list size of 50,000 patients and for this reason our current GMS sites (Grove Medical Centre, All Saints, Church Street, Bradley Medical Centre and Caerleon came together which together formed a list size of 22,000.

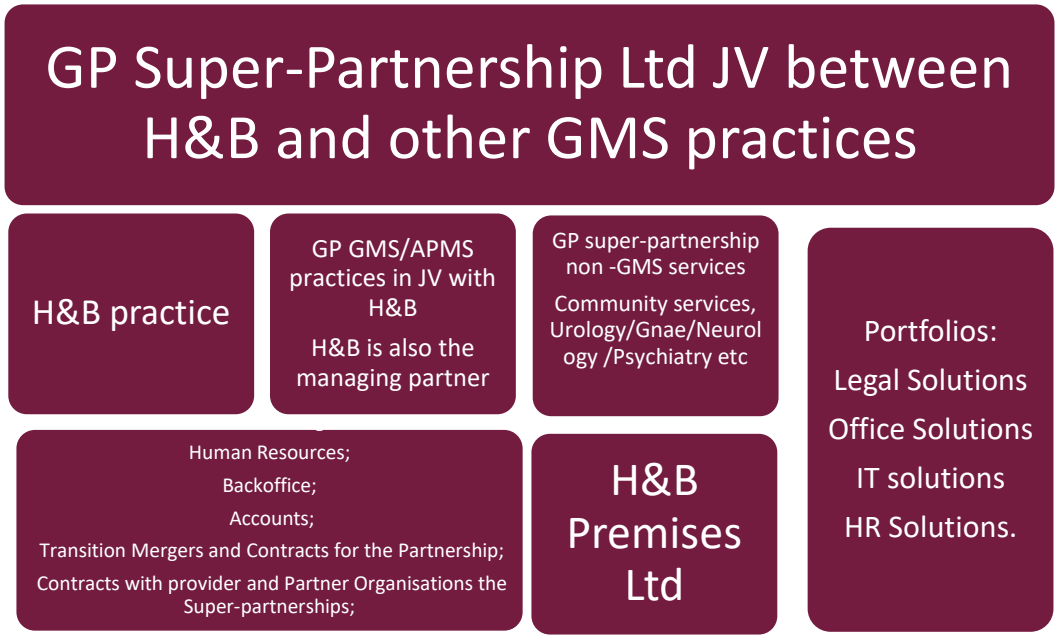
- After the 5 sites merged together to form part of Health and Beyond, in April 2019 we took on three AMPS practices (Ettingshall, Bilston Urban Village and Pennfields Medical Centre) taking our list size to 38,500 patients.

- As our global vision is to serve a million patients across the globe and for us to make this happen we needs to form a cohort of 50,000 patients within the locality of Wolverhampton, which will be the case once the proposed merger of Parkfields and Woodcross into the fold.
- Furthermore, Health and Beyond will not only be providing healthcare support to their patients but in the future will be offering the patients with the services such as: transport solutions, legal solutions and dental solutions.
- We wish to be the lead provider for the PCN. The practices in the network will jointly sign up to the network agreement.

Model 1: Acquisition Model



Model 2:



New 'Super-Partnership' Entity

A partnership agreement has been formed between the partners of the practices will be sufficient for a merger to take place between the GMS and PMS practice, however, there is a need for an additional structure, e.g. a company limited by guarantee or a company limited by shares, thus limiting individual partner liability. Our Super-Partnership Entity includes an APMS contract into the partnership.

Health and Beyond Strategic SWOT

Strengths

- Ablity to offer high quality services
- Enables rationalisation of quality frameworks and policies
- Partners are well motivated and are always striving achieve the success of the company.

NHS is less expensive that the medical systems which may come into our favour when organizing structures.

-According to WHO, we have the best systems with outcomes

Weaknesses

- May require extensive 'soft change management' to facilitate a new, standardised set of operational and managerial processes and protocols within a newly merged group of personnel
- Individual GPs may have less influence in the decison-making process within a large partnership.

Opportunities

- Merging parties do not need to have equal viabilty
- Can offer significant benefits through economic of scale
- Can establish joint ventures with other GP, NHS, Social and Heathcare organisations in the future.
- There is fragmented healthcare across the globe whereas there is more standardization within the NHS. The NHS PC comes across as an organized system with available systems in place to look at payment models and hence forth could be adapted to the current insurance models too.

Threats

- Poor planning and preparation can lead to future spilts following disintergration of relationship
- Collaborating with a largers GP organisation can temporarily incur an initial decline in income due to profit sharing arrangements
- Substantial risk of losing local connections and continuity with patients if staff become remote or too centralized.

There is financial risk to practices if not also incorporating a limited company (in a standard partnership model the individual partners are, unless contrary written agreement dictates otherwise, all equally and personally liable for the liabilities and losses of the partnership they are involved in);

Others:

- Practices would need to assess and determine the most appropriate legal entity, subject to their individual contract-types, and seek further advice/guidance from their core commissioner prior to agreement on the kind of merger they wish to achieve.

1.4 Process

1.4.1 Legal Process

A comprehensive partnership constitution has been developed including various deeds, management and profit-sharing principles and policies which will be templates for any future mergers or new partner appointments. The model allows for straightforward expansion and increase of size to whatever we feel will best suit future needs.

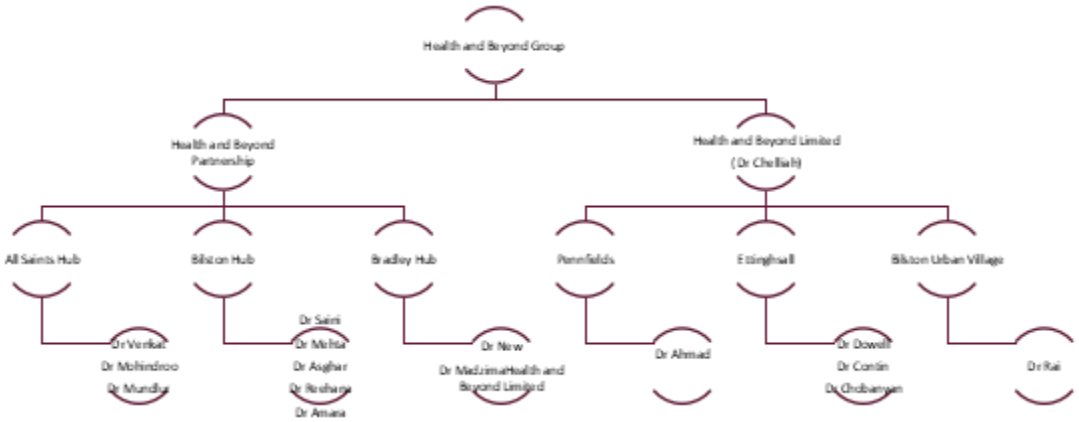
The legal process has been robust throughout our organization. Our partnership operates in accordance with our written Partnership Agreement which forms part of the governance of the partnership.

Furthermore, we have an extensive Shareholder's Agreement between our shareholders listing their roles, rights, power's and obligations in relation to Health and Beyond Ltd. We have Articles of Associations in place which forms the constitution of the Limited Company which all Shareholder's must adhere to.

Health and Beyond partnership and Health and Beyond Limited have a Service Level Agreement (SLA) which sets out that Health and Beyond Limited is the Service Provider and Health and Partnership is the Customer. The SLA also defines the services that the Customer will receive from the Limited Company. The SLA helps to draw a clear distinction and clarity between the two entities.

Health and Beyond also has a number of other agreements in place such as: Merger Agreements and Heads of Terms.

As an organisation we would like to use these expertise's and experience in helping practices/networks.



1.6 Quality and Patient Safety

1.6 .2 QOF RESULTS

To ensure a high standard is maintained when practice's merge, they will agree to have a dedicated administrator who will organize by monthly QOF meetings with nurses and GPs to focus on areas where performance is low, develop a practice action plan where the admin will monitor and ensure delivery. The newly formed practice intends to improve nursing capacity by employing an additional nurse.

Practice Name	QOF Overall Performance (2017-2018)
Grove Medical Centre	98.5%

The data used is from 2017-18 collected from (http://qof.digital.nhs.uk/search/index.asp)

1.6.3 Quality and Patient Safety

Health and Beyond are adopting new quality improvement methods and factors that promote high and robust quality across both service delivery and safe patients care, our actions are at multiple levels within the health system to nurture and support improvements of quality in general practice.

We have increased the number of members our governance team, not only to include GP's but also a range of other skills, to match modern day workings across both our on-going growth and promote new reassurance to patients and commissioners.

We are making commitments to building a culture and capability to support continual quality improvement, which includes validate our vision and values by ensure practice teams to actively embrace an ethos of putting patients first and seeking to provide excellent care, involving every member of staff in the mission of continually improving care, and valuing and incorporating patients in measuring and improving their care.

All our practices will evaluate their shared values and norms regarding the safety and quality of their care, we will be using staff surveys of culture and team discussions to take stock of the current

situation and identify areas for improvement. Quality improvement flourishes best in a culture that promotes: engaging and empowering all staff in measuring, understanding and improving quality accountability for improving, employing openness about performance and variability and incorporating rewards and penalties continual, rather than periodic, improvement, where improvement contributes to the fabric of the practice and is a part of every person's working day.

We are increasing the number and quality and skill of our leadership team to impart vision, enthuse staff and shape a bespoke culture. This is a distinct skill from the previous role of practice management. Effective leadership in a practice does not necessarily have to be given by a doctor, but it must be acceptable and effective for all staff. Adopting structures that value the contribution of all disciplines may sometimes involve non-medical partners – a move that a growing number of practices are finding helpful to fulfil ongoing improvement.

We are adding a number of clinical posts to our team, these include additional Clinical Pharmacists, Advanced Clinical Practitioners, and First Contact Practitioners, over the next three months. Working towards on development of First Contact Physiotherapy (FCP) service within Health and Beyond which view of extending it to larger MSK service consisting of multidisciplinary team of professionals involved in providing Physiotherapy/MSK/T&O/Rheumatology/Pain Management services.

With the NHS Long Term to development of new ways of working in primary and community will increase the focus on safety. We believe the inclusion and development of integrated care pathways with new types of clinicians in primary care and with patients moving seamlessly between primary, community care services is an opportunity for local systems as described above will develop robust clinical governance with clear lines of accountability for safer and bespoke care.

Our new primary care network gives us the opportunity to promote a robust safety culture couple with continuous quality improvement around patient safety in primary care. We see the role of the PCN clinical director will be developed to ensure the right expertise is in place to facilitate this within the group to support the new safety ascendancies.

These changes to improving the quality and safety of care across Health and Beyond. While meeting the demands of a more outcomes-based performance framework, together with the regulatory requirements of Commissioning Boards and Care Quality Commission. Making greater time commitments to patients in such a way we can use and adapt quality concepts of continual improvement, imparting practical skills, and the coaching of staff through their application and face to face values towards patient safety and proven quality becoming a key aspect of the practice's and patients environment.

We believe that the above not only moves toward a robust change in the quality of patients care but also enhances patients safety by:

Improving understanding of safety by drawing on our own intelligence from multiple sources of patient safety research.

Involvement in schooling patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system.

Improvement by redesigning and supporting programs that deliver effective and sustainable changes in the key areas of patients care within local communities and by local clinicals.

Whilst encompassing the introduction of patient safety and engagement leads whilst integrating with the National Patient Safety Improvement Program guidance. As of September 2019, we will have a monthly Patient Safety Meeting, outside of our monthly clinical meetings

1.6.4 Contract Review

Grove Medical (T/A Health and Beyond Partnership), a contract review was undertaken by members of Wolverhampton CCG, in July 2019, and the results are included in this business case (see attached appendices 1)

As a group we also use the QCS Management Systems, to take guidance and solace in all areas to support decision making and as a management tool.

1.7 Health and Beyond Premises & Portfolios

Grove Medical Centre

Grove Medical Centre is located in Steelhouse Lane, Wolverhampton. It has a detached building and has limited availability of parking spaces.

Currently the building is owned by Health and Beyond. This building is fit CQC Compliant with disability access and has scope for expansion.

All Saints

All Saints Medical Practice has got two sites. One of the site is located in Cartwright Street of Wolverhampton. It is a semi-detached property with an extension and has got limited car spaces. This property is mortgaged and Dr. Praveen Mundlur has 100% ownership. This building has got disable access is CQ compliant and has decent internal facilities.

Caerleon Surgery

The Caerleon surgery is owned by Dr. Arshad Asghar who had 100% stake and the building is mortgaged. This surgery is located in Dover street, Bilston. This site has got the basic disability provisions but has lack of parking facility. There is off road parking available but the road being very narrow it makes it very difficult to park and the patients might have to park on other roads during busy times in surgery.

Church Street Surgery

This a freehold premises which is currently owned by Dr Saini and Dr Mehta as Tenancy in Common.

Bradley Medical Centre

The premises is a freehold property and leased to Health and Beyond.

Parkfields Medical Centre

Owned by the Parkfield GP Partners however Purchased is agreed with H&B

1.7.1 Property Business Plan:

We will have 4 hubs. Hub 1 Grove Medical Centre and All Saints Surgery. We shall have a Hub 2 which is Bilston Super Hub which will consist of: Bilston Urban Village, Ettingshall, Church Street and Caerleon Surgery, then Hb 3 Bradley and Hub 4 Parkfields and Woodcross.

Out of the available sites the Grove Medical Centre has got the capacity for premises expansion. The existing building can be replaced by a new building which can accommodate All Saints practice to enhance the patient experience, and can house modern amenities in accordance with the CQC compliance. There is a provision of sufficient car parking adjacent to the building which is owned the Temple which is proposed to be built just opposite (across the road) to the surgery premises. The All Saints practice is located 0.4 miles away so this merger can be done without any disruption to the patients.

It is quite important to plan the transition and following tasks would need to be accomplished for a smooth merger of premises:

- Evaluation and disposing the existing premises
- Formation of a company with all participating stakeholders
- Identifying the development company
- Finalising designs, pricing, plans with appropriate permissions and approvals
- Temporarily moving Grove Medical Centre to All Saints during the construction period
- Identifying new premises to merge Caerleon with other Bilston Sites
- On accomplishing the construction/ Acquisition, moving the partner surgeries to the new location.

The purposed date for this would be January 2020

We have now purchased the proposed shared parking space. The Practices that will closed down will be potentially be converted to i.e. providing for mental health, learning disabilities, day Centre or care facilities or community clinics. This way we are trying to utilize the space from a network prospective.

1.8 Practice Analysis

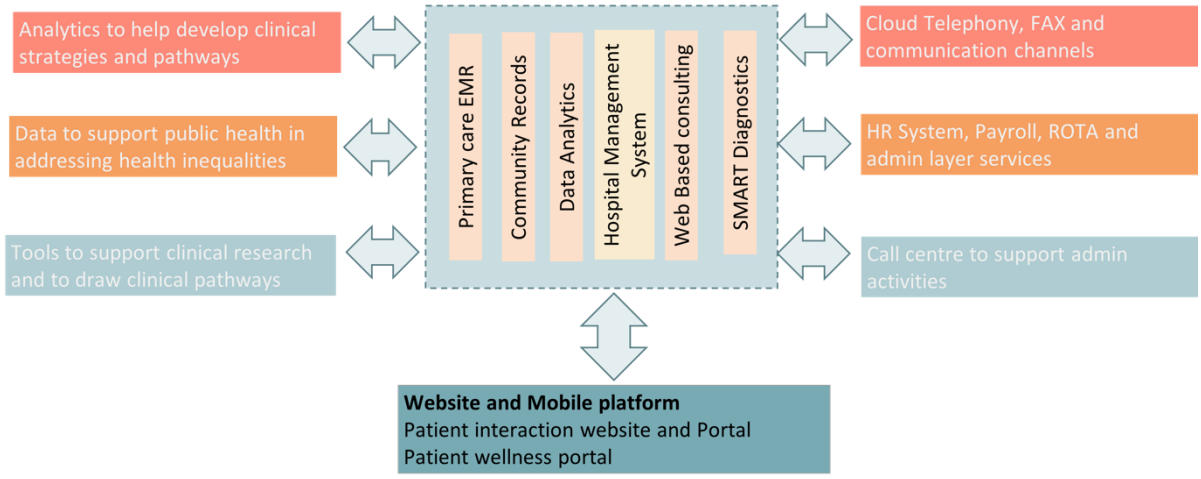
The merger will have a patient strength of **52,000** and will increase on addition of 3 more partners with whom the discussions are being carried out. After the merger, the partnership will have a strength of 11 GP partners, 5 Salaried GP, 12 nursing staff, 60 in reception and 15 in the Admin teams. One of the partners has already discussed his plans of retirement and would be reducing his sessions.

Post-merger, the advanced nurse practitioners and nurse practitioners and will integrate with clinicians to ensure the sharing of good practice and a consistent approach to the delivery of high quality care. By merging the practices, it can be ensured that a stable practice partnership is maintained that is reassuring to the staff and patients, and appealing to prospective new partners. It is anticipated and top priority to ensure that there will be no decline in the way the current contractual work is delivered. Access to the surgery will be improved as there will be a wide range of clinical staff that will be able to complement the delivery of primary care.

There will be a change in organisation structure and possibly there will be a reduction in staff post-merger and moving into a single premise. The existing staff can be retained for the time being till the new premise is constructed. The new premise is anticipated to be a fast-paced environment and realignment of work force is anticipated. It is although important to do staff consultations to make sure that they understand the importance of this merger and contribute in shaping this new organisation.

1.8.2 Systems and Processes:

The merger will give an opportunity to do a due diligence of the existing systems and replacing them with more efficient and latest systems. The existing clinical records system can be merged to make two new systems, one at each hub. Such initiative allows to draw pathways, behavioral patterns etc. and using data in more meaningful ways. Before the merger, the IT road map should be clearly identified and the outcomes should be clearly defined. A proper risk assessment is recommended before initiating the merger process of the IT systems.



The above diagram shows the IT ecosystem that is visualized to support this merger. Following outcomes are anticipated from the ecosystem:

- Two clinical systems one at each hub.
- Setting up a call Centre where in the patient can call to book appointments, order repeat prescriptions and to sign post the patients etc.
- A single system to manage the HR, Payroll and all administrative activities including staff ROTA and patient surveys.
- Introduction of new telephony systems which can cater for the hubs with multiple lines with automated call handling facility, this is planned for January 2020
- Introduction of analytics tools which will enable to enhance the patient care, social care and community care.
- One website which will have information for patients and enable them to access relevant healthcare apps.
- Provision of web consultation to be integrated to the website
- Tools for Inventory management, budget management etc.
- Insurance sector support integration

1.9 Finance analysis:

This analysis is still not robust as some data is missing but we can draw an average analysis out of the present data. All the three practices have different patient numbers and different income levels. Caerleon surgery has the highest staff expenses to Income ratio (54.54% in 2015 and 48.58% in 2016) and the finance expenses also due to an existing loan of GBP 40,000. (See Appendix 1 for financial assessment) All Saints surgery is being efficiently managed with moderate expenses and a high NET income to Income ratio (64%) for year 2015. The annual accounts for 2016 are still being drafted and are expected by end of Feb 2017. Caerleon Surgery has the lowest Net income ratio which is ~26% and Grove Medical Centre has ~54% for the same financial year.

The merger will garner a combined income of GBP 1.3 – 1.5 million per annum. Looking at law of averages and economies of scale the combined expenditure can vary between GBP 550 – 650K. Caerleon surgery can benefit from this merger as their NET income can be improved by just merging the admin services. There a clear scope for optimizing the financial performance and all the GP partners can draw a huge benefit out of it.

It is recommended that the three practices should go ahead with the due diligence of the merger. An in depth financial analysis needs to be carried out with projections and latest accounts statements. A viable exit option needs to be strategized to keep the working model flexible. It is important to carry on a risk assessment on availability of 2016 accounts of All Saints. Moreover, before making a final decision the partners should analyse the expected increase in the cost of capital over next 2 years. They also need to take into consideration economic conditions before making the final merger decision.

1.9 Advantages and outcomes of Merger

i) For Patients:

- Centralised patient appointment booking facility through call center.
- Implementation of longer opening hours to accommodate more patients in a day.
- Value-added Patient care from a modern, fit for purpose building with modern facilities.
- Access to experienced primary care health team with an excellent skill mix.
- Patients will have increase in access and more flexibility in terms of appointment times and choice of clinician.
- Provision of enhanced services and community based services as well as continuing to maintain high QOF achievement in order to maximise quality of service provision for patients.
- Focus upon long term conditions, developing and maintaining care plans for patients and ensuring access to the appropriate services for these patients.
- Provision to deliver enhanced services such as minor surgery and family planning for the patients.
- Enhanced services from the WSEC

ii) For Stakeholders:

- Enhanced buyer power. This merger will give the partnership the power to bargain and get the best prices from suppliers.
- Centralised admin team reducing admin burden.
- Integrated services to be delivered through common premises to ensure the sharing of good practice and a consistent approach to the delivery of high quality care.
- Guaranteed cost saving using unified and better systems, moving completely to digital and reducing paper administration.
- Proper exit strategy for partners who want to retire.
- Development of new innovative care pathways which will work at the interface of social and healthcare system.
- Proposal of incorporation of two existing pharmacy units at each proposed new hub which will be a value add service and will provide rental for such initiative which is and added advantage.
- Discussion with private insurance providers/insurers to facilitate private clinical work and insurance work.

- Enhanced services from the WSEC

Equality Analysis – Proposed Merger Between Health and Beyond Partnership with Parkfields and Woodcross Medical Practices

EQUALITY IMPACT ASSESSMENTS (EIA)?

We have a legal responsibility to assess how they will monitor any possible negative impact on (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation) equality, whilst promoting good relationships among communities.

The key purpose of our Equality Impact Assessment is to:

- Promote all aspects of equality.
- Identify whether certain groups are excluded from any of our services.
- Identify any direct or indirect discrimination.
- Assess if there is any adverse (negative) impact on particular groups.
- Promote good relations between people of different equality groups.
- Act as a method to improve services.

Other reasons for our Equality Impact Assessments are:

- It increases user/public/staff trust.
- It enhances value for money.
- It informs business plans.
- It increases social inclusion.
- It promotes understanding and sensitivity.

Equality Impact Assessment should not be seen as a separate exercise for Managers to undertake. It should be built in as an integral part of continuous service and performance review. Assessing for equality impact is an aspect of delivering service improvements. For some of the services, equality considerations may already be well integrated into service planning and review. The Equality Impact Assessment Process will simply enable services to document equality deliberations and conclusions and show transparency and accountability to the wider community.

As both parties are existing providers of services for patients for some years in close proximity to areas that form part of the South East locality of Wolverhampton CCG, we have identified several groups who have cosseted characteristics by analysis of our combined patient data. We as an organisation will ensure that due regard is given to the needs of our patient population during the said service mergers, including that of vulnerable groups, through effective engagement aligned with the profile of those possible affected by such changes.

1) Age: Older people preferred to see their named GP coupled with a regular Nurse and Health Care Assistant, which is dealt with within our workforce planning and recruitment, in the case of locums, we will be using affiliated GP's to the practice, and of course the current partners to ensure continuity of care, which is key to this proportion of the population. In the case of the merger then

all clinicians will be available across the locality thus meeting the patient's wishes, and supporting a allaying their anxiety.

2) Disability: Carers and people with disabilities were concerned primarily about journey times, the difficulties of getting on and off buses, ample disabled parking facility and access within practices including vulnerable groups. Carers of people with LD were concerned about a lack of understanding of the impact of intellectual disabilities that relate to their charges and their on-going illness e.g. pain control. They preferred to request a visit from their own GP due to issues with access. People with mental health problems were described as finding busy practice environment as an issue. We have protected supervised area for patients to discuss or sit and wait if they had severe and enduring mental illness which needed urgent medical appointment and plan to develop inclusive, supportive values and competencies across this sector . This has been considered when looking at the merger and having 7 sites within the South East locality of Wolverhampton CCG and each site have close proximity to at least one other. There is a mixture sites facilities both which match the needs identified in this analysis and in fact the merger gives improved access by public transport and has improved general parking and disabled parking across the 7 sites.

3) Gender reassignment: We have limited numbers to undertake an analysis current across the group, all requests are dealt with in line with the equality act 2010 in relation to gender dysphoria an plan to develop inclusive, supportive values and competencies Parkfields have had three patients who successfully transitioned and a further three currently transitioning.

4) Pregnancy and maternity: pregnant and expectant mothers prefer to see midwife's in practices, therefore avoiding unnecessary drawn out hospital journeys. There is also preference to see a female GP who has special interest in women's health. The merger will enhance this with great access across the locality and the increase in female doctors and a viable appoint scheduled to match patient's needs, which will include a request for a great depth of information and consistency which many younger mothers feel is missing and increasing concerns around Pre-eclampsia . The merger of Parkfields and Woodcross will increase the female population by 6946

5) Race: We found very little to differentiate minority ethnic experiences within our local practices from those of the white British population. There was a sense from some professionals that people from ethnic minorities had language and cultural barriers to access and needed longer appointment times creating a wait in the waiting room, there is very little if any evidence to support this statement. When auditing the clinical system there was no differential between timings, the main difference was around presenting conditions. Our population demographics by race shows that 68% of the population is white, with 64.5% of this number being White British and the remaining being Eastern European. Over 17% of the population is South Asian and are mainly Indian, almost 2% is Black, 2.5% are Chinese or other Asian, 5% are mixed race with 25% unknown.

6) Religion or belief: The South Asian population is mainly split between Sikhism, Muslim or Hindu, Christian was the highest and the remainder between , then low numbers of that worshiping Judaism, the Mormon Faith and Jehovah Witness's, and the complex needs that this collection of faiths present to patients healthcare needs, there are a number registered as having no religious beliefs.

7) Sexual Health: We found no differentiation between the reported experience of men and women, with the exception of females in many cases preferring female GP's.

8) Sexual orientation: No specific issues have been acknowledged for this group.

9) Civil Partnerships and Marriage: all our current staff are trained and have mandatory equality training which if not in will be extended to new staff allowing for everyone to be treat without any prejudice, we offer impartial accessible and equitable services to all patients.

10) Access to Services (opening times), is a topic that always divides young, old and carers and those that work and those that do not, to bridge this gap against normal opening times within our practices that are in close proximity to areas that form part of this merger, we have extended hours that cover five nights to 8pm, Saturday and Sunday 8am to 12.30pm and that gives additional appointments beyond the national average set against patient lists.

We have ensured that we have the right clinical skills in our practice's to meet the diverse needs of our patients, including those with protected characteristics, such as dermatology, diabetes, respiratory disease-asthma and COPD, child health surveillance, minor surgery , orthopedics, rheumatology, mental health, dementia, obstetrics, gynecology and cardiology. We also have strong values around safeguarding both in adult and children areas. Our entire clinical workforce will interchange within our sites to maximise and provide such skills locally, whilst promoting community healthcare, and providing familiar faces with admin staff, doctors across South East locality of Wolverhampton CCG and the South East PCN. The rationalisation will also offers a larger range of services to patients that was previous the case with prior to the newly proposed merger.

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NHS
Wolverhampton
Clinical Commissioning Group

Equality Analysis Form

Name of Project/Review	**Proposed Merger between Parkfields Medcial centre and Grove Medical Centre (Health and Beyond Partnership)**
Project Reference number	**Parkfields/Health & Beyond Partnership Sept 2019**
Project Lead Name	**Gill Shelley**
Project Lead Title	**Primary Contracts Manager**
Project Lead Contact Details: Number & Email	**Gillian.shelley@nhs.net 01902448334**
Date of Submission	**9/8 2019**
Version	**V0.1**

Is the document:	
A proposal of new service or pathway	**NO**
A strategy, policy or project (or similar)	**YES**
A review of existing service, pathway or project	**YES**

Who holds overall responsibility for the project/policy/ strategy/ service redesign etc
Grove Medical Centre partnership (Health and Beyond Partnership)
Who else has been involved in the development?
Wolverhampton CCG

Section A - Project Details

Preliminary Analysis – *copy the details used in the scoping report*

This Wolverhampton practice known as Grove Medical Centre has a list size of c 22,000 of patients currently operating across six sites as below

- Grove Medical Centre, 175 Steelhouse Lane, Wolverhampton
- All Saints Medical Centre, Cartwright Street, Wolverhampton
- Carleon Surgery, Dover Street, Bilston
- Church Street Surgery, Church Street Bilston
- Bradley Medical Centre, Hall Green Street, Bilston

The GMS Contract is held with the 9 Partners of Grove Medical Centre.

Parkfields Medical Practice has a patient list size of c13500 and operates across 2 sites

- Parkfields Medical Centre, Parkfileds Road, Wolvrehampton (main site
- Woodcross Health Centre, Woodcross, Wolverhampton

The resulting contract will be with Grove Medical Centre with Parkfields and Woodcross both becoming branch sites of this practice.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

- Patients
- Staff at Parkfields Medical Centre (both sites)
- CCG
- Other local practices may be affected

Section B – Screening Analysis

Equality Analysis Screening
It is vital that the CCG ensures that it demonstrates that it is meeting its legal duty, as the responsible manager you will need to identify whether a Full Equality Analysis is required. A full EA will only not be required if none of the following aspects are identified and you are confident there is no impact. *E.g. 'This report is for information only' or 'The decision has not been made by the CCG' or 'The decision will not have any impact on patients or staff'. (Very few decisions affect all groups equally and this is not a rationale for not completing an EA.)*

Screening Questions	YES or NO
Is the CCG making a decision where the outcome will affect patients or staff? *For example will the project result in you making decisions about individuals in ways which may have a significant impact on them? e.g. service planning, commissioning of new services.*	YES
If the CCG is enacting a decision taken by others, e.g. NHS England or Local Authority - does it have discretion to change, modify or mitigate the decision?	NO
Is the board/committee being asked to make a decision on the basis that this proposal will have a consequential effect on any change? e.g. Financial changes	YES
Will this decision impact on how a **provider** delivers its services to patients, directly or indirectly?	YES
Will this decision impact on any third parties financial position (i.e. Provider, Local Authority, GP Practices)? *For example are you removing funding from theirs or any contract?*	YES
If you have answered **NO** to **ALL** the above questions, please provide supporting narrative to explain why none of the above apply. (*Advice and guidance can be sought from the equality team if required).*	

If the answer to ALL the questions in the screening questions is "NO", please complete the below section only and do not complete a full assessment.

Please forward the form with any supporting documentation to Blackcountry.Equality@ardengemcsu.nhs.uk

These initial assessments will be saved and retained as part of the CCG's audit trail. These will also be periodically audited as part of the CCG's Quality Assurance process and the findings reported to the Chief Nurse, PMO Lead and the CCG's Governance team.

Please ensure you are happy with the conclusion you have made, advice and guidance can be sought from: David.king17@nhs.net or equality@ardengemcsu.nhs.uk

Sign Off / Approval (Section A and B)

Title	Name	Date
Project Lead		
Equality and Inclusion Officer		
Equality and Inclusion Comments		
Programme Board Review		
Programme Board Chair		

If any of the screening questions have been answered "YES" then please forward your initial assessment to David.king17@nhs.net or equality@ardengemcsu.nhs.uk

And complete the next section of the Equality Form Assessment, once you are ready to request approval of the change from the appropriate approval board.

If you required any support to complete the FULL Equality form, please contact the Equality Manager.

The Completed EA will then require a final sign off as per section 10.

Section C - Full Equality Analysis Section

If at an initial stage further information is needed to complete a section this should be recorded and updated in subsequent versions of the EA. An Equality Analysis is a developing document, if you need further information for any section then this should be recorded in the relevant section in the form and dated.

1. Evidence used *What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses*
Both parties are existing providers of services for patients for some years in close proximity to areas that form part of the South East locality of Wolverhampton Patients have been consulted by the practice as outlined in the business case with responses such as ‘ we are surprised this hasn’t happened sooner’ or ’its about time’

Corporate Assurance Impact	
State overarching, strategy, policy, legislation this review or service change is compliant with	To review the current contract provision to ensure the best outcome for patients and best financial value.
Will this review or service change fit with the CCGs Boards Assurance Framework Aim and Objectives? If yes, please indicate which ones *(see notes page for guidance)*	Aims & Objectives 1 & 2
What is the intended benefit from this review or service change?	The intended benefit is to provide continuing resilience to Parkfields Practice. Over a number of years the practice has lost partners and has experienced difficulty in recruiting GP’s as partners. Two of the current t partners are older GPs who could potentially retire in the near future.
Who is intended to benefit from the implementation of this review or service change?	Patients Practice
What are the key outcomes/ benefits for the groups identified above?	• Greater choice of GP male and female GP’s • Greater choice of where to be seen. • Increased availability of appointments • Use of email for advice and support • Local phlebotomy appointments • Resilience for the current Parkfields practice and staff.

1. Evidence used *What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses*	
Will the review or service change meet any statutory requirements, outcomes or targets?	Yes

2. Impact of decision *In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.*
2.1 Age *Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.*
2.1 Age Older people preferred to see their named GP coupled with a regular Nurse and Health Care Assistant, which is dealt with within our workforce planning and recruitment, in the case of locums, we will be using affiliated GP's to the practice, and of course the current partners to ensure continuity of care, which is key to this proportion of the population. In the case of the merger then all clinicians will be available across the locality thus meeting the patient's wishes, and supporting a allaying their anxiety.
2.2 Disability *Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/learning disabilities, cognitive impairments.*
Disability: Carers and people with disabilities were concerned primarily about journey times, the difficulties of getting on and off buses, ample disabled parking facility and access within practices including vulnerable groups. Carers of people with LD were concerned about a lack of understanding of the impact of intellectual disabilities that relate to their charges and their on-going illness e.g. pain control. They preferred to request a visit from their own GP due to issues with access. People with mental health problems were described as finding busy practice environment as an issue. We have protected supervised area for patients to discuss or sit and wait if they had severe and enduring mental illness which needed urgent medical appointment and plan to develop inclusive, supportive values and competencies across this sector . This has been considered when looking at the merger and having 7 sites within the South East locality of Wolverhampton CCG and each site have close proximity to at least one other. There is a mixture sites facilities both which match the needs identified in this analysis and in fact the merger gives improved access by public transport and has improved general parking and disabled parking across the 7 sites.
2.3 Gender reassignment (including transgender) *Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.*
Numbers are limited in allowing an analysis current across the group, all requests are dealt with in line with the equality act 2010 in relation to gender dysphoria an plan to develop inclusive, supportive values and competencies across and currently

2. Impact of decision
In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.

sit with one GP at a single site, who has two patients looking to pursue GR.

2.4 Marriage and civil partnership
Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.

No negative impact identified at this stage, will be reconsidered following Primary Care Commissioning Committee Options Appraisal decision.

2.5 Pregnancy and maternity
Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.

Pregnancy and maternity: pregnant and expectant mothers prefer to see midwife's in practices, therefore avoiding unnecessary drawn out hospital journeys. There is also preference to see a female GP who has special interest in women's health. The merger will enhance this with great access across the locality and the increase in female doctors and a viable appoint scheduled to match patient's needs, which will include a request for a great depth of information and consistency which many younger mothers feel is missing and increasing concerns around Pre-eclampsia . The merger of Parkfields and Woodcross will increase the female population by 6946

2.6 Race
Describe race-related impact and evidence. This can include information on different ethnic groups, Roma gypsies, Irish travellers, nationalities, cultures and language barriers.

We found very little to differentiate minority ethnic experiences within our local practices from those of the white British population. There was a sense from some professionals that people from ethnic minorities had language and cultural barriers to access and needed longer appointment times creating a wait in the waiting room, there is very little if any evidence to support this statement. When auditing the clinical system there was no differential between timings, the main difference was around presenting conditions. Our population demographics by race shows that 68% of the population is white, with 64.5% of this number being White British and the remaining being Eastern European. Over 17% of the population is South Asian and are mainly Indian Punjabi , almost 6.75% is Black, 2.5% are Chinese or other Asian, while just over 5% are mixed race.

2.7 Religion or belief
Describe any impact and evidence in relation to religion, belief or no belief on service delivery or patient experience. This can include dietary needs, consent and end of life issues.

Religion or belief: The South Asian population is mainly split between Sikhism, Muslim or Hindu, Christian was the highest and the remainder between , then low numbers of that worshiping Judaism, the Mormon Faith and Jehovah Witness's, and the complex needs that this collection of faiths present to patients healthcare needs, there are 20% that are registered as having no religious beliefs.

2.8 Sex
Describe any impact and evidence in relation to men and women. This could include access to services and employment.

There is little differentiation between the reported experience of men and women, with the exception of females preferring female GP's. The closure of the site

2. Impact of decision
In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should include any identified health inequalities which exist in relation to this work.

increase the opportunity for females to see female GPs by two fold

2.9 Sexual orientation
Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.

No specific issues have been acknowledged for this group

2.10 Carers
Describe any impact and evidence in relation to part-time working, shift-patterns, general caring responsibilities. (Not a legal requirement but a CCG priority and best practice)

Access to Services (opening times), is a topic that always divides young, old and carers and those that work and those that do not, to bridge this gap against normal opening times within our practices that are in close proximity to areas that form part of this merger, we have extended hours that cover five nights to 8pm, Saturday and Sunday 8am to 12.30pm and that gives additional appointments beyond the national average set against patient lists.
We have ensured that we have the right clinical skills in our practice's to meet the diverse needs of our patients, including those with protected characteristics, such as dermatology, diabetes, respiratory disease-asthma and COPD, child health surveillance, minor surgery , orthopaedics, rheumatology, mental health, dementia, obstetrics, gynaecology and cardiology. We also have strong values around safeguarding both in adult and children areas. Our entire clinical workforce will interchange within our sites to maximise and provide such skills locally, whilst promoting community healthcare, and providing familiar faces with admin staff, doctors across South East locality of Wolverhampton CCG and the South East PCN. The rationalisation will also offers a larger range of services to patients that was previous the case with prior to the newly proposed merger.

2.11 Other disadvantaged groups
Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the CCG in meeting its legal duties to identify and reduce health inequalities.

The practice will identify those patients they consider to be vulnerable and at risk of the change and will ensure they are aware of and understand the reasons for the site closure.

The merger of these practices should not have a negative impact on health inequalities.

Patients will have an improved range of services provided in suitable premises within over 7 sites as patients can choose to be seen at any f the practice sites,

3. Human rights *The principles are Fairness, Respect, Equality, Dignity and Autonomy.*				
Will the proposal impact on human rights?	Yes	☐	No	☑
Are any actions required to ensure patients' or staff human rights are protected?	Yes	☐	No	☑
If so what actions are needed? *Please explain below.*				
In line with the agreed approach and the Equality Analysis Form being reconsidered following Primary Care Commissioning Committee Options Appraisal decision, there should be no negative impact on human rights.				

4. How will you measure how the proposal impacts health inequalities? **<u>The CCG has a legal duty to identify and reduce health inequalities.</u>** *e.g. patients with a learning disability were accessing cancer screening in substantially smaller numbers than other patients. By revising the pathway the CCG is able to show increased take up from this group, this a positive impact on this health inequality.*
The merger of the 2 practices should not have a negative impact on health inequalities. The practice has ensured that they have the right clinical skills in their practice's to meet the diverse needs of their patients, including those with protected characteristics, such as dermatology, diabetes, respiratory disease-asthma and COPD, child health surveillance, minor surgery , orthopaedics, rheumatology, mental health, dementia, obstetrics, gynaecology and cardiology. They also have strong values around safeguarding both in adult and children areas. Their entire workforce will interchange within their sites to maximise and provide such skills locally, whilst promoting community healthcare. .

5. Engagement/consultation What engagement is planned or has already been done to support this project?		
Engagement activity	**With who?** *e.g. protected characteristic/group/community*	**Date**
Engagement with Practice staff and patient has commenced. – Practice events, letters to patients, posters and leaflets. Information on practice website	patient groups Staff	July 2019
Please summarise below the key finding / feedback from your engagement activity and how this will shape the policy/service decisions e.g. patient told us, so we will… (If a supporting document is available, please provide it or a link to the document)		

5. Engagement/consultation What engagement is planned or has already been done to support this project?		
Engagement activity	**With who?** *e.g. protected characteristic/group/community*	**Date**
Commenced July 2019 Practice events, letters to patients, posters and leaflets. Information on practice website Engagement with PPG		

6. Mitigations and changes *If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over the counter medication. It was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore an exception is provided for this group which has resolved the issue.*
No issues identified

7. Is further work required to complete this EA? *Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)*			
Work needed	**Section**	**When**	**Date completed**
The practice will continue to engage with patients via their PPG group and notices in reception areas and on website		*Throughout July, August and September*	*September 2019*

8. Development of the Equality Analysis *If the EA has been updated from a previous version please summarise the changes made and the rationale for the change, e.g. Additional information may have been received – examples can include consultation feedback, service Activity data*		
Version	**Change and Rationale**	**Version Date**

9. Preparation for Sign off	
	Please Tick
1) Send the completed Equality Analysis with your documentation to David.king17@nhs.net or equality@ardengemcsu.nhs.uk for feedback prior to Executive Director (ED) sign-off.	**X**
2) Make arrangements to have the EA put on the appropriate programme board agenda	**x**
3) Use the Action / version section to record the changes you are intending to make to the document and the timescales for completion.	**x**

10. Final Sign off The Completed EA forms must be signed off by the completing manager. They will be reviewed as part of the decision making process. The completed form should also be sent to PMO so that the CCG can maintain an up to date log of all EAs.	
Version approved:	
Designated People	
Project officer Gill Shelley, Primary care contracts Manager Name: Gill Shelley Date:	
Equality & Inclusion Review and Quality Assurance Name: David King Date:	
Executive Director Review: Name: Date:	
Name of **Approval Board** Primary Care Commissioning Committee at which the EA was agreed at: Approval Board: Approval Board Ref Number: Chair: Date: Comments: Actions from the Approval Board to complete:	
Review date for action plan (section 7):	

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NHS Wolverhampton Clinical Commissioning Group

WOLVERHAMPTON CCG
Primary Care Commissioning Committee
September 2019

TITLE OF REPORT:	Milestone Review Board (Quarter 1 2019/20)
AUTHOR(s) OF REPORT:	Sarah Southall, Head of Primary Care
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	To provide assurance to the committee on primary care work programmes based on assurance provided to the Milestone Review Board in July 2019.
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This report is intended for the public domain.
KEY POINTS:	• Milestone Review Board considered the assurance pack (Quarter 1) and concluded that there were a number of actions to progress in order to afford consistency and clarity in future iterations. An updated copy of the document is provided in Appendix 1 • One new risk was identified and a briefing note is provided in Appendix 2 for consideration regarding Digital First Primary Care. • Recruitment of Social Prescribing Link Workers has commenced and employment model agreed in principle. • The Primary Care Strategy has been reviewed and finalised for consideration by the Committee and can be found in Appendix 3.
RECOMMENDATION:	The committee should consider the content of the report provided and accompanying appendices particularly:- • Accept the assurance provided in the Primary Care Assurance Pack (Appendix 1) • Confirm if there are any queries and/or further considerations arising from the Briefing Note on Digital First Primary Care (Appendix 2) • Agree the employment model for Social Prescribing Link Workers aligned to Primary Care Networks. • Confirm if there are any amendments required to the Primary Care Strategy. If not the committee should recommend to the Governing Body that the strategy be ratified and implemented.

LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1 Improving the quality and safety of the services we commission 2 Reducing Health Inequalities in Wolverhampton 3 System Effectiveness delivered within our financial envelope

1.0 Background

The committee receive formal assurance from the Primary Care Milestone Review Board on a quarterly basis in line with governance arrangements set out in terms of reference for both the board and this committee. The initial source of assurance is provided in the form of an assurance pack. However there are a number of other items detailed in this report that the committee should be sighted on.

2.0 Primary Care Assurance Pack (Quarter 1 2019/20)

The Milestone Review Board considered and debated the assurance contained within the Assurance Pack and concluded that whilst they felt assured there were a number of actions required to afford greater clarity & consistency in future iterations of this document. Revisions have been reflected in the version attached (Appendix 1).

The board requested further information and/or action on the following items:-

- QOF+ Bowel Screening Training – assurance on uptake
- Primary Care Networks – Right Care Packs
- Access Utilisation – promotion of new roles & additional appointments
- Online Consultation – continued promotion of different consultation types and detail of uptake (including unallocated appointments)
- Practice Manager Development – different levels of training
- Care Navigation & Social Prescribing Referrals – improvement from practices with low referrals
- Peer Review – Workshops for Primary & Secondary Care Clinicians
- Two Way Texting – to be available to confirm appointments in access hub(s)
- Improvement Plans for Dementia & Learning Disabilities will also be included in future iterations

The board also reviewed the risk register and noted that a new risk would be prepared and shared in response to a national consultation - Digital First Primary Care and GP at Hand. All of the above changes have been reflected in version 2 of the assurance pack in Appendix 1.

3.0 Digital First Primary Care

A national consultation took place June to August 2019 lead by NHS England /Improvement focussing on possible changes to patient registration, funding and contracting rules. Detail within the consultation document focuses on patients having the right to digital first primary care. A practice based in London has expanded significantly over the past 18 months having a large proportion of out of area patients spanning many areas of the country. The same practice has recently opened a further branch in Birmingham and has a rapid expansion plan that has the potential to impact on the Wolverhampton population, Sandwell and West Birmingham practices are observing a consistent rate of registrations with the new branch.

NHS England has imposed a cap on registrations confining them to the Birmingham and Solihull CCG population however this is subject to review mid September.

Executives within the CCG were briefed and Clinical Directors from Primary Care Networks were invited to a briefing to explore the Wolverhampton Digital Offer and progress being made to implement this and also consider the implications of the consultation document. The CCG has responded to the consultation and will be maintaining contact with NHS England/Improvement in respect of their intention in response to the consultation and next steps. The CCGs Executive Team continue to be kept appraised of developments in relation to the Consultation and GP at Hand Practice that has opened in Birmingham, this risk has been assessed and included on the CCG and STP Risk Registers (Appendix 2).

4.0 Social Prescribing Link Workers

In accordance with the Network DES for Primary Care Networks the CCG have explored with Clinical Directors from each network how the additional link workers funded via a new allocation (5 years) attached to the DES will be introduced.

Three workshops have been held to ensure that NHS England Guidance is satisfied and the existing CCG commissioned service is complimented and built on so that the Social Prescribing Offer for the city is coherent.

All Primary Care Network Clinical Directors in Wolverhampton have concluded that their preferred employment model would be via the existing provider in addition to the CCGs existing contract. A memorandum of understanding between the CCG, Primary Care Networks and Employer has been prepared and due to be implemented in September 2019. The employer has successfully recruited 6 Social Prescribing Link Workers who will be aligned to a PCN when the commence employment later in September. The current contract with the CCGs Social Prescribing provider will be subject to regular contract and quality review processes, these have been agreed between the parties and are due to commence in October. The contract term will be until March 2021.

Funding for this service has been allocated nationally and claims will be managed in line with the Role Reimbursement Scheme. Local processes have been defined and will be implemented from September 2019.

5.0 Primary Care Strategy (Wolverhampton)

The strategy has been revised and updated to reflect progress that has been made since inception in 2016. As a result of the extensive work programme that was launched to aid implementation of the strategy and in response to the General Practice Five Year Forward View (GPFV) significant progress has been made to improve care design, manage workload and tackle workforce problems to afford patients better access to services that are provided in local communities.

The strategy reflects on this journey to bring together practices who are working more cohesively to care for their patients and the ability to demonstrate that primary care networks are well placed to achieve high levels of maturity due to the work that has taken place since 2016. Care has been redesigned enabling patients to receive care in other locations offering more flexibility and choice that fit with busy lifestyles. Particular attention has been given to workforce challenges primarily affecting the GP population and this work has also extended to practice nursing and the introduction of new roles including Clinical Pharmacists, Social Prescribers and Physicians Associates. Fundamental to these achievements has been the redesign of care provided in general practice. Patient satisfaction rates are evidentially improving although work continues to continuously strive to further improvement.

The CCG has invested with a view to achieving better outcomes for people with a diagnosis of diabetes and particular attention to diabetes prevention this is linked to work taking place to tackle obesity and alcohol. Also included in our framework is an important focus on dementia diagnosis and health checks for learning disabilities and serious mental illness.

The new strategy defines the priorities for the city and the anticipated timeline for further improvement to be realised. This is detailed in appendix 3.

***6.0* Clinical View**

Clinicians are actively involved in the programme of work and regular meetings are held with Clinical Directors to ensure they are kept sighted on and included in the delivery of the programme and commissioning in primary care.

***7.0* Patient & Public View**

A series of engagement events have been held during the strategy review providing patient and public feedback. Patients that the advent of new roles and patient information being shared among professionals was an area that posed anxiety. Different consultation types ie online services were welcomed by some but not all who engaged. The formation of Primary Care Networks was also topical.

All feedback from these events has been captured in a responsive action plan that will enable continued engagement and responsive action to take place over the coming months.

All practices are required to hold regular Patient Participation Group Meetings (PPGs) and also in line with the PCN Direct Enhanced Service Primary Care Networks are responsible for patient engagement. Each PCN has established regular meetings with their PPGs so that regular discussion can take place and allow patient(s) thoughts and suggestions to be shared and involvement encouraged, where appropriate.

8.0 KEY RISKS AND MITIGATIONS

8.1 A new risk has been recorded (Digital First Primary Care) and include don the CCG and STP Risk Register(s) and will be subject to review at regular intervals, this is not deemed to be a red risk.

9.0 IMPACT ASSESSMENT

9.1 Financial & Resource Implications

The arrangements for reimbursement for Social Prescribing Link Workers using the national allocation intended for Primary Care Networks has been agreed with the CCGs Finance Team and a corresponding process defined. However, the national allocation does not include overheads such as travel and equipment therefore this cost will be met by the CCG on a non recurring basis as the service is set up in year one.

9.2 Quality and Safety Implications

The Quality Team are sighted on the implications of the Digital First Consultation and have been actively involved in the Social Prescribing Link Worker Design Workshops held during the summer. There are no quality and safety implications evident at this point in time.

9.3 Equality Implications

A Quality Impact Assessment was undertaken when the initial Primary Care Strategy was prepared and approved this is now under review and will be considered by the relevant lead to ensure that the assessment is still sufficient and if not the appropriate amendments are made.

9.4 Legal and Policy Implications

None identified.

Name Sarah Southall
Job Title Head of Primary Care
Date: 22 August 2019

ATTACHEMENT(S)

Appendix 1 Primary Care Assurance Pack (Quarter 1 2019/20)
Appendix 2 GP at Hand Briefing Note
Appendix 3 Primary Care Strategy 2019-21

SLS/PCCC-JUL19/PCAU/V1.0

NHS
Wolverhampton
Clinical Commissioning Group

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View		
Public/ Patient View		
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team		
Equality Implications discussed with CSU Equality and Inclusion Service		
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager		
Other Implications (Medicines management, estates, HR, IM&T etc.)		
Any relevant data requirements discussed with CSU Business Intelligence		
Signed off by Report Owner (Must be completed)	**Steven Marshall**	**22.8.19**

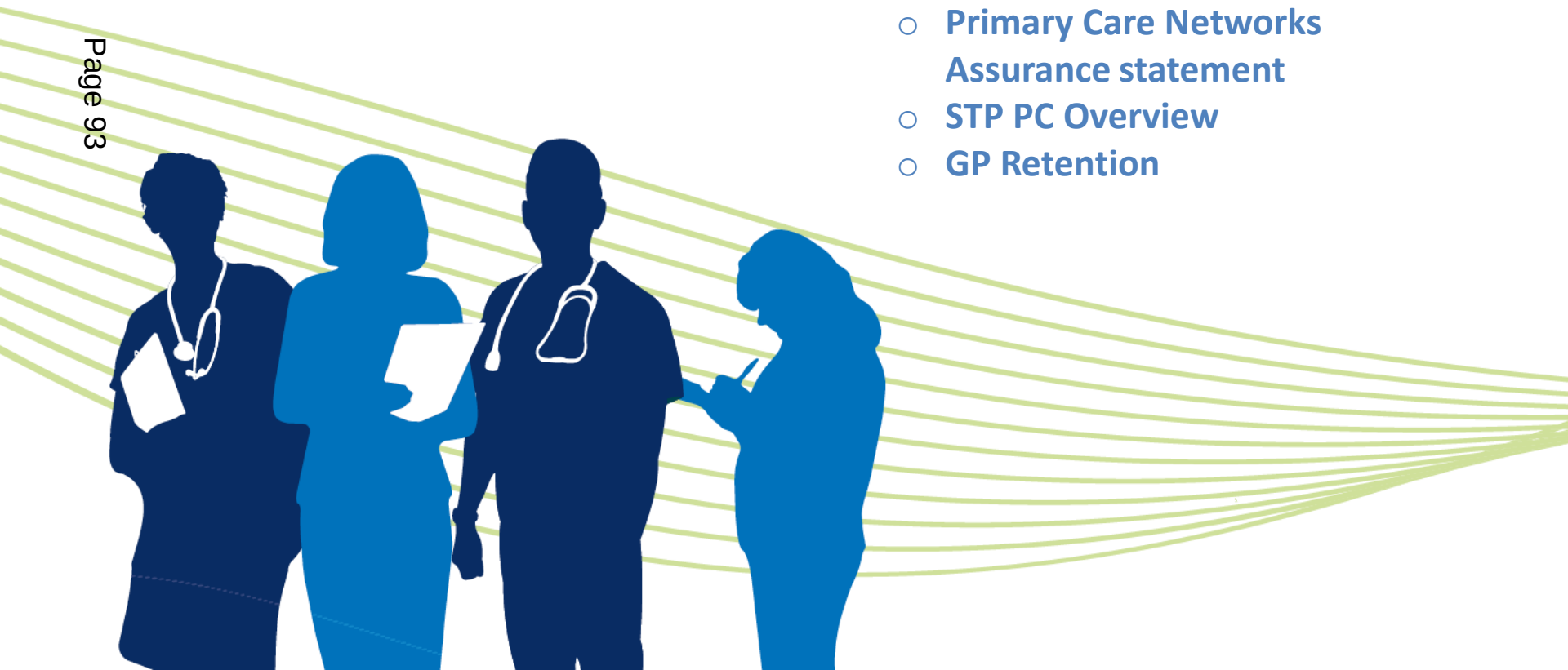
NHS
Wolverhampton
Clinical Commissioning Group

Report of Milestone Review Board : Assurance Report Quarter 1 2019/20

Contents

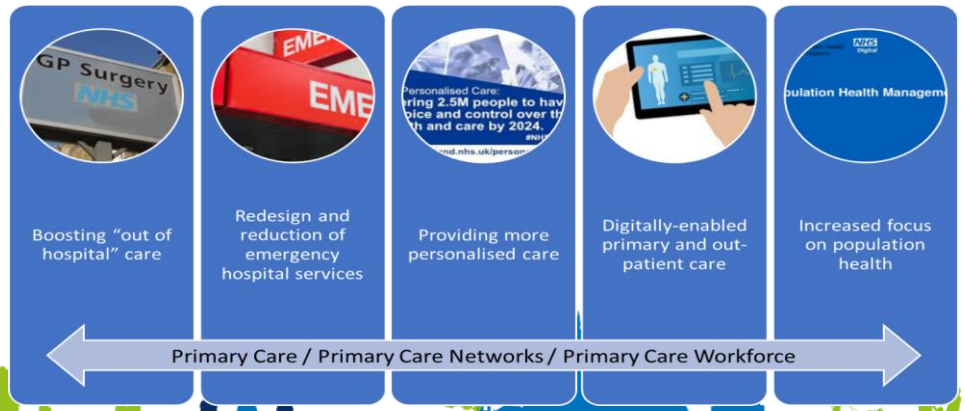
Work Programme(s) Overview

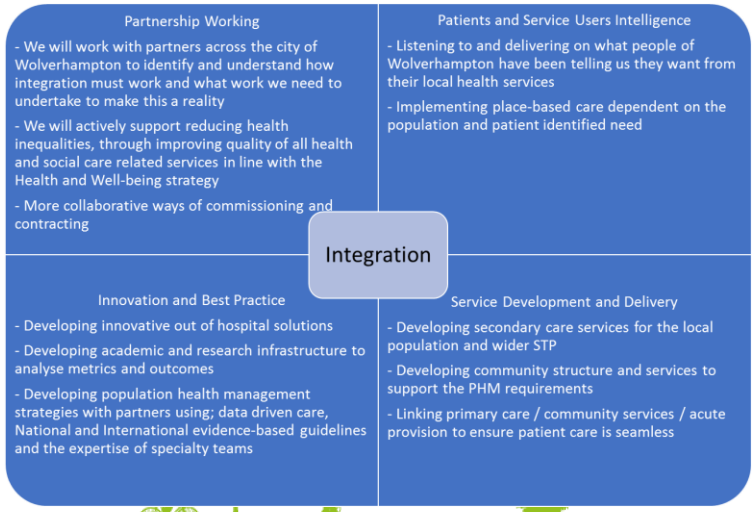
- Primary Care Strategy
- Work Programme Progress
- Primary Care Networks Assurance statement
- STP PC Overview
- GP Retention



Primary Care Strategy

- Strategy is being developed as a response to the Long Term Plan, and the challenges faced by Primary Care.
- Strong focus on development of PCNs and integration
- Feedback has been sought on the first draft
- Amendments have been made based on feedback





Work Programme - Progress

	Q1 Progress	Q2 Actions
Primary Care Strategy	Care navigation is currently being evaluated, with cohort 3 pathways being sought	Staff training and development in care navigation will take place
	Resilience programme has been circulated; process agreed by STP PC board;3 bids to be submitted	Submit bids for approval, dissemination and coordination of funds
	Access evaluation of 2018/19 is complete, utilisation is consistently growing.	inception of additional access minutes and DES requirements will be closely monitored. Advertisement campaign to be reinvigorated
	Primary care dashboard is in place; discussions held at STP level for the development of data for PCN use	Refresh data and present to PCNs, with feedback on additional requirements
	Full sign up of QOF+ scheme	development group to continue to meet to discuss issues and review performance
	Commissioning intentions road show planned	Commissioning road show sessions held across the city
	Peer review sign up by networks; sessions commenced	work is on-going with RWT to enable dialogue between consultants from the identified specialisms and the networks
	Review of LD heath checks action plan taking place	Implementation of refreshed action plan
	development of enhanced health in care homes model	Share with wider stakeholders and identify changes to services including finance
Primary Care Networks	Networks have formalised and applications have been approved. Network meetings are scheduled and are already taking place, CDs are in place, and the DES sign up is complete	Prepare for Network Investment & Impact Fund and additional requirements for cancer care, inequalities & CVD in Q3
	a series of workshops have been held with CDs and WVSC, to map out a model and agreement for SP link workers. Hosted model has been agreed	PCN sign off of agreement advertisement and recruitment of staff
	Recruitment of clinical pharmacists is taking place, payment process is agreed	roles to commence
	Des sign up (30 min/1000 patients) is complete. 5/6 networks have provision in place from 1st July	VI to commence from August
	discussions held at members meeting regarding enhanced health in care homes and network level delivery of proactive ward rounds	wider system is being reviewed, business case to be based on integration within wider structure and the skill mix within networks
	network development plans are being discussed within network meetings	confirm areas of development and support required to enable this

Work Programme - Progress

	Q1 Progress	Q2 Actions
Primary Care Digital Transformation	NHS111 sign up is complete, with one outlier. Phased installation is planned	Implementation up until September at practice level National solution to hub integrations anticipated
	Appointment utilisation tool is in place across all practices	practice training to take e place monitoring of usage and scoping of interoperability with reporting requirements feedback any issues to NHSE
	GP online triage is now in place in 70% of practices; utilisation continues to grow	monitor practices where utilisation is low review hub solutions roll out into remaining practices
	Video consultation sign up is on-going; 12 practices have equipment installed	Continuing to engage with practices, and support practices to engage with patients
	the national app is now live, potential to add other links locally is being explored	continue to develop local links and content
	Proxy access has been released for Patient Online	pilot for Pennfields to get proxy access for care home staff to begin
	Docman 10 deployment is on-going	due for completion in this quarter
	Mjog 2 way texting usage continues to rise, along with the number of cancellations received via this method.	monitoring to continue
	Preparations for pennfields and BUV migration is in place	Migration of Pennfields and BUV scheduled
Contracting	development of wound care model continues	Business Case presented to BIC Programme Board detailing financial split/ complex and simple definitions
	Post payment verification taking place for QOF and enhanced services	practice visits to be undertaken
	PCN submission, Des sign up and extended hours sign up all complete	Assurance Framework developed. Contract review visit schedule and content developed

Work Programme - Progress

Workforce and Development		STP Workforce strategy has been included in the new STP PC strategy	continue to work through strategy requirements with TFG
		Co-design of material to promote Primary Care as a place to work - NHS Careers etc. has taken place	New SLA to be put in place for training hub provision
		practice nurse strategy approval process has been happening across the STP	Launch of the strategy set for September
		PN retention initiatives are being scoped	launch of retention initiatives
		Confirm PN Education Programme for 2019/20 & dependency on Lead Hub	Nursing associate apprentice applications and selection of candidates to take place
		PC training and development plan has been developed	continue to identify training needs, especially around PCN development, leadership and support for key staff
		5 candidates for HCA apprentice roles are completing the process of application	further work around professional roles to address gaps in staff teams
		scoping of non clinical apprentices is complete and included in PC training and development plan	encourage practices to pilot the roles
		Discussions around MH therapists in networks have taken place	Workshop to be held to scope agreement between provider and network
		Retention programme is in place across the STP	continue to promote and encourage take up
		PLT for PMs has been held, in line with the requirements of the PM support offer	further sessions agreed and scheduled

Primary Care Networks

NHS England Assurance Statement 2019/20	Q1 Progress	Q2 Plans
Actively support the establishment of PCNs : every practice in England is part of a PCN (30-50,000 population) 100% coverage by 30 June 2019 (latest)	Members meeting held with discussions taking place. Guidance circulated to support incepton of Networks	Report to PCCC & GB in September on progress
Support the introduction of any nationally-agreed contract arrangements for PCNs, ensuring that community services are configured in line with PCN boundaries.	Social Prescribing Model developed Community Services Workstream confirmed	Social Prescribing Model confirmed in SLA (hosted by WVSC) Community Services Workstream Meeting to be held
Provide a minimum of £1.50 per head of financial support to PCNs for their management and organisational development. This investment should start in 2019/20 and continue each year until 31 March 2024	DES Applications/Panel NHSE Assurance Statement DES Sign Up & Contract Variations via Network Agreements & Contracts Team	Proccess for payments to be agreed Claims, monitoring and payments to commence
Support PCNs in their development and ensure they are practically supported to access the PCN Development Programme by 31 March 2020.	Draft Prospectus & offers received/shared with Networks.	All PCNs have EOIs for TFC Programme TFC Diagnostic assessments held
Ensure that PCNs are provided with primary care data analytics for population segmentation and risk stratification based on national data, complemented with local flows, to allow them to understand in depth their populations' health and care needs for symptomatic and prevention programmes including screening and immunisation services by 1 July 2019 at the	Meeting with BI leads to review extent of provision including gaps (Wolves SA completed)	National Dashboard Released Q1 PCN Dashboard (CCG) Issued including Community Services & Mental Health Data
Ensure that PCNs work together including at place level to ensure they play a full role in improving services commissioned and provided at that level, including urgent and emergency care services, and ensure every PCN is working to implement the comprehensive model for personalised care.	Group Leads Meeting will change to CDs Meeting from July CD Terms of Reference considered and finalised, prepare for new format meeting from July	Publish Network Development Plans 1 July 2019
Ensure that the delegated budgets received are used to support the development of all practices in the context of PCN development, ***with a detailed local plan published by 1 July 2019 showing that every practice is actively engaged and all activity is completed by 31 March 2020*** (ensuring delivery of at least two high-impact actions set out in the GPFV including	All practices have achieved more than 2 high impact actions, and reported back to NHSE. All PCNs have confirmed EOI in the PCN development programme	Network Development Plans in place by 1 July 2019 and enactedc throughout quarter
Ensure that the local practice development plans continue to identify those practices who need more intensive and immediate support to stabilise, build their resilience and become sustainable. 75% of 2019/20 sustainability and resilience funding (allocated by NHS England) must be spent by 31 December 2019, with 100% of the allocation spent by 31 March 2020.	Resillience funding has been confirmed, with the proccess difined and agreed at GPFV board	Identify practices requiring support CCG to submit application STP Assurance Report to NHS England confirms update on each allocation/scheme.
Continue with commissioning and deployment of 180 pharmacists and 60 pharmacy technician posts (funded by the Pharmacy Integration Fund, with support from NHS England Regional Independent Care Sector Programme Management	Coverage confirmed, gaps in provision identified and network agreements in place	Role Reimbursement Scheme Commences
Work with HEE to ensure robust training programmes are in place to adequately support workforce plans.	Training hub review concluded; options for continuation of provision presented to board	TNA to take place prioritisation of delivery and funding to be secured from board monitoring to take place via the Workforce TFG
Continue providing extended access to general practice services, including at evenings and weekends, for 100% of the population. This must include ensuring access is available during peak times of demand, including bank holidays and	Group level access arrangements in place, NHS Contracts agreed.	data collection and monitoring ensuring 100% coverage and minimum utilisation
Integrate extended access with other services at scale to deliver value for money and efficiencies and support compliance with national core requirements to maximise capacity, availability and utilisation of appointments for 100% of the population.	Practices and Networks have addressed the challenge of providing required times (45min and 30 min DES) delivery plans are in place for 1st July commencement	Go live 75 minutes per 1,000 patients delivered by each Network [RWT 1 August 2019] Q1 Data Collection & Submission
Workforce (Primary Care) Strategy - network data refresh and workforce plan - extends to review & appraisal with member practices and employing agency for any new roles within the network.	workforce dashboard review NWRT replaced CCG dashboard	Review March Baseline Data in Dashboard Review of impact Recruitment & Retention Initiatives are having
Patient engagement as per DES	PPG chairs updated on Networ Des and changes to groups Primary Care Strategy engagement events held, questions and feedback reviewed	PCNs engage with PPGs at practice & network level Network priorities agreed with PPGs Engagement priorities / projects commence
timeline etc also includes change of CD	PCN Development report confirms role of PCCC	Network change notifications to be taken to PCCC if any

STP PC Overview

STP PC Strategy

Confirmation received from NHSE that the STP Primary Care strategy has been received and signed off.

Projects

- Four pillars
- First 5 Network
- Welcome Back
- Wise 5
- Annual GP Conference
- Accelerator programme
- GPN Scheme
- Resilience Fund
- Pharmacy Network

GP Retention

The GPRISS Project was successful in developing and delivering a number of GP retention schemes, providing GPs with personal support, support to practices and wider system support/improvements to achieve the purpose and aims of the project.

33% of GPs STP wide from each CCG (Dudley, Walsall Sandwell & West Birmingham and Wolverhampton) enrolled on one or more of the schemes. Across all schemes 324 expressions of interest were received; 218 actual applications; and 207 approved applications.

The project is being continued during 2019-20 under the Primary Care Workforce Retention Project as part of the organisations GP Forward View work programme and strategy. Post GPRISS project BCWB STP will continue to invest in ways to support not only GPs but the wider general practice workforce, including practice nurses, who might otherwise leave the profession, clinical pharmacists, and is encouraging local systems to act by working with practices, and identify ways to encourage and support general practice workforce to remain in practice.

Commissioned Services

- Contract & Quality Review Arrangements
- Social Prescribing
- Primary Care Counselling
- The Sound Doctor
- Care Navigation
- Advice and Guidance
- Online Consultation / Triage
- Workflow Optimisation
- Home Visiting Service

Contract & Quality Review

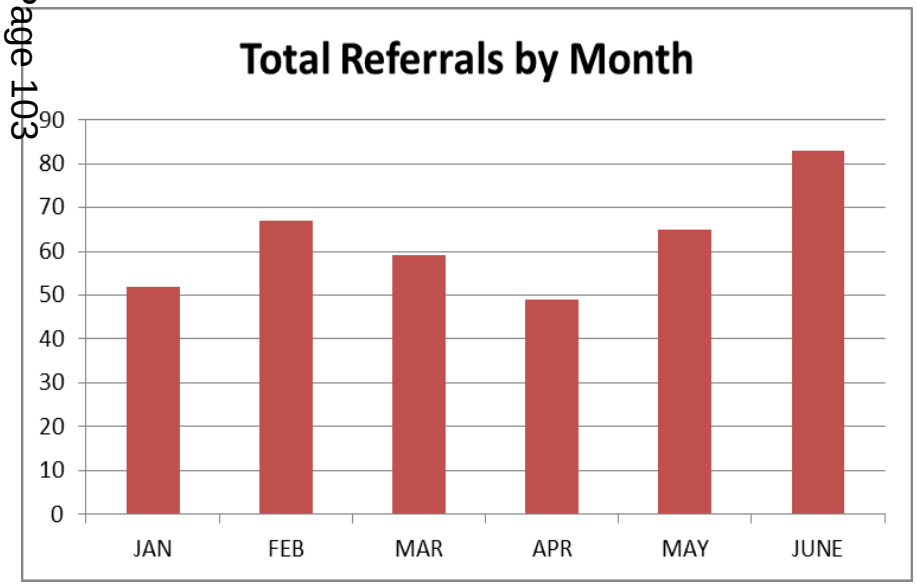
Below is the schedule for contract and quality review arrangements.

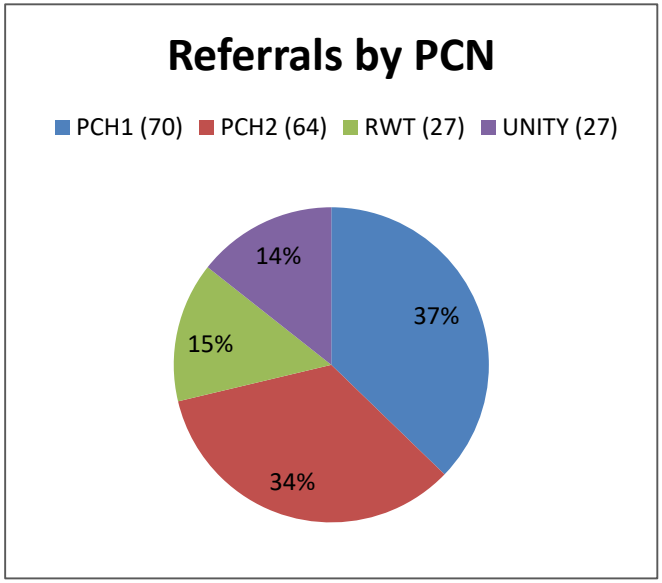
Contract	Provider	Monitoring regime	Responsible person	Dates of meetings
Special Access Scheme	East Park Medical Practice	Quarterly meetings & review	Gill Shelley	October, February April
Out of Area patient registration Scheme	Newbridge Medical Centre	Quarterly telephone review	Gill Shelley	October, February , April
Primary Care Counselling Service	Relate	Quarterly meetings	Mandy Grewal	September, November, January, March
Social Prescribing	Wolverhampton Voluntary Sector	Monthly data submission Bi monthly monitoring meeting	Sharon Nisbett & Helen Tranter	September, November, January, March
Information and education for patients with long term conditions	Sound Doctor	Quarterly review	Jo Reynolds	September, November, January, March

Social Prescribing

Highlighted points from Q1 data:

- There were **197** referrals in Q1; 101 were from GPs.
- 51% of clients over 60, 49% 18-60 years of age.
- 70% of referrals were for women, 30% for men.
- Top referrers are Wolverhampton Total Health/ PCH1 practices - Newbridge Surgery, Whitmore Reans Health centre & Duncan St Primary care centre.
- Cumulative referral status for the service from May 2017 to date is 1088 referrals.
- More referrals were made in June than any month this year.



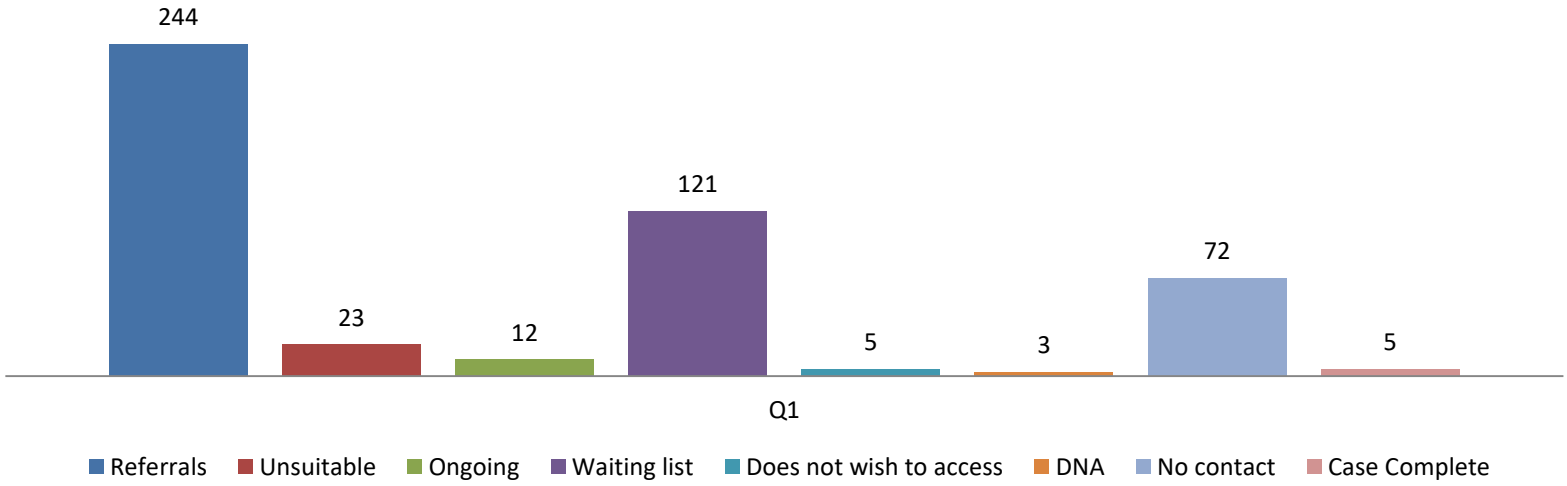


Social Prescribing Link Workers

Social prescribers in PCNs

- Wolverhampton Voluntary Sector Council (WVSC) will employ the Social Prescribing Link Workers (SPLW) with the understanding that they will then be assigned to a PCN. This is described as a hosted model.
- Throughout Q1 there has been monthly workshops and meetings to progress this between WCCG, WVSC and PCNs
- A MOU has been drafted and is currently being signed off by Clinical Directors.
- SPLW recruitment has been completed and the successful candidates are expected to be in post by the end of September onwards.
- Activity will be appropriately coded at practice level via SPLW(s) in the clinical system. Extracts based on this activity will be used for monitoring purposes, alongside PSIAMs data from the provider. Contract monitoring will take place through the steering group, where each PCN CD will be invited.
- PCN referral target i.e. minimum number of referrals will be set in Q2 for all PCNs to ensure services are fully utilised in line with referral criteria.
- Referral rates will be monitored and discussions will occur with practices identified with low referral rates. Outcomes will be shared with their respective Clinical Director.

Primary Care Counselling

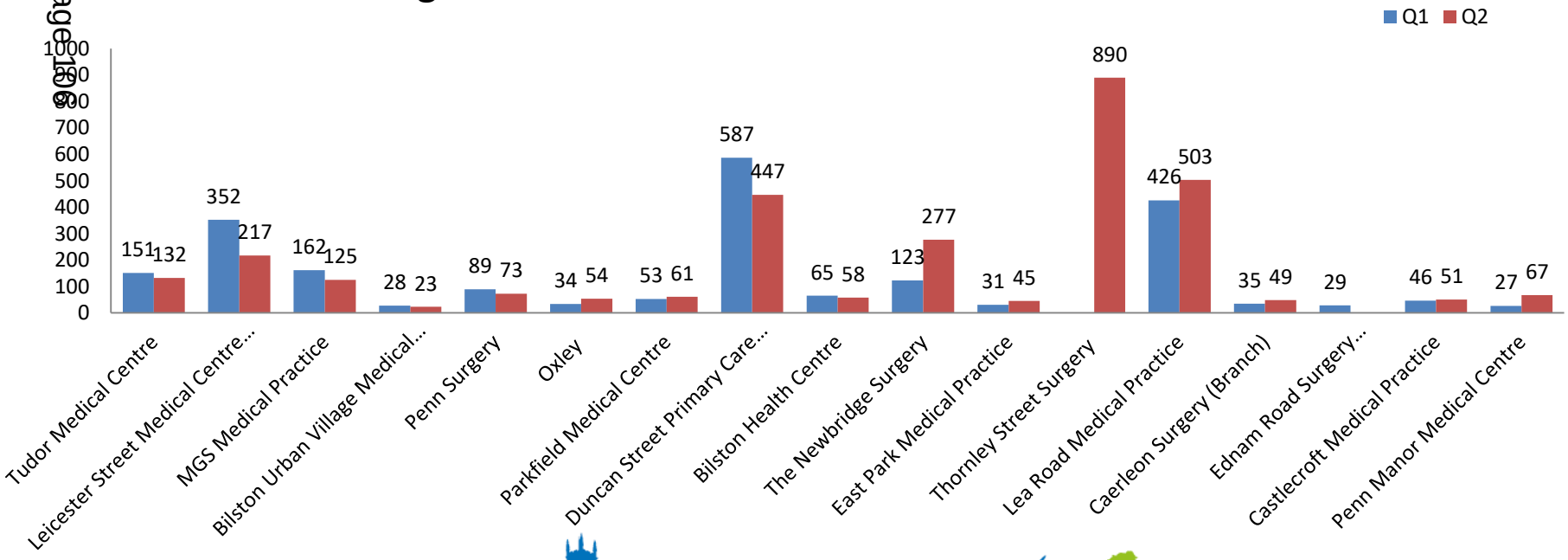


Referrals	There have been 244 referrals in Q1.
Waiting list	There are **121** patients that were referred during Q1, waiting to be seen which represents 50% of the total referrals. Analysis of the data shows there are still 30 patients from 18/19 Q4 referrals still waiting to be seen. This means the total number of patients on the waiting list at the end of Q1 is actually **151**.
Q1 wait in service - Range	The longest waiting time is 89 WD / 120 CD which is the maximum time within the quarter with a referral date of 1st of April 2019. The shortest wait time are those who were referred at the end of the quarter.
Access to service time (Time from referral by GP and first attendance)	From 1st April – 1st July the service's average access time is 14 WD (17 CD) from referral to first attendance. The longest response time is 59 WD. The quickest is 1 WD. The data will be analysed further to reveal if there are issues with the recording of data and patient choice, which may be the cause of some of the delays. This will be raised at the next contract review meeting on the 10th September.

The Sound Doctor

- Videos are to be embedded in the online consultation/ triage system.
- Integration with the patient online app is to be explored, so that patients using the app can access the videos from that point
- The ability to automatically generate text messages upon diagnosis is to be explored
- The Sound Dr to present at Septembers Practice Manager Support Network session to encourage engagement
- Provision to be promoted with GPs and other clinical staff, to ensure all are aware of the ability to text information.
- Training for admin staff on the text messaging system has taken place, to enable confidence in sending the links to relevant patients
- A review of high and low utilising practices is to take place with targeted promotion to those that require it.
- A spotlight on TSD has gone into PCN newsletters
- Dementia content to be promoted as part of Dementia Friendly practices
- Videos to be played on waiting room screens in practices
- Provision to be promoted with carer support groups
- Videos to be included in Care Navigation

Sound Dr Q1 & Q2 figures

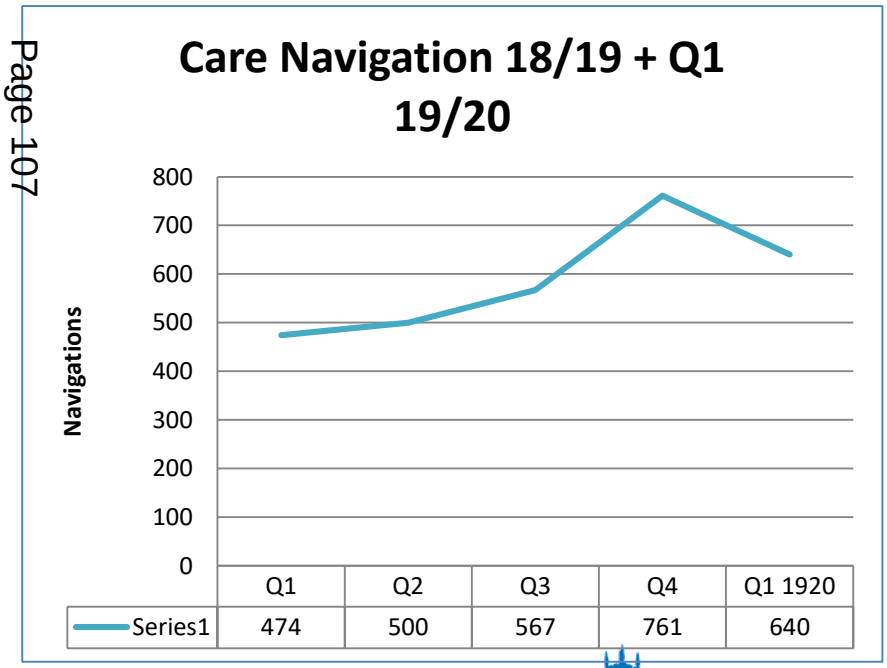


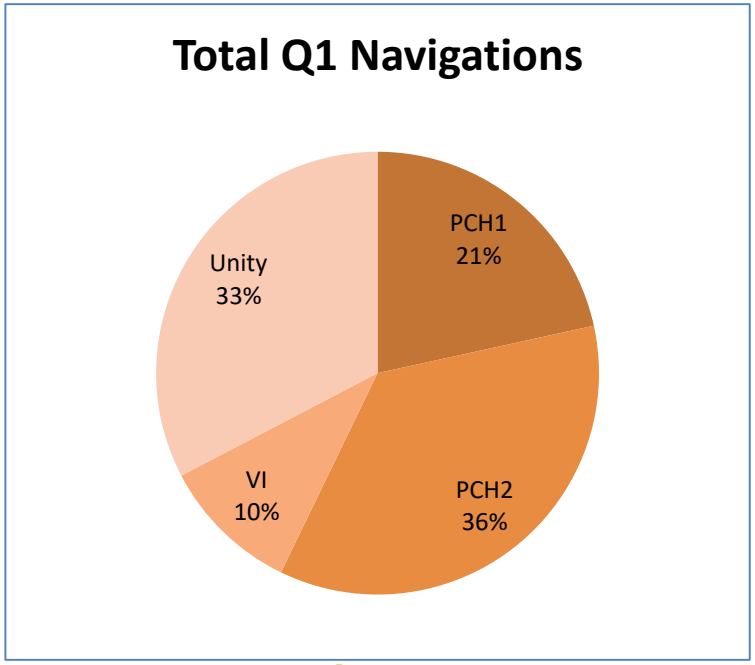
Care Navigation

Care Navigation was launched in February 2018. All practices have used the template to record navigation of patients. To date there has been **2942 navigations** recorded on the clinical template. In Q1 there have been **640** navigations, which is slightly less than Q4 18/19.

Data revealed a decrease in activity across all practices. As part of an ongoing review, feedback is being gathered via survey monkey to understand experience in practice and how they can be supported further.

There are updates scheduled for September for first contact staff, where they can expect to get a refresh, review feedback and input into Phase 3 scoping. Discussions will be held with practices who have seen a decrease in navigations, and outcomes will be fed back to respective Clinical Director.



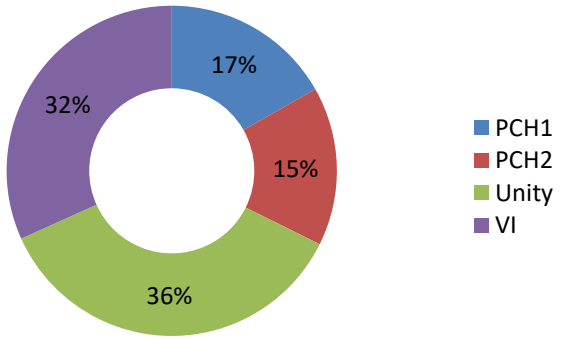


Choose and Book Advice and Guidance

Clinical Specialty	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Dietetics	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Elderly Care	1	0	0	1	0	0	0	0	0	0	1	3	2	0	0
Endocrine/ Diabetes	2	0	3	0	10	3	0	0	4	7	1	4	4	4	0
General Surgery	1	2	0	1	0	0	0	0	0	0	0	0	0	1	0
Gynaecology	5	2	3	7	2	3	0	0	6	5	3	1	4	3	6
Haematology	9	8	10	6	8	6	0	0	0	9	7	7	8	7	6
Neurology	1	3	0	3	1	1	0	0	1	4	3	1	3	2	3
Orthopaedics	1	0	0	0	2	0	0	0	0	0	0	0	0	1	1
Paediatrics	1	1	5	1	7	1	0	0	4	3	3	2	2	5	1
Plastic Surgery	0	0	0	0	0	0	0	0	1	0	0	0	2	0	0
Respiratory	2	2	0	5	1	1	0	1	3	0	1	0	4	2	0
Urology	4	2	2	3	4	3	0	0	6	2	5	2	5	1	5
Total	**28**	**20**	**23**	**27**	**35**	**18**	**0**	**1**	**25**	**30**	**25**	**20**	**34**	**26**	**22**

- Most requested subjects are Haematology (91) Gynaecology (50) Urology (44) Diabetes (42) and Paediatrics (36).
- Compared to other STP areas, Wolverhampton offers a limited number of specialisms. This is being addressed and the workforce task and finish group continue to scrutinise this data.
- Capacity alerts will be mandated on Choose and Book shortly, with all considered capacity being RAG rated based on wait times.
- Pre-existing relationships between Primary and Secondary Care clinicians will mean that GPs will liaise directly with some consultants.

Request breakdown by Group (to date)



Online Consultation

Video Consultations

There are currently 27.5% of practices live and able to offer video consultations. Roll out of this system continues in line with the engagement plan, and has been included in the engagement roadshow that is currently underway. Practices are contacted on a monthly basis and encouraged to sign up, and supported throughout the process. Currently installed : Poplars, Primrose Lane, Coalway Road, Lead Rd, IH medical, Newbridge, Mayfield, Lower Green, Ashfield Rd, Grove, Fordhouses Medical & Dr Mudigonda's Surgery. All other practices yet to confirm installation. Activity Reporting available from internal clinical system search. All remaining RWT Practices Alfred Squire, Warstones, Thornley Street, West Park Surgery, Dr Bilas (by October).

NHS111

All Practices but one have submitted completed sign up forms. The Pilot Practices are due to be rolled out shortly, this information will be circulated once available. Interoperability with 111 into the hubs is yet to be resolved nationally- there are updates needed to Adastra system to enable the remote appointment book to be accessed. This is a national problem, which NHSE are aware of and working on. System testing is underway in neighbouring areas. Wolverhampton are ready and awaiting switch over with 111 provider. However due to the number CCGs in the queue, there may be a delay.

Next Steps

- Digital workstream will ensure roll out of video consultation and online triage to all practices by the end of 2019.
- To Continuation of engagements sessions in and around the City
- PCNs are currently exploring digital first options and will confirm intentions for hub delivery in Q2.
- There is a national consultation underway June-August, and CCG intend on responding.

Online Triage

Online Triage

Rollout to practices commenced late 2018 continues . We are currently working with 7 practices to arrange installation for October. Expected uptake trajectory:

- 74% (September)
- 76.1% (November)
- 100% (December)
- Utilisation reports monthly from September
- GPFV Monitoring Tool (Quarterly)

Patient Access (Patient Online)

- Platform for Online Consultations ie Triage & Video etc
- Engagement sessions at practice level (IM&T)
- Engagement with wider community ie Schools, social Clubs, St Johns, Churches, Mosques, Councillors etc (IM&T)
- Engagement Roadshow (CCG)
- Practice Level Sign Up (MJOG)
- Currently % registered

Workflow Optimisation

Progress

- Implementation summary of each practice discussed at contract review meeting
- GP audits and workflow protocol are not registered on the system for any practices. However this may be an IG issue, that the practice have not allowed access, rather than incomplete.
- Each PCN to have a webinar, where the team will give a practical demonstration of what is required.
- There is an opportunity for PCNs to evolve a central team/ system for workflow, this is to be raised with the Practice Managers.
- Webinars are scheduled for each PCN, where the team will give a practical demonstration of what is required.

Next steps

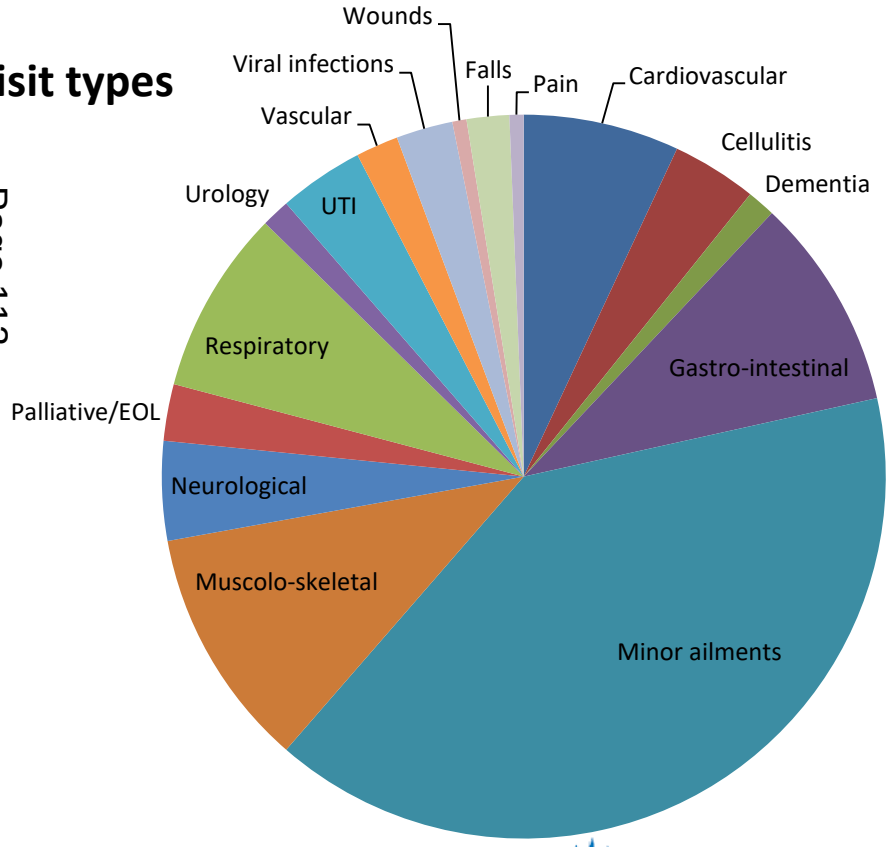
- A review of who has completed all of the online modules will take place
- Discussions will be held at PCN Practice Manager meetings regarding engagement at practice and PCN level.
- Webinars will be held to support engagement and knowledge of the system.
- Action plans will be put in place to develop practices
- Practices that are not engaging will be exception reported at the next MRB. There are currently 8 practices on the list.

GP Home Visiting Service Pilot Project

Face to Face Contacts

TeamName	Initial	Nov	Dec	Jan	Feb	Mar	Apr	May	Grand Total
CCG GP HOME VISITING SERVICE	Initial	33	88	116	102	99	80	75	593
	Follow up	12	32	42	45	59	46	36	272
Grand Total		**45**	**120**	**158**	**147**	**158**	**126**	**111**	**865**

Visit types



Key Points – Q1

- Every referral that was received by the service was contacted, with minimal referrals being declined.
- 182 referrals were received across April and May 2019. of those 158 were accepted (87%).
- Those that weren't accepted were due to inappropriate referral (8), capacity (11), cancellation by GP (4) and admission to hospital (1).
- As expected, the majority visits were in the patient's own home.
- The pilot has been extended until the end of October 19.
- Patient satisfaction is high.
- Staff changes include additional resource i.e. Healthy Care Assistant & administrative support.

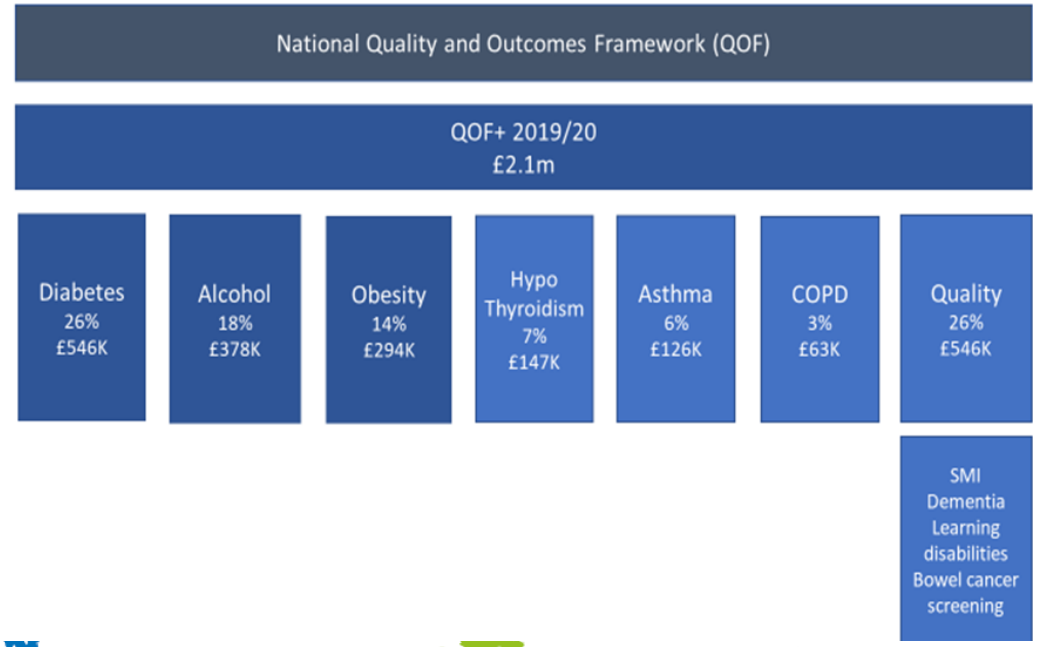
Enhanced Services

- QOF+
- Improving Access
- Basket Service
- Health Checks
- Peer Review
- Mjog
- Thrive into work

QOF+

- QOF+ Development Group meetings for monitoring , review and development have been scheduled. Schedule of the meetings can be seen within the table.
- Brief QOF+ update given at Team W.
- End of year spend on 2018 Scheme c£1m (£200k underspent/ under achievement).
- Draft 2019 Scheme shared for comment, approved at PCCC May & issued to practices late May 2019. End of year position:
  - 19 Indicators total
  - 100% achievement [Diabetes, Alcohol & Obesity]
  - Remaining indicators were achieved by 23-38 practices

Month	Purpose
May	Status check/queries & issues
July	
September	
November	Development opportunities & preparation of potential new content for 2020 AND Review of existing indicator performance/achievement
December	
January	
February	
March	



QOF+ Implementation Timescales

Q1 2019/20	Q2 & 3 2019/20	Q4 2019/20	Q1 2019/20
• Approval at PCCC (May 2019) • Practice Sign up (May 2019) • Implementation support from CCG Group Managers & IM&T Facilitator(s) group managers & IM&T Facilitators.	• Review of progress against scheme – IM&T Facilitator(s) & Group Managers • QOF+ Development Group Meeting • FAQ Document update/issued	• Practices ensure clinical systems are up to date in anticipation of final searches being carried out • QOF+ Development Group Meetings held monthly to amend/enhance scheme for 2020/21	• Data extract to determine practice performance • CCG confirms level of award • Practices confirm/accept/ raise issue(s) • Payment to practices based on performance • Approval of 2020/21 Scheme

Further development of schemes in response to member feedback

Support through existing governance arrangements

- Group Manager(s) & Clinical Director(s) via Group Level Meetings
- QOF+ Development Group
- Opportunity for discussion at Members meetings

Approval & Launch

Implementation within Practices

Monitoring & Support from CCG

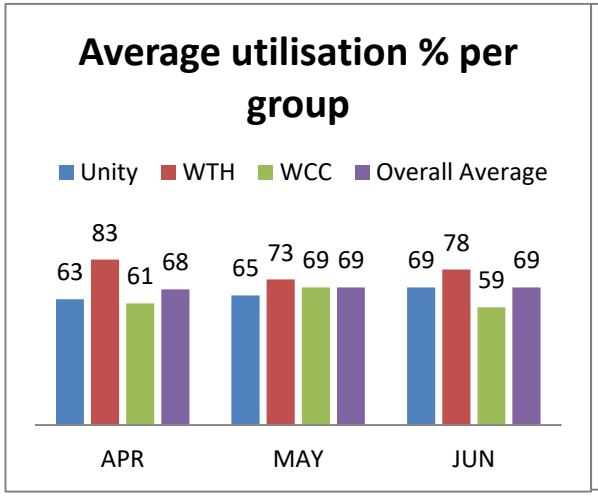
Extended Access- Performance

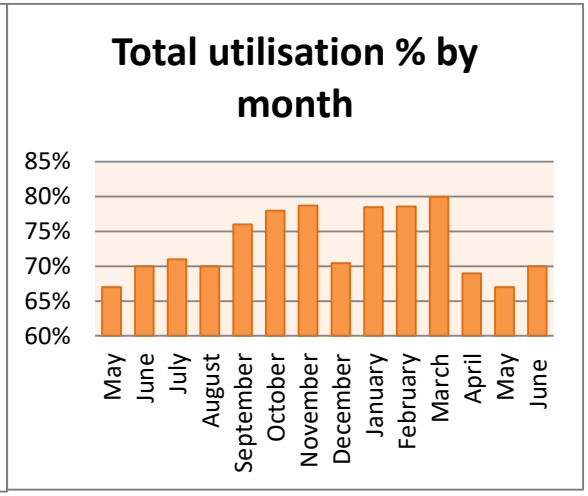
TOTAL FOR Q1

Day of the month	Available	Booked	DNAs	Utilisation
1	396	301	26	69%
2	322	217	37	56%
3	157	132	22	70%
4	470	359	42	67%
5	290	197	21	61%
6	322	239	38	62%
7	353	237	30	59%
8	398	329	38	73%
9	299	214	26	63%
10	168	145	11	80%
11	458	355	49	67%
12	292	191	20	59%
13	366	284	34	68%
14	321	231	33	62%
15	434	351	32	74%
16	331	220	29	58%
17	180	152	17	75%
18	448	375	51	72%
19	328	241	35	63%
20	392	304	38	68%
21	315	220	27	61%
22	419	325	34	69%
23	299	208	19	63%
24	163	147	15	81%
25	420	353	40	75%
26	280	193	23	61%
27	449	346	45	67%
28	362	255	40	59%
29	408	342	32	76%
30	476	338	57	59%
31	41	38	1	90%

Total	10357	7839	962	70%

- The Q1 utilisation rate is 70%.
- The average for the previous year was 72%.
- Q1 saw an increase in provision to 45 minutes were provided per 1000 patients. (The previous requirement was 30/1000). This has impacted the percentage utilisation overall.
- Unity are now providing access for both RHWT PCN and Unity PCN, increasing to two hubs across the city.

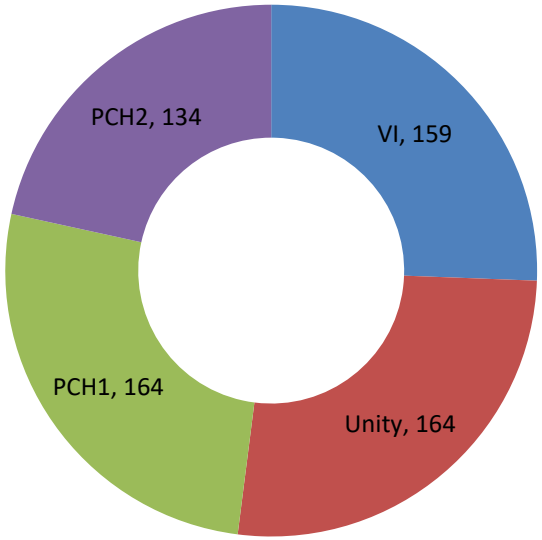




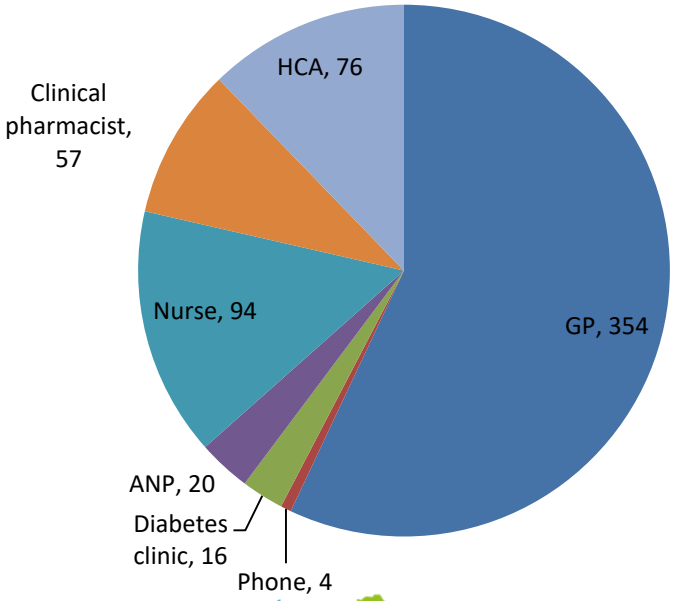
Extended Access - Appointments by Practitioner

The charts below are an average weekly breakdown of extended appointments available across Wolverhampton.

Extra appointments weekly average by PCN



Average weekly appointment breakdown



Primary Care Basket Services

- New CCG Costing Template approved at PCCC in May 2019
- Implementation is ongoing currently.
- Review of data for 18/19 below, split by PCNs.

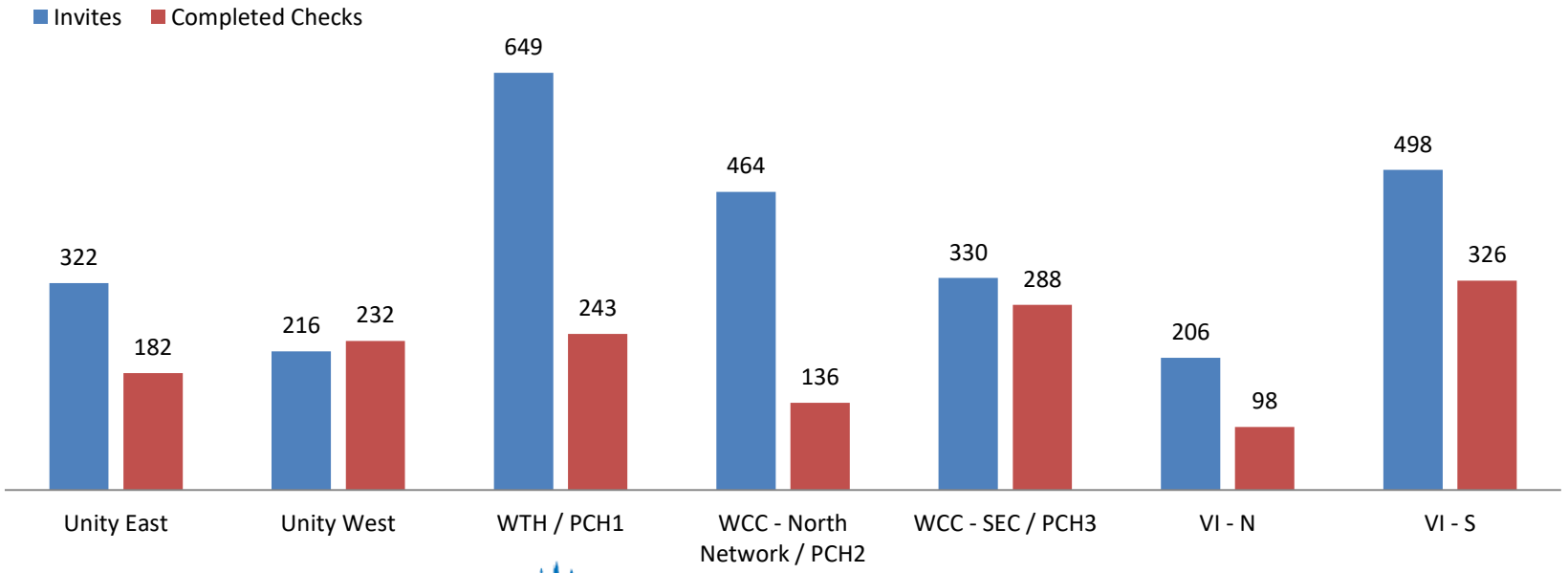
	BASKET													
18/19	Suture/Clip/Staple Removal	Pre-Op Check	Dressing Changes - post secondary care treatment - COMPLEX	Dressing Changes - post secondary care treatment - SIMPLE	12 lead ECG's as part of pre-op or at request of secondary care	Ear Syringes as part of audiology prep	Pessary Changes	Post-Op Checks	Admin of Gonadorelin (Zoladex and Prostrap) Hormone Implants	Subcutaneous injection of Heparin - only where a patiuent or carer is unable to self-administer	Subcutaneous injection of Heparin - Administgration of Epoetins only where a patiuent or carer is unable to self-administer	Testosterone	Denosumab	Minor Injuries
PCH1 TOTAL	309	9	495	1163	8	110	30	97	310	0	0	13	14	307
PCH2 Total	809	81	1023	3536	146	154	63	287	301	4	0	63	25	608
Unity Total	705	101	512	2883	65	301	45	347	404	64	26	44	50	849
VI Total	555	12	465	1705	86	464	93	116	314	0	0	102	37	543
Overall Total:	**2378**	**203**	**2495**	**9287**	**305**	**1029**	**231**	**847**	**1329**	**68**	**26**	**222**	**126**	**2307**

Health Checks

Wolverhampton is currently performing to top quartile standard, and the uptake conversion rate has reached the same percentage as the East & West Midlands figure (53%). In April and May a total of **1505** Health checks were completed and this meant that **53%** of patients who were invited received a NHS Health check.

Midlands Data	
Percentage of people that received an NHS Health Check that were offered in Q1	53.20%
Percentage of people that received an NHS Health Check that were offered in 18/19	49.20%

April & May 19



Health Checks

Total completed health checks for 18/19 = **5994**, of which it is **estimated*** that;

- 900 patients identified as having a **high risk of CVD** (>20% Qrisk score)
- 200 diagnosed with **hypertension**
- 75 diagnosed with **type 2 diabetes**

Total completed health checks for April & May 19/20 = **1505**, of which it is estimated that;

- 251 identified as **High risk CVD** (>20% Q risk score)
- 50 diagnosed with **hypertension**
- 19 diagnosed with **type 2 diabetes**

*These are estimations given when applying the Public Health England health matters national statistics on Health checks.

Year	Invites	Health Checks	Uptake
17/18	4126	2459	60%
18/19	11624	5994	52%
Increase	282%	201%	

Peer Review

Project Details							Savings Position						
UI Ref	Boards	Work Stream • Acute • Mental Health • Community Health • Community Care • Primary care • Prescribing • Continuing Care • Other	Name	Data Source	TYPE	Lead	QIPP Annual Plan £	Planned Savings YTD (April to May)	Actual Savings YTD (April to May)	Total Savings Variance YTD (April to May)	Variance from Annual Plan and Total Cumulative Savings £	% of Annual Plan Achieved	RAG RATING (YTD)
93	MMO PC	Primary Care	Demand Management	BI	TF	Jo Reynolds	£ 178,000	£ 28,000	£ 103,870	£ 75,870	£ 74,130	58%	LOW RISK

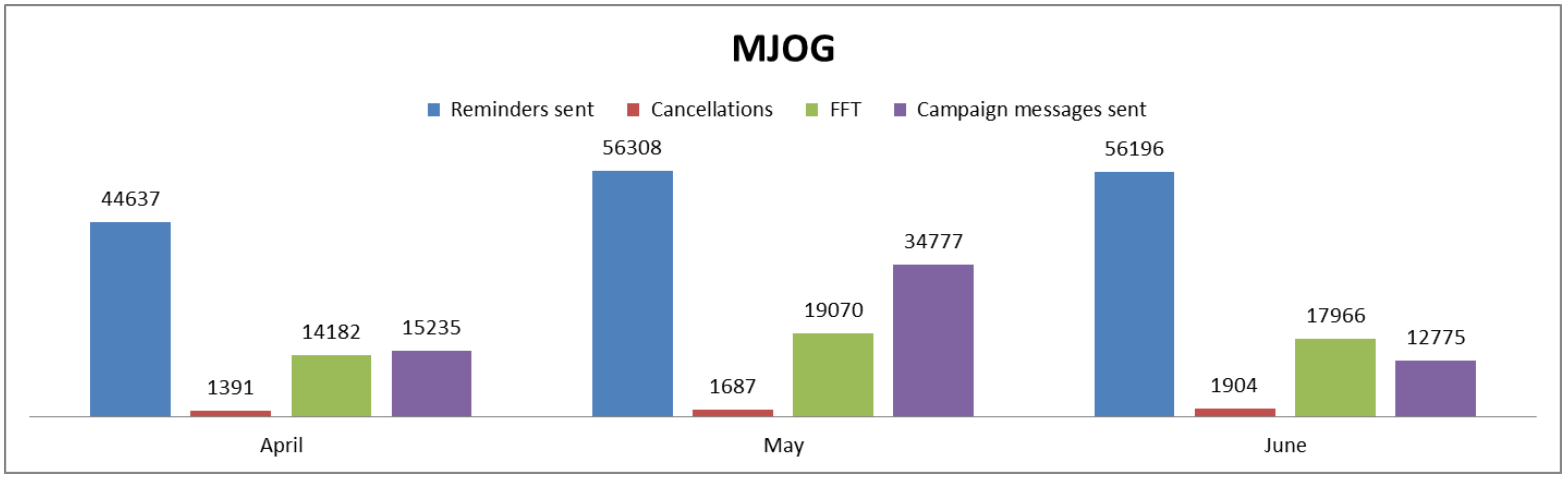
Leads Expected Year End Position (FOT)						
QIPP Annual Plan £	FOT as at June £	FOT as at July £	FOT Change	Plan & Actual	April Mth 1	May Mth 2
£ 178,000	£ 178,000			Plan	£ 14,000	£ 14,000
				Actual	£ 40,956	£ 62,914

Next Steps

- Discussions with RWHT regarding consultant involvement in meetings.
- Training and webinar events are being discussed as options.
- Coms will be circulated highlighting advice and guidance and reiterating clinical pathways to all staff.
- A programme of work is being discussed at BIC board, focusing on refreshing the pathways and developing a platform of content to support the new roles within the practice team

Peer review	Progress
RWT PCN	first meeting will be held on Thursday 5th September, to allow time to prepare the data and give the Clinicians time to prepare their sessions. Meetings will be held monthly following this.
Unity East/ West PCNs	Unity have declined to sign up to the specification, as they feel that it offers limited clinical value. The group have committed to supporting the development of a platform for pathways
WNN	Dermatology has been discussed in June. Outcomes to be fed back to practices, WCCG and secondary care when available.
WSEC	ENT has been discussed in June. Outcomes to be fed back to practices, WCCG and secondary care when available.
WTH	Dermatology has been discussed in June. Outcomes to be fed back to practices, WCCG and secondary care when available.

Mjog



- **4982** appointments in Quarter 1 have been able to be reallocated, due to cancellations through text message.
- Participation in FFT continues to be higher than previously recorded due to text messaging.
- Figures remain static, however there continues to be an increase in Reminders being sent from practices.
- Network level provision being explored, unable to currently provide at hub level. This issue is linked to DNA rates, as hubs are unable to confirm appointments through MJOG. IM&T took an action from MRB to identify a solution, and funding has been identified to support this.

Q1	Reminders sent	Cancellations	FFT	Campaign messages sent
April	44637	1391	14182	15235
May	56308	1687	19070	34777
June	56196	1904	17966	12775
Total Q1	157141	4982	51218	62787

Thrive into Work

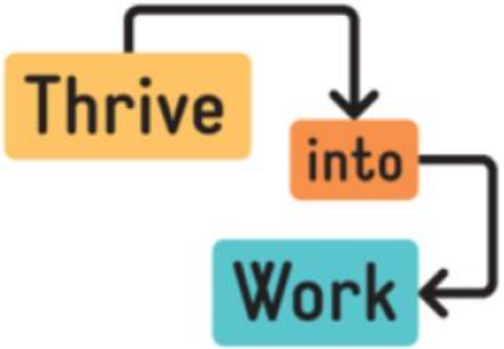
Anyone can refer via **www.thriveintowork.org.uk** and GP teams can also refer via e-RS. GP teams across Wolverhampton, Dudley and Sandwell are working with their CCG and Thrive into Work to set up bespoke new ES clinics to generate large volumes of referrals. There is also an enhanced service that two PCNs (WTH & RWT) have signed up to, with an expectation to deliver 350 *appropriate* referrals.

Most common health conditions:

- Stress/anxiety
- Fatigue/problems with memory
- Depression
- Pain/discomfort

Trial highlights June 2018 – May 2019:

- 1944 people on the trial
- 952 in treatment group
- 181 job starts



Well done to the top GP team referrers so far!

GP Practice	Lot	Referrals
Quarry Bank Surgery	Dudley	23
Cape Hill Medical Practice	SWB	15
Links Medical	Dudley	13
Newbridge Surgery	Wolverhampton	13
Parkfields Medical Practice	Wolverhampton	13
Thorns Road Surgery	Dudley	12
Newtown Health Centre	SWB	11
Ridgeway Surgery	Dudley	11
Rangeways Road Surgery	Dudley	10
Kingswinford Health Centre	Dudley	7

Conclusions

- Commissioning Intentions 19/20
- Conclusions and Next Steps

Commissioning Intentions

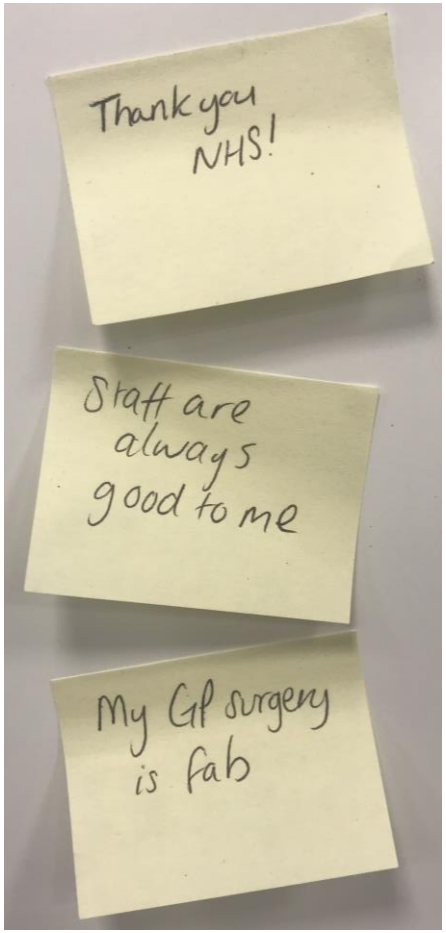
There is a comprehensive engagement plan in place, with agreed support from CSU around the engagement for commissioning intentions for 2019/20.

Highlights from Q1:

- A Senior Communications Officer joined the Primary care team from CSU.
- An Engagement roadshow across the city has taken place. A variety of locations have been visited, such as GP surgeries, health centres, libraries, New Cross hospital and other events across the city.
- 174 surveys had been completed, with many more conversations being had at stands. This is now being evaluated and the top themes coming from the roadshow include:
    - Access to appointments and booking appointments
    - Waiting times
    - Communication from practices so the public know what is available and who from (i.e GP, Practice Nurse, Clinical Pharmacist etc.)

Plans for Q2:

- A series of recommendations will be identified from the survey responses given and associated work plans will be developed to help inform the commissioning intentions and priorities for WCCG during 2020/21.
- Continued engagement at a neighbourhood level for practices, networks and WCCG.
- There are a number of projects in development to utilise and strengthen Social media. This will form part of the work programme for the dedicated communications support going forward.



Conclusions & Next Steps

Conclusions

- Communication & engagement roadshow continued into Q2 with some valuable insight gained. The evaluation and recommendations will be considered at WCCG boards during Q2.
- Primary Care Networks preparation work continued through Q1 and applications have been submitted.
- 6 PCNs are now active in Wolverhampton from 1st July. The PCNs will be labelled differently from Q2 to reflect the Networks more accurately.
- 6 Clinical Directors were appointed.
- Reviewing the Q1 data shows that both commissioned and enhanced services are performing consistently.
- Digital work streams continue to progress, development & engagement within practices continues.
- Workforce Development is continuing to be strengthened and there is now an agreement regarding the Training Hub.
- Primary Care Strategy Review & STP Primary Care Strategy Completed.

Next Steps

- Reclassification of PCNs to reflect the changes post application – 6 active networks now, not 4.
- Communication & engagement roadshow evaluation and feedback.
- Progression of Primary Care Network development plans.
- Clinical Pharmacists and Social Prescribers in PCNs recruitment. Social prescribing model to be agreed, and MOU signed.
- MH therapists in PCNs workshop to be held.
- Clinical Directors Meetings commence.
- Care Navigation to be reviewed and strengthened by a third Phase. Updates scheduled for September.
- Resilience funding applications to be submitted.
- GPN Strategy to be officially launched.
- Peer review activity to be supported by comms, advice and guidance promotion and additional training.
- Workflow optimisation to be discussed at network level.
- QOF+ development group to review data and identify issues.
- Extended access and DES hours to be monitored and any capacity issues identified.
- Further Dementia Friends development and driving this forward to extend the amount of dementia friendly practices in Wolverhampton .

NHS
Wolverhampton
Clinical Commissioning Group

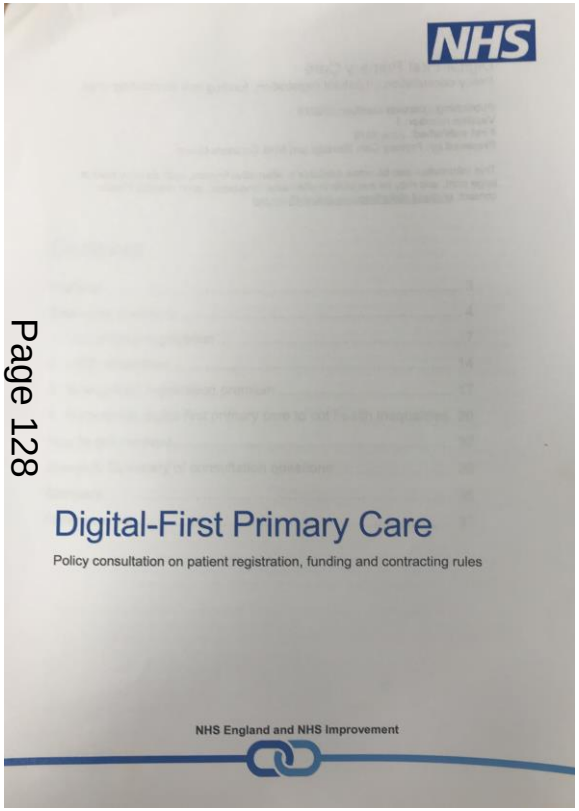
Call to Action : Digital First Primary Care

15 August 2019

PCN Clinical Directors & CCG Executives

Prepared by : Sarah Southall, Head of Primary Care

AGENDA



1.00 pm Welcome & Introductions

1.10 pm Background – Digital First Primary Care

1.15 pm National Consultation Document

1.45 pm SBAR – GP at Hand

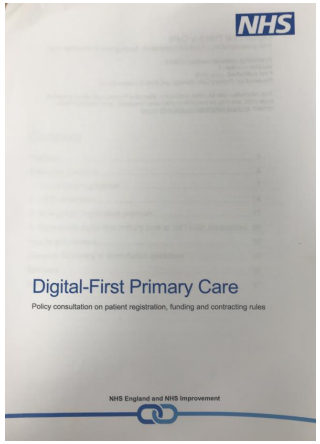
2.00 pm Online Services - Local Picture

2.15 pm Next Steps – Response to Digital First Primary Care

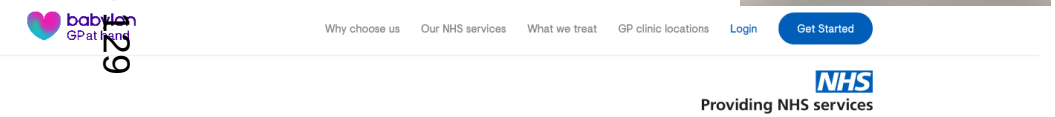
3.00 pm Close

Background – Digital First Primary Care

National Requirement:-
Practices will have available Online Consultations to patients AND
Repeat Prescribing by March 2020



National Requirement:-
111 Direct Booking Practice Level October 2019 & hub/PCN by March 2020



If you need to be seen in person, you can go to any of our clinics

9/10 appointments can be done quickly and safely via video call, but we know sometimes you'll need to see somebody in person. In these cases you'll have the option to book into one of our London or Birmingham clinics.

OHP Announce partnership with Digital Provider, LIVI KRY

OHP LIVI

LIVI to reach over 400,000 Birmingham and Shropshire patients with announcement of new NHS partnerships

Birmingham and Shropshire – 11 August 2019 – From today, 470,000 patients across greater Birmingham and Shropshire will be able to access GP services on their smartphones and tablets with digital healthcare app, LIVI.

National Consultation Document
Digital First Primary Care

- NHSE/I Policy Consultation on patient registration, funding and contracting rules

- June 2019 to 23 August 2019
  1. Out of Area Registration
  2. CCG Allocations
  3. New Patient Registration Premium
  4. Harnessing Digital-First Primary Care to cut health inequalities
  5. Series of consultation questions……..

- Regional & National Meetings to raise the profile (August)

- CCG SBAR (August) and corresponding actions

Digital first

- Patients have the right to digital first primary care
- Achieved by helping existing practices digitize their offer, NHSE has committed to creasing a new framework for digital suppliers to offer their platforms and products to primary care on standard NHS terms for use from 2021

Overview

- Amendment the out of area registration rules
- Number is rising and system is being some providers to increase numbers of patients across vast geographies. Challenges include:-
  - Delivering integrated service and population based care
  - Delivering screening services
  - Commissioners to plan budget for local services
- Hence rules are being revisited. The proposal is set a number of out of area patients that a practice can register in any one CCG if a provider exceeds that threshold contract will be issued to provider and new premises will be opened in the CCG geography

New patient registration premium

- To apply new criteria for payment of the new patient registration premium
- Proposed that new patient registration premium is only paid if a patient remains registered with a practice for an agreed period if between 6&12 months

Proposed APMS contract terms

full PMS essentials under GMS throughout core hours, established physical premises to offer face to face services in the CCG area such as areas of deprived, provide services for all cohorts of patients, integrate with local services, co-operate with the relevant PCN, become a member of the CCG, agree APMS terms, spec & pricing

CCG Allocations

Proposal to enable quarterly recalculation of CCG funding to reflect patient movements which have been stimulated by registration with digital first practices in London.

The document describes two possible approaches to making the adjustment to reflect health needs of the population

by using the practice specific need indices

ii) by using the indices of the digital practice itself

In addition we propose the make dedicated adjustments to take account of very rapid growth in Babylon GP at Hand in 18/19

GP at Hand : SBAR - Situation

1. GP at Hand is digital first practice based in London – disruptive innovation
2. Patients are registering with the practice out of preference to access online services that have been developed with Babylon Health enabling patients to access online contact with a GP ie mobile access to symptom checker, video consultations via mobile app
3. Registrations are a combination or temporary or permanent registration with GP at Hand sites
4. GP at Hand seek to respond to patient queries within 2 hours, the average response time is 20 minutes – the service is available 24/7
5. A new site has recently opened in Birmingham encouraging registrations from patients who live/work within 40 minutes of the site in Gulliver Street (off peak travel time)
6. A meeting was convened with Hammersmith & Fulham CCG & BSOL CCG on Thursday 1 August to provide greater insight into the potential impact on neighbouring CCGs/STPs
7. The Birmingham Site opened mid June and there are currently 246 registered patients, far less than expected. Targeting students in the city, intentions for fresher's week in particular
8. Due to concerns with pathways management for Immunisation & Screening Programmes NHS England has imposed a cap on the number of registrations (cannot exceed 2360)
9. BSOL CCG are working closely with Hammersmith & Fulham CCG along with NHS England and Public Health England to manage the impact of the Birmingham Branch site opening
10. Keys risks for Hammersmith & Fulham CCG ie prescribing & rent/rates reimbursements default to membership organisation due to branch status of the Birmingham site
11. Key risks for BSOL CCG ie patient safety regarding application of care pathways eg 300+ GPs to register for use of ICE system at Birmingham Hospitals, local incentive/enhanced service offers should extend to the GP at Hand Branch, Health Scrutiny Panel require assurance about patient care/safety concerns,
12. Next Assurance meeting with both CCGs, NHS England & Public Health with GP at Hand is on 12 August – the cap on registrations may be lifted & patients from Wolverhampton and across the Black Country may choose to register
13. Digital First Primary Care Consultation (contract) is currently live and due to close on Friday 23 August – we have an opportunity to provide feedback
14. Due to the impact on Sandwell & West Birmingham CCG they are active participants in fortnightly assurance calls with other stakeholders

Background

1. GP at Hand is a GMS Practice based in Hammersmith & Fulham CCGs membership
2. There are multiple branch sites that have opened close to major transport networks encouraging patients to access quick and timely GP support when they need it
3. The GMS practice list size prior to it's name change in 2017 was c6,000 patients this has risen to 58,000 in 2019
4. Hammersmith & Fulham are unable to oppose the actions of the practice when opening additional branches (legal advice sought), significant cost pressure to CCG if more sites are opened in other STP areas – no financial liability for other CCGs in current contracting model
5. Registrations in 2017 & 2018 fluctuated, patients deregistered within 3 months of registration returning to their original practice, this has since become more stable
6. Additional sites are classed at branch sites operating under one ODS and M code. However, the Birmingham site has recently been allocated it's own ODS code enabling site based registration and management of patients to be easily traceable
7. Babylon Health employ 300+ GPs and continue to offer attractive rates of pay/package(s)
8. Hammersmith & Fulham regard GP at Hand at one PCN due their list size but treat the Birmingham site as a neighbourhood and in turn requires GP at Hand to engage with PCNs in Birmingham ie CDs Meetings
9. Patients who register tend to be 21-30 age group and have been those who ordinarily had been high users of A&E/111 – this activity has notably reduced and includes mental health patients also
10. GP at Hand sites work in accordance with Local Prescribing Formularies hence no adverse impact has been observed on spend nor antimicrobial prescribing
11. GP at Hand are a TPP/System One Practice that interfaces with Babylon Health software and the NHS App

Assessment

1. **Impact on the Wolverhampton & the Black Country**

- Registrations from West Birmingham patients are particularly evident c15-20 per week since mid June
- Potential for Wolverhampton patients to register given the attractiveness of the service ie quick access and site now available in Birmingham
- Practices may loose income if large numbers of patients choose to register with GP at Hand (Global Sum is currently paid annually)
- Wolverhampton practices have online services available but uptake is poor, despite publicity
- If large numbers of Wolverhampton patients register and/or a further sight opens closer to patients GP at Hand should be included in PCN discussions / development and local enhanced services/QOF+ scheme
- CCG advertising & availability of online functionality continues to be advertised to encourage local uptake to mitigate the risk of loosing patients from practices

2. **Public Health**

- All screening programmes affected ie colonoscopy based on ODS code - Birmingham patient referred to London - this has been addressed - protocol in place for non London patients
- Management of diabetics has been a concern ie eye screening service annual cycle (depends on registration may/may not be picked up)
- Bowel - cohort of patients in this age group is very small
- Screening programmes delivered by regional teams ie London, patients from other regions could potentially be missed however PHE have prepared protocols to mitigate this but not yet agreed hence no new arrangements in place yet. Being managed by local team PH Team with BSOL CCG

3. **Babylon Health & UHB**

- Software solution to interface with the hospital being developed, other trusts may do so too (trust sub-contract service provision or enter into an agreement to purchase the software/platform)
- RWT may choose work in conjunction with Babylon Health for service delivery (can't sub contract twice) or software solution

Recommendation(s)

1. Risk to be included on the CCGs Risk Register due the impact of GP at Hand on the possible changes to contracting rules should the consultation be approved implemented in GMS contracts (August 2019)
2. Maintain close liaison with Hammersmith & Fulham CCG to remain sighted on judgements of Primary Care Commissioning Committee & Governing
3. Outcome of GP at Hand Assurance Meeting will be shared after 12 August
4. Digital First Primary Care Consultation should be considered and a CCG response prepared before 23 August
5. Recognise locally the impact at CCG level should large numbers of patients register with the Birmingham Branch and/or should a further branch open in close proximity of Wolverhampton patients – multi agency response local & national including NHS England and Public Health
6. Alert CCG Teams including Safeguarding, Quality (pathways), Public Health to the potential impact on Wolverhampton patients and the importance of preparedness ie Immunisation and Screening Programmes
7. Explore with provider trusts their intention(s) to work in partnership with Babylon Health (GMS contracts sub contracted to RWT cannot be sub contracted again to Babylon Health for provision of medical services)
8. Arrange Call to Action Meeting with CCG Executive attendance and Clinical Directors from all PCNs (post national meeting on 13 August)
9. CCG advertising campaign for different consultation types and extended access will be reviewed to ensure robustness and impact to affect patient behaviour change
10. Include SBAR in next report to PCCC (September 2019)
11. Review risk fortnightly with Executive Team to ensure they remain sighted & well informed

Local Picture

Video Consultation (installed)

- Poplars
- Primrose Lane
- Coalway Road
- Lea Road
- IH Medical
- Newbridge
- Mayfields
- Lower Green*
- Ashfield Road
- Grove
- Fordhouses Medical
- Dr Mudigonda

All other practices yet to confirm installation

Activity Reporting available from internal clinical system search (*sound quality issue with Lexicom)

All remaining RWT Practices Alfred Squire, Warstones, Thornley Street, West Park Surgery, Dr Bilas (by October)

Online Triage

Rollout to practices commenced late 2018 & continues

However:-

- Dr Sharma (refused)
- East Park (workload)
- Keats Grove (nil response)
- Castlecroft (workload)
- Dr Whitehouse (nil response)
- Showell Park (nil response)
- Bilston Urban Village (transfer / site merger)

Practices will be instructed regarding installation date in order to meet the national target

- 74% (September)
- 76.1% (November)
- 100% (December)
- Utilisation reports monthly from September
- GPFV Monitoring Tool (Quarterly)

Patient Access (Patient Online)

- Platform for Online Consultations ie Triage & Video etc
- Engagement sessions at practice level (IM&T)
- Engagement with wider community ie Schools, social Clubs, St Johns, Churches, Mosques, Councillors etc (IM&T)
- Engagement Roadshow (CCG)
- Practice Level Sign Up (MJOG)
- Currently % registered

Patient Engagement Roadshow – What Matters to You?

- 11 Site Visits (June/July 2019)
- Online Survey & Social Media Publicity
- WCCG website 397 hits on engagement banner
- 174 Surveys fully completed
- Complimentary feedback regarding care in general practice
- Waiting times for appointments consistent issue
- Access to appointments same day/weekends in PCNs not known
- Different consultation types not clear either
- Feedback includes information about other services including urgent care, mental health etc
- Action Plan under construction
- Publicity also under review……..

	Yes, I would be prepared to	No, I would not be prepared to	Not sure/ would need more information
I would be prepared to talk to a healthcare professional over the phone	63.8%	15.5%	20.7%
I would be prepared to book appointments, see my test results and view my healthcare record online	53.4%	25.9%	20.7%
I would be prepared to see my healthcare professional face to face for an appointment	100.0%	-	-
I would be prepared to have my GP appointments online	37.9%	37.4%	24.7%
I would be prepared to receive the care I need within the community at another nearby location	67.8%	10.9%	21.3%

Next Steps

Response to Digital First Primary Care

- Out of Area…..what should the threshold be?
- 1000-2000 patients dictates the need for a branch / separate APMS contract
- Place of residence is more reasonable approach than place registered
- Two triggers i) growth of self registration with a provider ie out of area ii) under doctored area
- The consultation currently infers – intent to lead to changes to patient registration dataset to ensure registered vs residence (local health need – correct branch)
- Initial feedback suggests consideration of a percentage of CCG % population rather than specific number (particularly as CCGs are merging)
- Choice of patients and impact on CCGs where branch will be imposed by NHSE/I required
- NHSEs intention to introduce a route for business as usual (list of approved providers)
- Connecting patients with PCNs and community services – APMS provider becomes part of PCN (depending on size)
- Preferred model of NHSE is that provider partners with existing practices/PCNs
- Implications for Urgent care and out of hours plus many other pathways ie maternity, screening
- Workload for CCGs where new branch opens can't be under-estimated

Impact on Wolverhampton – SBAR : GP at Hand

- Recommendations made to foster broader discussion
- Cap on registrations in BSOL area remains until September
- Publicity at practice level to promote availability
- Recognise the impact on practice income
- Recognise potential disruption & impact on CCG allocations

Male	Female	Total av per practice 20-30y
445	435	880

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NHS
Wolverhampton
Clinical Commissioning Group

Primary Care Strategy 2019 - 2021

August 2019

Version 1.4 FINAL DRAFT

Contents

1.0 Introduction

The first primary care strategy was published by Wolverhampton CCG in 2016, in anticipation of being fully authorised to commission Primary Care (General Practice) in March of the following year. The strategy laid out a series of aspirations:-

- The over-arching outcomes following the implementation of the Primary Care Strategy
- Our plans for a fundamental shift to treating more people in a community setting (as part of the Right Care, Right Place, Right Time overall CCG strategy)
- How General practice will operate at greater scale, underpinned by network alliance; non-clinical support between and amongst practices; GP IT; workforce and estates
- The influence that General Practice hold as the gateway to commissioned activity in Wolverhampton (Practices as Commissioners)
- How Procurement and Contacting for new services will be deployed in the emerging and forming GP networks.

In pursuing this strategy, much progress has been made and this revised document provides us with the opportunity to consider progress made and the next steps in recognition of national policy changes and in particular the NHS Long Term Plan that advocates Primary Care being the bedrock on which all other services should be built.

2.0 Context

2.1 The National Directives and Plans

The NHS Long Term plan, released in early 2019, sets out the new vision for the NHS for the next ten years. This vision, seeks to develop New Models of CAre in which patients get more options, better support and effective joined-up care, at the right time, in the optimal care setting. This way, care will be more pro-active, and people will be able to take more control of their own physical and mental health and wellbeing.

The Long-term Plan describes what changes need to be made by all healthcare services such as the development of new job roles and how digital solutions such as Apps will support patients to access care in new and different ways, to give patients an all-round better experience of care

There are 5 major changes identified which build on the aspirations outlined in the GP Five Year Forward View (2016).These are:

2.2 Local - Wolverhampton

Our vision for the future is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources.

In order to achieve this, we have five priorities for the coming year:

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

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

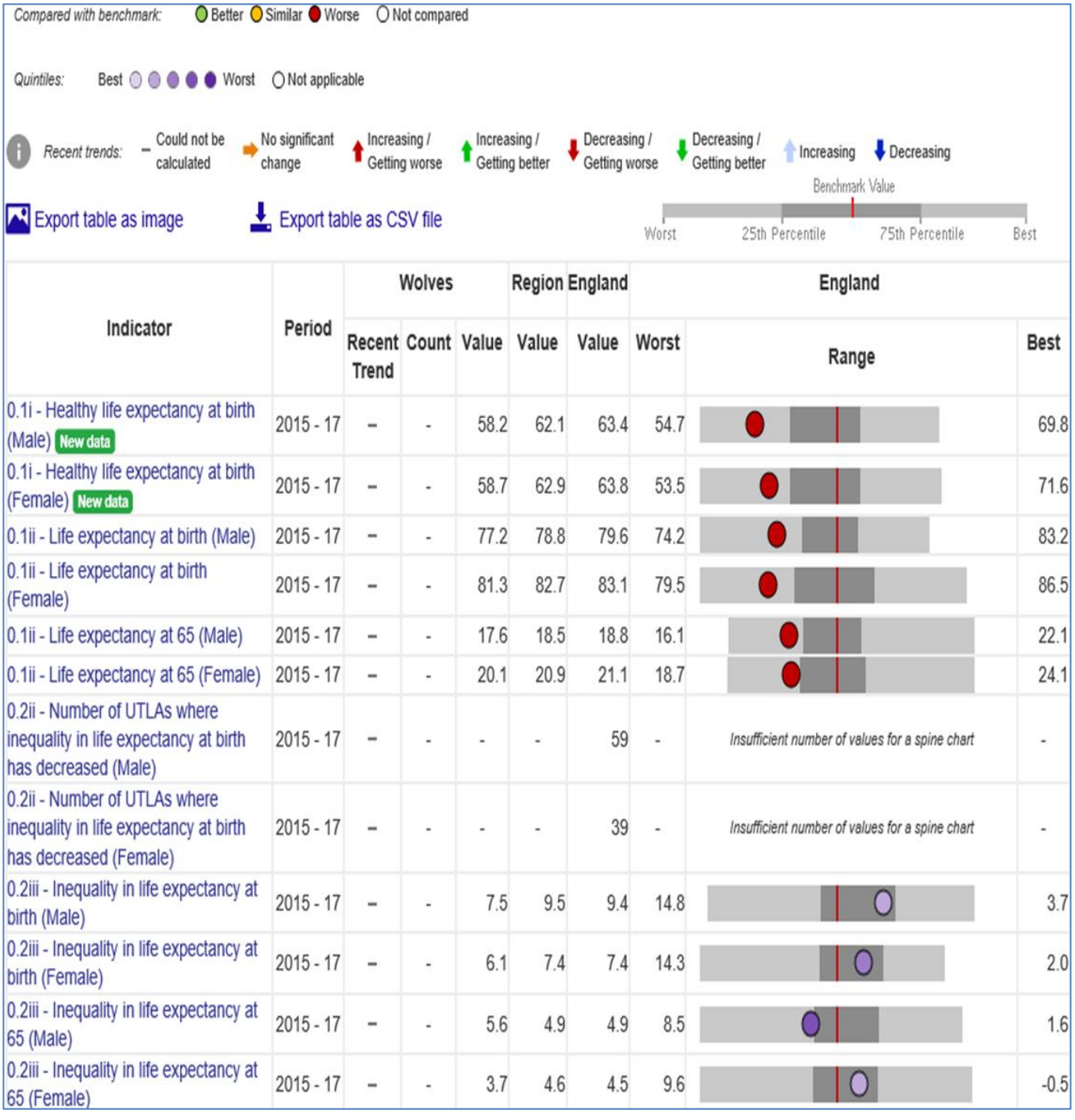
The City of Wolverhampton's population has been growing in recent years, and now stands at in excess of 290,000 in April 2019.

The city is ethnically diverse, with 35.5% of residents in 2011 being of BAME (Black and Minority Ethnic) heritage. Furthermore, 16.4% of the population in 2011 were not born in the UK. Many religions are followed, and the city has the second-highest proportion of Sikh residents in the country. A fifth of the population is disabled, similar to the English average using Experian's Mosaic classification system (updated in early 2016) provides the following profile. The largest proportion of households in the city are the 'Family Basics' group (18,585 or 17.8%) who are described as "families with limited resources who have to budget to make ends meet". The second most common household type is Transient Renters (15,798 or 15.2%), households comprised of "single people privately renting low cost homes for the short term". The third most common household is Modest Traditions (13,188 or 12.7%), who are "mature homeowners of value homes enjoying stable lifestyles".

3.0 Challenges

Wolverhampton has a number of health challenges relating deprivation including childhood obesity, child poverty, infant mortality (higher than the England average but improving) but with fewer secondary school age pupils having tried/smoking. Further details can be found in the city's Joint Health & Wellbeing Strategy 2018-23.

Through adopting a collaborative approach between the CCG, Public Health and our practice groups NHS Health Checks are at the highest rate they've ever been in the city having been one of the worst performing CCGs/Local Authorities in England in 2016/17.



Indicator	Period	Wolves			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
0.1i - Healthy life expectancy at birth (Male) New data	2015 - 17	–	-	58.2	62.1	63.4	54.7		69.8
0.1i - Healthy life expectancy at birth (Female) New data	2015 - 17	–	-	58.7	62.9	63.8	53.5		71.6
0.1ii - Life expectancy at birth (Male)	2015 - 17	–	-	77.2	78.8	79.6	74.2		83.2
0.1ii - Life expectancy at birth (Female)	2015 - 17	–	-	81.3	82.7	83.1	79.5		86.5
0.1ii - Life expectancy at 65 (Male)	2015 - 17	–	-	17.6	18.5	18.8	16.1		22.1
0.1ii - Life expectancy at 65 (Female)	2015 - 17	–	-	20.1	20.9	21.1	18.7		24.1
0.2ii - Number of UTLAs where inequality in life expectancy at birth has decreased (Male)	2015 - 17	–	-	-	-	59	-	*Insufficient number of values for a spine chart*	-
0.2ii - Number of UTLAs where inequality in life expectancy at birth has decreased (Female)	2015 - 17	–	-	-	-	39	-	*Insufficient number of values for a spine chart*	-
0.2iii - Inequality in life expectancy at birth (Male)	2015 - 17	–	-	7.5	9.5	9.4	14.8		3.7
0.2iii - Inequality in life expectancy at birth (Female)	2015 - 17	–	-	6.1	7.4	7.4	14.3		2.0
0.2iii - Inequality in life expectancy at 65 (Male)	2015 - 17	–	-	5.6	4.9	4.9	8.5		1.6
0.2iii - Inequality in life expectancy at 65 (Female)	2015 - 17	–	-	3.7	4.6	4.5	9.6		-0.5

We know that Primary Care plays an important role in improving the health of local populations, but we also recognise that changing how patients receive care will be a collective responsibility of patients not just be the responsibility of Primary Care Networks and the Practitioners that work within them. We have to continue to develop and implement a programme of at scale initiatives.
We are introducing a genuine parity of esteem through transformation of services, policy change and societal attitude.

Responding to the NHS 10-year Plan's focus on Mental Health we are creating a system where patients have easier access to services:-

- get early diagnosis and prevention
- have smoother transition from child to adult mental health services
- grow stronger, and early links with education
- ensure that primary care is supported to help but does not become the default for every patients
- make sure that all patients in crisis have support 24/7
- can access same day emergency and can get help to prevent suicide when they feel this is the only option left to them.

3.1 Reduce Inequalities

Improvements in life expectancy are a key success indicator and focus for all the partners within Wolverhampton. To achieve these, the council and public-sector partners will be working together to transform health outcomes across the city. Public Health will support and provide external advice to partners beyond the NHS and social care in taking a place-based approach.

Key to extending the reach of public health will be a primary care service equipped with the skills to engage, influence and persuade, with the ability to tell the story using data and evidence, whilst continually strengthening relationships.

Although the City of Wolverhampton is younger than the English average, it still has challenges from an aging population, and by 2041 is projcted that 60,935 residents will be aged 65+, which is a rise of 42%.

In response to the future challenges which all services will experience the City of Wolverhampton has a Health and Wellbeing programme, which we fully support and are a key partner in developing and delivering. The Joint Health and Wellbeing Strategy 2018-2023 has created three overarching priorities are thematically grouped as follows:-

3.2 What we have achieved so far

We are piloting initiatives, chosen as part of our previous strategy with the aim of both improving general primary care services and supporting a shift of care into the community.

Over the last 2 years Primary Care services have put in place:

- Practices actively engaging to afford more resilience and improve patient care.
- Improved access to Primary Care providing additional appointments through introducing hubs in the community with appointments available until 8 pm weekdays plus weekends and bank holidays.
- More services available at weekends including dedicated nurse appointments, pharmacy reviews, phlebotomy and other specialist clinics available for patients to access.
- Primary care counselling service for patients to access in a timely manner closer to home and without referral to mental health services.
- A Special Access Service for patients who have been excluded from General Practice lists as a result of violent or aggressive behaviour.
- A local Quality Outcomes Framework (QOF+) focussing on the prevention and treatment of conditions including diabetes, obesity, alcohol, hypothyroidism, COPD and Asthma and also included in the scheme are physical health checks patients on learning disability or serious mental illness register(s) and finally cancer screening too.
- The Supporting of patients to be treated at home or in a nursing home when previously they would have been treated in a hospital
- Increased palliative care services available to those who wish to die in their place of choice
- Improvements in the health and social care of people with Long Term Conditions including:
- Diabetes, CVD (AF diagnosis, warfarin treatment and NOACs, hypertension, heart failure and stroke, cardiac rehab following MI) and COPD
- Improved the health and social care of the frail elderly
- A strong emphasis on putting the patient at the centre of our planning and encouraging primary care to work together to achieve improved population-based health and well-being

3.3 Our Vision for Primary Care

Supporting the continued improvement and development of Primary Care in Wolverhampton is one of our main priorities over the next 2 years which we will achieve through implementing this strategy.

This strategy is intended to reflect our ambitious programme of system-wide, large-scale change and recognises the importance of primary care as the foundation of our entire health system.

Our vision for the future is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources.

However, it's important to recognise there will be a continued focus on general practice services and will not directly cover other primary care services such as dentistry and ophthalmology. This reflects the fact that the CCG's membership is comprised of general practitioners and the CCG's responsibility to ensure the continuous improvement of

primary medical services. These other services are still being commissioned by NHS England however, how these change in response to the 10 Year Plan, and changes to any plans will be undertaken in due course.

1. **Priorities for Developing Primary Care**
   - Setting up Primary Care Networks
   - Population health management
   - Improving access in general practice
   - Mature Primary Care Networks through implementation of the Network DES
   - Active involvement in the development of the Integrated Care System

2. **Our Clinical Priorities for Primary Care**
   - Frailty
   - Children and Young People
   - End of Life Care
   - Mental Health

3. **NHS Long Term Plan**
   - Boost out of hospital care
   - Reduce pressure on emergency hospital services
   - Control over your own health and more personalised care
   - Digitally enabled primary and outpatient care
   - Focus on population health – moving to Integrated Care Systems everywhere

The Long-Term Plan has committed to increase available funding for community and primary care. We will use this additional funding on improving our services e.g. developing our Primary Care Networks is fundamental to the success of this strategy.

Supporting the continued improvement and development of Primary Care is a key ambition for Wolverhampton CCG, reflected in our work programmes however introducing reforms to Primary Care will not occur over night and bring with them both structural and operational challenges.

4.0 Opportunities

4.1 Primary Care Networks

In Wolverhampton we have worked with General Practice to put the foundations in place for practices working as networks. A primary care network (PCN) consists of groups of general practices working together across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. These networks provide care for populations between 30 – 50k patients. There is a greater opportunity for GP practices to provide a wider range of services situated closer to the patient's residence.

In operating in such a way, network of practices will be in a position provide a wider range of primary care services to patients, involving a wider set of staff roles than might be feasible in individual practices, for example, 'First Contact Physiotherapy, extended access and social prescribing. Networks will receive specific funding for clinical pharmacists and social prescribing link workers in 2019/20, with funding for physiotherapists, physician associates and paramedics in subsequent years.

These networks will be the footprint around which integrated community-based teams and community and mental health services will develop. Networks will use data to assess the needs of the local population and identify people who would benefit from targeted, proactive support.

Although the GP practice will be part of a wider network of practices, they will still retain their unique identity and relationship with their own patients and continue to provide local services to their patients.

Since national guidance was published in March 2019, the CCG have worked closely with practice groups to formalise working arrangements as Primary Care Networks. In May 2019 the CCG approved 6 applications from groups of practices which contractually formalises their working relationships via the Network 'Directly Enhanced Service' (DES).

It is expected that these6 primary care networks will strengthen and develop their services based on population health need. There are four overarching Programme areas that national directives are steering local deployment.

PCN Development
All six networks will be supported by the CCG to mature in a timely manner. to the CCGs acknowledges the challenges of competing priorities PCNs will face All PCN will be required to identify, from available data, their population health needs and prepare a full DES Network Agreement in June that addresses each of the following:-

Schedule 1 – Network Specifics
Schedule 2 – Additional Terms
Schedule 3 - Activities
Schedule 4 – Financial Arrangements
Schedule 5 - Workforce
Schedule 6 – Insolvency Events
Schedule 7 – Arrangements with organisations outside the network

Network agreements will be regularly updated to reflect the maturity and the changes that arise in the implementation phase. The Network DES recognises that practice remain independent and there may be occasions when a practice may leave or join a network. These changes will be proposed to the CCG Commissioning Committee to ensure that the requirements of the Network DES (specification and guidance) have been met prior to any change.

By the end of 2019/20 there will be new national service specifications attached to the Network DES to be enacted in 2020/21 the DES will continue to be developed over subsequent years as part of the 5 year deal for GPs.

The speed of collaboration will be critical to the maturity and effectiveness of each of our networks in Wolverhampton. This has been a core component of the 5 year strategy in the Wolverhampton Clinical Strategy and practices are now well placed to develop at pace. The CCG has been and will continue to be committed to supporting and encouraging PCN development along with other stakeholders and partners and strive to achieve better services for patients. The PCN situation for Wolverhampton is hlighlighted in the table below

Name	Composition
Wolverhampton North Network	7 practices | 52,584 patients
Unity East Network	8 practices | 32,867 patients
Wolverhampton South East Network	7 practices | 56,933 patients
Vertical Integration	8 practices | 55,516 patients
Unity West Network	5 practices | 38,197 patients
Wolverhampton Total Health	6 practices | 56,321 patients

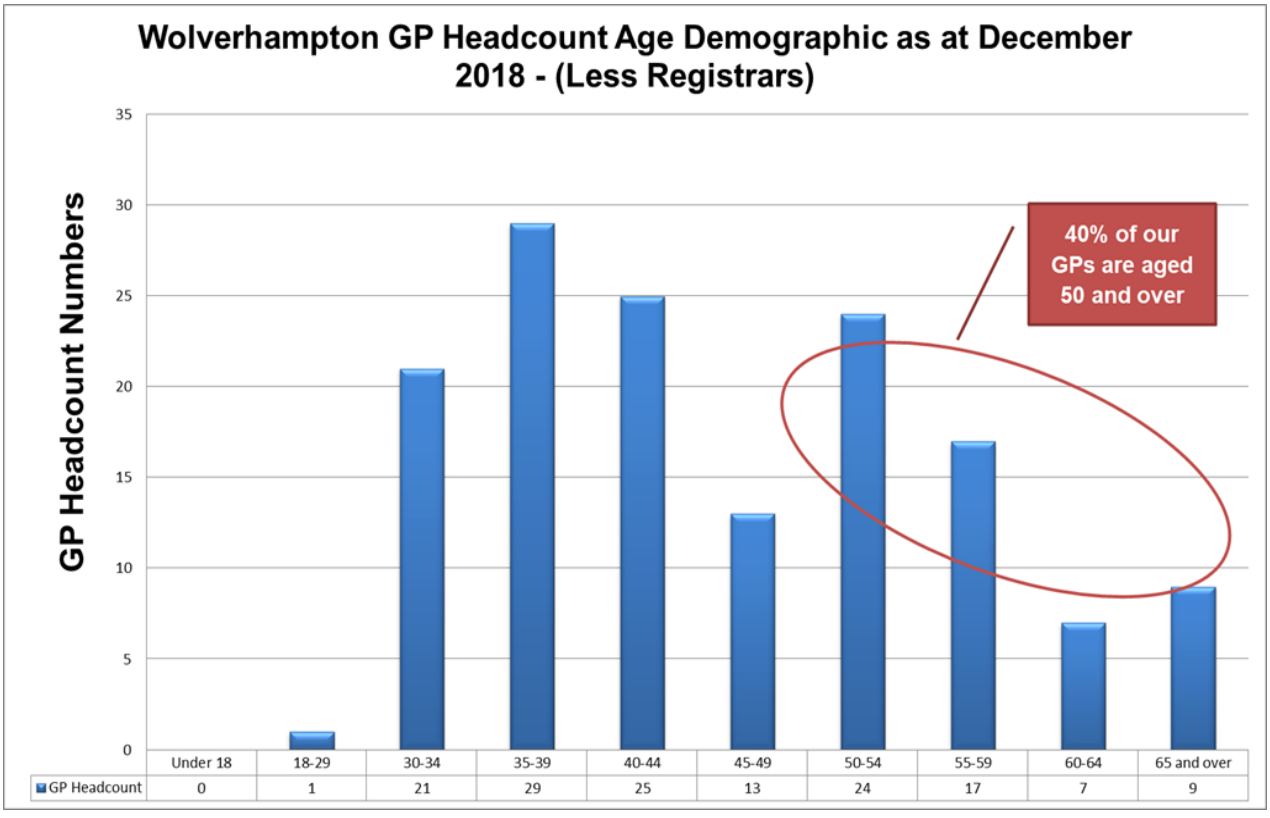
4.2 Workforce

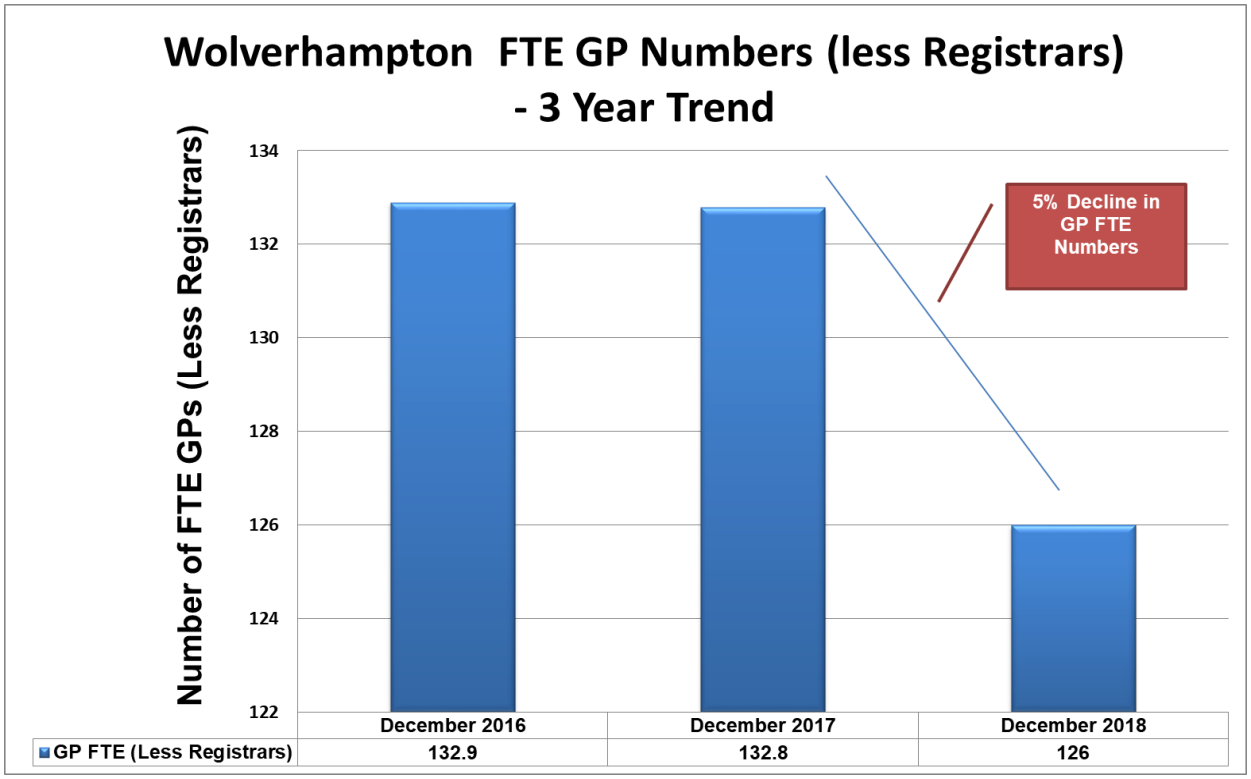
The increase in demand General Practitioners face has been a significant cause for concern due to the number of GPs either leaving the profession or newly qualified Doctors not wanting to enter the Primary Care.

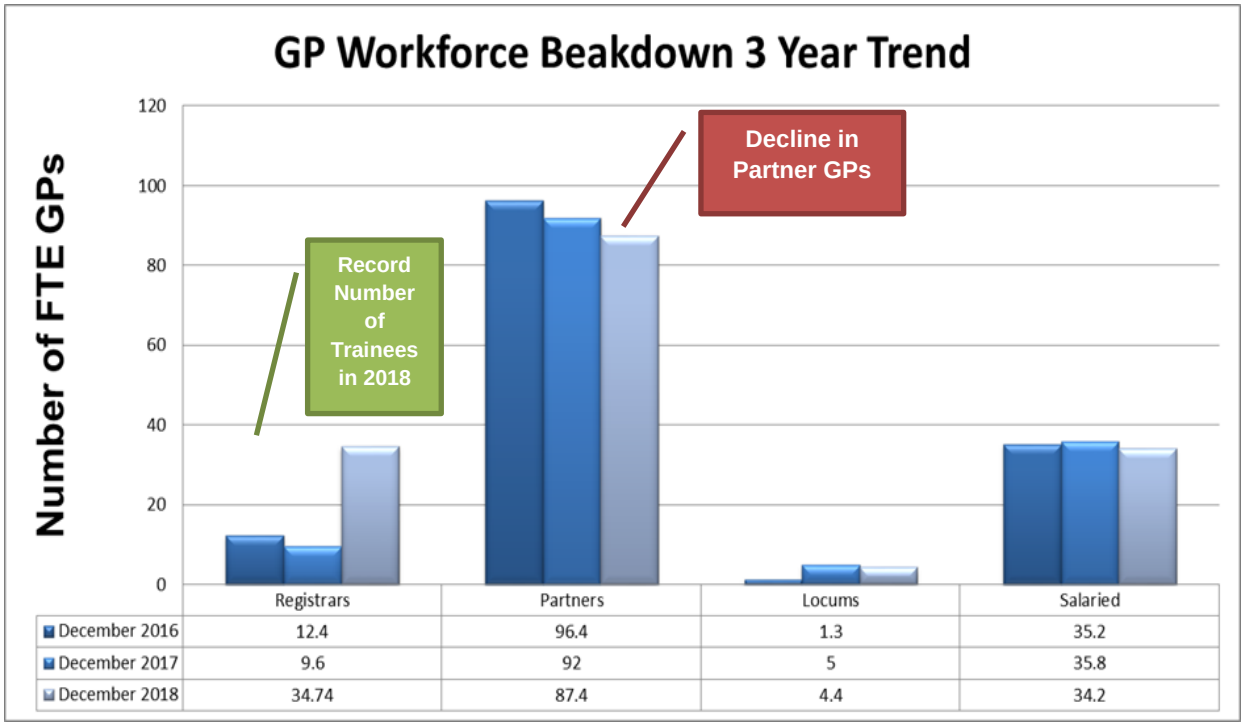
In addition, there are added complexities with the aging workforce profile of GPs. This has been recognised through the partnership work between the Black Country and NHS England and Intensive Support Site funding has allowed the greater interaction and co-design of a series of initiatives to attract and retain GPs in the Black Country. In Wolverhampton we are establishing stronger links with our training practices and Training Programme Directors to support GP Trainees to complete their training and find substantive employment in the area.

The CCG does recognise also the importance of close working with GPs to ensure we achieve a sensible flow of GPs both at early, mid and late career – the objective being to keep GPs in the profession in order to sustain an even distribution across the age profile.

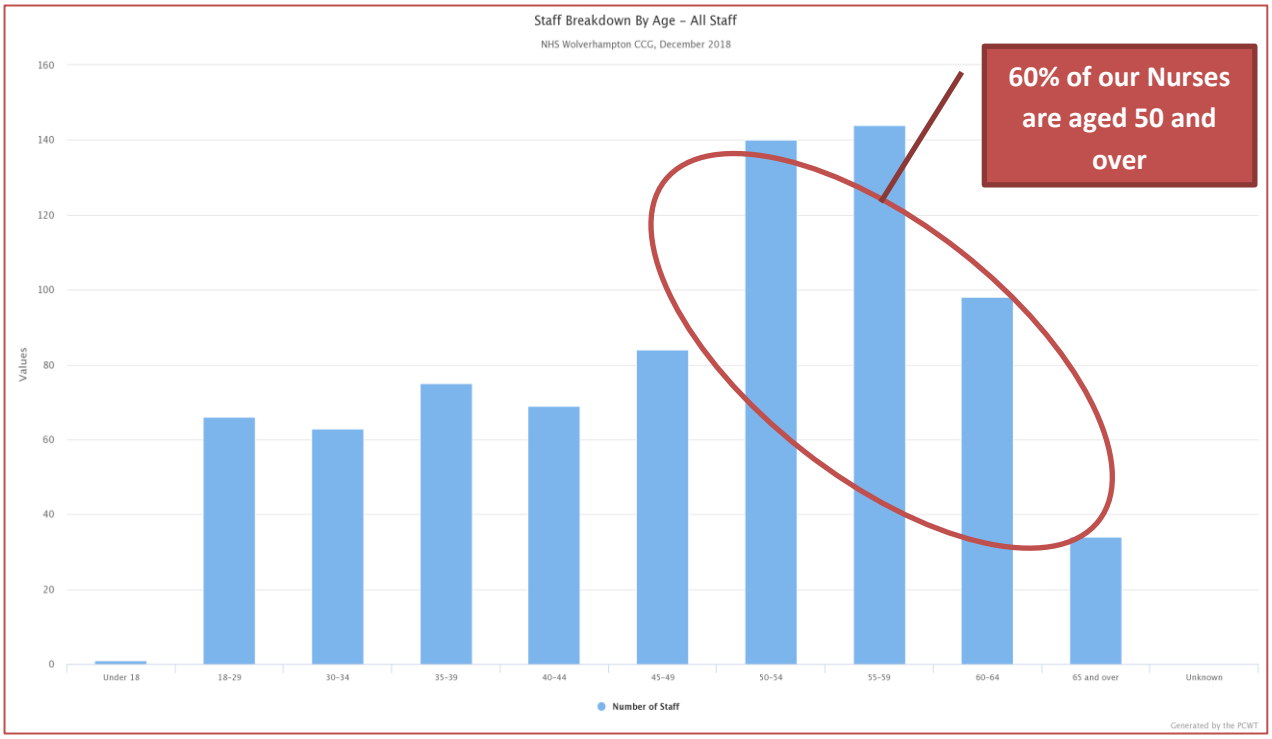
There are a number of GP workforce retention initiatives that are actively promoted and being accessed by Wolverhampton GPs affording mentoring, networking and portfolio careers and also access to expert advice on career planning and other support for GPs who wish to return to practice and want to be part of our membership.







Similarly, the practice nurses age profile emphasises the importance of working with practices to develop and promote general practice nursing as a career for the future. A high proportion of practice nurses are nearing retirement. Through our local engagement with the workforce and educational providers, a suite of retention projects will be co-designed to improve practice nurse retention. Improved rates of student placements have begun to be realised however, more work needs to be done to develop and strengthen our workforce. The STP General Practice Nurse Strategy is also due to be launched in September 2019.



There will be an expansion of nursing and other undergraduate training places and there will be an increase in international recruitment. There will also be an increase in the number of volunteers.

4.3 Estates

Our estates plans have been developed in response to the national and local drivers for change and by building on our progress to date, we will continue to develop a fit for purpose estate and support management system to:-

- Improve the capability and capacity for Primary Care provision to address population growth and demographic change
- Support and enable the delivery of clinical strategies and new models of care
- Deliver better service integration, improvements in service efficiency and better outcomes for our residents
- Improve the effective utilisation of the estate
- Increase efficiencies and ensure value for money both from our existing estate and from any investments in estate developments
- Improve the quality, flexibility and condition of the estate
- Reduce risk and improve service resilience at local and system levels
- Rationalise and dispose of surplus or unfit estate.

Our estates team will, through our governance systems and continuing stakeholder engagement, ensure that the plans remain as live documents and will be updated to reflect emerging new models of care, changing need and funding resources.

There is close collaboration between the estates function, primary care commissioners and the locality planning infrastructure. he Local Estates Forum and other planning forums ensure close collaboration with the wider health and care stakeholders. The estate strategy will continue to be service led and the estates strategy will enable us to achieve clinical and service aims and plans.

The CCG will maintain a focus on the efficient management and utilisation of and value for money from the existing estate. There are many alternatives available other than new or extended buildings.

4.4 Digital

The Long-Term Plan clearly articulated the need for improved access for patients, including., patients having better access to their health care records. This will be implemented through an integrated online triage solution, accessible via the NHS Patient Access app and also directly through the patient access portal on the GP Practices websites. Improving patient choice will further be expanded through the deployment of an online Video Consultation solution. Patients will have the option of choosing the type of consultation they receive and this will also support patients who struggle to access services directly at the practice.

The development of the Insight Shared Care Record will allow clinicians access to patients' full records as they move between healthcare professionals.

The 111 service will be able to book patients directly into GP appointments at practices with Wolverhampton.

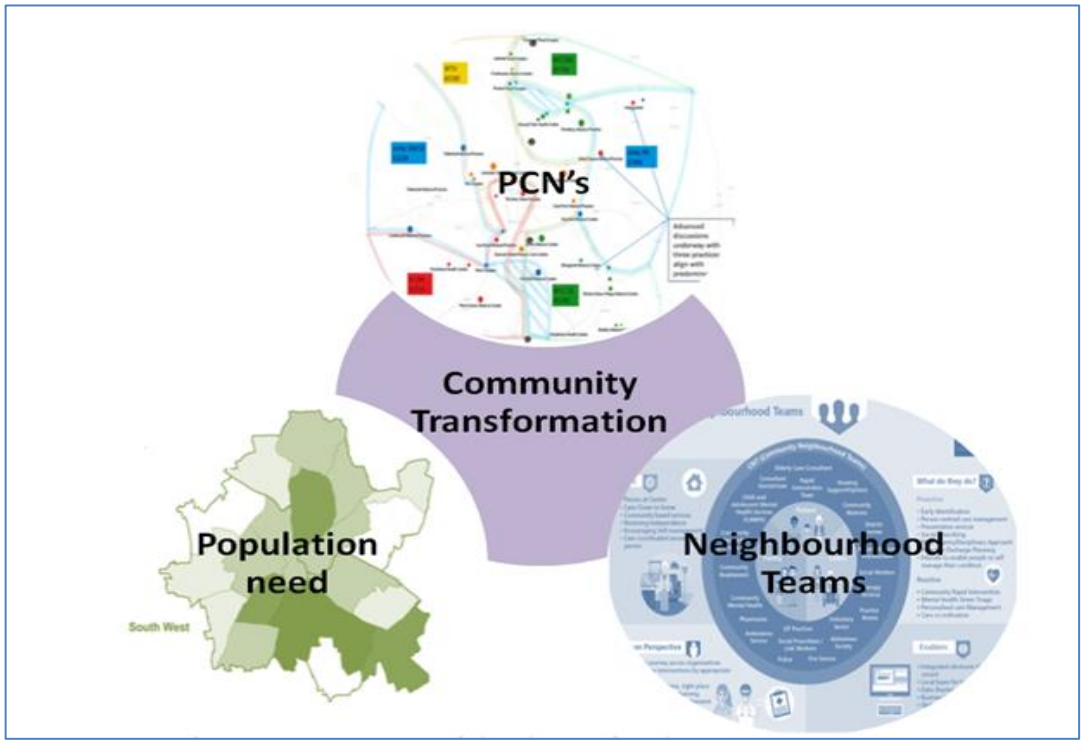
Through the HSCN programme the CCG is installing a brand-new network infrastructure replacing the old broadband N3 lines with scale able IPVPN lines that will allow the network to expand with the requirements of the organisation moving forward.

4.5 Inter-dependencies with the NHS Long Term Plan

4.5.1 Boost out of hospital care and move to greater collaborative working between Primary and Community Health Services

Wolverhampton is committed to continuing and building upon the work already achieved in developing system wide health and care integration with a strong focus on care closer to home but going forward, with a much stronger emphasis on 'wrapping' this integration around Primary Care. The NHS Long Term plan investment into developing Primary Care Networks supports the journey that Wolverhampton has already been already embarked on. A key shift over the life of this strategy, supported by Wolverhampton's Integrated Care Alliance will bring into place, will see:-

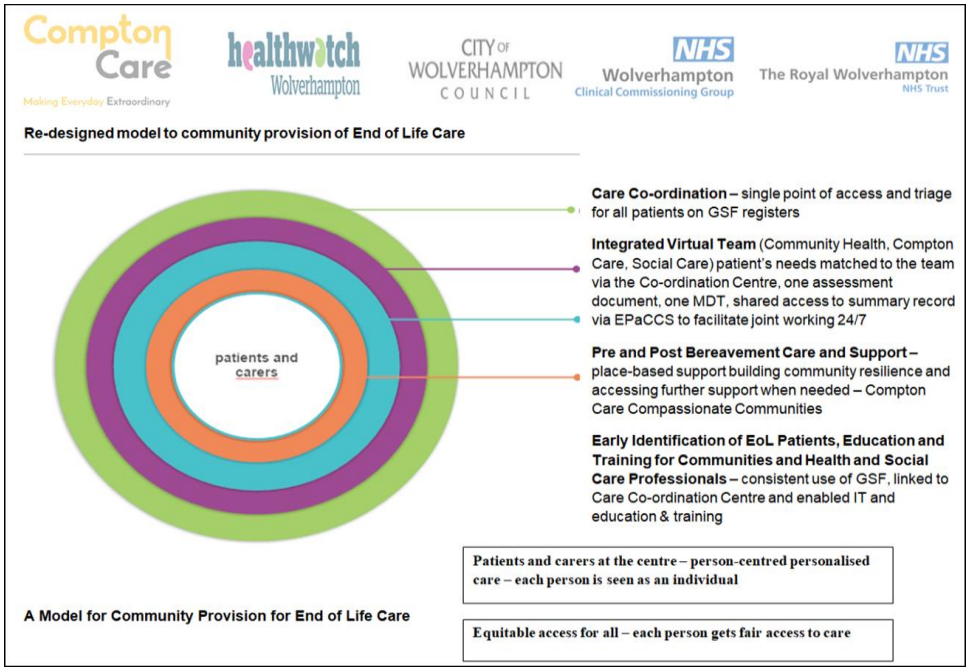
- A transformed Community Services supporting PCNs in Wolverhampton that will offer:-
    - Improvements for patients at the end of life, and the need to reduce the numbers of patients dying in an acute bed
    - Increased capacity within community services and admission avoidance initiatives
    - Aligned care provision with population need
    - Integrated locality hubs to maximise joint working opportunities with system partners including Adult Social Care, Housing, Mental Health and the Voluntary Sector (one of which has been fully operational since December 2018)
    - Flexible, viable and sustainable community services now and in the future



- Fully integrated, structured, Community Multi-Disciplinary Team (MDT) approaches that will enable each Primary Care Network to access social care, voluntary sector, housing, mental health and community health skills, knowledge and expertise. This will prevent patient escalating into acute care where appropriate and work with patients who have been accessing acute services but who can be better supported closer to home and in their communities. For the population of Wolverhampton, this means more integrated, person centred care. The MDT approach is already in progress with over 50% of practices across the city active now and plans in place for the remainder to go live during 2019/2020.

- Each practice will benefit from a home visiting service to enable more patients to be triaged and treated in their own homes.

- A new end of life community based model of delivery



- We will work with our PCN's to help them identify priorities for their development and gain access to the support offers that become available, including organisational development that will support the ongoing integration of Community bases services with PCNs

4.5.2 Reduction in pressure on emergency hospital services

Wolverhampton will continue to promote actively primary and community-focused alternatives to hospital for unplanned care. There has already been substantial resources and pathways designed to prevent hospital attendance for those at risk of unnecessary hospitalisation. We will continue to improve and develop:

- Improved access to out of core GP hours over and above the General Medical Services contract.

- Integrated MDTs in primary care for patients identified requiring a multi-disciplinary approach to assure the appropriate care at home in the community and away from urgent/emergency care where appropriate. Primary Care MDT co-ordination, will make use of personalised care plana and a shared care record across Health, Social Care and Mental Health providers.
- Additional primary care sessions during bank holidays.
- Urgent Treatment Centres (UTC) to more appropriately manage primary care patients who attend the acute site.
- Integrated NHS 111 with the UTC to allow direct booking of primary care appointments as an alternative to emergency department attendance.
- A Primary Care in-reach approach to support care and nursing home patients to be treated without the need to convey into hospital supplemented by rapid support at times of an exacerbation of a condition

4.5.3 More control over your own health and more personalised care when you need it

Personalised care is one of the five major practical changes to the NHS that will take place over the next five years, as set out in the NHS Long-Term Plan. Primary care and PCNs are well place to support individuals to manage their own personal health and care.

Primary care will play a pivotal role in this in a number of ways:

- Implementing social prescribing within PCNs
- Expanding on good practice models such as health coaching and programmes such as Make Every Contact Count.
- Introducing Shared Decision Making (SDM) with patients.
- Ensuring that patients have personalised care plans where appropriate concentrating on "what matters to me".
- Ensuring a co-ordinated, multi-disciplinary approach to managing personalisation at a "universal" and "targeted" level

We have adopted an approach to delivering the personalisation agenda based on 6 nationally recognised evidence-based components. These include:

- Shared decision making.
- Personalised care and support planning.
- Enabling choice, including the legal rights to choose.
- Social prescribing and community-based support.
- Supported self-management.
- Personal health budgets and Integrated personal budget

Going forward our aim is that we:

1. Progress Policing and Community Safety Partnerships (PCSP)/ health coaching training programme across the entire STP.
2. Deliver two strategic co-production events for people across the STP so they are aware of the work we are undertaking to support them in managing their own health and well-being.
3. Strengthen peer support offers by using outputs from peer support mapping and commission facilitation training for groups through the four local Community and Voluntary Services.
4. Engage with commissioners over strategic direction and ensure contracts support on-going personalisation.
5. Plan and deliver a training programme for health coaching and personalised care support through the year.
6. Explore PHBs for high intensity users and integrated personal budgets for children and young people with Education Health and Care (EHC) plans.

4.5.4 Digitally enabled primary and outpatient care will become main stream

Effective digital solutions should be the norm rather than the exception. Our digital infrastructure will support patients to use digital solutions to access information on their conditions, make bookings into their local GP practice (and soon PCNs), place orders for repeat prescriptions and understand their health needs through online digital support for example, smoking cessation and weight management.

We will seek to align nationalS and local priorities at scale to support improved clinical outcomes. For example, having virtual MDT consultations with both primary and secondary care health professionals so that care can be jointly planned for the patient.

Digital is a key enabler for improvement and in turn, aligned to the NHS Triple Aim. Wolverhampton forms part of an STP Digital Workstream which will realise the opportunity to align organisational priorities for digital with the overarching objectives for primary care as detailed within both the STP Clinical and Primary Care strategies.

Specific work to be undertaken over the life of this Strategy is as follows:-

- **On-Line Consultation** - consulting with patients using technology including email, skype, text and telephone. Wolverhampton Practices are expanding on their online consultation facilities to enable functionality to be made available to all practices over the life of this Strategy and twin tracking this technical work with proactive on-site marketing and engagement for GP practices and patients in order to maximise the uptake and opportunity

- **NHS App** - NHS App will continue to be a national platform providing people with a ‘front door’ into a range of online health and care services. Wolverhampton is committed to promoting and ensuring digitally enabled services are interoperable with the NHS App. It is already proving to be an important platform in enabling the public fast and reliable access to i.a. NHS 111, practice appointment booking, renewal of prescriptions and viewing of GP medical records. The NHS App will further evolve through seamless integration with the smartest and most effective applications, tools and services on the market. Wolverhampton will:-

- Ensure that all practices in our area have GP Online Services access technically enabled within their system Ensure all practices have reviewed their GP Online services settings to ensure they are appropriate for patient use
- Ensure all relevant staff are briefed on the NHS App rollout and requirements for supporting patients
- Review 111 Online provision to ensure appropriate for potential increased usage/activity from exposure within the NHS App

- **Extended Access NHS 111 Direct Booking**
  Wolverhampton will work with Practices and Providers to ensure full coverage by September 2019. This work enables 111 to have access to directly book appointments into locally provided extended access hubs.

- **A Black Country and West Birmingham wide interoperability platform** aimed at data sharing across a wider footprint of providers is underway. Through a Walsall and Wolverhampton collaboration, a project is in delivery implementing a repository based shared care platform. This will lead to introduction of a wider shared care record and identification. Ensuring information captured within clinical care settings is appropriately and securely shared will not only enhance care but also provide management information to support secondary usage such as commissioning and public health activities.

- **Working with partners, patients and providers to develop and promote digital solutions for patients and staff** that enable:-
  - Access to more self-management/help tools such as Apps and videos that support the management of Long Term Conditions such as Asthma and Diabetes
  - Access to digital networks/groups for patients and staff to enable peer support and information sharing
  - Maximising the use of digital media to promote the local area as a great place to live and work to help attract and retaining staff in Primary Care

4.5.5 We will increasingly focus on population health – moving to Integrated Care Systems everywhere

Our Local place-based Integrated Care Alliances (ICA) is being developed and implemented in support of the clinical strategy. This is an emerging vehicle for bringing together health and care services for our populations

We have committed to use all the enablers we have at our disposal to make integration a reality:

- We will use our commissioning strategy as a lever for change. We recognise the unique opportunities this allows, and the innovative approaches that will support this strategy.
- Through our introduction of PCNs we will be able to support local decisions on how services are provided and support network and neighbourhood-based delivery models.
- Through our approach to place-based care we will promote integration and joint working with local authority and social care colleagues. Joint working and where appropriate joint appointments will be encouraged.
- We will undertake system transformation across all partners to re-enforce a one system principle,. Made up from primary, community and intermediate care teams this will increase the capacity and responsiveness of our services to those who need it.

5.0 Primary Care Services

We have supported the new deal for General Practice, the new Contract (2019) and funding arrangements which include:-

- Network DES funding is predicated on practices confirming their willingness to collaborate and work together as a network (not necessarily merging existing contracts) whilst maintaining their independence. The network application process concluded in May 2019 and 6 networks have been approved for the city. Funding will flow to the Network's nominated provider as set out within the respective Network Agreement.
- Individual practices who have signed up to the Network DES will receive an additional payment for engagement with the Primary Care Network Scheme. This is the only funding that is paid directly to practices for participation in the DES.
- In support of the DES NHS England will invest in a number of new roles, importantly the introduction of a Clinical Director in each network and a proportion of funding for this role on a basis of 0.25 WTE per 50,000 patients, at national average GP salary (including on-costs). This will be provided on a sliding scale based on network size and will rise in subsequent years.
- Funding for new roles including Social Prescribing Links Workers (100%) and other professionals including Clinical Pharmacists, Physicians Associates, First Contact Practitioners and Paramedics (75% contribution).

New roles will be introduced over a 3 year period and will be key to networks maturity and will equip them with the workforce they need to tackle population health needs that can be met in the community.

5.1 Finance

Financial planning for Primary Medical Services spanning the next 5 years forms part of the CCGs overall financial plan. The plan includes allocations for the Network Contract DES (£1.50 per registered patient) intended to support the day-to-day operation of the network and Practice Engagement Payment (£1.76 per registered patient).

The following table shows the financial breakdown for primary care funds based on the new GP contract payments and other allocations that have been confirmed for the GP Five Year Forward View (GPFV):

Descriptor	Source	Value	Payee
Network DES	CCG Discretionary	£1.50 per patient	Network
Practice Engagement Payment	CCG Delegated	£1.76 per patient	Practice
Improving Access Fund	NHS England	£6 per patient	CCGs
GPFV (Resilience, Retention, Admin & Clerical, Online Consultation, Practice Nursing)	NHS England	19/20 £1,167 20/21 £1,274	STP (Wolverhampton CCG) - [Plan in place]
GFPV Achieving Sustainable GP Workforce Targeted Retention (Four Pillars)	NHS England	19/20 £127k	STP (Wolverhampton CCG) - [Plan in place]
GPFV First 5s	NHS England	19/20 £50k	STP (Wolverhampton CCG) - [Plan in place]
Social Prescribing 100% Funding	NHS England	19/20 x 1 20/21 x 2 21/22 x 3	Per Network
Clinical Pharmacist(s) 70% Funding	NHS England	19/20 x 1 20/21 x 2 21/22 x	Per Network
Clinical Director Funding 0.25/1day per week	NHS England	19/20 £0.51 per patient 20/21 £0.57 per patient	Network
First Contact Practitioner (70%)	NHS England	20/21 x 1 21/22 x 2	Network
Physicians Associate (70%)	NHS England	20/21 x 1 21/22 x 2	

5.2 Directed Enhanced Services

One of the most critical parts of developing our Primary Care Network is how funding will be allocated. The main mechanism is through an agreement called a Directed Enhanced Services (DES), also being referred to as the 'Primary Care Network Contract'. The DES details how the funding will be allocated by services and the diagram below highlights which ones we are focusing on and what we need to consider implementing this effectively.

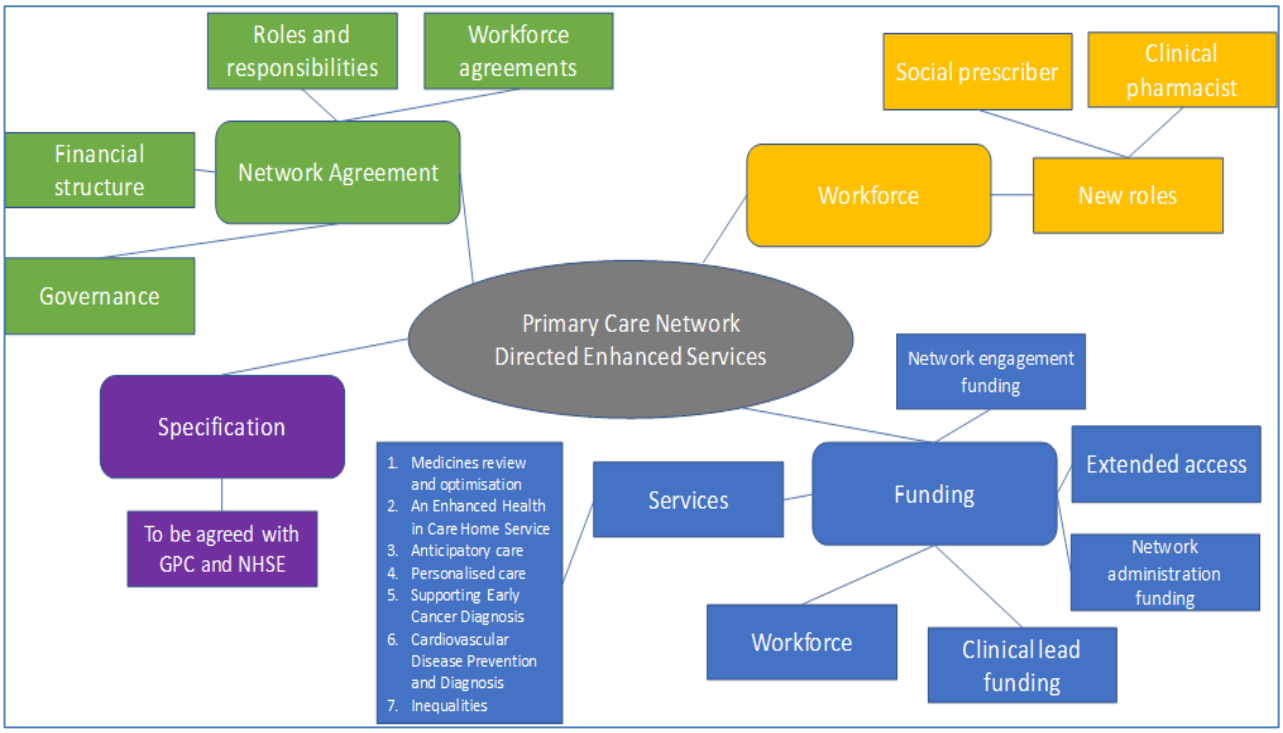
Having agreed, signed off contracts for services and the new way of working begun, the networks will have a good level of financial security. This security means that the networks can focus on formation and the delivery of front-line patient care without having to worry about current funding streams.

Other DES Specifications that the CCG actively encourage practices to participate in are as follows:-

- Learning Disability Health Checks
- Minor Surgery
- Vaccination Programmes (Shingles Catch Up, Pertussis, Meningococcal Freshers, Seasonal Influenza & Pneumococcal Polysaccharide Vaccination Programme 2019/20)
- Extended Access (till July 2019)

Practices are required to 'sign up' to these direct with NHS England and collaborative monitoring takes place in year with the CCG. NHS England may alter/vary their offer in years beyond 2019/20.

Public Health also commission services from General Practice, primarily NHS Health Checks.



5.3 Quality Outcomes Framework (National)

NHS England commission a national framework for general medical services contract holders in England. This is a voluntary scheme comprising of a collection of clinical and public health indicators organised by disease or intervention categories and have been selected representing care that is principally the responsibility of general practice and there is good evidence of health benefits that are likely to result from improved care provided in primary care.

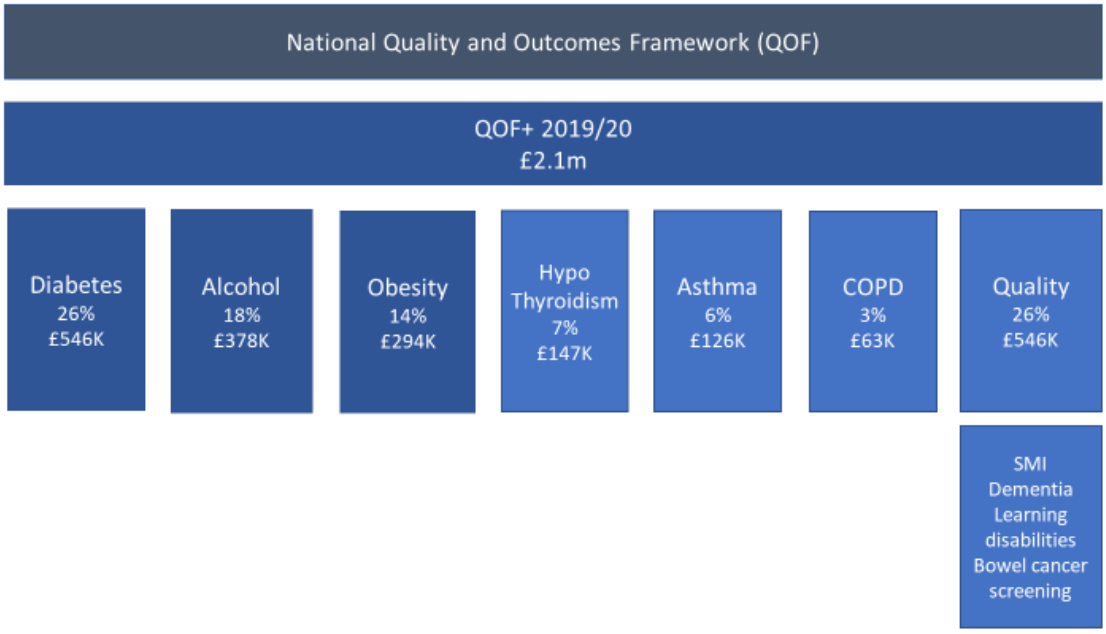
There are a number of clinical domains including atrial fibrillation, heart failure and hypertension and dementia and mental health. Nationally In 2019 more indicators will be added to some domains including diabetes, blood pressure control and cervical screening. A new quality improvement domain (QI) that focuses on prescribing safety and end of life care have also been introduced but the QI domain is likely to be subject to change year on year.

5.4 Quality Outcomes Framework (QOF+ Local)

Locally, the CCG introduced QOF+ in 2018/19 with particular focus on prevention of deterioration and/or ill health. The scheme was designed in conjunction with GPs from within the membership and designed to complement work already taking place in QOF whilst tackling areas of concern in the city.

The initial priorities including diabetes, alcohol and obesity and comprised of 19 indicators for practices to work towards the scheme has been developed further in 2019/20 and spans other priorities including COPD, Asthma, Hypothyroidism and a small compliment of quality requirements.

There are now 34 indicators and the value of the scheme has increased to £2.1 m in 2019/20.



5.5 Local Enhanced Services

The CCG invests additional local funding based on population health needs, these are of course prioritised to ensure

- QOF+
- Minor Surgery (Networks)
- Improving Access
- Minor Injury
- Basket of Services

All practices are actively encouraged to participate at practice and/or network level affording patients localised care delivery, closer to home.

5.6 Our Approach to Integration

The Long-Term Plan states that by 2021 Integrated Care Systems (ICSs) will cover the whole country.

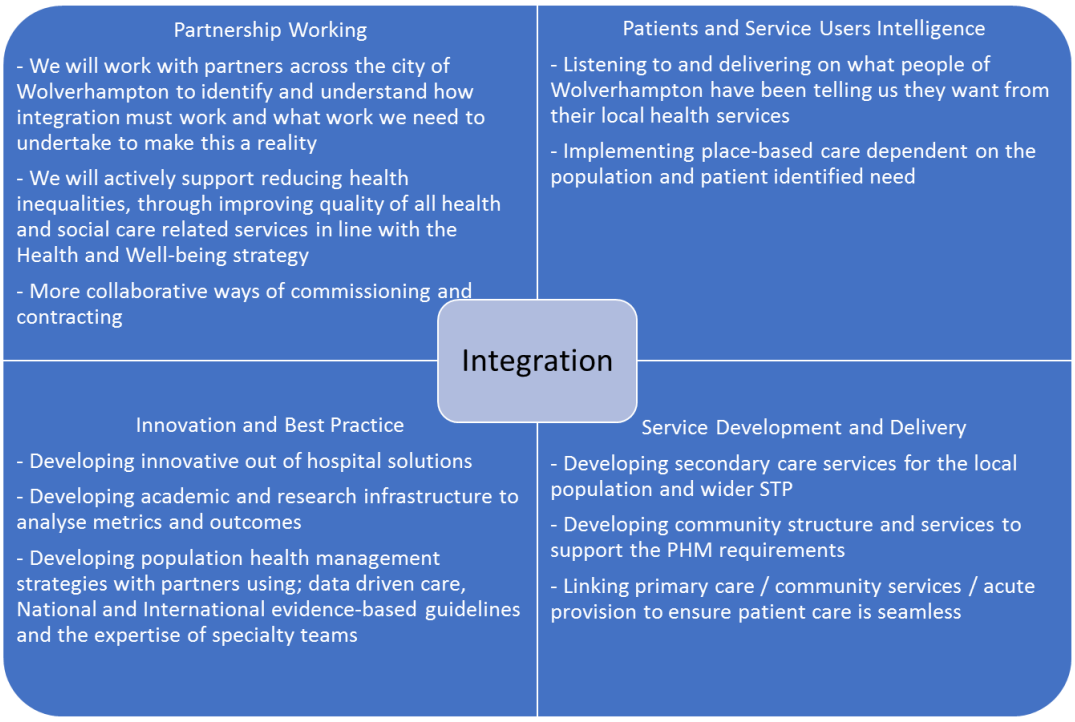
Nationally there has been the development of a new integration framework. We are a committed partner within the Black Country and are supporting the development and adoption of this new Integrated Care approach has been created to ensure that all associated organisations:

- Are committed to working in partnership in the best way possible to support our service users, carers and their families
- Support the development of integrated care for more specialist services
- Listen and co-produce services with our service users and stakeholders
- Play a pro-active role in developing the Wolverhampton Integrated Care Approach.

We also recognise that integration is an important enabler within Primary Care Networks and our aims for delivering integrated care within Wolverhampton can be split into the following areas:

- Partnership Working
- Patients & Service User Intelligence
- Innovation & Best Practice
- Service Development & Delivery

The illustration below provides more detail about how integration will be achieved for each component.



As part of the integration plan, the CCG will support the development of Multi-Speciality Community Provider and Primary and Acute Care Systems which will deliver new ways of delivering more integrated services in primary care and community settings.

Clinicians have identified a range of clinical priorities with the overall objective of improving experiences of care for patients first and foremost whilst also improving the way in which primary and secondary care professionals work seamlessly to improve care for their patients.

We are continuing to Integrate systems by ensuring we place Primary Care at the centre of the patient's pathway and work with, for example Local Authorities and the third sector taking advantage of their experience and knowledge for example contributing and signing up to key frameworks such as the Social Care Green Paper.

To help us to continue to meet our aspirations will draw on a number of key support functions to help deliver on the above. These include workforce development, contract management, IT and estates. By doing this we will ensure that any new service development or pathway changes are robust and that the needs of the patients and the staff will be met.

We use data and population health analysis to understand the needs of our patients. Through this we have targeted our resources into long-term conditions such as diabetes, alcohol abuse, obesity and cancer screening (QOF+). We are also redesigning key pathways, developing new roles and improving the way in which care is delivered we aim to strengthen all our primary care services, which will in turn help us to improve the health of patients and to continue to deliver an improved and consistent level of service.

6.0 Work Streams and Delivery Programme

In order to deliver the priorities detailed in this strategy a comprehensive programme of work has been developed to enable the CCG to meet the challenges and opportunities - our aims and aspirations outlined within this strategy. The over-arching work programme, which will be delivered over the next 2 years, has been developed from; conversations with patients on their experiences, from clinicians on where they know patient care can be improved, from internal teams, from data and information that is constantly reviewed as well as national priorities. A summary of the improvements that will be realised over the next 2 years are summarised in Appendix 1.

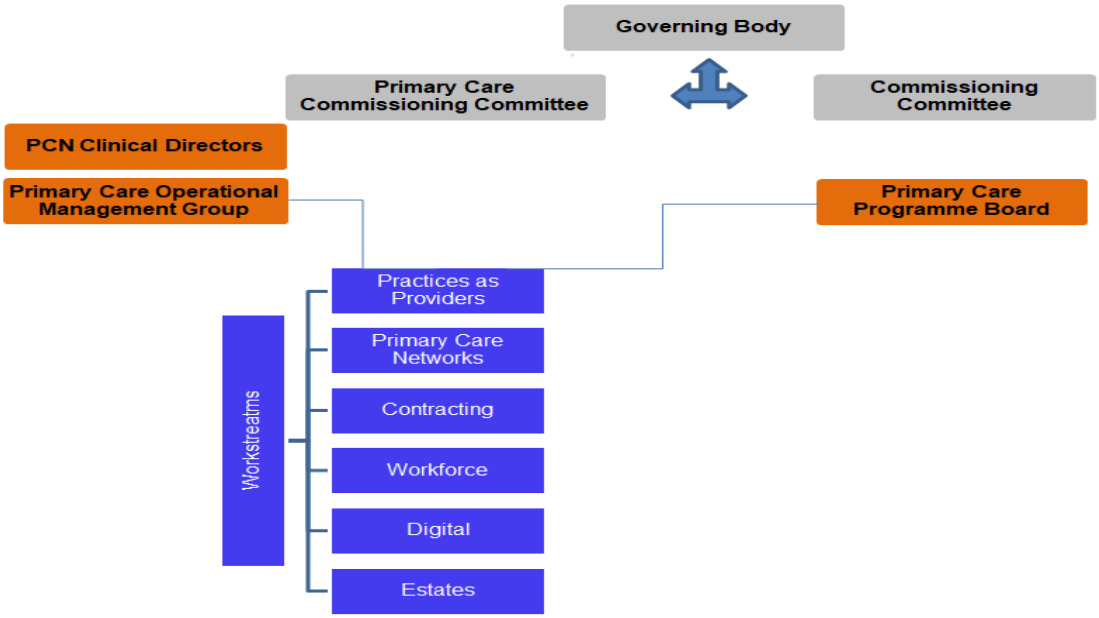
6.1 Our Delivery Programme

The changes within Primary Care are happening at a pace not seen before within the NHS. Formation of Networks, introduction of new Primary Care roles for staff such as the Physicians Associate, changes to contracts and new contracting and funding flows all make the need for good, robust governance and therefore accountability vital.

Being able to continually demonstrate that we consider these changes in Primary Care and the impacts on patients, individuals and our organisation is of paramount importance. This focus on accountability helps to keep the organisation transparent and ensure that the services it commissions are safe and deliver quality that all would expect in the 21st Century.

We do this through our clinical and non-clinical advocates as part of our Board and sub-committees. At the forefront of this is our commitment to ensuring we really 'hear' our patients and the experiences of care they had received by our services. Our engagement processes must therefore be robust and effective to reflect this.

As a CCG we have implemented the below accountability structure so that we are able to demonstrate to all stakeholders how we make decisions and how we hold ourselves to those decisions. This also aids us to have oversight on service changes and understand what the impact on our populations will be.



This structure also supports us with effective communication and information sharing between and across all stakeholders.

6.2 Measuring and Monitoring Quality in Primary Care

The Primary Care Contract Review process will be a significant influence in the measurement of practice and network quality to ensure our Primary Medical Services Contracts (GMS, PMS and APMS) are robust and are delivering the outcomes they said they would. We have implemented an on-going programme of contract monitoring and review visits this enables us to make declarations to NHS England with confidence.

The responsible committee will be regularly updated on practice and network performance using data and assurance measures that will demonstrate if networks are maturing in line with national guidance. There are a wide variety of indicators used to measure how well practices and networks are achieving and those in need of support.

As this strategy shows, the aim is to increase the support to patients, within primary and community settings so they are better equipped to manage their own health needs.

Our focus on areas such as diabetes prevention and management, asthma and respiratory conditions, maternity and parenting support and online therapies for common mental health problems will, in part, help to achieve this and also social prescribing, as part of the Network requirements to further support care being delivered in the community and closer to patients' homes. Social prescribers are included in both our workforce plans and Network structures.

6.3 Communication, Engagement and Participation

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

Over the past 12 months we have worked across Wolverhampton to strengthen our communication and engagement processes. This is enabling us to involve local people in Wolverhampton-wide service change. Our commissioning intentions are based partially

on what we have heard from our community. There are a plethora of ongoing engagement sessions that take place across the city, some disease specific others more generic.

Engagement sessions held during the summer of 2019 regarding Primary Care services have confirmed what patients would like to see:-

- Easy access to urgent GP services 24 hours a day 7 days a week – different individuals wanting this provided in different ways, but the key themes were urgent and preferably with a GP who has access to information about their health problems
- Less urgent access to as wide a range of services as possible close to home available at their own or another practice within the Primary Care Network. This would also include specific types of clinic including diabetes, respiratory etc.
- Variety of health professionals in primary care for minor ailments, provided they had the training required and were able to make easy onward referrals to the GP or other services. Patients with multiple long term conditions were more hesitant to see alternative health professionals as they thought it was important that the health professional understood their history and they valued consistent, face to face care.

Groups felt that they needed further education to understand the solutions being investigated and what this would mean in practice. They also felt that if results were made available electronically they may need support to understand them and it may not be suitable to make all results available online. Concerns were raised regarding data security and the level of information being made available between care groups and professionals it was felt that more detailed information could be shared face to face in MDT meetings and any information sharing between groups and professionals must meet data security requirements.

This illustration was prepared based on one of a number of engagement events that took place over the summer 2019 and helped to capture the thoughts and views of patients and the public.

We are continuing to engage locally about both health and social care services delivered locally, and across the Black Country footprint. We will build on the collective work we have undertaken with partners so that we continue to play our part in delivering integrated care by place and across the Black Country. In this way, we will ensure Wolverhampton residents have a role in the developing health and care landscape and that their voices are heard.

We will continue to use the outcomes from engagement events and forthcoming events to help shape how we integrate our services and deliver first class care.

We will continue to draw on a range of two-way communication channels and engagement techniques to reach and listen to our target groups, including:

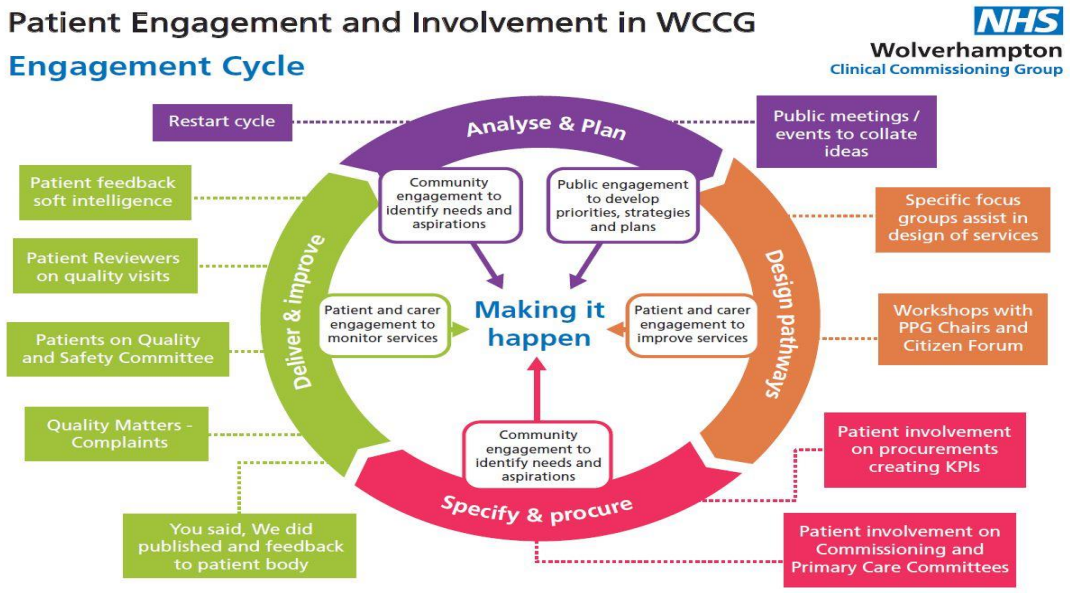
- Regular stakeholder mapping – to refine our understanding of the communities we need to engagement with
- Outreach activity such as events and roadshows
- Press and public relations including regular content for print and broadcast media, where appropriate
- Social media
- Newsletters and other communications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

The Primary Care Team have a series of engagement activities scheduled for 2019 and also plan to extend 2021 these briefly comprise of the following areas of importance although this is not an exhaustive list:-

- Frailty & OTs in general practice
- End of Life Care
- Paediatric Pathways
- GP Home Visiting Service
- Primary Care Network Development
- Different Consultation Types & New Roles in General Practice
- Redesign of Wound Care Services

Engaging with and involving our CCG colleagues will have additional focus over the coming year as we understand the implications of the Long-Term Plan for the future of clinical commissioning groups. We know that colleagues welcome regular staff briefings, which are led by our Accountable Officer. Our staff have the opportunity to engage with the Executive Team on their floor walks or take time for a brief chat 'Coffee with the Chair' which is held monthly.

Engagement with the community in line with the CCGs Engagement Strategy will continue. Primary Care is one of a number of influencing factors that forms the basis for both the engagement and commissioning cycles.



6.4 Implementing the Strategy and Monitoring our Progress

There are many priorities identified in this strategy. In order for the priorities to be worked through sufficiently they will all be captured in the CCGs Work Programmes, many firmly rooted within the Primary Care Team. There are six task and finish groups that have defined work programmes to manage the workload in a prioritised and co-ordinated way. The activities arising from the individual work programmes will be routinely reviewed by the responsible executive(s) and committees in order for timely assurance to be provided to the CCGs Governing Body. Periodic reports will be provided for the entire programme to the Milestone Review Board. A robust programme management office approach has been adopted to ensure that delivery & non-achievement are actively captured and reported.

The assurance reporting provided to Milestone Review Board (quarterly) is intended to provide a balanced view of delivery (and non-delivery) across all priorities from each respective task and finish group.

Following approval by the responsible Committee, Primary Care Commissioning Committee there will be a series of activities that take place to ensure the strategy reaches a range of stakeholders as defined in the diagram below:-

Engagement events will be taking place on an ongoing basis based on the CCGs Commissioning Intentions, Primary Care Network activities and other associated CCG engagement priorities with both staff and the local community to ensure that the work programmes understood and the benefits are being realised to meet the needs of our community.

6.5 Conclusion

Primary care is now more important than ever and despite the challenges faced and significant pressure and constrained resources local people have access to comprehensive and universal healthcare which is free at the point of need. This is testament to our hardworking, committed staff in practices who try to provide the very best care they can.

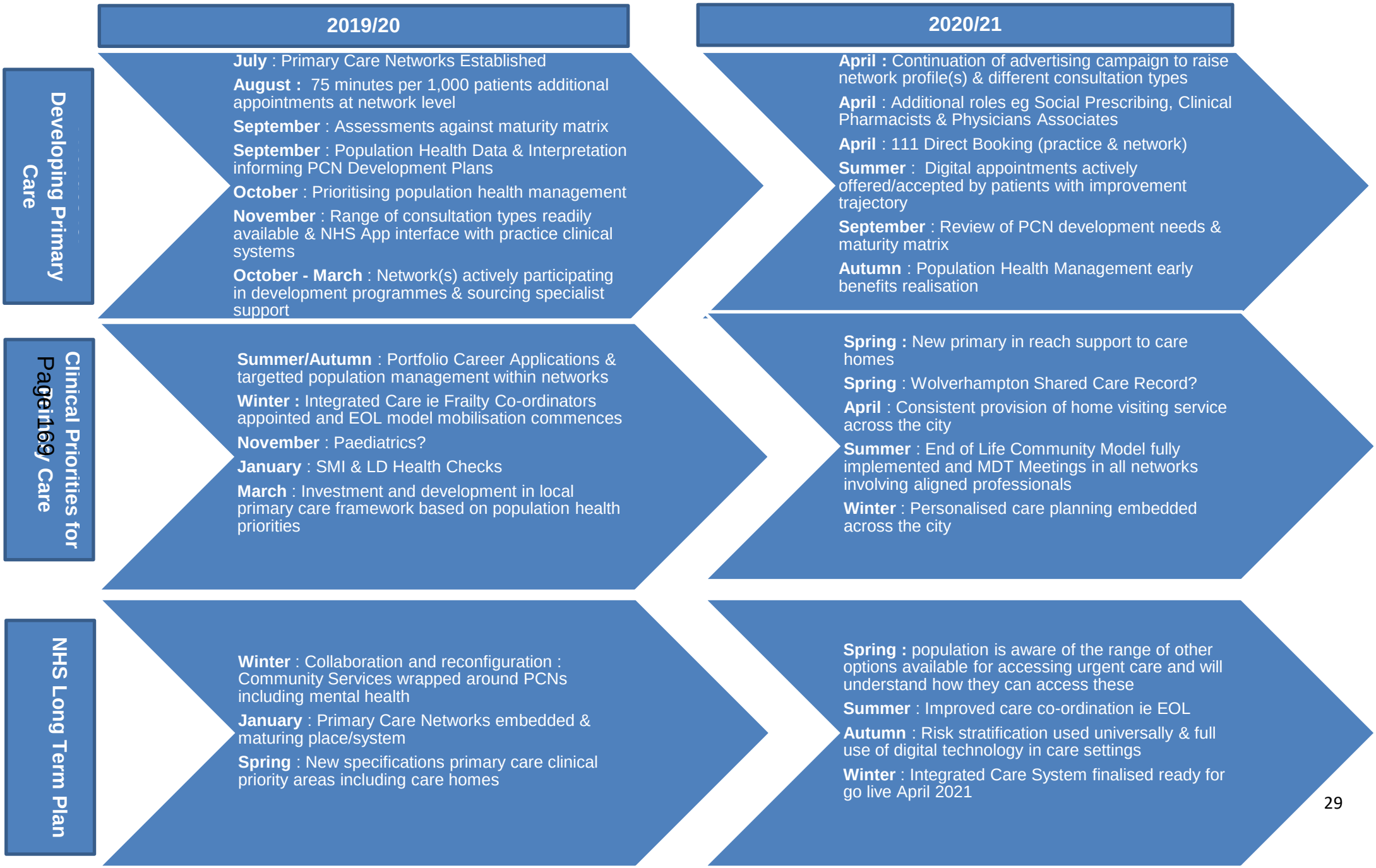
This strategy and the Black Country STP Primary Care Strategy (2019) define an improvement journey for the exceptional healthcare our population deserves and that everyone can access. We believe that we should develop a true partnership between the users of our service, their carers, our public and our primary care providers, to strive to achieve better health care.

We know that primary care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing on-going mental and physical health conditions and helping people recover from episodes of ill health and injury. Through growing new workforce roles, introducing new primary care models and utilising digital and estate solutions, we will change how we deliver care to our population.

However, there are significant challenges being faced by primary care, in particular general practice. We need to radically rethink primary care if we are to deliver sustainability beyond the current decade. This is due to the increase in workload with the uncertainty of future workforce and the need to manage increasing numbers of people with multiple and complex health needs.

Our vision for primary care in Wolverhampton is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources. The deliverability of the strategy is twinned with the commitments defined in the STP Long Term Plan and Primary Care Strategy that pave the way for system transformation over the next 5 years although reliant on the foundations within this strategy to achieve those longer term objectives. All the these documents are designed to give us the best chance to make care accessible for patients and ensure as far as possible that the developments and service improvements are delivered to the the highest standards possible with the resource we have available to us.

Appendix 1
Primary Care - High Level Delivery Plan



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WOLVERHAMPTON CCG

Primary Care Commissioning Committee
September 2019

TITLE OF REPORT:	STP Primary Care Strategy 2019-2024
AUTHOR(s) OF REPORT:	Sarah Southall, STP GPFV Programme Director
MANAGEMENT LEAD:	Sarah Southall, Head of Primary Care
PURPOSE OF REPORT:	To confirm the status of the STP Primary Care Strategy.
ACTION REQUIRED:	☒ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	Public
KEY POINTS:	• Further to the committee receiving a draft version of the STP Primary Care Strategy in May 2019 the document has since been strengthened based on feedback from all CCGs across the footprint. • The Strategy was submitted to NHS England in June for initial consideration and their approval was confirmed early July.
RECOMMENDATION:	1. The committee should note that the strategy has been approved by NHS England 2. The committee have a final opportunity to confirm if they wish for any amendments to be made to the document. This opportunity has also been given to other CCG Primary Care Commissioning Committees due to the short timescale for submission to NHS England in June. 3. Note that implementation of the strategy will commence following final feedback and the committee will be kept sighted on progress being made through links with the STP GPFV Programme Board.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	1 Improving the quality and safety of services we commission. 2 Reducing health inequalities in Wolverhampton. 3 System effectiveness delivered within our financial envelope.

Enclosure(s): STP Primary Care Strategy V1.8

SLS/PCC-STP PCS/Sept19/V1.0

1. Purpose

1.1 To confirm the status of the strategy following initial consideration in May 2019.

2. Background

2.1 As referenced in the NHS Long Term Plan the STP is required to produce a Primary Care Strategy that articulates the vision and key priorities for the STP. Two main component parts of this strategy must focus on Workforce and the development of Primary Care Networks across the footprint.

2.2 A greater level of assurance, as well as funding opportunities are increasingly being targeted at STPs rather than CCGs and it is vital that there is a Strategy and Plan to manage these processes and maximise opportunities

3. STP Strategy

3.1 The Strategy has been approved by NHS England as all key requirements were satisfactorily evidenced in the draft submitted to them. The strategy specifically focuses on Governance (including financial reporting) and the development of a GPFV Programme Board, Workforce and training hub future state, Digital – via a strong focus on on-line consultation and 111 inter-operability, the development of primary care networks and estate transformation.

The strategy is firmly linked the STPs local plan to fulfill the Long Term Plan, particularly the key elements for out of hospital care, emergency hospital services, self-care, digital primary care and movement to become an integrated care system.

Measurement of the progress being made to implement and achieve the strategies objectives will be achieved with oversight from the STP GPFV Programme Board who will be responsible for ensuring measurement of all 9 areas takes place.

4. Clinical View

4.1 Clinicians from across the Black Country footprint have informed the development of the strategy, representatives include medical and nursing colleagues from the Clinical Leadership Group and CCG Clinical Chair(s), GP Leads etc.

5. Patient & Public View

5.1 A series of engagement events have taken place in each in each CCG and findings are captured within the strategy forming the basis for improvements in primary care over the next 5 years.

6. Key Risks & Mitigations

6.1 The STP Risk Register overseen by the GPFV Programme Board includes risks associated with the delivery of the objectives ie digital. This will be reviewed a project and programme level and shared in regular updates to Primary Care Commissioning Committees.

6.2 Equality Implications

At local level CCGs have in place Equality Impact Assessments, an overarching assessment will be undertaken at STP level for the Long Term Plan that includes Primary Care.

6.3 Quality & Safety Implications

The STP Chief Nurse has been involved in the development of the strategy and an active member of the GPFV Programme Board.

6.4 Legal & Policy Implications

A separate Wolverhampton Primary Care Strategy also exists and defines more specifically the local programme of work that underpins how we will respond to the requirements of the NHS Long Term Plan. Therefore, the Wolverhampton Strategy is an important link and source of assurance for the committee to recognise.

REPORT SIGN-OFF CHECKLIST

This section must be completed before the report is submitted to the Admin team. If any of these steps are not applicable please indicate, do not leave blank.

	Details/ Name	Date
Clinical View		
Public/ Patient View		
Finance Implications discussed with Finance Team		
Quality Implications discussed with Quality and Risk Team		
Equality Implications discussed with CSU Equality and Inclusion Service		
Information Governance implications discussed with IG Support Officer		
Legal/ Policy implications discussed with Corporate Operations Manager		
Other Implications (Medicines management, estates, HR, IM&T etc.)		
Any relevant data requirements discussed with CSU Business Intelligence		
Signed off by Report Owner (Must be completed)	**Sarah Southall**	**22.8.19**

Black Country and West Birmingham Sustainability and Transformation Partnership (STP)

STP Primary Care Strategy

2019/20 to 2023/24

Version 1.8 – Final Submission,
28th June 2019

Version Control

Version Number	Date	Author	Details of Update
1	285/2019		First Draft for consideration
1.1	30/5/2019	Paul Aldridge	Revised Draft based on initial consideration
1.2	14/6/19	Sarah Southall	Revised Draft based on feedback
1.3	17/06/19	Arden GEM	
1.6	20/6/2019	Paul Aldridge	Revised draft
1.7	26/6/2019	Paul Aldridge	Revised to incorporate NHSE feedback
1.8	28/6/2019	Paul Aldridge	Final Submission

Authorisation

Date	Name	Position
June 2019	Sarah Southall	Programme Director – GPFV Black Country STP

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1 Executive Summary

1.1 Executive Summary

Our ambitions are for high quality healthcare for the 1,450,000 people who live in the Black Country and West Birmingham areas. Our vision is for both healthier lives and better healthcare for our patients by working with our population to sustain and improve primary care services while reducing health inequalities.

We have many deprived areas. We have some of the highest infant mortality rates in the country, poorest academic achievement of school leavers which in turn impacts upon economic prospects. We have growing prevalence of obesity accompanied by low physical activity and many households living in fuel poverty. Now more than ever, and with greater determination we need to progress initiatives aimed at supporting healthier lifestyle choices, mental wellbeing and addressing socio-economic and environmental issues that contribute to poor health and inequalities.

Despite these local challenges, our local NHS is a success story. Despite significant pressure and constrained resources local people have access to comprehensive and universal healthcare which is free at the point of need. This is testament to our hardworking, committed staff that work every day to provide the very best care they can.

We continue to provide more treatment year on year to meet the relentless growth in demand and activity. We respond to the plethora of guidance, evidence and technological developments with optimism and dedication in delivering services. Public support for what we do is unwavering, which speaks for itself (Kings Fund research September 2017).

This strategy is the beginning of an improvement journey for the exceptional healthcare our population deserves and that everyone can access. We believe that we should develop a true partnership between the users of our service, their carers, our public and our primary care providers, to strive to achieve better health care.

We know that primary care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing on-going mental and physical health conditions and helping peoples recover from episodes of ill health and injury. Through growing new workforce roles, introducing new primary care models and utilising digital and estate solutions, we will change how we deliver care to our population.

However, there are significant challenges being faced by primary care provision and in particular general practice. We need to radically rethink primary care if we are to deliver sustainability beyond the current decade. This is due to the increase in workload with the uncertainty of future workforce and the need to manage increasing numbers of people with multiple and complex health needs.

Through innovation and creativity, our STP has begun to make progress against many of the challenges our primary care services face. This strategy describes our vision and illustrates how the STP will work together to support and enable primary care to; obtain the necessary skills, workforce and infrastructure to deliver an efficient, resilient and sustainable service for our population. Part of our vision is to commission integrated pathways of care that are firmly rooted in primary and community services.

We commit to a continuous drive to deliver services of the highest quality and value, and more importantly this strategy is a key component in ensuring we continue to commission locally while remaining focused on our main aim; ensuring primary care remains at the heart of a person's care.

2 National Context

2.1 National Context

The demands on health and care resources are rising year on year. People are living longer with ever more complex conditions. Continuing progress in treatments and medical techniques comes with new costs and expectations and modern lifestyle issues such as obesity are causing an increase in long-term conditions.

'There has been a steady rise in patient expectations, a target driven culture and a growing requirement for GPs to accommodate work previously undertaken in hospitals, or in social care. This has resulted in unprecedented pressure on practices, which impacts on staff and patients. Small changes in general practice capacity have a big impact on demand for hospital care, so the need to support general practice in underpinning the whole NHS has never been greater' – Dr Arvind Madan, GP Five Year Forward Plan, 2016.

The STP is committed to transforming services to meet these rising demands. We must make the most of modern care through innovation and best practice to change the way we spend money and use our limited resources.

This includes how we adopt new care models such as Primary Care Networks (PCNs), new business processes and outcome frameworks. We must also support how we reform financial flows.

We must focus on how we change behaviour towards self-care and how we shift demand away from our hospitals towards a more primary and community-centred approach. Ultimately all partners work together to create a fit-for-the-future health and care system.

3 The Black Country and West Birmingham STP Vision

'*All organisations will provide excellent and consistent care from the right person, at the right time and in the right place*'.

Black Country and West Birmingham STP Vision

3.1 The STP Vision for Primary Care

The long term vision for primary care in the Black Country and West Birmingham is to develop a resilient and sustainable model of primary care founded on practice based registered. This vision will be based on the following principles:-

- A primary care system that will be General Practice led, rather than General Practice delivered
- Be focussed on prevention and commissioned for outcomes based on the population need within each PCN
- Be multidisciplinary, organised and delivering services at scale within each PCN and place
- Make the best use of technology to improve experience and outcomes for people
- Will deliver improved experience and better outcomes – determined and measured by those accessing our services
- Support and enable people to stay well and manage their own health though better use of technology and community assets
- Enable the primary care workforce to increase their skills, knowledge and competences
- Develop and enable community-based academic activity to improve effectiveness, research and quality

3.2 What does success look like in 2024?

An integrated and proactive approach to Population Health Management

- Population segmentation is used regularly to identify the needs of the population and opportunities to invest in cost-effective preventive care.
- Health inequalities are mapped and reduced through specific services and engagements - the outcomes of these analyses are used to tailor services to the specific needs of the population.
- The STP is able to ensure that PCNs are able to identify, develop and invest in a range of preventive services to meet predicted future challenges in relation to the population's health.
- Community activities/resources/assets are mapped and connected at PCN levels and regularly updated in a directory of support available to health and social care across the STP
- Community health and wellness initiatives are set up and delivered in collaboration with local communities
- PCNs are utilising community assets in each place to connect those most in need (lowest activation) with community resources.
- People with long term conditions are systematically identified and supported to take control of their own health and wellbeing.

Reduced Pressure on our Urgent Care Systems

- Risk stratification systems are used universally to proactively identify people who might benefit from anticipatory care to prevent exacerbations
- Once identified, those at-risk receive enhanced rapid response care provided by relevant disciplines in the MDT, including support from health, social care, voluntary and independent sector where appropriate
- Engagement and education programmes are in place. This includes outreach in schools and other community settings and care homes. Programmes are planned and delivered with community groups.
- The population is aware of the range of other options available for accessing urgent care and will understand how they can access these.
- There is functionally integrated service that incorporates NHS 111, primary care out of hours and ambulance care, minimising the number of hand offs.
- Processes are in place to minimise delays between NHS 111 receiving a call and a patient being assessed over the phone by an out of hours clinician
- Primary care out-of-hours (OOH) services have arrangements in place with NHS 111 to enable call-handlers to directly book appointments where appropriate.
- Shared systems allow NHS 111 and out of hours services to make appointments to in-hours general practice
- People may be referred to a range of services, including: support for self-care, referring to a specialist or dispatching an ambulance

- Access to a person's information is governed by appropriate information governance controls
- All partners, including NHS 111, have access to update all special patient notes (SPNs) and advanced care plans (ACP), in 50% of calls to 111 or 999 that were transferred to a clinician, the patient had a Summary Care Record with consent to share.

Continuity of Care

- People receive the same standard of care across the footprint, delivered according to the same care pathways.
- People receive appropriate clinical services that include referral to primary care appointments, referring to specialists, referring to self-care services.
- People can access non-urgent clinical services such as x-ray facilities, blood testing, ECGs etc. there are appropriately trained to staff to interpret testing and give advice as a result.
- GP practices are working across practice boundaries with each other and with community service teams. This may include shared clinical governance, audit and improvement processes; shared professional development and HR; pooling of staff for resilience or improved access to expertise.
- Primary care teams are using the 10 High Impact Actions to release time for care, and establish new ways of working, with a particular emphasis on technology enabled care and self-care.
- Staff can access new opportunities to develop special interests, for example in a particular clinical speciality or skill, or in leadership, training and service improvement.
- Shared working practices, processes and governance are in place, allowing for professionals to work as a single team in each PCN - even where they come from different settings originally.
- A focus on responding to the small number of requests for an urgent home visit through a rapid assessment by a clinician, usually by phone to prioritise, with an opportunity to plan an alternative to a hospital admission
- A defined practice standard for the first time from first call/contact to initial assessment and referral. Performance is monitored against this standard
- A range of appointments for People to access same-day, including telephone consultations, e-consultations and walk in clinics, as well as face to face appointments. No patient is attending A&E because they cannot get an appointment with the GP
- Provide early morning appointments for children who have deteriorated during the night to avoid People attending A&E before visiting a GP
- Practices take part in the discharge planning of frail and vulnerable people to ensure easy transition and fast re-settlement of their patients back in the community

- Practices have an operational model in place to ensure that continuity of care, particularly for the elderly and those with long term conditions or additional vulnerabilities, are cared for in a practical way.
- Personalised support and care for people with long-term physical and mental health conditions
- MDTs are operating in support of every PCN. The person is at the centre of their multi-disciplinary team and the person and carers are actively involved in decision making
- MDTs regularly review those persons that have been identified as being at the greatest risk of developing complex needs as well as those who already need high levels of support as well as a chance to offer support to team members. Clinical risk stratification in place to identify patients for MDT support
- MDTs have access to mechanisms that facilitate ongoing and unscheduled conversations remotely so that cases are discussed in real time and they can access support and advice in a timely and efficient manner. Consistent and effective procurement of mobile technology is in place to facilitate these discussions and there are clear reporting and clinical governance structures in place
- MDTs have access to shared electronic patient care records.
- All people with complex care needs have an integrated health and social care plan which anticipates their care needs and is accessible to all professionals working within the care model, including acute and urgent care providers and social care
- People and their carers co-produce and own the care plan with the MDT responsible for delivery against the care plan
- There is a structured, ongoing learning and development programme in place for the whole MDT in a shared environment / includes peer-to-peer learning
- There is a care coordinator (or similar) that is the link between the person and the core MDT that ensures continuous conversation / seamless transition of care
- MDTs covering health and social care use recognised business intelligent systems to systematically, proactively and regularly identify people for admission or discharge from case load
- Anticipatory care planning using business intelligent systems are in place across the STP to identify those most at risk from disease or deterioration. MDTs discuss care planning arrangements
- MDTs are involved in discharge planning before people are discharged - working with specialists and the person to co-design a care plan to support their transition into the community.
- Care Coordinator approach connects with social care / voluntary sector care to provide appropriate support on discharge from acute setting
- Specialists, including consultants, are integrated physically and virtually into community teams providing advice without the need for referrals

- Secondary and primary care clinicians are able to contact each other by email, Skype and telephone to discuss cases.
- GPs with extended roles are integrated into the primary and community teams as an alternative to referral to secondary care
- There is clear referral criteria agreed upon by all partners, referral criteria is supported by guidelines
- There are standardised testing protocols and guidelines for diagnostics to reduce duplicative testing
- People can access rapid specialist advice 24 hours a day, seven days a week in case of exacerbation, facilitated by technology
- Specialist, including consultants, are integrated physically and virtually into community teams providing advice without the need for referrals

A more diverse and sustainable workforce

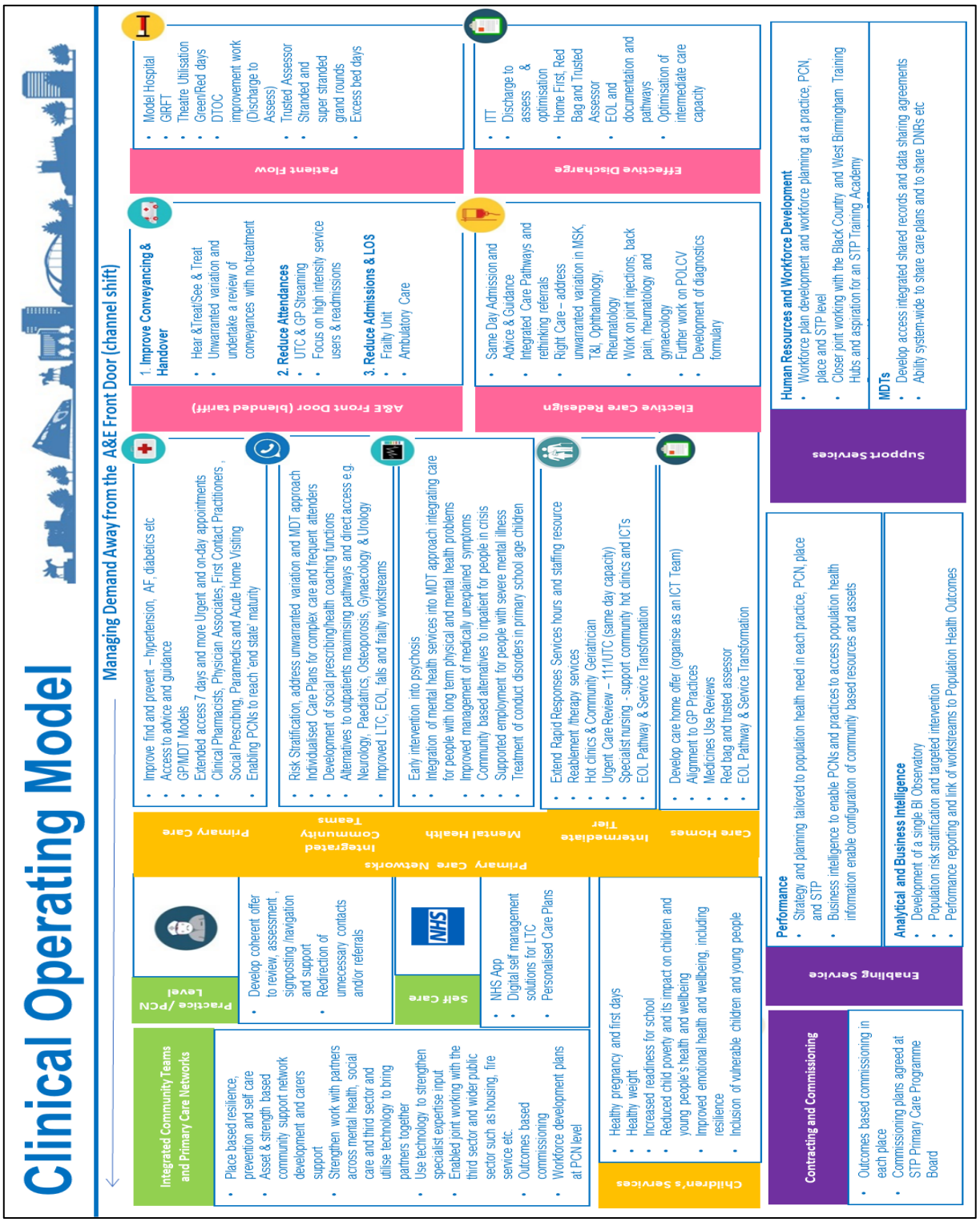
- A workforce strategy will be in place that enables the delivery of a sustainable primary care model in each PCN.
- Training and education needs will identified based on population health need within each PCN – this will be enabled by improved workforce planning, talent management and career pathway and progression support available through the STP.
- Primary Care Networks will have incorporated and embraced a number of new roles to support their registered population including Clinical Pharmacists, Physician Associates, Nursing Associates, Social Prescribing Link Workers, Paramedics and First Contact Practitioners.
- Health and Care professionals are choosing to work and stay in the Black Country and West Birmingham
- Opportunities exist for all members of the workforce to develop their careers, enhance their skill set and practice across the Health and Care system

3.3 Wider Primary Care Services

The STP recognises the opportunity to strengthen allegiance to wider Primary Care services including Dental, Pharmacy and Optometric. The STP will work towards exploring these opportunities at a Neighbourhood level over the life of this Strategy, working closely with our PCNs and NHSE.

3.4 STP Clinical Operating Model

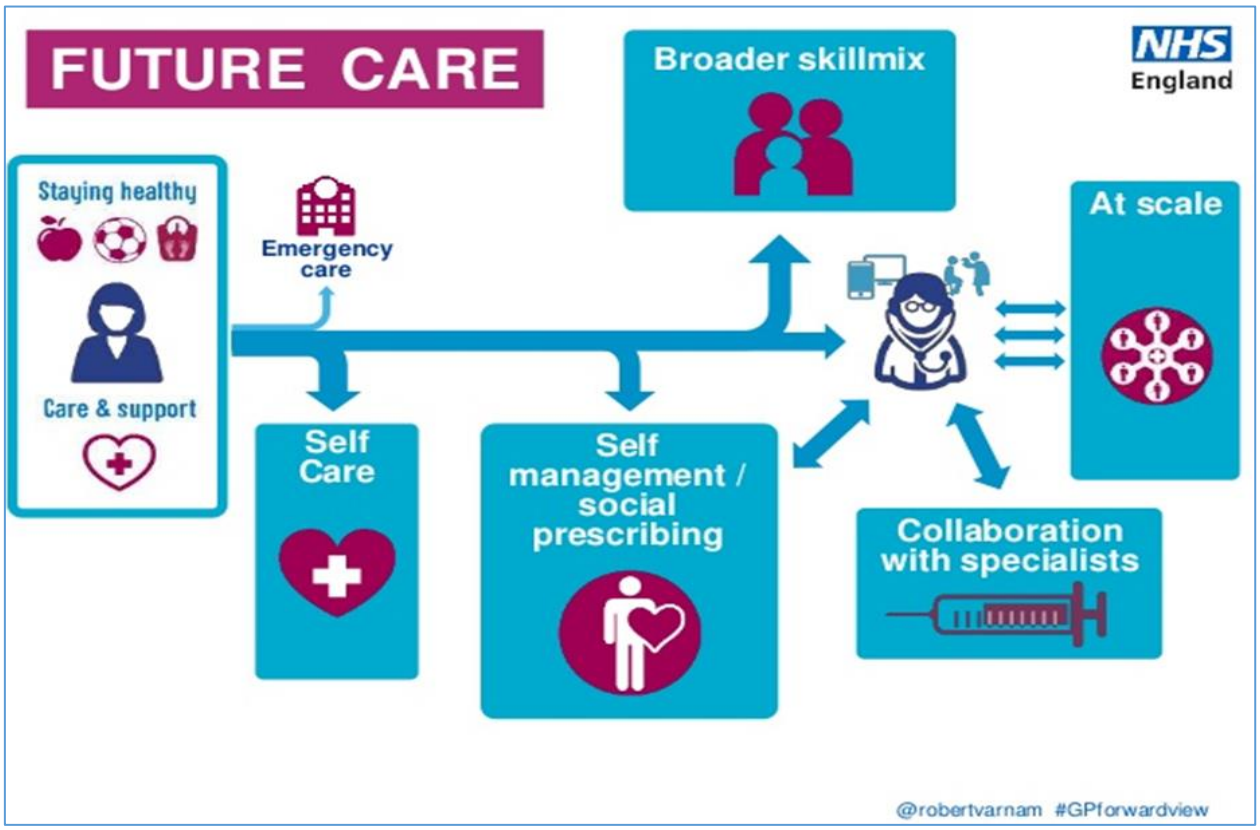
The STP will follow the below Clinical Operating Model in order to deliver the vision:-



STP Clinical Operating Model

3.5 Future Model of Care

The principles aligned our vision enable us to work collectively and collaboratively across all stakeholders for the greater benefit of the population we serve. At the heart of this strategy is the principle that collaboration within and across services, whilst ensuring our public benefits from new care models, is how we want to operate as an STP. The STP will follow the below model of Future Care:-

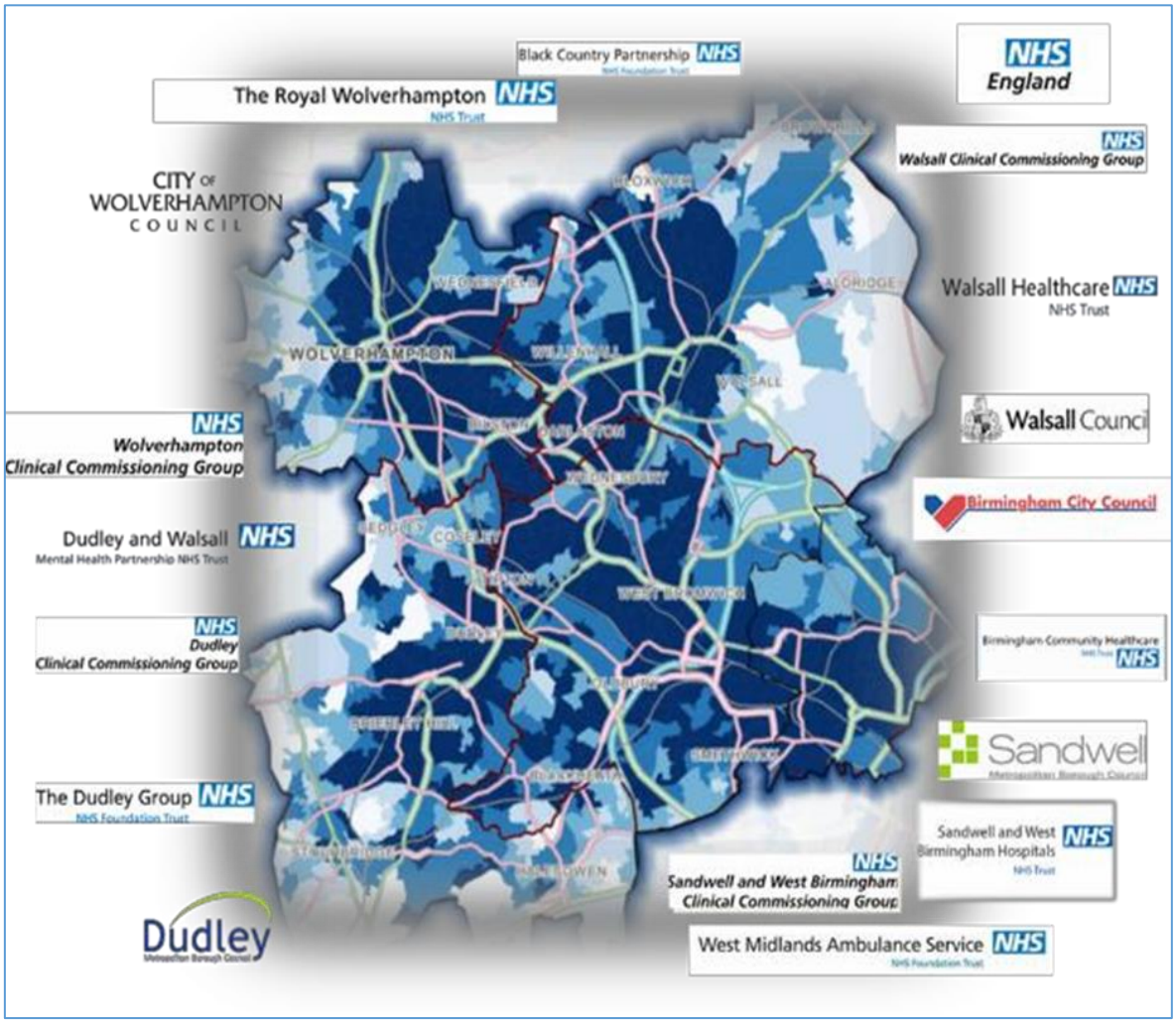


STP Future Care Model

4 Introduction

4.1 Area Covered

The Black Country and West Birmingham STP comprises the Boroughs of Dudley, Sandwell, Walsall, the City of Wolverhampton, Ladywood and Perry Barr in Birmingham, and covers 356 square kilometres.



STP Map and Partners

Health and Care organisations employ 6% of the total Black Country and West Birmingham workforce and brings £2bn per annum into the local economy. Incidentally it is estimated that a similar figure is how much its costs for informal care provided by friends and family members.

4.2 The Local Population

The STP is home to circa 1.4 million people, accounting for one fifth of the West Midlands population. The age profile for the STP is similar to the West Midlands profile with an ageing population, and there are more women than men.

After years of decline our population is starting to increase and diversify in ethnicity, with 26% of people from Black and Minority Ethnic (BME) origins, particularly from the Indian Sub-Continent and the Caribbean. This is compared to the national average of 9%.

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The STP has 9.5% of all the authorised and tolerated traveller sites in the wider region and has sizable Polish and Somali communities as well as growing numbers of refugee and asylum seekers.

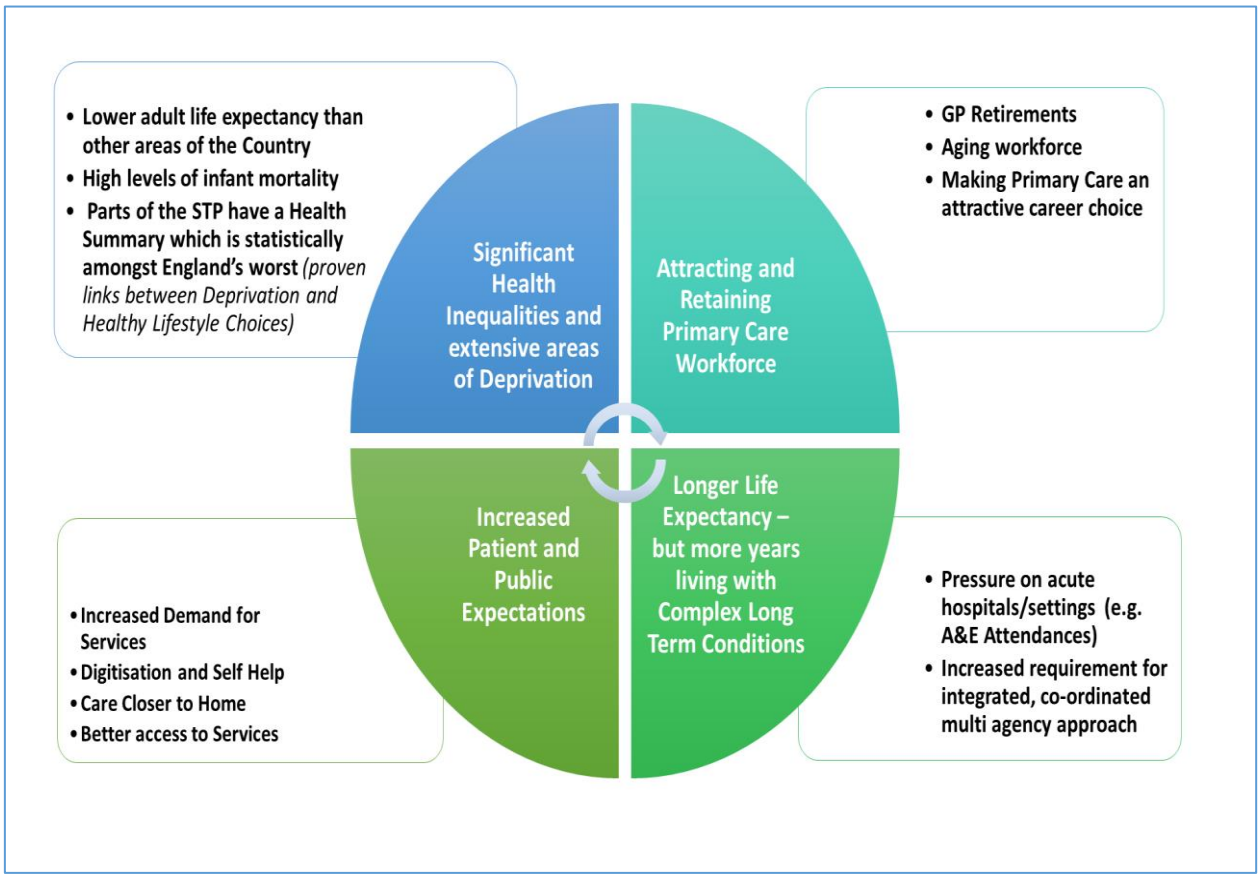
The predicted population growth across the STP footprint is expected to be in line with the national avenge but weighted towards these BME populations and particularly South Asian groups. About 4% of Black Country households have no one who has English as their main language.

Given the aging population, changes in demography and forecast increases in demand outstripping increases in funding, meeting primary care's vision will require joint action with all partners. Attention must be given to progressing positive changes in the wider determinants of health, growing self-care and strengthening community resilience.

Our thinking on what and where we focus our resources and change effort is consistent with the latest policy directives from NHSE/I e.g. to establish ourselves as an Integrated Care System (ICS) and to adopt the nationally mandated changes within primary care such as PCNs. However, this will require a shift in both culture and mind-set as all STP organisations will need to work in partnership to address issues that

4.3 Local Challenges

In addition to the ongoing funding pressures across partners, the STP region faces significant system wide challenges. The recurring themes across the region are shown in the diagram below:



STP Regional Challenges

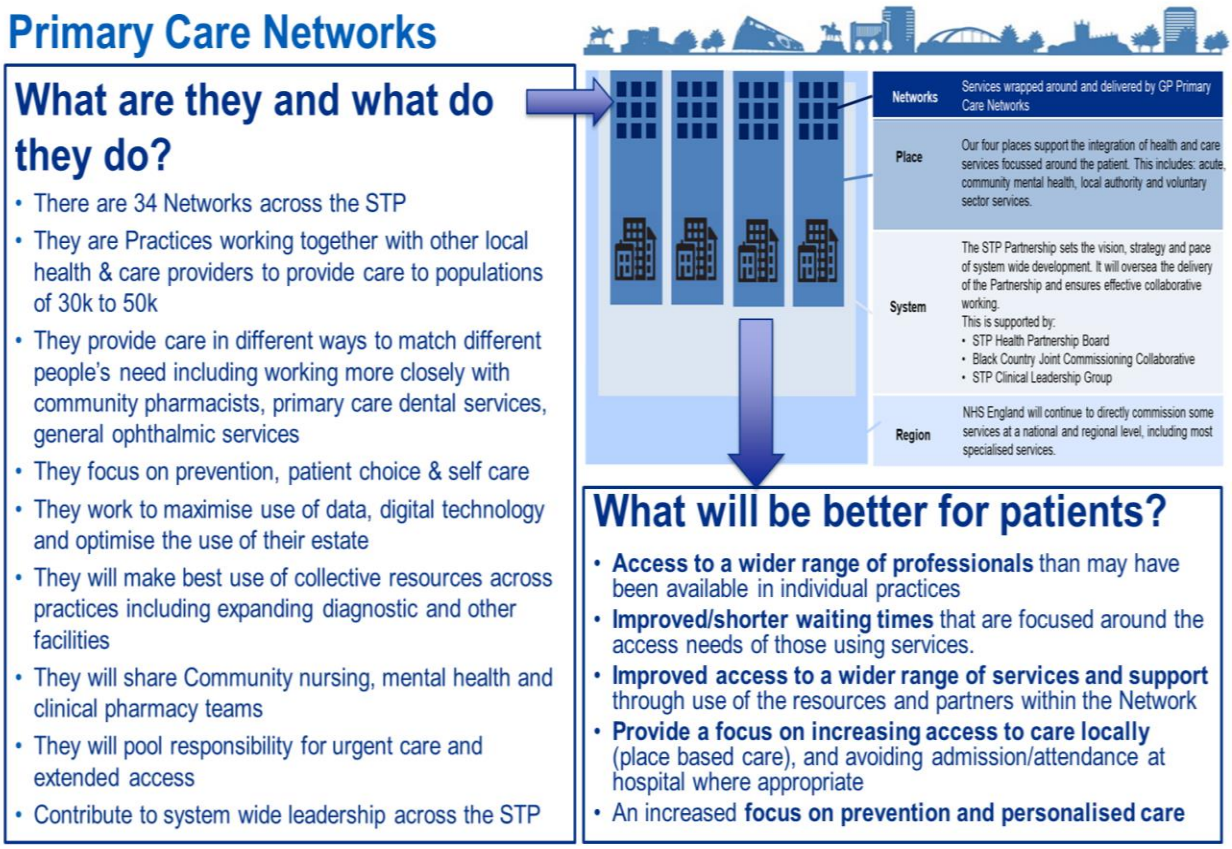
Some of these challenges are a function of changes in: population need and growing complexity of care; deprivation resulting in poor health and wellbeing; how we organise and provide services; the fact that quality of the care we offer varies unnecessarily from place to place; and the way we engage with patients and the public

The STP is clear that we face gaps in care quality and health outcomes and we risk not being able to afford all the services our populations need unless we act and strengthen our primary care services.

Acting on multiple fronts the planning and decision-making process by the STP leadership team provides us with a framework for structuring and delivering future change. This is managed through a robust system of Governance – see Section 6.2

4.4 Primary Care Networks

The STP currently consists of 216 Practices which have formed into 34 Primary Care Networks. The STP views the development of our Primary Care Networks as a key component to the success of this Strategy, meeting its challenges and delivering the overall vision for the Region.



STP PCN Infographic

The people in our Region have told us what matters to them most is continuity of care, delivered closer to home when they need it. They tell us that they don't want to go to hospital unless it's necessary and don't want to keep repeating their story to a revolving door of professionals involved in their care be it GPs, Specialist Clinicians in acute settings, Community Health Professionals (such as District Nurses), Social Workers or other vital community based services.

The development of Primary Care Networks provides a structured and supported opportunity to make this a reality over the next 5 years – building on the foundations and learning from some great practice that have already been put in place across the our patch. Over the life of this Strategy our Primary Care Networks will:-

- Prioritise prevention and early detection of those conditions most strongly related to health inequalities
- Provide a sustained focus by individuals, communities and organisations on the big four lifestyle changes which improve health, wellbeing and quality of life: stopping smoking, healthy eating, an active lifestyle and keeping alcohol intake to safe levels are essential to tackle the higher rates of illness and early death experienced by the people of the Black Country and West Birmingham
- Have a renewed focus on the early identification of the risk factors of disease, including the aggressive identification and management of heart disease
- Promote and develop all opportunities to improve self-care, through education programmes giving people and their families a larger stake and responsibility in the ongoing management of their condition.
- Reduce infant mortality through holistic support for families from before birth, with a priority for maternal health interventions
- Take action across all agencies to encourage and support older people to maintain an active lifestyle to prevent and reduce falls and fractures which lead to loss of independence at local level.

The STP will support the developments of PCNs in the Region by:-

- Supporting the formation of PCNs through the work of local Primary Care teams
- Working with PCNs to support the development of their development plans and workforce requirements
- Providing the capability and expertise to help provide and analyse system wide population health data at PCN level
- Encourage and support PCNs to access and take advantage of the development opportunities and prospectus being prepared nationally to help transition their networks towards full maturity
- Encourage and ensure Clinical Directors are involved as equal partners in the STP Governance processes at both Primary Care and system wide level decision making forums
- Acting on PCN workforce and development plans at an STP level to ensure that PCNs are supported at a system level to broaden and strengthen the Practice team which will enable people to have access to the right professional at the right time
- Ensure that interdependencies with other existing and emerging place based transformation programmes are managed and supporting PCNs to reach maturity by 2024. *Examples are the Better Care Fund Programme that continues to develop integration models of Health, Housing and Social Care at place level that will be essential to the success of PCNs as well as the*

emerging models of integrated care (Integrated Care Alliance, Dudley MCP, Walsall Together and Health Lives Partnership)

Although our PCN's vary in size they adhere to the specification and criteria laid out in the national guidance. As at the time of writing this strategy our PCNs have:

- Submitted agreements on form and function and early sight on what services will be provided by the networks (we achieved the 15th May 2019 submission deadline).
- Agreed staffing requirements e.g. clinical directors, practice pharmacists and social prescribers. Work is underway across each network to understand what other workforce models and configurations are needed in support of primary care (see the narrative throughout this strategy).
- Started conversations on identifying what's included within each respective area's Directed Enhanced Service (DES), contracts and made early steps on how the financial flows will work.

The timescales we are working to (and achieving) for full development and implementation of our PCNs is in line with the national timescales as shown below:

Date	Requirements
15th May 2019	Network contract application to be submitted to Clinical Commissioning Group (CCG) confirming clinical lead, patient coverage, list size and payment methods
31st May 2019	CCGs confirm network coverage and approve variation to GMS, PMS and APMS contracts
Early June 2019	NHSE and General Practitioners Committee (GPC) England jointly work with CCGs and Local Medical Committees (LMC) to resolve any issues
1st July 2019	Network contract DES goes live across 100% of the country
July 2019 – March 2020	National entitlements under the 2019/20 network contracts start

Primary Care Network Delivery Milestones

4.5 Primary Care Workforce Statistics

The current position of our primary care workforce is shown in the table below, along with the trajectory that has been agreed with NHSE for the year 2019/2020. *Source: General Practice Workforce Final 31 December 2018, Experimental Statistics, NHS Digital):*

Workforce	FTE As At December 2018	FTE Ambition for March 2020	FTE Variation
GPs	689	**712**	+23
General Practice Nurses	414	**414**	0
Physician Associates	8	**16**	+8
Pharmacists	25	**33**	+8
Administrative Staff (including Social Prescribers)	1,741	**1,775**	+34
Direct Patient Care (e.g. HCA, Nursing Associate, Phlebotomist)	245	**253**	+8

STP Primary Care Workforce Statistics

Within the life of this Strategy we will have a minimum of 170 additional new roles to those in the table above in place across our 34 Primary Care Networks (noting that the STP currently has some of these in place and that Social Prescribers are included in the ambitions above). There will be some flexibility with some of these roles and the numbers may change as PCNs continue to form and develop their workforce plans

Role Name	Minimum Number of FTE	By When
Social Prescribing Link Workers	34	2019/20
Clinical Pharmacists	34	2019/20
First Contact Practitioners (e.g. Physiotherapist, Occupational Therapist)	34	2020/21
Physician associates	34	2020/21
Community Paramedics	34	2021/22

To ensure our workforce plans come to fruition, we will be monitoring our performance, trends and changes closely. This will be through our existing governance functions, so we are sighted on any issues or deviations to our above aspirations. Corrective actions will be taken as per our escalation and decision-making process.

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4.6 Key Budgetary Numbers

The STP has a draft financial plan calculated for Primary Medical Care services, General Practice Information Technology (GPIT) and PCN support/development to 2023/24, but this has yet to be calculated and reviewed in detail as CCGs are not due to submit 5-year financial plans until autumn 2019.

STP	2018/19 FOT at M11 £000	2019/20 Plan £000	2020/21 Plan £000	2021/22 Plan £000	2022/23 Plan £000	2023/24 Plan £000
Primary Care Co-Commissioning						
General Practice - GMS	121,655	127,149	132,539	138,331	144,810	152,201
General Practice - PMS	2,626	2,666	2,792	2,925	3,071	3,237
Other List-Based Services (APMS incl.)	16,401	14,290	14,902	15,561	16,299	17,140
Premises cost reimbursements	23,261	22,269	23,212	24,226	25,363	26,660
Primary Care NHS Property Services Costs - GP	-	1,561	1,619	1,682	1,754	1,837
Other premises costs	191	213	221	230	241	253
Enhanced services	18,081	19,326	20,108	20,954	21,904	22,993
QOF	14,891	15,501	16,179	16,907	17,718	18,641
Other - GP Services	271	398	424	449	475	504
Delegated Contingency	-	567	591	616	645	678
Enhanced Services - PCN DES	-	548	568	591	616	645
Sub-total - Primary Care Co-Commissioning	**197,378**	**204,487**	**213,156**	**222,473**	**232,897**	**244,788**
PMC Allocation	**197,950**	**204,487**	**213,156**	**222,473**	**232,897**	**244,788**
(Adverse) / Favourable to Allocation	**572**	**(0)**	**-**	**-**	**-**	**-**
Core Services (Extract)						
Practice Transformation Support/PCN Development	3,247	2,218	2,304	2,369	2,430	2,488
GP IT Costs	4,984	5,234	5,157	5,336	5,523	5,719
Grand Total	**205,609**	**211,939**	**220,617**	**230,177**	**240,850**	**252,995**

Draft 5-year Primary Care Financial Plan (STP) (see section 12 for further information)

The CCGs have included within their plans funding for the Network Contract DES (£1.50 per registered patient) intended to support the day-to-day operation of the network and Practice Engagement Payment (£1.76 per registered patient).

The following table shows the financial breakdown for primary care funds based on the new GP contract payments and other allocations that have been confirmed for the GP Five Year Forward View (GPFV):

Descriptor	Source	Value	Payee
Network DES	CCG Discretionary	£1.50 per patient	Network
Practice Engagement Payment	CCG Delegated	£1.76 per patient	Practice
Improving Access Fund	NHS England	£6 per patient	CCGs
GPFV (Resilience, Retention, Admin & Clerical, Online Consultation, Practice Nursing)	NHS England	19/20 £1,167 20/21 £1,274	STP (Wolverhampton CCG) - [Plan in place]
GFPV Achieving Sustainable GP Workforce Targeted Retention (Four Pillars)	NHS England	19/20 £127k	STP (Wolverhampton CCG) - [Plan in place]
GPFV First 5s	NHS England	19/20 £50k	STP (Wolverhampton CCG) - [Plan in place]
Social Prescribing 100% Funding	NHS England	19/20 x 1 20/21 x 2 21/22 x 3	Per Network
Clinical Pharmacist(s) 70% Funding	NHS England	19/20 x 1 20/21 x 2 21/22 x	Per Network
Clinical Director Funding 0.25/1day per week	NHS England	19/20 £0.51 per patient 20/21 £0.57 per patient	Network
First Contact Practitioner (70%)	NHS England	20/21 x 1 21/22 x 2	Network
Physicians Associate (70%)	NHS England	20/21 x 1 21/22 x 2	

STP Primary Care Funds

Work is ongoing to quantify the impact of the workforce, estates and digital investments required to deliver the new models of care. This will also include any potential funding required to offset the cost of these where they cannot be contained within existing published allocations to 2023/24.

5 The case for change

5.1 Demographic Profile

The STP has approximately 1.4 million people who reside within its boundaries and each area has its own health and care challenges (as highlighted in table 1). In 2014/15 it was estimated that over nine million contacts (GP appointments, outpatient appointments, day cases, inpatient admissions and accident and emergency (A&E) episodes) were seen across the four STP areas and of these three quarters were estimated to take place in primary care. Some 44% of NHS contacts were estimated to be for the non-working population including children, retired individuals and unemployed and inactive people aged less than 16 and over 64 years, (MLCSU Strategy Unit, 2017).

Across the STP we have identified a number of key drivers that play a significant role on the development of future illness which directly links to our primary care provision. These are: education, employment, wealth, housing, nutrition, family life, transport and social isolation *(see Appendix 2 for the STP clinical strategy for more information on demography and determinants of health metrics).*

To understand the type and size of challenge we face, we regularly undertake data analysis, using systems such as Fingertips (PHH) and from within our Business Intelligence teams. For our area we have found that:

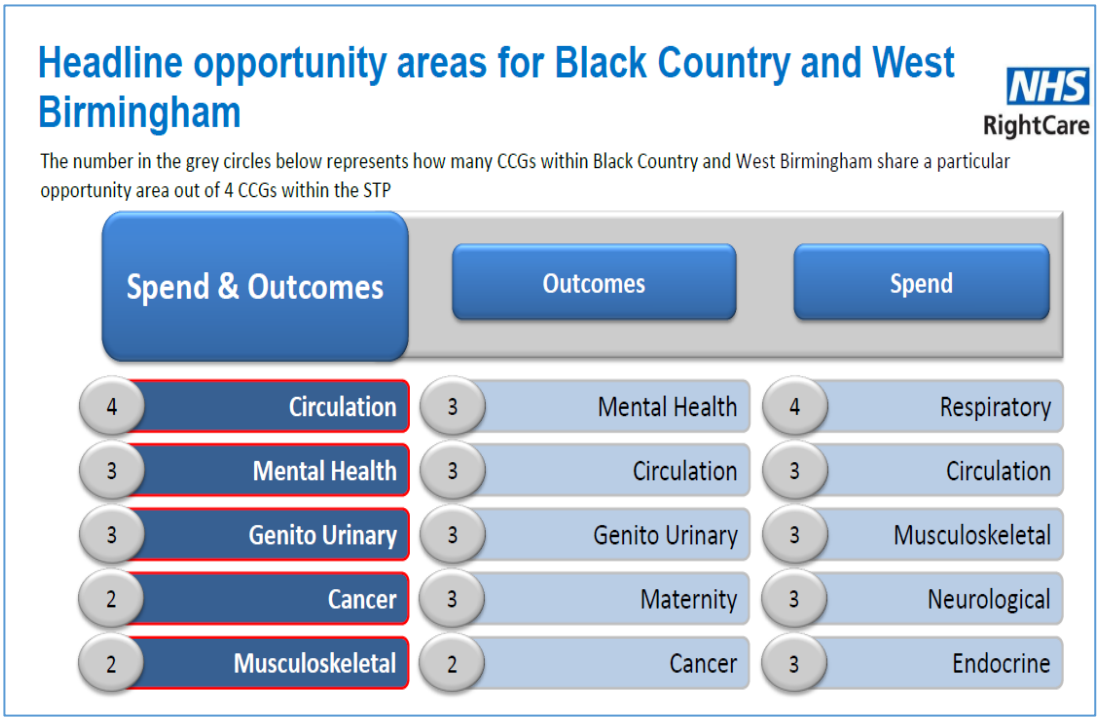
- Depression rates are higher across the STP compared to England average.
- Diabetes prevalence is much higher across the STP when compared to the England average.
- We have some of the highest infant mortality rates in the country, whilst smoking rates in pregnancy remain high, and breast-feeding rates are low.
- By the time a child starts school, they are much less likely to be ready for school than in other areas. Starting school ill-prepared makes it more difficult to catch up later, which is reflected in poorer GCSE results. In turn this leads to poorer employment opportunities, less earning potential, greater likelihood of teenage pregnancy, unemployment or providing unpaid care.
- Both child and adult obesity rates are high, whilst physical activity levels are relatively low. Poor air quality is harmful to health, and unhealthy fast food is easily available. In turn this increases the risk of diabetes and other weight-related conditions prematurely.
- Rates of admissions for alcohol and for violence are high, and many users of adult social care say they feel socially isolated and experience poor health related quality of life.
- Rates of falls and hip fractures in older people are high, as are households living in fuel poverty meaning people are exposed to the risk of cold housing in winter exacerbating long-term conditions.
- Mortality from conditions considered preventable is relatively high and we have a high prevalence of long-term conditions compared with England and West Midlands averages, especially in relation to hypertension, diabetes, chronic

kidney disease, chronic heart disease, depression and dementia. This is demonstrated in the table below:

Condition	England	West Midlands	Dudley	Sandwell	Walsall	Wolver-hampton
CHD: Recorded prevalence (all ages)	3.20%	3.40%	4.00%	3.50%	4.00%	3.50%
CKD: QOF prevalence (18+)	4.10%	4.60%	6.30%	4.60%	5.20%	4.40%
Diabetes: Recorded prevalence (aged 17+)	6.40%	7.30%	7.00%	8.60%	8.70%	8.10%
Hypertension: Recorded prevalence (all ages)	13.80%	14.80%	17.70%	15.50%	15.60%	15.20%
Number of adults with dementia known to GPs: % on register	0.74%	0.73%	0.76%	0.69%	0.77%	0.82%
Number of adults with depression known to GPs: % on register	7.30%	7.60%	8.60%	6.90%	7.80%	7.90%
Stroke: Recorded prevalence (all ages)	1.70%	1.80%	2.00%	1.70%	1.80%	1.80%

STP Disease Prevalence % Compared to National

We also use Right Care data from the Commissioning for Value pack (2016) to identify areas where can make improvements in care delivery. The four areas below (labelled 1-4) identify our opportunity areas to improve quality and spend. However, this does not mean that the quality of care we currently provide is poor.



Right Care Opportunity Areas for STP

Using data in the above ways will help us to demonstrate and monitor that the changes we are introducing through, for example, our PCNs and strengthened primary and community service, are having a positive impact.

In 2012 the Kings Fund undertook analysis which looked at how England's population demography would change over the next 20 years. Although these findings showed changes at the national level it was surmised that these would give indications which would be applicable to local area populations. The key findings to note were:

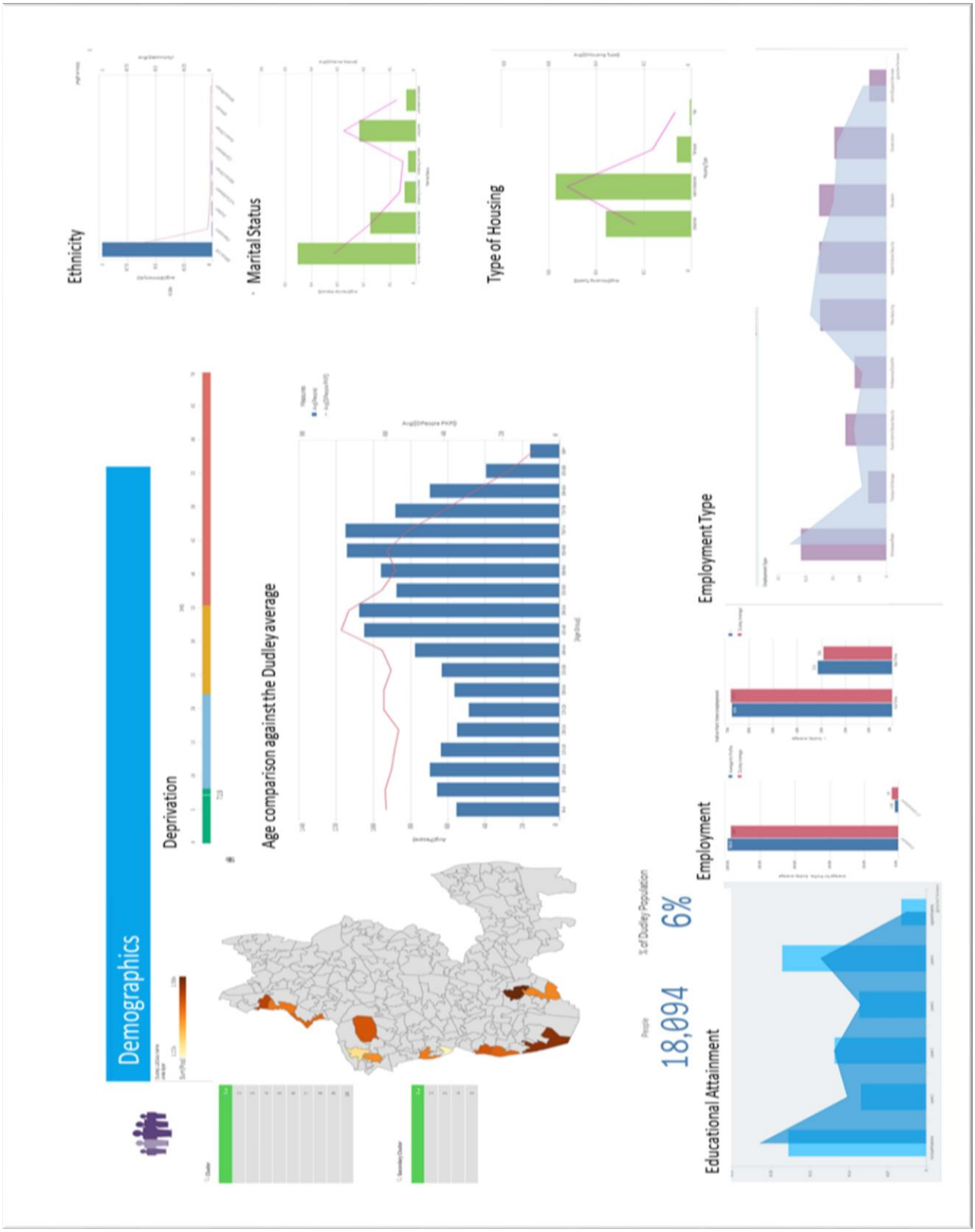
The population is growing **Over the next 20 years (2012-2032) the population in England is predicted to grow by 8 million to just over 61 million, 4.5 million from natural growth (births – deaths), 3.5 million from net migration.**	**The population is becoming more diverse** **By 2031, ethnic populations will make up 15 per cent of the population in England and 37 per cent of the population in London**	**More people are living alone** **By 2032 11.3 million people are expected to be living on their own, more than 40 per cent of all households. The number of people over 85 living on their own is expected to grow from 573, 000 to 1.4 million.**
After recent growth, the number of births each year is expected to level off Over time birth rates have fluctuated quite significantly. Current predictions are that the annual number of births will level off to around 680,000–730,000 births per year.	Life expectancy and healthy life expectancy are growing In 1901 baby boys were expected to live for 45 years and girls for 49 years. In 2012, boys could expect to live for just over 79 years and girls to 83 years. By 2032, this is expected to increase to 83 years and 87 years respectively. Healthy life expectancy is growing at a similar rate, suggesting that the extra years of life will not necessarily be years of ill health.	The population is ageing The combination of extending life expectancy and the ageing of those born in the baby boom, just after the Second World War, means that the population aged over 65 is growing at a much faster rate than those under 65. Over the next 20 years the population aged 65-84 will rise by 39 per cent and those over 85 by 106 per cent.
After a recent decline, the number of deaths each year is expected to grow The number of deaths each year is expected to grow by 13 per cent from 462,000 to 520,000 by 2032.	Health inequalities persist Men and women in the highest socio-economic class can, on average, expect to live just over seven years longer than those in the lowest socio-economic class, and more of those years will be disability free.	

Kings Fund Population Growth Analysis, 2012

As we know, primary care is the first point of contact in circa 75% of cases. Looking at changes in national population data and applying it to our STP we will see a circa 17% overall increase in our population by 2032, those aged 65-84 will rise by 39 % and those over 85 by 106 %. When presented with figures like this it shows us the scale of the challenge our primary care services face.

5.2 Primary Care Network Demographics

The STP is supporting to align these demographic profiles to the emerging PCNs and identifying a list of key health priorities for each of the PCNs as well as a baseline from which to measure impact over time. Work has already started on producing information at PCN level in co-design with Clinical Directors with pre-existing good practice, functionality and capability being shared – one example of which is below:-



Dashboard extract example of a PCN

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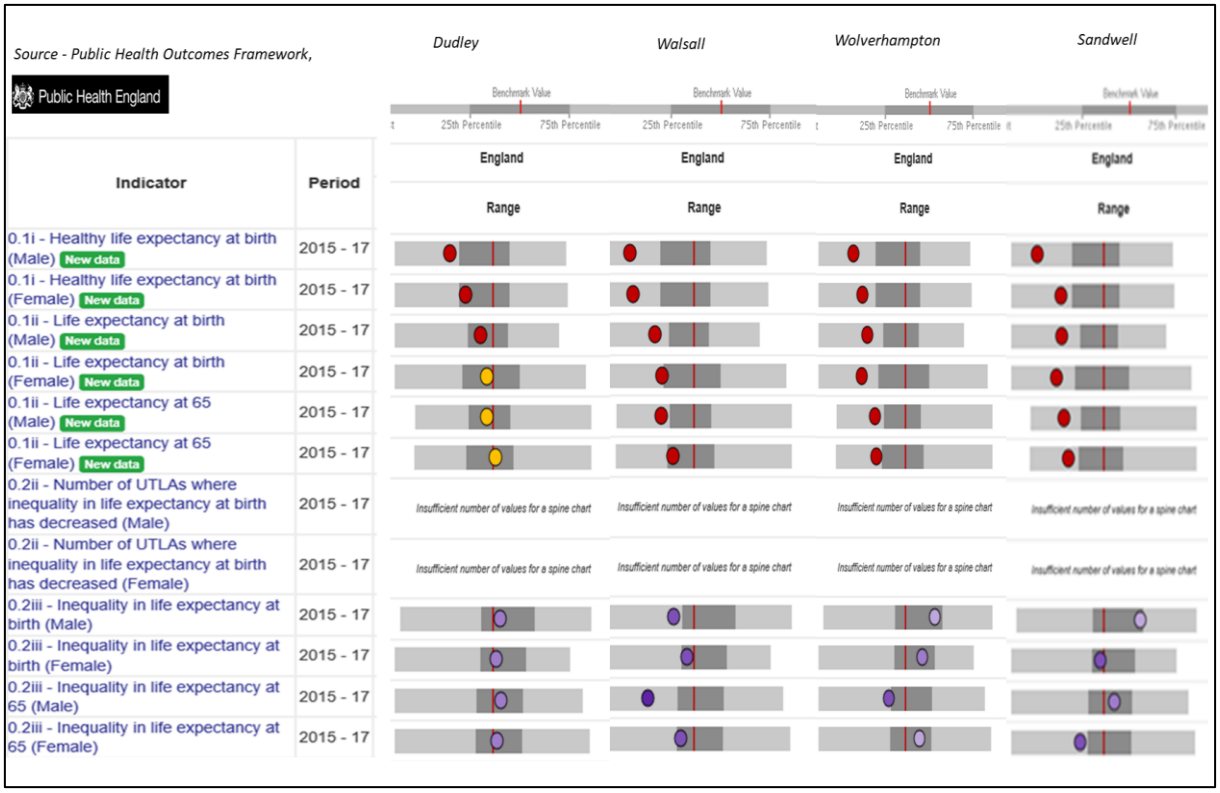
The STP recognises that PCN level analytics are at a very early stage and will continue to be developed and refined across the STP and provided to PCNs and STP Governance forums alike to both inform commissioning decisions (STP and Local) and as a mechanism to assess the impact of PCNs over time.

Whilst we recognise that this information will provide a greater level of local detail and significant value to the PCNs and STP much of challenges across the STP geography are consistent as evidenced by Public Health data below:-



Source - Public Health Outcomes Framework,

Public Health England

Indicator	Period	Dudley	Walsall	Wolverhampton	Sandwell
		Benchmark Value; 25th Percentile; 75th Percentile	Benchmark Value; 25th Percentile; 75th Percentile	Benchmark Value; 25th Percentile; 75th Percentile	Benchmark Value; 25th Percentile; 75th Percentile
		England Range	England Range	England Range	England Range
0.1i - Healthy life expectancy at birth (Male) New data	2015 - 17				
0.1i - Healthy life expectancy at birth (Female) New data	2015 - 17				
0.1ii - Life expectancy at birth (Male) New data	2015 - 17				
0.1ii - Life expectancy at birth (Female) New data	2015 - 17				
0.1ii - Life expectancy at 65 (Male) New data	2015 - 17				
0.1ii - Life expectancy at 65 (Female) New data	2015 - 17				
0.2ii - Number of UTLAs where inequality in life expectancy at birth has decreased (Male)	2015 - 17	Insufficient number of values for a spine chart	Insufficient number of values for a spine chart	Insufficient number of values for a spine chart	Insufficient number of values for a spine chart
0.2ii - Number of UTLAs where inequality in life expectancy at birth has decreased (Female)	2015 - 17	Insufficient number of values for a spine chart	Insufficient number of values for a spine chart	Insufficient number of values for a spine chart	Insufficient number of values for a spine chart
0.2iii - Inequality in life expectancy at birth (Male)	2015 - 17				
0.2iii - Inequality in life expectancy at birth (Female)	2015 - 17				
0.2iii - Inequality in life expectancy at 65 (Male)	2015 - 17				
0.2iii - Inequality in life expectancy at 65 (Female)	2015 - 17				

5.3 Primary Care Workforce

Our aim is to ensure that we provide a primary care workforce, now and in the future that ensure people receive safe, sustainable and high-quality care. This will require us to be bolder and braver than ever before about how our workforce is shaped and provided. We want our STP to be a great place to work and support individuals grow into new and exciting roles. We see workforce transformation as a core element of the change needed within primary care to meet the growing demands.

As we are in the process of developing our new 10-year workforce strategy (which details our ambitions, aims and plans to create our fit for the future workforce) we took the decision to move ahead on developing new skills and roles that support delivery of our emergent PCNs. For example, we are introducing social prescribers, physician associates, GP practice pharmacists, first contact practitioners and network clinical directors across 19/20 and 20/21.

We are also in the process of working through our intentions for other roles such as primary care mental health nurse, nurse associates and paramedics.

The full timescales and rollout plans will be detailed in our STP nursing and workforce strategies however we envisage this to be from 2020 onwards. It's fair to say that having a reshaped workforce, working across professional boundaries and ensuring staff are able to support delivery of high quality of care for our population is one of our highest priorities. *Our Workforce Retention Plan 2019-20 with more information is included at Appendix 10*

The STP is committed to continuing to support, improve and develop workforce plans and initiatives over the life of this Strategy and will be sustained by a combination of Programme and Project Support for the GPFV, existing Primary Care Teams and the re-designed Training Hub/Academy continuing to work in strong partnership with HEE, HEI, FE, NHSE colleagues and our LWAB.

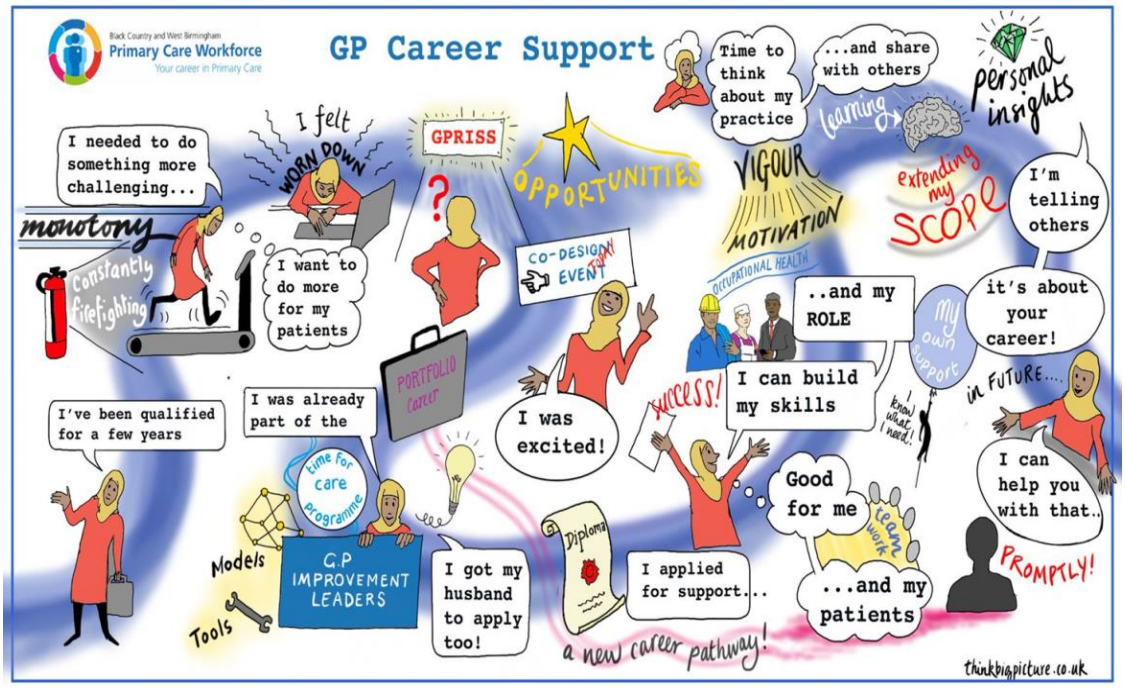
5.4 General Practitioners

The STP co-designed and delivered a number of successful and nationally recognised GP retention schemes (see below video link) during 2018-2019 as part of its work as a GP Retention Intensive Support Site (GPRISS).

Much of our future workforce plans are built upon this successful approach. The evidence we collected in support of this showed us:

- 224 expressions of interest were received across all schemes, which represented almost 1/3 of our GP workforce.
- 153 applications for schemes were received and 148 approved.
- We estimated that that up to 50% of these were potentially thinking of leaving the area, profession or early retirement. This is based on evidence from co-design events, case studies *(see illustrated example below)* and NHSE outcome calculations *(GP Retention Impact Estimation Tool).*
- Some of our schemes are now being rolled out on a regional basis using the learning from our approach to these schemes.
- The below video link and case studies give more details on what we did and what this delivered

  https://www.youtube.com/watch?v=4hcglczmmMw&feature=youtu.be



Case Study Example – GP Portfolio Careers

To continue to strengthen the GP workforce, the STP will be undertaking a number of schemes across the next 5 years to proactively promote, facilitate and fund the below initiatives (starting in 2019 and running through the life of this strategy). The will offer these to all its GPs and Registrars without exception. These schemes are:

Incentivising Portfolio careers:
Developing flexible GP career opportunities. Helping GPs enhance their skills and knowledge in area(s) of specialist interest to extend their role beyond General Practice. Funding available for training needs and access to secondary care support.

First 5 and GP Trainee Network:
Supporting newly qualified GPs and GP trainees transition into General Practice. Encourages networking, peer support, exploration of career opportunities and small group learning opportunities over a series of events. Funding available to kick-start a portfolio career. This scheme is designed and delivered in collaboration with the RCGP Midland Faculty.

Peer Mentoring:
Supporting GPs with career planning and development, as well as those experiencing difficulties. The scheme is tailored to the needs of local GPs and delivered in a confidential, flexible and supportive environment.

Pre-retirement Coaching Forum:
Practical support and guidance (including pensions, estates and indemnity costs) for GPs considering retirement or that have recently retired. Providing solutions for GPs to remain in clinical general practice.

STP GP Retention Schemes

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In addition, we have also made a commitment to:

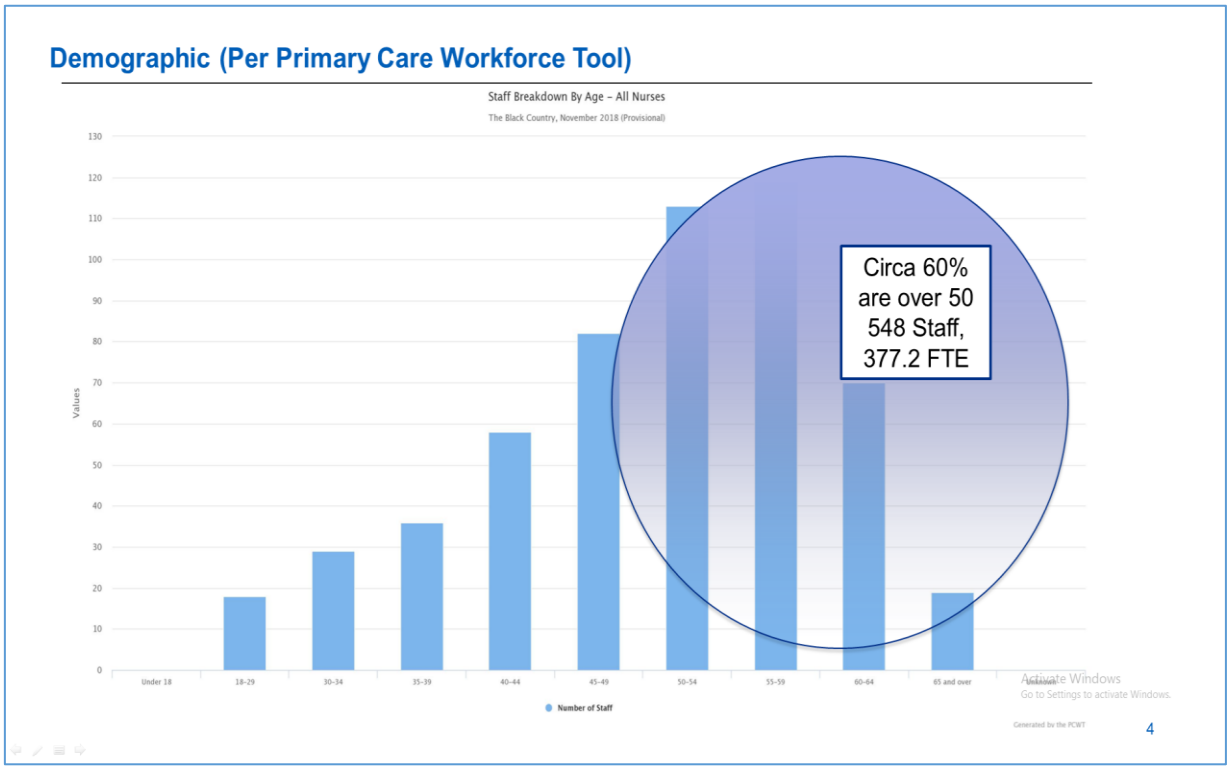
- Work more closely with our trainees to increase the conversion rate so that more stay and practice in the Black Country and West Birmingham. We will do this by:
- Developing tracking processes for all trainees (in line with General Data Protection Regulations (GDPR) legislation) both as a mechanism for proactive work to shape and keep relevant support offers but also as a backward look to understand why some choose not to work in the area and where they go to practice.
- Actively promoting the career opportunities and schemes on offer in the Black Country and West Birmingham at every given opportunity.
- Identify and develop our GPs with Extended Roles and those wanting portfolio careers to work within our PCNs and acute/community providers.
- Continue to actively promote the national offers available to GPs around leadership, coaching and developing PCNs.
- Maximise any International GP Recruitment (IGPR) offer that becomes available. The STP has approved plans in place to achieve this and the infrastructure to join the programme if requested.
- Work proactively with overseas settlers across the STP footprint (typically refugees and asylum seekers). We have identified a number of individuals that were medics in their country of origin and are in the process of developing proposals for a new funded pathway, aimed at bringing them into our workforce. However, this will not be a short-term piece of work but will help us with strengthening the pipeline of new trainees in our area (we envisage this running through years 2, 3 and 4 of this strategy).
- Actively promoting the national GP Retention Scheme
- Work in partnership with STP organisations to attract and recruit more post CCT fellowships.
- Continue to work with partners, training hubs and PCNs to transform primary care. This aims to maximise our opportunities to relieve workload pressure for GPs by:
    - Proactively encouraging the development and implementation of new roles in partnership with PCNs. As part of this we will ensure any organisational development and change management support is offered.
    - Exploiting new technology to enable more effective processes, improved access options and greater opportunities for people to self-manage appropriate health conditions in the way they want.
    - Continuing to work towards an integrated Multi-Disciplinary Team (MDT) approach to primary care that builds capacity and capability from social care, community health, mental health, acute and voluntary sector partners.

This work has already begun and will run across the life of this strategy and in line with the developing workforce and nursing strategies.

5.5 General Practice Nursing

As part of our strong approach to workforce planning and management, we have identified the General Practice Nurse (GPN) workforce as a key area of focus for us in 19/20 and beyond to support our plans for PCNs. In the last quarter of 2018/19 we undertook a targeted insight programme to understand the challenges and opportunities within this workforce. The outcomes from this told us two vital messages:

- Almost 60% of our current GPN workforce are either at or approaching an age where retirement is a realistic option
- The demography (see below) indicates a significant risk in the pipeline to this staff group;



Current GPN STP Demographic Profile

In February and March 2019, we undertook further engagement with our GPN and Health Care Assistants to further test our assumptions from our insights programme. This revealed a number of key themes of improvement that the GPN and Health Care Assistant (HCA) workforce felt needed addressing to increase their likelihood of staying in the profession for longer, and to attract more nurses into general practice. These were:

- There is significant variation in terms and conditions across the STP and a lack of transparency of career progression and opportunities. Most GPNs would favour standardised terms and conditions for the profession.
- There is not enough protected learning time to help support developing PCNs, peer support, sharing best practice, digesting key policy and to be actively involved in planning and leading transformation changes on the GPFV, Long-Term Plan and GPN 10-point action plan.

- There is not enough recognition of the role and functions performed from a health professional and public perspective.
- There needs to be more involvement of these staff groups in operational and strategic leadership within the STP and PCNs.
- There needs to be more time to invest in developing students and sharing their experiences, so they stay in the roles and area.
- There needs to be more time for front line care and clinical activity

Using this information in conjunction with the workforce and nursing strategies, we have agreed that we will:

- Implement the co-designed STP GPN strategy *(see Appendix 3).*
- Co-design and develop a GPN network across each area of the STP.
- Work with partners (Health Education England (HEE), NHSE and PCNS) to invest in portfolio careers for GPNs.
- Promote GPN recognition schemes such as awards and help other professionals and the public to understand more about their role.
- Proactively work with practices, training hubs and education providers to influence general practice as a more attractive career option with a transparent career pathway. This will include developing more training practice places for GPNs and working to utilise existing experienced nurses for mentorship and support for trainees.
- Promote the national leadership schemes proactively to GPNs and work to influence emerging PCNs to include GPNs in operational and clinical leadership roles.
- Work with PCNs across the STP to develop more transparent and consistent terms and conditions for GPNs.

5.6 Administration, Clerical and Reception Staff (including Practice Managers)

We recognise the vital role that the administrative, clerical and reception workforce plays in shaping and delivering primary care. We have therefore committed to invest in the workforce to:

- Continually develop their professional skill set and academic knowledge to enhance their own personal development and develop practice/PCN capability, efficiency and effectiveness.
- Develop pathways into direct patient care roles for those staff that want to do this, thus creating a primary care career pathway for these staff.
- Create and sustain supportive professional networks across the STP to share good practice, provide peer support and build key relationships that will enable PCNs to succeed.
- Support and encourage the learning and implementation of core business improvement techniques that enable continuous improvement to be introduced in the Practice and PCN environment.

- Continue to expand their roles to offer front line support to people to navigate/signpost to alternative and more appropriate care access points. The STP has well established models of active signposting and care navigation that have been implemented over the 18 months prior to the workforce strategy development. We are committed to expanding active signposting and care navigation services where there is opportunity identified by PCNs and support continuous improvement of the function.
- Share best practice and develop existing social prescribing models with PCNs. The STP has already-established models of social prescribing in place. These have a key function in many integrated locality-based MDTs. The STP will embrace the opportunity from the development of PCNs to increase the capacity of this function and implement in line with national guidance.

5.7 New Primary Care Roles

The STP has embraced the development of new roles and through working closely with partners, practices and PCNs is beginning to transition these into the primary care setting. We will continue to support PCNs with the introduction of the new roles being supported by NHSE as part of the plan to expand the PCN workforce

Social Prescribing Link Workers

Social Prescribing functions are already embedded across most parts of the STP, but the development of Primary Care Networks enables the benefits of this function to reach across all PCNs and our population through specific funded roles. Social Prescribing Link Workers will be in post across each network during 2019/20 and will:-

- Assess how far a person's health and wellbeing needs can be met by services and other opportunities available in the community
- Co-produce a simple personalised care and support plan to address the person's health and wellbeing needs by introducing or reconnecting people to community groups and statutory services
- Evaluate how far the actions in the care and support plan are meeting the individual's health and wellbeing needs
- Provide personalised support to individuals, their families and carers to take control of their health and wellbeing, live independently and improve their health outcomes
- Develop trusting relationships by giving people time and focus on 'what matters to them
- Take a holistic approach, based on the person's priorities, and the wider determinants of health.

Physician Associates

Physician Associates (PAs) work to the medical model in the diagnosis and management of conditions in general practice and hospital settings, under the supervision of medical practitioners (GPs, consultants). They can supplement and complement GPs and nursing staff and see a range of patients whose cases vary in complexity. This enables the GP to see more complex patients and frees up time for other tasks such as visiting or teaching. A PA can see both acute and chronic patients

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and is able to undertake numerous tasks both clinical and managerial where appropriate. Studies from general practice in England and Scotland have shown PAs to be safe, effective and liked by patients.

We have a dedicated PA ambassador across the STP who has already supported us in raising awareness of the role and developed successful internships alongside our partners at HEE. Our plan is to continue to develop this role however, like all new developments coming into long established traditional organisations this will take time, effort and organisational development to embed and spread.

We will utilise the opportunity networks afford us, and the development of our workforce plans to influence this. We have set ourselves a challenging target of doubling our numbers during the next 12 months, but the development of Primary Care Networks enables the benefits of this function to reach across all PCNs and our population through specific funded roles by 2020/21

Clinical Pharmacists

Clinical Pharmacist roles are already in place across parts of the STP, but the development of Primary Care Networks enables the benefits of this function to reach across all PCNs and our population through specific funded roles during 2019/20. Clinical Pharmacists will:-

- Work as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas.
- Be prescribers, or will be completing training to become prescribers, and will work with and alongside the general practice team.
- Take responsibility for the care management of patients with chronic diseases and undertake clinical medication reviews to proactively manage people with complex polypharmacy, especially the elderly, people in care homes, those with multiple co-morbidities (in particular frailty, COPD and asthma) and people with learning disabilities or autism (through STOMP – Stop Over Medication Programme).
- Provide specialist expertise in the use of medicines whilst helping to address both the public health and social care needs of patients at the PCN's practice and to help in tackling inequalities.
- Provide leadership on person centred medicines optimisation (including ensuring prescribers in the practice conserve antibiotics in line with local antimicrobial stewardship guidance) and quality improvement, whilst contributing to the quality and outcomes framework and enhanced services. Through structured medication reviews, clinical pharmacists will support patients to take their medications to get the best from them, reduce waste and promote self-care.
- Have a leadership role in supporting further integration of general practice with the wider healthcare teams (including community and hospital pharmacy) to help improve patient outcomes, ensure better access to healthcare and help manage general practice workload. The role has the potential to significantly improve quality of care and safety for patients.

- Develop relationships and work closely with other pharmacy professionals across PCNs and the wider health and social care system.
- Clinical pharmacists will take a central role in the clinical aspects of shared care protocols, clinical research with medicines, liaison with specialist pharmacists (including mental health and reduction of inappropriate antipsychotic use in people with learning difficulties), liaison with community pharmacists and anticoagulation.

(See Appendix 4 for Case Studies; Practice Based Pharmacists)

As a leader in this field, the Black Country and West Birmingham Integrated Pharmacy and Medicine Optimisation Leadership Group recognise the workforce challenges for general practice. They are working with our primary care services and PCNs to ensure the STP has the right level of appropriately skilled pharmacists to provide professional and clinical leadership and support.

However, we recognise growing this workforce is challenging as there is both a national and local staff shortage. The STP has committed to develop our GP pharmacist workforce starting with undergraduates through to consultant and chief pharmacist roles.

The main activities we are undertaking to achieve this are:

- Producing plans outlining how the pharmacy workforce can be developed to support the NHS Long-Term Plan.
- Mapping out the current pharmacy workforce across the STP footprint to identify the gaps.
- Developing guidance and a support network for this new workforce to ensure they are deployed into the system with the right skills, knowledge and expertise.
- Align our plans to the workforce strategy, developing a framework and network to support the pharmacy workforce from undergraduate, post graduate, early career through to advanced career development. Adopt portfolio career pathways to support the pharmacy workforce. Look to sharing good practice and excellence from the local CCGs and trusts.
- Develop a pharmacy deanery approach to support the pharmacy workforce expanding. This is being driven through our workforce sub-group (and in collaboration with primary care teams).

Nursing Associates

The STP is proactively developing this role by offering a number of Nursing Associate apprenticeships to the current workforce to upskill HCAs. This provides a pathway to general practice nursing. Our longer-term plan for these roles is to positively promote and introduce them with our PCNs.

First Contact Practitioner (from 2020/21) and Community Paramedics (from 2021/22)

As part of our plans to develop the PCN workforce the STP will work together to support recruitment to physiotherapy and community paramedic roles in line with national PCN guidance. As with all other roles being considered and introduced we will build on existing models within the current workforce and introduce these in PCNs and the wider system.

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Mental Health

The overall strategy across the STP is to align Community Psychiatric Nurses (CPNs) to PCNs. These services will provide more specialist mental health support for those who require it but who do not need or are unable to access secondary care, or who have been discharged from secondary care because their mental health problem is stable. By working alongside networks mental health workers can ensure there is joined up physical and mental health support.

We are also planning to provide mental health support closer to home and in less restrictive settings. This helps us to ensure there is less likelihood of people falling through the gaps and then going into avoidable crisis. Having a mental health worker attached to or working alongside networks will also improve the knowledge, confidence and capacity of other primary care professionals.

In all parts of the STP there is a clear plan to align CPNs with PCNs. This builds on existing models of integration with primary care such as practice, community and locality MDTs.

5.8 Development of an STP Training Academy

The STP has a real focus on how we support primary care and emergent PCNs through ongoing training, development, education and leadership (within our clinical and non-clinical workforce).

We are working in partnership with Health Education England to aspire to be an STP wide Training Hub; this will form a foundation for the development of an academy in the longer term. This will also include application of continuous improvement approaches so staff can feel confident in implementing and transforming primary care services.

Our existing training hubs and aspiration to become a medical education academy will create greater support to all staff in the wider general practice team. This will develop and grow their skills and knowledge in a range of areas; leadership development, new and refreshed clinical skills development and application, service improvement and project management tools and techniques, new ways of working to aid managing demand and care redesign. Within this there will be the opportunities for individuals to gain more formal qualifications. For example, Wolverhampton CCG has funded 15 practice managers through the National Association of Primary Care NVQ practice manager diploma (PMD). This diploma equips practice managers with the skills to be able to manage practices and networks and covers modules such as business and operations, financial management, human resources, new contracting models and workforce development.

5.9 Monitoring Continuous Improvement

The STP will continue to monitor workforce levels and continually assess the impact of all of its schemes. It will do this through:

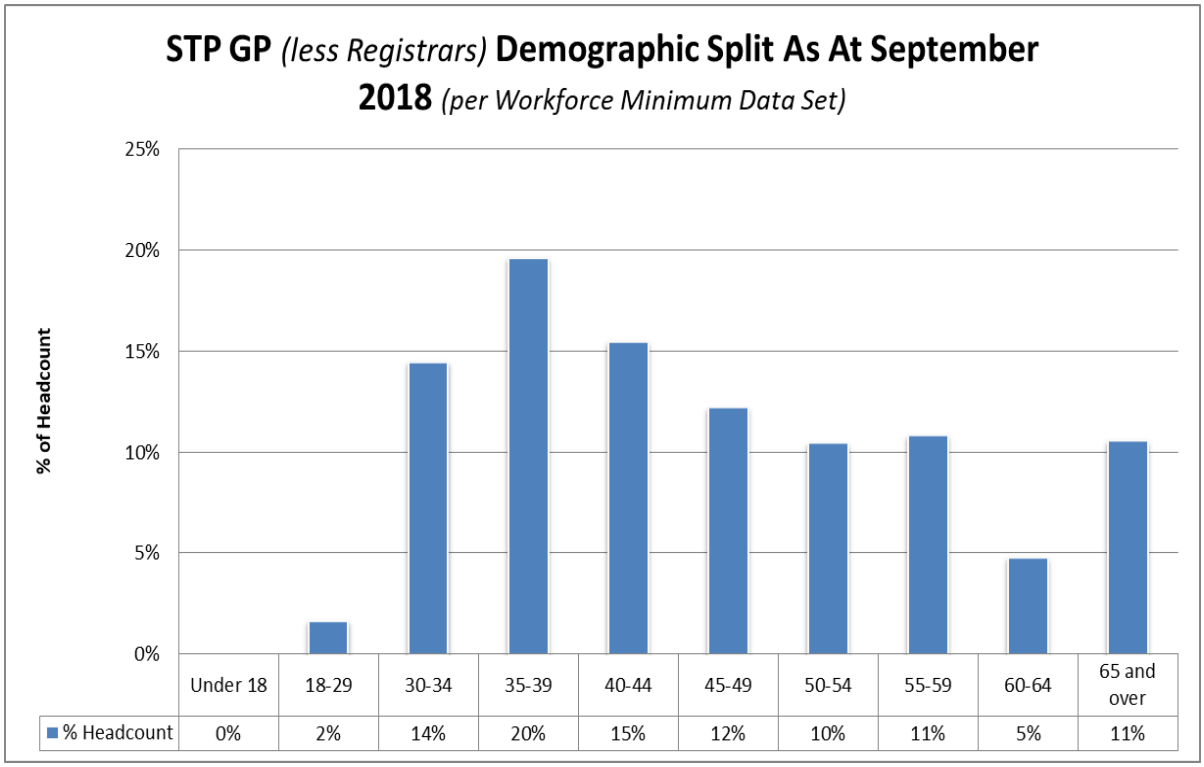
- Producing regular workforce dashboards by STP area as part of routine governance processes and reviews.

- Continuing to capture outcomes from schemes and initiatives e.g. case studies and working to continuously improve offers to the primary care workforce.
- Continuing to develop and work closely with PCNs and as an ICS to maximise workforce opportunities and blur the lines of primary and community care e.g. developing more portfolio career GPs, GPNs, post Certificate of Completion Training (CCT) fellowships and apprenticeships.
- Continue to develop and expand our training academies and hubs.
- Robust training needs analysis for our PCNs aligned to demand.
- Maximises funding opportunities.
- Delivery of operational and day to day work required for successful delivery of the STP primary care workforce retention plan.
- The STP will continue to understand what matters to our workforce and provide this insight to commissioners, partners and PCNs. This will help us to shape and invest resources into the right schemes and initiatives. We have also committed to continually innovate, improve and review best practice to develop the STP as a great place to have a career in primary care.

5.10 Anticipated Workforce Challenges

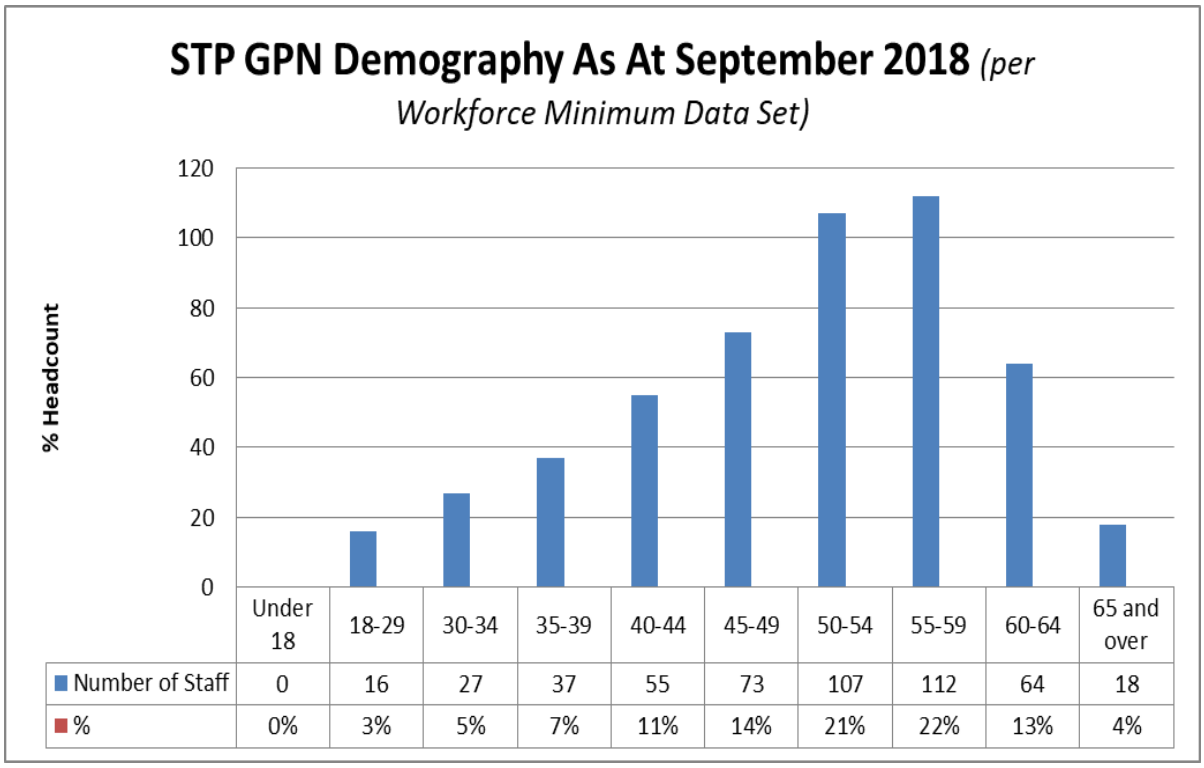
Modelling a trajectory beyond a year is highly complex. However, using HEE modelling techniques the STP will need to have a GP workforce of circa 790 full time equivalent (FTE) GPs by March 2023 to meet predicted demand. Given the past levels of recruitment and retention, as well as predicted retirements this would leave the STP with a forecast gap 47 GP FTEs.

Further analysis of the workforce also shows us that 27% of GPs across the STP (less Registrars) are aged 55 and over and as per HEE modelling guidance likely to retire within the next 5 years. In the STP this represents a headcount of approximately 214 GPs (see table below) which is significantly more than the 21% national comparator figure published in the *General Practice Workforce Final 31 December 2018, Experimental Statistics, NHS Digital:*



STP GP Demographics

We also know that almost 60% of the STP General Practice Nursing workforce aged over 50 with many planning their retirement as the next stage of their lives. The table below clearly shows the lack of a sustainable pipeline should the retirements become a reality.



STP GPN Demographics

The purpose of this strategy is to highlight the STP plans to proactively utilise and maximise every opportunity that the GPFV and PCNs presents to recruit, retain and transform our general practice workforce. This is to ensure that there is the right capacity in the system to ensure primary care can deliver its sustainable model into the future.

In order to meet the ambition for 19/20 and onwards the assumptions are:

- That 60% of GP trainees currently due to complete training in the next 12 months in the Black Country and West Birmingham decide to transition into general practice in the STP (this assumption is based on HEE methodology). This equates to 60 additional full-time equivalent GPs.
- That HEE methodology for forecasting GP retirements is robust (that all GPs currently aged over 55 will retire over the next 5 years). This equates to 41 full time equivalents for the current year.
- That we manage to retain as many GPs through our retention schemes as planned (to help minimise early retirements) and to encourage those GPs that were thinking of leaving the area, UK or profession to stay and enjoy a rewarding career in the Black Country and West Birmingham.
- That we can access at least some IGPRs and maximise other schemes that increase full time equivalent GPs in the area such as the GP Retainer Scheme.
- That we continue to proactively promote and grow the wider workforce and embrace new role opportunities. This will include working in close partnership with system partners to maximise apprenticeship levy opportunities.
- That there will be enough vacant posts available and advertised in practices and networks to recruit to.

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- That the GPN schemes are funded and have the impact of at least retaining the current net number of FTE in the STP.
- That all PCN social prescriber roles are advertised and filled in line with PCN national guidance.

We will be testing these assumptions out through our soon to be developed workforce and drafted nursing strategies to ensure the above are correct. Our Networks will be critical in supporting the changes needed (and we have position these to fulfil this) to make improvements in the health and well-being of our population. We also recognise that there are a number of enablers at our disposal to support delivering this strategy, specifically the Estates and Digital strategies.

5.11 Estates

We know that primary care is at the forefront of demand for services and will continue to be the bed rock of NHS care as part of an ICS. Primary care is more than ever dependent on the provision of modern, fit for purpose and flexible premises from which to operate.

So that we understand where our challenges are (and will be in the future) we recently commissioned the development of a new primary care estate strategy for the four CCG's. Although these are at CCG level we will ensure the main findings are aggregated and considered by the STP.

The table below illustrates an example from Walsall CCG's primary care strategy of an approach used to identify estate challenges.

Drivers for Change	Estates Impact
Population growth	Additional GP practices incorporated within community health facilities wherever possible. Integration of GP and community care at scale, provided through multi-specialty centres
The financial challenge across the health economy must be addressed, but the quality of service must also be maintained	Estate savings and efficiencies needed to assist reduction in spend on infrastructure. Modern, purpose-built premises with bookable spaces for use by many providers will ensure quality of provision
Need to drive efficiencies via closer work with provider organisations	Integrated, multi-specialty healthcare centres provide potential solution, including greater efficiencies in administrative services
Pockets of multiple deprivation, with high levels of high-risk behaviours and multiple conditions	Use of the estate for preventative measures can be achieved through reconfiguration Multi-speciality centres needed for frail elderly and those with Long Term Conditions/Complex needs.

STP Estates Drivers

These estates strategies are scheduled to be completed and approved by the end of July 2019 and this will mark an important milestone in our journey to develop a robust primary care estate plan at ICS, place, PCN, locality and neighborhood level.

At the time of developing this strategy the following should be noted:

- Planning assessments were measured against the main themes within primary care network development and GPFV plans.
- Other relevant STP strategic plans and external factors such as housing development and demographic changes were considered.

As part of this review of our work programmes we identified that we now have more than 40 major schemes either recently completed, approved and in progress, undergoing final approvals and/or in development over the next five-year planning period.

However, whilst this demonstrates excellent progress almost 30 of the potential schemes are targeted for completion by the end of 2022 and therefore require significant input over the next 18 months. Finalising these plans and achieving sign-up and sign-off will often take two years from approval to construction. These timescales represent a challenge in terms of finalising detailed plans for premises whilst the workforce and service models are still evolving.

The STP has identified the following estate challenges:

- Updating the condition, suitability and utilisation database for our 260+ GP practice locations (includes a separate count for all practices working in shared buildings). The STP is in the process of seeking Estates and Technology Transformation Fund (ETTF) funding to commission surveys for our premises during 2019-20 to provide a consistent baseline database and to support the work already in progress to update the *Shape* estate database.
- Our existing primary care estate programme development costs are funded through a combination of the ETTF programme and business as usual funding. We face a significant challenge as a system to fund the circa 30 major improvement and development schemes both for primary care and for hub developments, where a financial commitment is required from multiple organizations. The STP will jointly prioritise and agree the funding for these in line with our estate strategies.
- The STP also has a strong financial and organisational responsibility to ensure the whole primary care estate is fit for purpose, has appropriate capacity and achieves the best possible value for money. To achieve this, the STP will promote smart, generic space design through its proactive project review and approval process.
- The size and configuration of premises will be directly influenced by: the current and projected patient numbers, need for generic clinical rooms, the changing nature of our primary care workforce and the drive to employ more GPs and other clinical and support staff.

This will significantly impact on the number and design of clinical rooms and other facilities in the future as, for example the length of consultations and patient flow through the new PCNs will increasingly vary as we move away from the traditional GP consultation model. To support us in managing this we will:

- Introduce agile administration spaces across our primary care schemes and more general estate.
- Further develop our new primary care estates management model as part of the developing joint commissioning arrangements.
- Ensure that the estate utilised by providers is fit for purpose and demonstrates best value for money and that costs are reduced wherever feasible.
- Work with Local Authority partners to confirm the housing development programme and plan for the impact on the local population, including considering demographic changes and local needs. This includes work to ensure systems are in place to obtain funding through Section 106 and the Community Infrastructure Levy across all our local authority partners.
- Work to improve our relationships with NHS property services and community health partnerships to improve the management and development our estate.
- Develop systems to improve utilisation and address void spaces across our primary care estate.
- Continue to focus on potential premises and land disposal opportunities resulting both from our primary care estates changes and developments and opportunities arising from the emergence of new service models.

The STP anticipates that by planning additional estate capacity it will cope with population growth to the mid 2020's. This should improve utilisation and be enough to allow the rollout of digitisation, to establish appropriate systems to absorb general population growth and demographic changes for a number of years. However, this does not include the impact of other out of hospital service developments where more services and activity are provided in the community.

Our estate plans will remain as live documents as local planning continues to evolve. This will be managed and delivered in line with our governance form.

5.12 Digitisation

Utilising digital solutions to support primary care systems and staff to be able to manage the ever-growing pressures they face is a key consideration for our STP. Exploiting new systems and solution, such as virtual consultations and unified care records, will benefit the workforce by easing the pressure on how and where they see people. Digitisation will support people in embracing new ways of accessing services that are convenient to them.

Creating an STP wide digital infrastructure that works across partners cannot be delivered easily. The numerous challenges that the STP face are:

- Identifying current and legacy systems and how they interact with one another i.e. how systems integrate or operate together.

- Developing skills sets of staff and patients and keeping up to date on new digital systems and solutions. This includes how we deliver ongoing investment in training and development and how we release staff to continually do this.
- How we empower our population to adopt digital approaches to support their care.
- The magnitude in resource requirements (both costs and people) in creating a digital infrastructure for example how we replace old or out-dated equipment and access to systems.
- How we introduce new systems and processes.
- How do we use data and information to make smarter decisions.
- How we adopt new technologies that cut across clinical care delivery.

Approximately 12 months ago each STP area developed individual locality based digital roadmaps. These were used to demonstrate how digital solutions would be considered for each of the respective areas. The main themes were reviewed as an STP and aggregated to develop an STP wide digital strategy. This strategy outlines the aspirations for a 'digitally connected black country health and social care system' that enables self-care and promotes wellbeing'.

We underpinned our approach by developing 6 core principles which created the rules guiding the STP. These are:

STP Digital Principles

The STP has also agreed our main areas of focus in developing the digital landscape across the next 5 years:

- Empowerment; Using technology people can access and contribute to their health and care record.
- Infrastructure; A resilient infrastructure across the STP which enables access to information to support decision making (place-based working).
- Integration; With the enabling economy wide infrastructure, standards and principles being a fundamental requirement for the interlinking of systems. Standards adopted nationally with the appropriate information governance framework and agreements eliminate organisational and regional boundaries to wider digital interoperability.
- Intelligence; Development of robust business intelligence across the STP to support decision making and identification of best practice models leading to improved care.
- The below blueprint shows our areas of focus, across the digital agenda for the next 5 years. Delivery of each of these areas will be through the STPs programme and PMO structure.

	Place Based Teams (Vertical Integration)	Horizontal integration	Mental Health & Learning Disabilities	Maternity & Infant Health	Workforce Transformation	Infrastructure
Interoperability	Connected Clinical system providing consolidated view of the patient in the context in which the patient is being viewed	Develop shared IT solutions to support Back office, histopathology and microbiology and interventional radiology service	Working to have a shared a consolidated view of the patient in the context in which the patient is being viewed across the Black Country		Consolidated view of the patient in the context in which the patient is being viewed accessible from multiple locations	Development of systems to support
Workforce and patient engagement			Development of Patient Portal to access Primary Care and Secondary Care Information	Development of Patient Portal to access Primary Care and Secondary Care Information		Development of Patient Portal to access Primary Care and Secondary Care Information
Collaboration	Connected Clinical system and shared care record	IT Infrastructure development to support consolidated Back office function			Clinical access to a consolidated view of the patient in the context in which the patient is being viewed	Development of optimised patient access in the Black Country
Access/Reach	IT Support of integrated place based teams				Provision of a Patient portal to shared care record	Interconnected Black Country network infrastructure
Apps and Tools					Access to Clinical apps via mobile devices	Infrastructure to support apps and wearable technology

STP Digital Blueprint High Level Programmes

Element 4 goes into further detail on our digital aspirations.

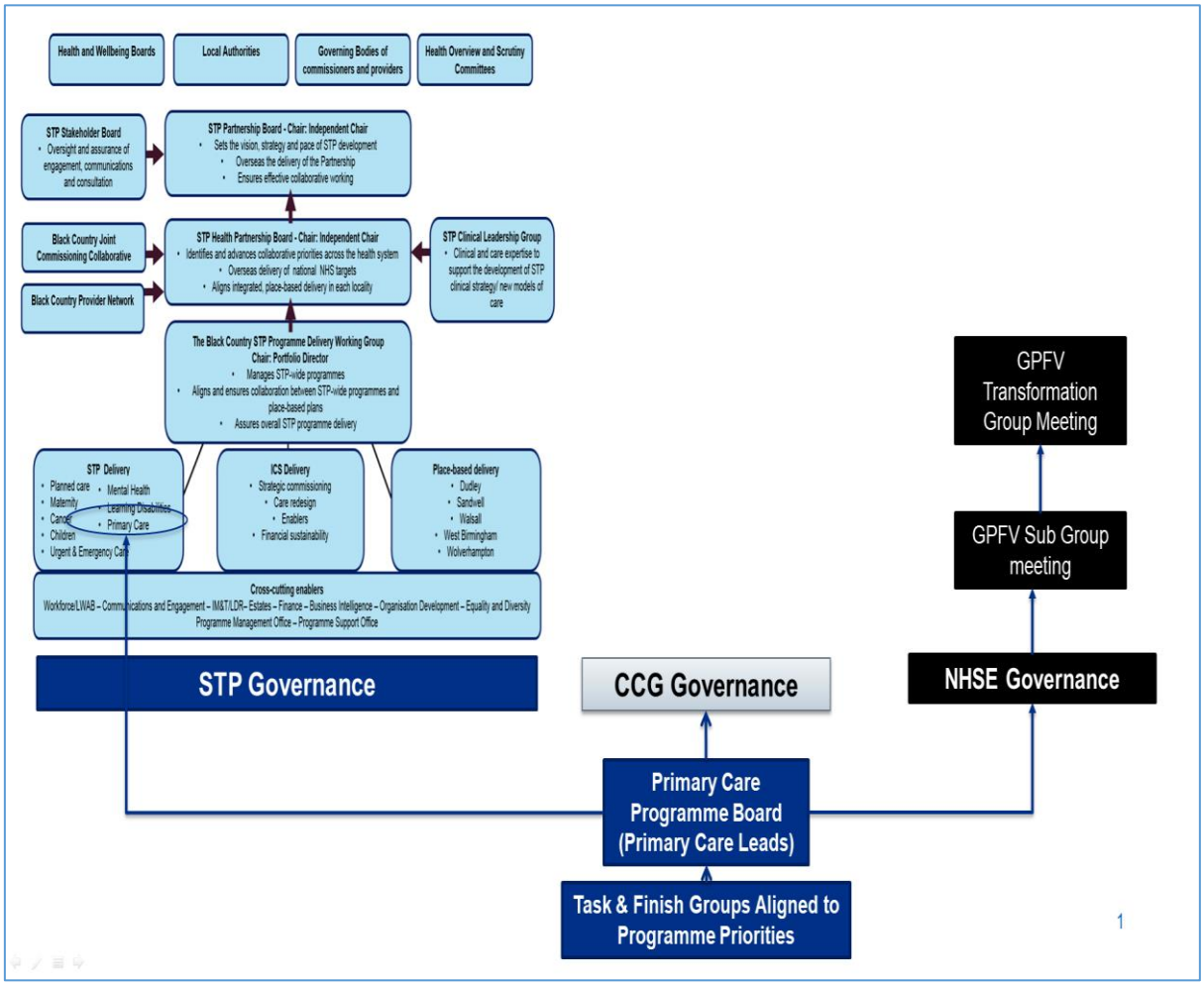
6 Fulfilling the NHS Long Term Plan

6.1 STP Memorandum of Understanding (MOU)

The STP leadership team has made a strong commitment, as both individual organisations and as the STP to support delivering the requirements for primary care as laid out in the Long-Term Plan. This commitment is enacted through the jointly agreed MOU which is based on the principle that the STP will *'provide a mechanism for securing the Parties agreements and commitment to sustained…delivery of STP plans…to realise a transformed model of care across the Black Country and West Birmingham".* The MOU's purpose is clear; it binds the parties to the common purpose of delivering a clinically, socially and financially sustainable health and care system that will improve the health and wellbeing of the population and address inequalities. However as noted this requires the parties to recognise the scale of change required and that its impact may be differential on the parties. The MOU recognises the role of primary care and affirms its intention to work for the benefit of the whole system not simply that of partner and associate members (see Appendix 5 for full details of the MOU).

6.2 Governance

The STP has well established programme governance of which primary care is a key component. This is shown in the below diagram - *Black Country & West Birmingham STP Governance Structure at May 2019*



Black Country & West Birmingham STP Governance Structure at May 2019

The Primary Care Programme Board (PCPB) fulfils the primary care STP delivery function of the STP programme and works to a current Terms of Reference (TOR) (see Appendix 6 for full details of the TOR).

The programme has a senior responsible officer, programme director and programme manager leading and delivering the GPFV programme of work in partnership with primary care commissioning leads from across the STP. The programme has a structured programme management approach with robust plans and project documentation prepared and reviewed monthly by primary care leads, the STP PMO and NHSE via the Regional GPFV Transformation Groups.

Delivery of the primary care element of the programme continues to develop at pace through a number of task and finish groups. These focus on the delivery of core elements of the programme such as; workforce retention and the co-design of specific GPN schemes, PCN implementation and clinical pathway transformation. Other enabling programmes of work across the STP such as estates and digital also contribute to the delivery of the overall programme. These groups operate within the wider programme and produce specific plans and other project documentation such as risk/issue logs. These will report into the STP Primary Care Programme Board for governance purposes.

In terms of funding allocations, the STP has a well-established process of receiving and accounting for funding via the STP host organisation as evidenced by the processes in place to receive and account for £450k of GPRISS funding in 2018/19. As part of the of the primary care programme Board financial plans for funding allocations are developed and decisions ratified by each CCG PCCC and/or Governing Body. Financial monitoring statements are prepared monthly and reviewed by the Board.

The STP is developing a metrics dashboard *(see section 11 of this strategy)* as one method of reporting and monitoring the impact of the programme over time. Recognising that many of the schemes that this strategy covers will take time to impact on the dashboard e.g. increasing numbers of GP, the STP will also utilise other techniques to evaluate schemes such as case studies, targeted surveys and events, all of which will be reported as part of the STP communications strategy.

6.3 Transformation and Programme Development and Delivery

The STP has adopted a joint management and stakeholder approach to how it identifies cross-system programme areas and how it plans delivery of any associated programmes and projects.

This is important as it aligns STP partners to the outcomes expected for large scale change programmes such as implementing PCN's. This helps to create an environment where service co-production can work and although one organisation might be the lead, it would be recognised that it is for the STP to support and align resources, if needed to take corrective actions.

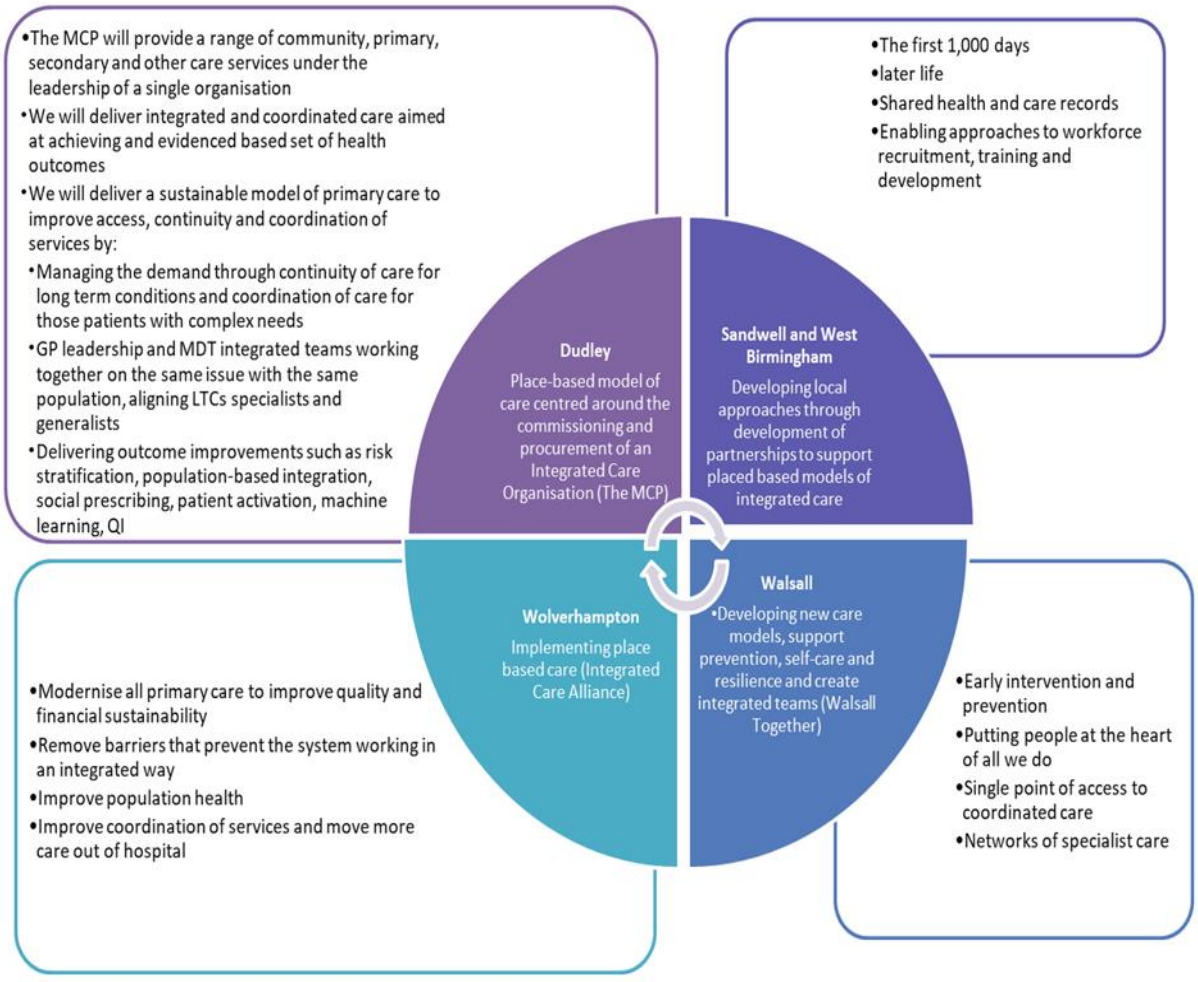
7 Key element 1 - We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services

7.1 Current Situation

Our local place is a fundamental foundation in delivering an ICS across the Black Country and West Birmingham. Being able to define and articulate delivery and provision of care at the local place is critical to us in delivering the right structure across a larger setting.

We have in each of our STP areas developed and implemented local place-based models of care for example MCPs. These aim to deliver improved access to local services for our population, greater continuity of care for those with ongoing conditions and more coordinated care for those with the most complex needs. This work is consistent with the STP intention that integrated care will provide services that are delivered in the right place and at the right time to those who need them.

The main initiatives and their key priorities underway in each area to support integration and develop our primary care infrastructure are:



Integration Programmes by STP CCG

Each place based integration model across the STP will work to the same overarching principles and a consistent set of outcomes. These are shown below:

STP Aligned Principles

As partners we are working collectively to integrate services and through this dissolve traditional barriers between all sectors within the STP. However, this will not be achieved over night and will require all system partners to change. We have committed to use all the enablers we have at our disposal to make integration a reality:

- We will use our commissioning strategy as a lever for change. We recognise the unique opportunities this allows, and the innovative approaches that will support this strategy.
- Through our introduction of PCNs we will be able to support local decisions on how services are provided and support network and neighbourhood-based delivery models.
- Through our approach to place-based care we will promote integration and joint working with local authority and social care colleagues. Joint working and where appropriate joint appointments will be encouraged.
- We will undertake system transformation across all partners to re-enforce a one system principle, for example we are introducing new urgent community response and recovery support teams within areas. Made up from primary,

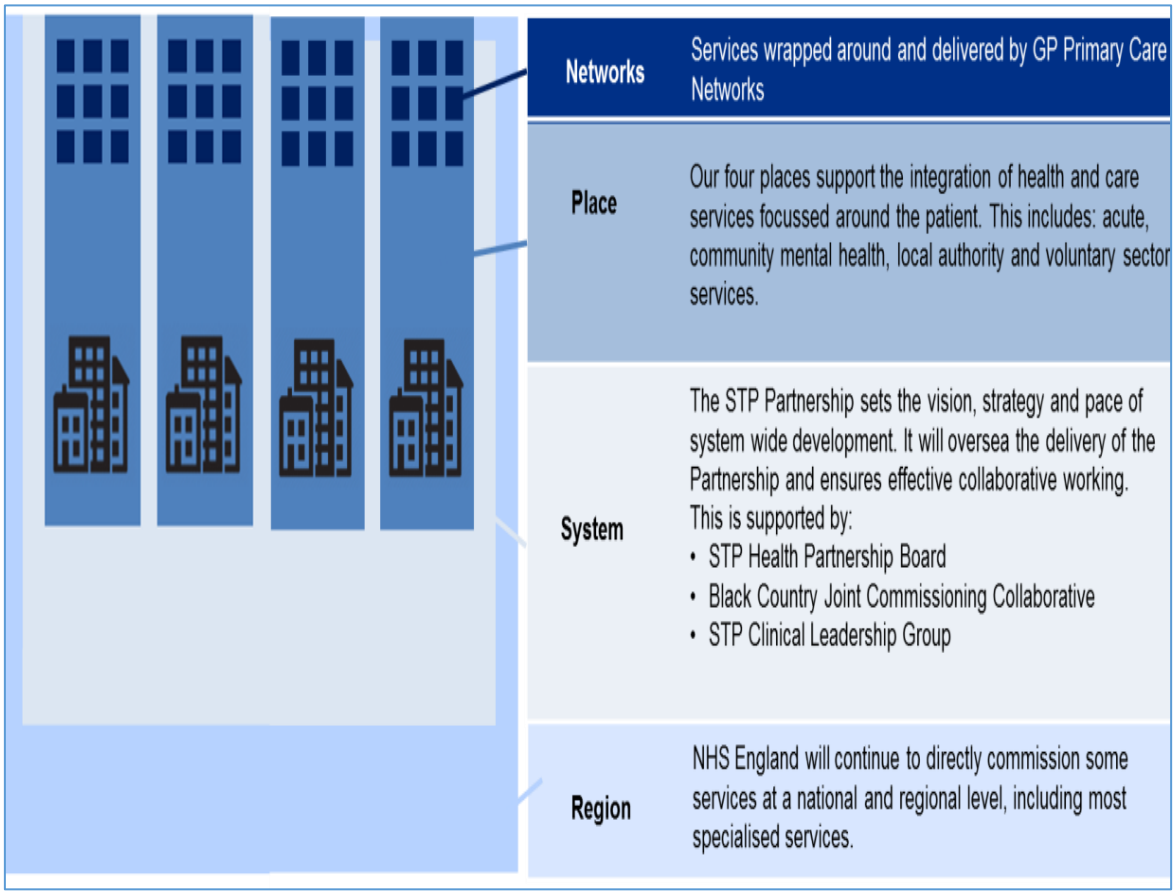
community and intermediate care teams this will increase the capacity and responsiveness of our services to those who need it.

- We have expanded our community MDTs which will align with PCNs, based on neighbouring GP practices. This will result in fully-integrated primary and community-based healthcare. People living in care homes will receive guaranteed NHS support and our population will jointly be supported to age well.
- Working with CCGs, local authority and other system wide partners, we will seek to make joint decisions based on shared intelligence and joint resource allocation. Artificial system barriers will be overcome to allow person centred care to be the focus of our approach.

7.2 How our Services will be integrated

As shown above there are various mechanisms being used to support integration. In addition there are strong governance and programme frameworks in place. Through these approaches we will plan system-wide services that are based on need and place and not on individual organisational pathways that often do not interconnect.

The diagram below shows how we see our networks working with and being supported by other partners/providers to enable integration:



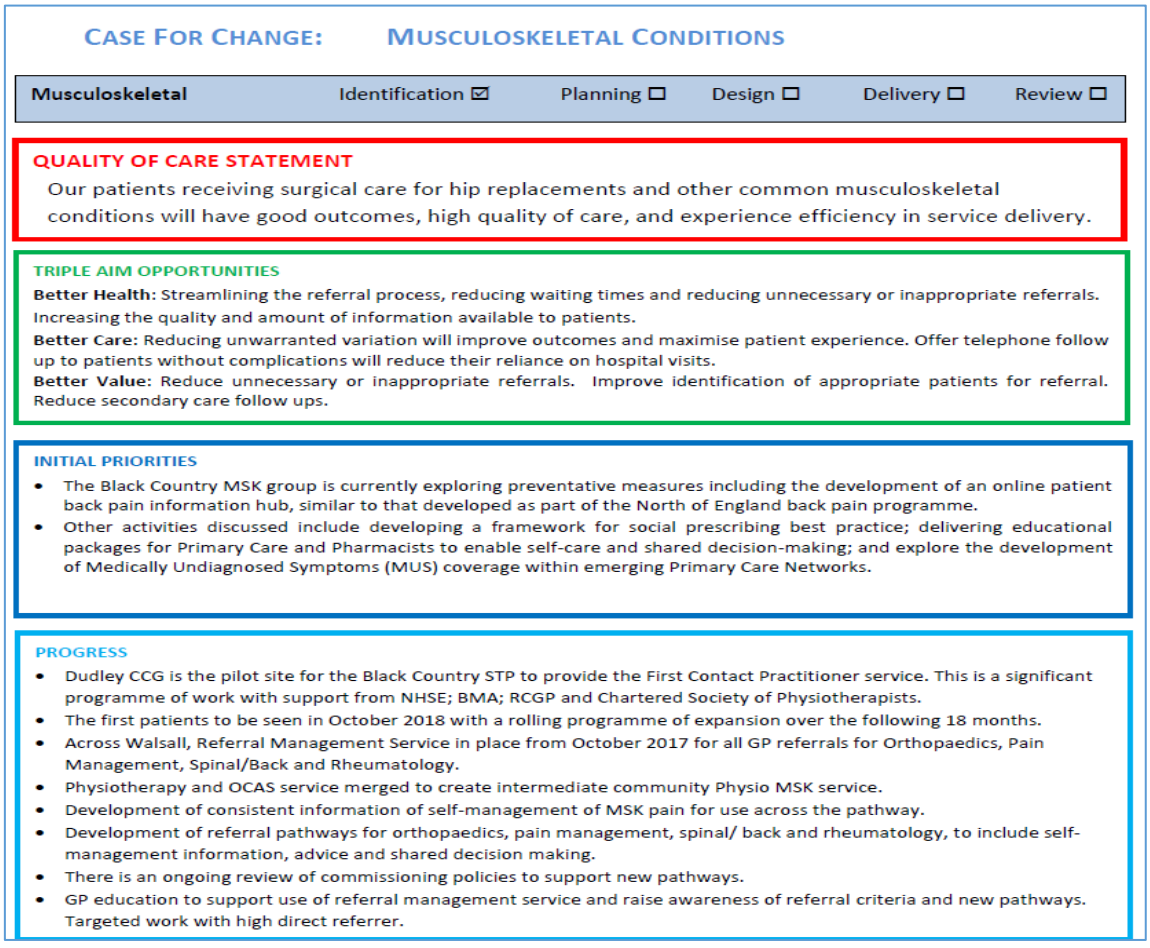
STP PCN Integration

Within our network we will include traditional community (and some secondary) services so these can offer a greater range of service in primary care. This includes:

- Mental health and wellbeing.
- Contraceptive and sexual health advice.

- Education and delivery of public health programmes.
- Screening and immunisation provision.
- Managing and supporting long-term conditions.
- Positive lifestyle changes.
- Health promotion, protection and screening.
- Travel advice.
- Management of risks (drugs, alcohol, weight management, smoking cessation).
- Managing acute events.
- Long-term conditions including exacerbations and continuing care.
- Medicines management.
- Triage

An example of how we have begun to do this is through our STP Musculoskeletal steering group. This group has representatives from partner organisations across the Black Country and West Birmingham. This group has co-designed the new model of care starting at the beginning of the individual's pathway i.e. prevention and lifestyles support through to, if needed surgical intervention. The case for change is shown below:



CASE FOR CHANGE: MUSCULOSKELETAL CONDITIONS

Musculoskeletal	Identification ☑	Planning ☐	Design ☐	Delivery ☐	Review ☐

QUALITY OF CARE STATEMENT

Our patients receiving surgical care for hip replacements and other common musculoskeletal conditions will have good outcomes, high quality of care, and experience efficiency in service delivery.

TRIPLE AIM OPPORTUNITIES

Better Health: Streamlining the referral process, reducing waiting times and reducing unnecessary or inappropriate referrals. Increasing the quality and amount of information available to patients.
Better Care: Reducing unwarranted variation will improve outcomes and maximise patient experience. Offer telephone follow up to patients without complications will reduce their reliance on hospital visits.
Better Value: Reduce unnecessary or inappropriate referrals. Improve identification of appropriate patients for referral. Reduce secondary care follow ups.

INITIAL PRIORITIES

- The Black Country MSK group is currently exploring preventative measures including the development of an online patient back pain information hub, similar to that developed as part of the North of England back pain programme.
- Other activities discussed include developing a framework for social prescribing best practice; delivering educational packages for Primary Care and Pharmacists to enable self-care and shared decision-making; and explore the development of Medically Undiagnosed Symptoms (MUS) coverage within emerging Primary Care Networks.

PROGRESS

- Dudley CCG is the pilot site for the Black Country STP to provide the First Contact Practitioner service. This is a significant programme of work with support from NHSE; BMA; RCGP and Chartered Society of Physiotherapists.
- The first patients to be seen in October 2018 with a rolling programme of expansion over the following 18 months.
- Across Walsall, Referral Management Service in place from October 2017 for all GP referrals for Orthopaedics, Pain Management, Spinal/Back and Rheumatology.
- Physiotherapy and OCAS service merged to create intermediate community Physio MSK service.
- Development of consistent information of self-management of MSK pain for use across the pathway.
- Development of referral pathways for orthopaedics, pain management, spinal/ back and rheumatology, to include self-management information, advice and shared decision making.
- There is an ongoing review of commissioning policies to support new pathways.
- GP education to support use of referral management service and raise awareness of referral criteria and new pathways. Targeted work with high direct referrer.

Case for Change MSK

7.3 Workforce Configuration

As highlighted through this document we will develop a 10-year workforce strategy for the STP (2019/20). This will incorporate requirements for acute, community, mental health and primary care. It will reflect the requirements of new care models across the STP, such as the PCNs supported by additional investment in community and primary care services, as described in the STP's medium term financial plans. The plan will also describe the STPs approach to:

- Recruitment of new workforce, both medical and non-medical.
- Training and education.
- Retention of current staff.
- International recruitment.
- Enhancing productivity.
- Leadership and talent management.

As also stated within this strategy we are investing heavily in developing our primary care workforce. This is through development of new roles, funding and STP wide training and development as described in earlier sections.

7.4 Service Delivery

Each of the four areas has a formal structure in place which supports them to deliver programmes seen as critical in shifting appropriate services out of hospitals. These structures also support integrated working (the above being one such example). These programmes report up through the STP governance structure, so the system can be assurance that progress is being made.

We have started to jointly plan service changes so, as an STP we can ensure that any proposals consider impacts and benefits on out of hospital care.

Each of our places aims to deliver an integrated, responsive and innovative primary and community care service.

This approach will enable stronger integration of primary care with other services, as our GPs are supporting co-ordination of the care provided to their patients in collaboration with other services. One of the main approaches that will enable this is the use of MDTs to co-ordinate a person's care (see Appendix 4 for Case Studies: MDT Working).

Over the next 12 months we will continue to evolve and integrate teams to become part of the wider primary care health team and continue to mature our PCNs.

The CCGs are already working collaboratively within the STP, taking consistent approaches to the way in which we commission and develop primary and community care. Some examples of what we have undertaken are:

- Collaborative workforce planning.
- Bidding and securing additional resource to support training and development of primary care staff to manage more complex care.
- Joint working with the Black Country and West Birmingham training hub to implement our GPFV plans which supports appropriately diverting the flow of patients out of hospitals.

In 2019/20 we will:

- Contribute to the development of the STP primary care strategy including network formation and maturity.
- Contribute and lead on specific projects on behalf of the STP.
- Identify areas for a common approach to the commissioning or contracting of services across the STP.
- Identify and develop common approaches across care pathways and service developments. This includes how we further integrate the workforce.

We have identified that we need to employ other enablers to develop out of hospital care and further integration between services. We will use technology to achieve this. The Long-Term Plan identified a move towards improved access for patients, meaning patients will need (and have) better access to their health care records.

We will facilitate this through a number of solutions including:

- Deployment of integrated online triage solutions that are accessible via a number of pathways. They include the NHS app and other third-party apps available within each CCG.
- Directly through the patient access portal on the GP practices websites.
- Improving patient choice will be further expanded through the deployment of online video consultation solutions. This is being piloted in Wolverhampton and Dudley and will provide choice to patients in the type of consultation they receive. It will also support patients who struggle to access services at the practice but would be able to access them from home.

Driving improvements in patient care is at the forefront of our digitisation programme. Having a Shared Care Record (SCR) across the STP will allow health and social care professionals to give much better continuity of care as patients move between partner services.

7.5 Governance

Please see sections 6.2 for an overview of our governance structure. This will be applied to each key element within this section.

7.6 Resourcing

Please see section 13 for the detail on funding and resource issues and proposed, projected spend.

8 Key element 2 - The NHS will reduce pressure on emergency hospital services

8.1 Current Situation

Across the STP emergency admissions for frailty and ambulatory care sensitive conditions are amongst the worst in the country. In 2014/15, there were 28,530 admissions for ambulatory care sensitive conditions costing £57.6m (identifying potential QIPP opportunities, MLU Strategy Unit, 2015).

Although this pertains to a small cohort of patients, the current ways in which services are provided result in us spending a large proportion of our resources inefficiently. Effective care planning and considering the whole needs of the individual is essential. Ensuring all staff work together to plan and support an individual's care brings with it a number of benefits. These include; helping people maximise the use of existing networks in their communities and reducing social isolation as we know these are drivers of hospital attendances. We have introduced a number of initiatives aimed at reducing emergency department pressure. These are:

Our A&E Delivery Board has developed and established a workstream which looks to reduce pressure on emergency hospital services. Workstream 2 - Pre-Hospital Urgent Care and Attendance Avoidance

The main interventions within this workstream are:

- Development of an MDT rapid response service.
- Continued implementation of the high intensity users and complex cases programme. This is reducing attendance at A&E by a cohort of patients who attend A&E most frequently.
- Extending the support of the care homes nursing support team to further reduce conveyances from care homes to the emergency department.
- Enabling ambulance crews to make contact with the NHS 111 Clinical Advice Service (CAS) to prevent avoidable conveyance to hospital.
- Engaging those GP practices whose patients have the highest utilisation rates of urgent and emergency care services to seek a reduction in unwarranted variation.
- Optimising the degree of flu vaccination implementation and up-take.
- Extending enhanced access to primary care.

Another major intervention we are working toward (to be implemented during 2019/20) will be a single point of access for urgent community response. This will clinically triage referrals from GPs, ambulance crews and the NHS 111 CAS, and co-ordinate the response of community resources. The aim of which is to prevent avoidable hospital admission.

We have been enhancing our primary care infrastructure through the introduction of networks and new finance and contracting models. For example, we support our networks to adopt additional, enhanced services (via DES and other mechanisms). These will improve primary care access and opening times and provide more traditional hospital specialist services that manage patients through MDTs, who have more complex health and social care needs.

We will also support this through a targeted programme of primary care investment. With our proposed extra investments of £25m to GP services by 2021 we will:

- Have an extra 25,000 primary care appointments a year made available.
- Ensure all children under 5 and adults over 75 will be guaranteed same day access to GP appointments, meaning 200,000 people will be able to see a family doctor when they need to.
- Change the flow of care so over 1,000 people a month, who turn up at A&E, will be able to have their problem assessed and treated by a GP, reducing waits and improving care.
- By 2021, over 100,000 people will be saved a trip to hospital for their outpatient care, with more treatment offered in PCNs.
- Collectively we have discussed and agreed common sense changes to the way our GPs, hospitals and care services work together. This will reduce the number of people visiting A&E by 3,000 a week by 2021 through adoption of new care models e.g. PCNs and partnerships meaning faster treatment and care for the most seriously ill.
- Recruitment of additional pharmacist support within practices and networks, addition of a repeat prescribing function and commissioning link workers has assisted practices in providing a strong social prescribing function.
- By 2021, instead of having to be admitted as an emergency to hospital, an extra 1,000 people each week will be cared for in their own home or local community by doctors, nurses and paramedics.

Having a strong primary care infrastructure so patients can access the care they need will help to reduce the pressures on hospital emergency departments.

8.2 The Role of Primary Care

The STP has (and continues to) actively promoted primary and community-focused alternatives to hospital for unplanned care (using models identified above). Within the STP there has been a planned diversion of resources into pathways designed to prevent hospital attendance and increase acute capacity for those requiring acute care. We have:

- Commissioned improved access over and above the General Medical Services contract.
- Developed MDT reviews in primary care of patients with long-term conditions.
- Introduced extended hours access to primary care across practices.
- Additional primary care sessions during bank holidays.

- Developed Urgent Treatment Centres (UTC) to more appropriately manage primary care patients who attend the acute site.
- Integrated NHS 111 with the UTC to allow direct booking of primary care appointments as an alternative to emergency department attendance.
- Established an MDT to support care and nursing homes through enhanced training and rapid support at times of exacerbation.
- Created a high intensity user service to support patients who frequently access the urgent care system, to identify services to meet their long-term needs.
- Commissioned community capacity for those requiring social care assessment for long-term needs, either to avoid admission to hospital or allow more rapid discharge.
- New community-based beds for patients who are unable to weight-bear but do not need to be in an acute bed.

8.3 Workforce

As highlighted through this document we will develop a 10-year workforce strategy for the STP (2019/20). This will incorporate requirements for acute, community, mental health and primary care. It will reflect the requirements of new care models across the STP, such as the PCNs supported by additional investment in community and primary care services as described in the STP's medium term financial plans. The plan will also describe the STP's approach to:

- Recruitment of new workforce, both medical and non-medical.
- Training and education.
- Retention of current staff.
- International recruitment.
- Enhancing productivity.
- Leadership and talent management.

As also stated within this strategy we are investing heavily in developing our primary care workforce. This is through development of new roles, funding and STP wide training and development as described in earlier sections.

8.4 Service Delivery

We are seeking to make a stepped-change in the way we commission emergency and urgent care services. We will do this through a focus on ambulance services, as the key shared connecting service that operates across the system and its interface with all other providers and, through the strengthening of our primary care services.

We commission ambulance services jointly across the West Midlands and, in partnership with them we intend to change the way this is undertaken in the future. However, as part of this we also intend to develop the Black Country and West Birmingham model for emergency and urgent care. This sets out how services will be able to interface with each local hospital and PCN to improve the experience of patients, reduce avoidable attendances and provide enhanced care to people in the community. To support this, we have so far:

- Improved the standards and the quality of primary care.
- Enabled patients to have better access to services, with better continuity and co-ordination of their care.
- Enabled primary care to develop and integrate with the MCP.
- Collaborated across the Black Country and West Birmingham to support sustainable and resilient primary care.
- Improved access to primary healthcare clinicians through PCN development.
- Reduced unplanned hospitalisation for chronic ambulatory care sensitive conditions.
- Reduced in hospitalisations for asthma, diabetes and epilepsy in under 19s.

We have, throughout the pages of this strategy rehearsed how our primary care services will change to support delivery of new models of care and the Long-Term Plan. In much the same way as key element 1 we have also implemented, through our STP clinical strategy, a programme of work focused on delivering better urgent and emergency care. The progress and outcomes for this programme and individual projects are managed within our overarching programme structure.

As previously stated we have an STP wide approach to how we use digitisation to support primary care. We will however ensure a focus in the next 12 months on enhancing access for patients through the NHS 111 service. The main priority within this key element is implementing IT systems that allow access to the NHS 111 service so that organisations can book patients directly into general practice appointments at practices avoiding an unnecessary attendance to an emergency department.

8.5 Governance

Please see section 6.2 for an overview of our governance structure. This will be applied to each key element within this section.

8.6 Resourcing

Please see section 13 for the detail on funding and resource issues and proposed, projected spend.

9 Key element 3 - People will get more control over their own health and more personalised care when they need it

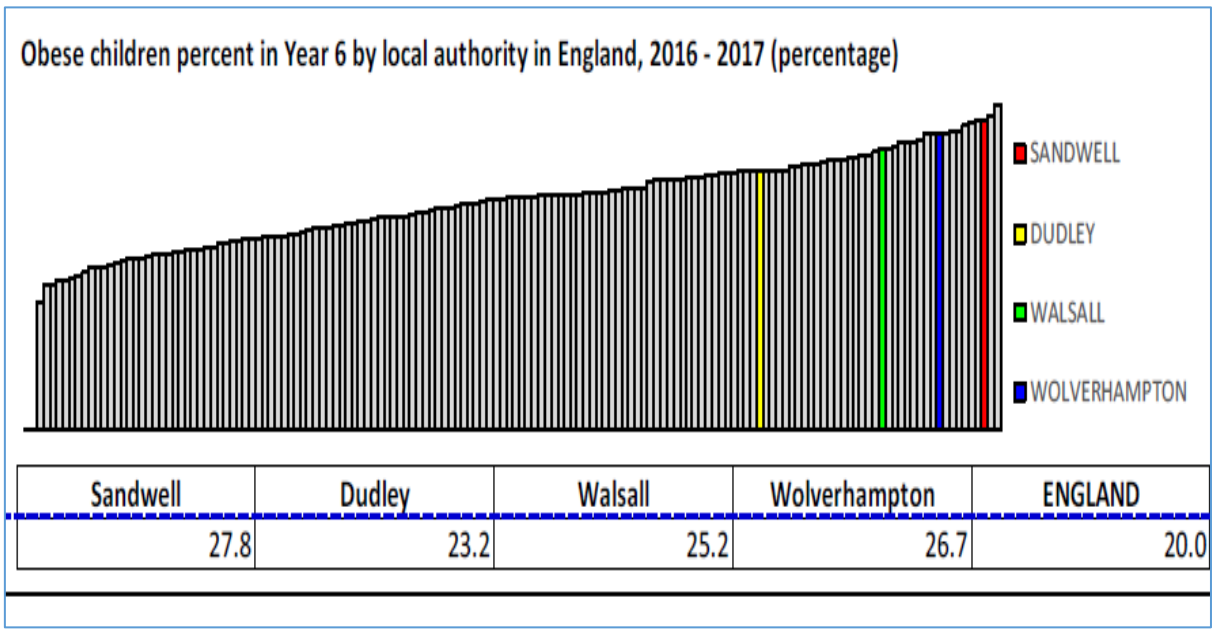
9.1 Current Situation

Our public have told us they want:

STP Patient Feedback

We agree with everything above and to create a better future for our population, we must change the way we do things. This means providing more preventative care in new and innovative ways whilst keeping the local feel that patients want.

We need to provide support in locations that are more suitable and easier to access such as local health and community centres and in other, less common environments such as supermarkets and libraries. We need to use all the enablers we have to meet people's lifestyle needs. For example, using digital and technological mediums such as remote care monitoring and lifestyle management apps so that people can access the support they need when they need it. However, this is easier said than done when you consider the challenges we face as a system. The below is a snap shot of how we compare to the England average across a number of lifestyle and prevention measures.



Sandwell	Dudley	Walsall	Wolverhampton	ENGLAND
27.8	23.2	25.2	26.7	20.0

% Obese Children Compared to National Average

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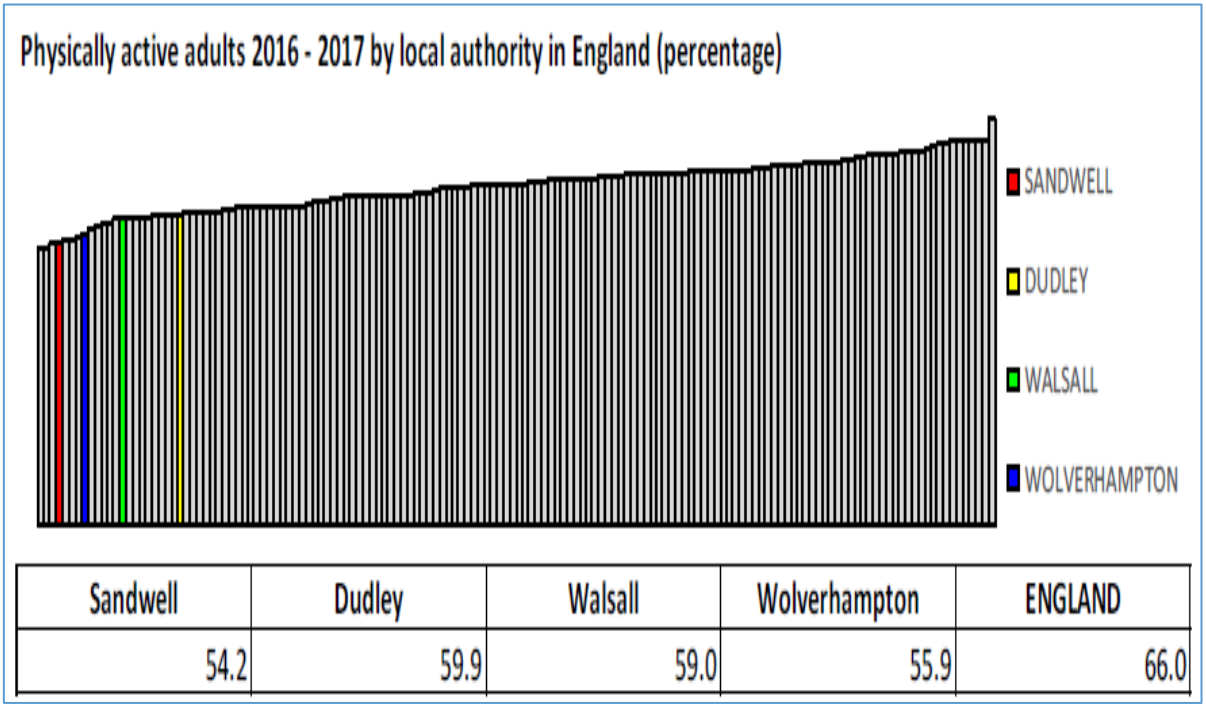


Sandwell	Dudley	Walsall	Wolverhampton	ENGLAND
54.2	59.9	59.0	55.9	66.0

% Active Children Compared to National Average

It cannot just be down to health and social care partners to manage patient's health for them. However, we do need to create a system which gives the population opportunities to access the support they need, when they need it and in a way that is easy for them.

The STP has committed to achieving a positive step change in population health & outcomes. We will achieve this through integrated, standardised place-based services built around the registered list which deliver both patient-centred and population-centred care. These will also be commissioned based on outcomes not activity. Specifically:

- We will support patients taking control of their own health plans where possible, empowering patients to live a healthy life is vital to this.
- We will close the gap between life expectancy and disability free life expectancy, so our population can enjoy longer lives with less health-related problems.
- We will promote improved outcomes through clinical intervention and health and lifestyle improvements. We recognise there are a number of areas that are impacting on the health of our population. Some will be addressed by education, some by social change and some by lifestyle change.

9.2 Role of Primary Care

Personalised care is one of the five major practical changes to the NHS that will take place over the next five years, as set out in the NHS Long-Term Plan. Primary care and PCNs are well place to support individuals to manage their own personal health and care. Primary care will play a pivotal role in this in a number of ways including:

- Implementing social prescribing within PCNs (this has begun across the STP).

- Expanding on good practice models such as health coaching and programmes such as Make Every Contact Count.
- Introducing Shared Decision Making (SDM) with patients.
- Ensuring that patients have personalised care plans where appropriate concentrating on "*what matters to me*".
- Ensuring a co-ordinated, multi-disciplinary approach to managing personalisation is in place at both a universal and targeted level.

As a system we also need to ensure we build on the learning we have undertaken to support how we drive personalisation. For example, Dudley CCG was chosen to be an NHS England demonstrator site for personalised care in 2018/19. This meant:

- All patients with long-term conditions having personalised care plans undertaken as part of the Dudley Quality Outcomes for Health Framework. This resulted in holistic reviews and care plans being undertaken for 15,000 patients by the end of 2018/19.
- Health coaching and Patient Activation Measures (PAM) being piloted in three of their practices.
- Dudley stroke association going live with PAM in April 2019 and Dudley MBC using PAM for their self-management programmes.
- Dudley is expecting to rollout health coaching and PAM to all the PCNs.

We need to spread the learning and adoption of what worked well across the wider system and learn from what we could have done better. These types of principles are how we see integration supporting us to create a better health and social care landscape across the STP.

9.3 Workforce

As highlighted through this document we will develop a 10-year workforce strategy for the STP (2019/20). This will incorporate requirements for acute, community, mental health and primary care. It will reflect the requirements of new care models across the STP, such as the PCNs supported by additional investment in community and primary care services as described in the STP's medium term financial plans. The plan will also describe the STP's approach to:

- Recruitment of new workforce, both medical and non-medical.
- Training and education.
- Retention of current staff.
- International recruitment.
- Enhancing productivity.
- Leadership and talent management.

As also stated within this strategy we are investing heavily in developing our primary care workforce. This is through development of new roles, funding and STP wide training and development as described in earlier sections.

9.4 Service Delivery

We have adopted an approach to delivering our STP wide personalisation agenda based on 6 nationally recognised evidence-based components. These include:

- Shared decision making.
- Personalised care and support planning.
- Enabling choice, including the legal rights to choose.
- Social prescribing and community-based support.
- Supported self-management.
- Personal health budgets and Integrated personal budgets

We have introduced a programme management structure to help drive delivery of the above evidence-based components. These programmes will be managed as per our programme delivery and governance structures. Examples of what we have delivered so far are:

- We have strengthened our focus on this agenda by appointing a senior STP executive to oversee this programme from Sandwell and West Birmingham Hospitals. This will ensure there is the seniority within the system to be able to challenge partners, agree decisions at the STP Board and act as an advocate and champion for this very important agenda.
- We are 'choice' compliant across all four CCGs as at February 2019 (SWB resubmitting self-assessment).
- We have PAM MOUs in place/soon to be in place at all CCGs with affiliate agreements planned/in place for 25 general practices who will be trained in health coaching.
- We have developed the Black Country and West Birmingham health coaching-training model and have 22 social prescribing link workers in place/being recruited/being secured through business case approval.
- Sandwell and West Birmingham has bid for funding to be made available through the Better Care Fund to further support our social prescribing aspirations. We have, as part of this, agreed that business cases can be shared to other sites to help them shape and develop their social prescribing offer.
- We have secured agreements that all four CCGs will offer Personal Healthcare Budgets (PHBs) as default for Continuing Healthcare patients from April 2019 and we continue to develop our PHB offers in Mental Health (as per section 117) and Personal Wheelchair Budgets (PWBs). We expect to see a growth in PHB numbers through the life of this strategy.

(See Appendix 4 for Case Studies: Social Prescribing)

We have, as highlighted above, implemented a number of projects to support our population across a number of aspects of prevention. Going forward our aim is that we:

- Progress Policing and Community Safety Partnerships (PCSP)/ health coaching training programme across the entire STP.

- Deliver two strategic co-production events for people across the STP so they are aware of the work we are undertaking to support them in managing their own health and well-being.
- Strengthen peer support offers by using outputs from peer support mapping and commission facilitation training for groups through the four local Community and Voluntary Services.
- Engage with commissioners over strategic direction and ensure contracts support on-going personalisation.
- Plan and deliver a training programme for health coaching and personalised care support through the year.
- Explore PHBs for high intensity users and integrated personal budgets for children and young people with Education Health and Care (EHC) plans.

(*See Appendix 4 for Case Studies: Health Coaching).*

Recognising that digital solutions play an important part in patients managing their health and well-being we have, as part of our overarching digital strategy, identified several key initiatives we will implement over the next 2 years.

These are:

- Introduction of GP online consultations. This project is backed by national funding and has been deployed across all four STP Localities. This supports patient's access services via apps and directly through their practice websites.
- We have piloted support for patients with diabetes within Wolverhampton through the rollout of freestyle libra. This monitors user's insulin levels without the requirement to do pinprick tests. Dudley is supporting patients with long-term conditions through use of its health app. Moving forward the NHS app will be deployed across the STP and the range of services offered by the app will be expanded as it is developed by the NHS.
- We will also offer more personalised therapeutic options to patients thanks to advances in precision medicine. This will facilitate a more fundamental shift towards more 'person-centred' care, with a wider move to "shared responsibility for health" over the next five years.
- The NHS Personalised Care Model is to be rolled out nationally and social prescribing, using link workers in PCNs, will help us to develop tailored plans for individuals and connect them to local groups and support services as needed. Accelerating the rollout of PHBs will also give people greater choice and control of their care planning and delivery and end-of-life care will be personalised also.

9.5 Governance

Please see section 6.2 for an overview of our governance structure. This will be applied to each key element within this section.

9.6 Resourcing

Please see section 13 for the detail on funding and resource issues and proposed, projected spend.

10 Key element 4 - Digitally-enabled primary and outpatient care will go mainstream across the NHS

10.1 Current Situation

As highlighted earlier each of the Black Country and West Birmingham CCGs has a primary care digital programme in place. There is, of course an amount of variation due to historic development of differing primary care strategies and each of the areas agreeing and developing different digital priorities. Whilst there is now general cohesion in programmes across the STP aligned by GP systems of choice, the patient choice agenda, the GP Five Year Forward View and the Long-Term Plan there has not been a single strategic vision on digitisation for primary care.

There is now agreement across the four CCGs to harness the opportunity afforded by the STP primary care and digital strategies to converge previously disparate programmes into a cohesive, interoperable portfolio of work to support the STP and the delivery of the NHS Long-Term Plan.

The STP is developing a Digital Strategy, working in line with the NHS National timeline for a response to the LTP in autumn 2019. The STP Digital Strategy will be included in the STP 5-year Plan at this time.

Our organisations are adopting digital solutions to become more efficient and effective in both care delivery and organisational business. For example, Sandwell and West Birmingham CCG is rolling out Microsoft Office 365 to give its workforce greater flexible to work in a more agile way. Eventually this will be rolled out to all areas across the CCG so that healthcare professionals can benefit from these new approaches to care delivery as well. We are also looking to implement and support the following:

- **On-Line Consultation** - consulting with patients using technology including email, skype, text and telephone. The STP is working towards or expanding on their online consultation facilities and whilst we recognise that this work has initially developed at place level, the STP has now developed a Digital Workstream which will work to deliver a consistent set of on- line consultation functions across the STP accessed via the NHS App, share best practice and aspire to align any future procurements of solutions. The STP is working to ensure all Practices have a solution implemented by April 2020 and twin tracking this technical work with proactive on-site marketing and engagement for GP practices and patients in order to maximise the uptake and opportunity

- **NHS App** - NHS App will continue to be a national platform providing people with a 'front door' into a range of online health and care services. The STP is committed to promoting and ensuring digitally enabled services are interoperable with the NHS App. It is already proving to be an important platform in enabling the public to interact with the NHS digitally, giving fast and reliable access to symptom checking, NHS 111, practice appointment booking, renewal of prescriptions and viewing of GP medical records. The NHS App will further evolve through seamless integration with the smartest and most effective applications, tools and services on the market. The STP will

    - Ensure that all practices in our area have GP Online Services access technically enabled within their system (in line with their current GMS contractual commitments)
    - Ensure all practices have reviewed their GP Online services settings to ensure they are appropriate for patient use (there is an GMS practice contractual commitment for 25% of appointments to be available online by July 2019)
    - Ensure all relevant staff are briefed on the NHS App rollout and requirements for supporting patients
    - Review 111 Online provision to ensure appropriate for potential increased usage/activity from exposure within the NHS App

- **Extended Access NHS 111 Direct Booking**

  This function is already available across the majority of the STP, with plans and place to ensure full coverage by September 2019

- **A Black Country and West Birmingham wide interoperability platform** aimed at data sharing across a wider footprint of providers is underway. Through a Walsall and Wolverhampton collaboration, a project is in delivery implementing a repository based shared care platform. The learning from this will lead to introduction of a wider shared care record and identification of wider organisations and care settings that will benefit from the sharing of information. In addition, ensuring the information captured within clinical care settings is appropriately and securely shared will not only enhance care but also provide management information to support secondary usage such as commissioning and public health activities.
- We are also upgrading Provider Patient Administration System/Electronic Patient Record system (PACs/EPR).

10.2 Role of Primary Care

Effective digital solutions should be the norm rather than the exception. Our digital infrastructure should; support patients and the public to be able to use digital solutions to access information on their conditions, make bookings into their local GP practice (and soon PCNs), place orders for repeat prescriptions and understand their health needs through online digital support for example, smoking cessation and weight management.

By reviewing the local and national priorities and aligning delivery across primary care we can harness the opportunities available at scale to support improved clinical outcomes. For example, having virtual MDT consultations with both primary and secondary care health professionals so that care can be jointly planned for the patient.

Digital is a key enabler for improvements defined within the STP clinical strategy which are, in turn, aligned to the NHS Triple Aim. The digital workstream will realise the opportunity to align organisational priorities for digital with the overarching objectives of the STP and for primary care as detailed within both the clinical and primary care strategies.

10.3 Workforce

Our approach to delivering a digitally fit workforce will be based on the delivery of themes to support the workforce and empower patients so that the demands upon staff are reduced.

The foundation of this vision is based upon access to the appropriate information at the right time to improve knowledge and therefore increase independence and resilience through self-care. These themes are:

- Empowerment - using technology patients and citizens access and contribute to their health and care records.
- Infrastructure - a resilient infrastructure across the Black Country and West Birmingham health and social care economy that enables access to required information to support decisions from anywhere supporting place-based working.
- Integration - with the enabling economy wide infrastructure, standards and principles being a fundamental requirement for the interlinking of systems. Standards adopted nationally with the appropriate information governance framework and agreements eliminate organisational and regional boundaries to wider digital interoperability.
- Intelligence - development of robust business intelligence across the Black Country and West Birmingham to support decision making and identification of best practice models leading to improved patient care.

As part of the digital and workforce strategies, we will support programmes of work which equip the workforce of today and tomorrow with the skills they need to operate within a new landscape.

We are also investing heavily in developing our primary care workforce. This is through development of new roles, funding and STP wide training and development as described in earlier sections.

10.4 Service Delivery

We have an extensive programme of digitisation planned across the next 5 years. Our main programmes are:

- Electronic Document Management.
- Electronic Referrals.
- Telehealth.
- Electronic Prescription Services release 2.
- Integrated Shared Care Record.
- Clinical System Support, Data Sharing, Wi-Fi will be available in all practices.
- Outreach/Mobile Working - this will allow staff to work across the local area in patients' homes and in other clinical settings such as care homes.
- Local Electronic Service Directory - we will compile a local service directory to include primary, secondary, community and voluntary sectors. This will ensure the correct pathway is followed for individuals with a shared approach; reducing the likelihood of inappropriate referrals to secondary care.

The above will be underpinned by effective change management which facilitates maintaining momentum through any changes.

In parallel to the implementation of the above programmes we will:

- Continue to work towards system interoperability (the ability to exchange information between health and social care systems). This will provide a single consolidated view of the patient in the context in which the patient is being viewed, supporting operational excellence within of new models of care.
- Utilise the latest and appropriate technologies to engage all parties within the system including clinicians, staff, patients and partners.
- Facilitate cross organisation collaboration driving efficiency and productivity to close the finance and efficiency gap.
- Utilise technology to extend the reach of health and social care to bridge the care and quality gap.
- Implement and promote the use of digital tools and applications in support of health and wellbeing.
- Build on existing achievements and the required coherence between technology and health and care services by adopting ubiquitous access to clinical information assuring availability in the right place, at the right time to support clinical decisions.

- Be paper free at the point of care by 2020.
- Adopt new standards as appropriate. This will be particularly relevant as an STP wide interoperability capability is developed with a focus on cyber security and GDPR.
- Continue gaining maximum value from the outsourced CCG IT and GPIT service level agreements and continued alignment of the IT strategy and IT service to the organisational strategic objectives.

Success can sometimes be difficult to measure or attribute to one or two changes. However, we know we will have succeeded when clinical computer systems are interoperable and facilitate communication and information sharing between services and organisations and, when creative and innovative digital solutions are available which support and empower people to manage their own health.

10.5 Governance

Phase 1 of the STP digital programme will be to develop an STP digital enabling strategy. This will describe how the STP's clinical strategy will be supported by digital enablers such as shared records and patient empowerment via access to information. The strategy will also be informed by the NHS Long-Term Plan, STP workforce, PCN establishment, Digital Maturity A and the Local Digital Roadmap (LDR) 10 Universal Capabilities & Ambitions. This will be developed by December 2019 (see Appendix 7 for version 1 of the LDR).

The second phase will be an STP digital enabling programme which will align defined milestones such as funding availability, other STP programme delivery dependencies and importantly the existing commitments of partner organisations. To allow for strategic foresight but temper that with the pace of technological developments, the plan will span the next 3 years. Year 4 will be a refresh of the delivery programme and a review against STP/ICS clinical priorities.

Please see section 6.2 for an overview of our governance structure. This will be applied to each key element within this section.

10.6 Resourcing

Stakeholders from across the Black Country and Wet Birmingham are already members of the STP digital programme Board. This is attended by commissioner and provider digital leads and will include social care and STP clinical guidance.

Current resource for primary care IT is ring-fenced through allocated funding to CCGs from NHS England. These budgets are fully committed to existing obligations such as GP clinical systems provision and support. Additional funding opportunities are provided through the ETTF and Health Service Led Investment (HSLI) which are co-ordinated across the Black Country and West Birmingham.

Sections 3.6 and 12 go into further detail on funding and resource issues and proposed, projected spend.

11 Key element 5 - Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere

11.1 Current Situation

The STP is making excellent progress in delivering new care models which can be evidenced by the outcomes seen from our vanguard sites. We have established; the Dudley MCP, Modality and MERIT, alongside the Wolverhampton Integrated Alliance, Sandwell and West Birmingham Healthy Lives Partnership and Walsall Together to support our integration aspirations. There remains however further progress required to realise the full benefits of these new care models.

11.2 Role of Primary Care

The STP is well progressed in the delivery of 'place-based' integrated models of care, however the operating model, contractual model and phasing of implementation varies across each of the boroughs.

Local place-based models of care including Integrated Care Alliances (ICA) and Integrated Care Organisations (ICO) are being developed and implemented across the STP in support of the clinical strategy. These ICAs are emerging vehicles for bringing together health and care services for defined populations. They aim to; deliver improved access to local services for their whole population, greater continuity of care for those with ongoing conditions and more coordinated care for those with the most complex needs. This work is a key deliverable for the system in transitioning to an ICS.

Each 'place' has its own path to an ICA/ICO, but each 'path' is drawn from the same central principle (as defined earlier). This will bring health, social care and voluntary sector organisations together, to achieve improved health and wellbeing. This will deliver local models of care that are tailored to their populations, but which also benefit from working alongside each other as part of the wider system described below.

Integration Approaches across the STP

To support the implementation of our place-based models of care, the following initiatives are being implemented in 2019/20:

Primary care networks of local GP practices and community teams

PCNs will underpin the provision of integrated care across the STP. In 2019/20, service and pathway integration will reach beyond primary care to include other health and care services. This will include district nursing, pharmacy, social workers, community psychiatric nursing, social prescribing, housing and a range of other roles to support patients' care in their own communities. This has been implemented in parts of the STP footprint already and will be expanded to all areas, recognising the differences in approach that may be required.

Community services are based on geographical footprints to mirror PCNs for approximately 50% of the population. We expect this to be at 100% by March 2020.

GP Five Year Forward View

It has been three years since the implementation of the STP Primary Care GPFV commenced. It remains a priority to continue to deliver all GPFV projects in line with existing implementation plans as in-line with this strategy.

The strategy will cover a 5-year period to 2024. 2019/20 will therefore be a transition year.

Quality and Outcomes Framework (QOF)

NHS England and Improvement have sanctioned significant changes to the GP Quality and Outcomes Framework (QOF). This will include a new Quality Improvement (QI) element which is being developed jointly by the Royal College of General Practitioners (GPs), National Institute for Health and Care Excellence (NICE) and the Health Foundation.

CCGs within the STP have already begun to move away from using QOF indicators and towards locally defined measures. An example of this is the Dudley Quality Outcomes for Health (DQOFH) which is a key part of the proposed Integrated Care Provider contract for them.

Similar local outcome frameworks are being developed across the STP and therefore we will continue to work within the requirements of the national framework until our local frameworks are sufficiently developed. In preparation for transition to a local framework we will work closely with regulators to advise on the risks relating to accurate data collection and national performance consequences (such as CCG Improvement and Assessment Framework) when moving from QOF.

Guaranteed NHS support to people living in care homes

We are developing plans to meet the NHS Long-Term Plan's goal of upgrading NHS support to all care home residents by 2023/24. This will ensure we create stronger links between PCNs and their local care homes, with all care homes supported by a consistent team of healthcare professionals, including named general practice support.

Possible legislative change

The STP supports the ambition for legislation changes to deliver new care models. This is not likely to impact in 2019/20 but appropriate consideration will be given if proposals are published in-year.

11.3 Workforce

There are two key priorities for the STP in relation to workforce; Local Workforce Action Board (LWAB) and the Organisational Development/Human Resources (OD/HR) workstream.

A common aim of both workstreams is to address the workforce challenges faced by primary care, and our organisations by working across organisational boundaries. We will not resolve the challenges we face (including the potential reduction in GP workforce across the Black Country and West Birmingham) without an STP approach.

The LWAB and STP continue to work closely with the Clinical Leadership Group to consider proposals on current workforce and future requirements.

The LWAB brings together health and care organisations and key stakeholders across a broad range of workforce issues and will develop solutions and agree a work programme to support the wider STP workforce agenda. These will include areas such as; strategic HR issues, recruitment including overseas recruitment, staff retention and absence as well as education and training. The LWAB has five programmes which have objectives within each of these to drive forward the workforce agenda. These are:

- Workforce capacity, innovation and change.
- Recruitment and retention.
- Working stronger together.
- Staff Well-being and engagement.
- Leadership and education.

The HR and OD workstream will contribute to improving wider system working in relation to HR/OD support to the process and management of STP resourcing ensuring fair and transparent systems are in place.

As highlighted through this document we will develop a 10-year workforce strategy for the STP (2019/20). This will incorporate requirements for acute, community, mental health and primary care. It will reflect the requirements of new care models across the STP, such as the PCNs supported by additional investment in community and primary care services as described in the STP's medium term financial plans. The plan will also describe the STP's approach to:

- Recruitment of new workforce, both medical and non-medical.
- Training and education.
- Retention of current staff.
- International recruitment.
- Enhancing productivity.
- Leadership and talent management.

11.4 Service Delivery

The service pathways are currently in development across the STP. At this time, we predict that they will sit at the provider level or ICA, which is below the ICS. Whilst there are differences in design and pace of development with each local ICP, there are also many common themes which we will be collaborating on increasingly as four CCGs. These themes include:

- Health and care services being brought together as a means of responding to the needs of a growing frail elderly population displaying multiple co-morbidities.
- Creating a more resilient primary care system and placing the patient registered with general practice at the centre of the care model.
- A population health approach to managing demand.
- A move away from activity-based contract models to our Integrated Care Partnerships/Providers being responsible for the delivery of a set of health and wellbeing outcomes.

Each CCG has begun work on developing an outcomes framework to look at improvement in patient health over time. We are committed to working together to align these frameworks, which predominantly focus on the health management of our local populations, with a view to agreeing an overall common outcomes framework for the ICS.

11.5 Governance

During 2018/19 we have established governance and reporting process for all STP work streams and programmes. We will continue to refine and improve processes focusing on delivering positive changes for the benefit of the patient.

Governance of the STP will be further strengthened in 2019/20 to incorporate the membership of PCNs and the development of appropriate risk management frameworks to manage financial risk across the STP.

During 2019/20 the STP will support member bodies through periods of organisational change. Over the next year we will be preparing for the merger of Black Country Partnership FT and Dudley & Walsall Mental Health Trust, the establishment of a joint management team across the four STP CCG's from April 2020 and the establishment of Dudley MCP.

Please see section 6.2 for an overview of our governance structure. This will be applied to each key element within this section.

11.6 Resourcing

Please see section 13 for the detail on funding and resource issues and proposed, projected spend.

12 Measurement

12.1 Baseline and Measuring Change

The STP primary care strategy is built on the foundation of ensuring all transformational change is developed based on empirical evidence and professional business design methods. This is to ensure that:

- Financial and human resource allocations are targeted in the right areas where transformation is required i.e. achievement of the vision and outcomes outlined in this strategy.
- A robust approach and methodology is followed so there is a defined structure to follow, for example development of the case for change, Project Initiation Documentation (PID) and risks and issue logs.
- A baseline exists upon which to measure the impact of the transformation.
- Progress can be monitored and reported robustly.
- Adoption of new care models, such as PCNs can be developed and rolled out to a methodology which facilitates delivery of the aims and objectives.

Across the STP we are implementing a large programme of change within primary care to meet the growing system challenges and to support delivery of key outcomes within the GPFV and the Long-Term Plan. However, to ensure that all changes proposed and progressed supports the population we use the following approaches and methods:

- Robust data collection and analysis from a range of sources e.g. National Workforce Reporting Tool (NWRT), HEE, local CCGs and NHSE sources to set ambitions and target areas for development and/or change.
- Good application of change and programme, PMO approaches so there is a structured approach to delivery.
- STP-wide stock taking of current activity and position to ensure there is a documented baseline from which to manage progress e.g. on the development of online consultation, on the implementation of the 10 High Impact Actions.
- Staff engagement and co-design approach using a variety of methods such as events, workshops and surveys.
- Public and patient engagement.
- Researching, sharing and utilising best practice both locally and nationally.
- Piloting schemes and evaluating impact before wider rollout.
- Ensuring that all stakeholders involved in change schemes are clear on success measures, metrics and outcomes from the outset.
- Ensuring the right governance is in place to monitor work undertaken and provide assurance that the changes are resulting in improvements.

We ensure that we apply established design techniques to our change processes such as logic modelling when we are designing schemes.

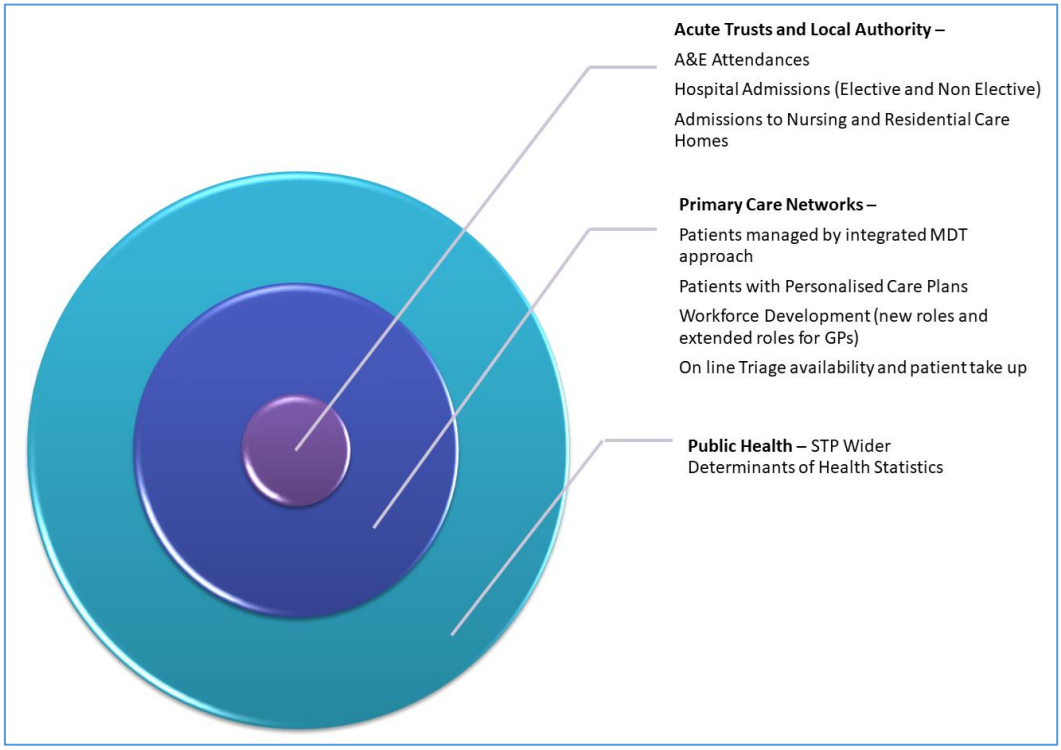
We also recognise the importance of sharing and publishing the changes we have made. We use a variety of methods to evidence the impacts of change we have realised across our programmes. These include:

- Case Studies (*see section 5.4 for example*).
- Speaking, presenting at local and national events and conferences.
- Our intra and internet sites.
- Videos / social media – e.g. https://www.youtube.com/watch?v=wavltz1nr-4&feature=youtu.be
- Metrics dashboards – see accountability section.
- Newsletters (see below example).

STP Newsletter on Workforce

As the integration model associated with PCNs takes shape, baselining and managing the impact of the change will encompass more data sources, partners, systems and processes than ever before.

This will bring together information from a number of different sources designed to measure the impact across all the key elements of the STP. An example of how we look to layer data is shown below. This helps us to understand for example how wider determinants of health influence acute hospital admissions.



Data Alignment across STP Level

12.2 Monitoring the Workforce Plan

This strategy details our approach to workforce, the types of initiative we are introducing and the proposed benefits for our population. This also includes our overarching approach to programme delivery governance and accountability.

The STP is committed to investing both financial resources and Programme, PMO delivery resources into delivering the workforce plans and our soon to be created workforce strategy. As a minimum we would expect to achieve the workforce ambitions submitted to NHSE on an annual basis *(see Paragraph 4.5 for the ambition for 19/20)*.

The primary goal of our workforce plans is to help make the STP a great place to work where primary care becomes a first class and first choice career pathway.

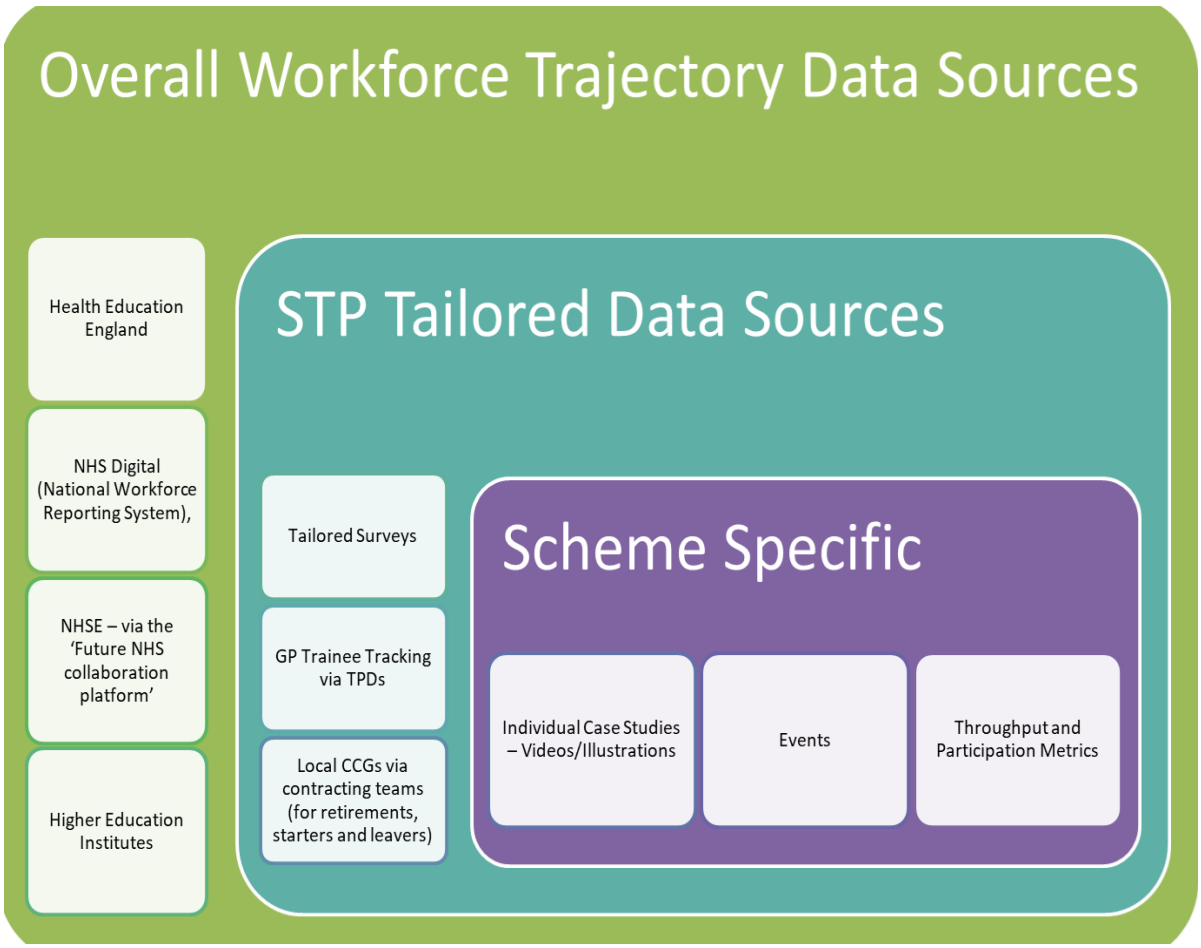
We recognise though the importance of having robust and varied ways of measuring and evaluating the impact of our investments. We will manage this in the following way:

- Obtain, extract and analyse regular workforce reporting data from verified sources including HEE, NHS Digital (National Workforce Reporting System), NHSE (via the 'Future NHS collaboration platform), higher education institutes

and local sources via CCG contracting teams (for retirements, starters and leavers).

- Using the above information, we will compare our ambitions using a Metric Dashboard which includes a robust narrative of the progress of the plans/schemes against each aspect of the workforce. This will then be presented as a standing item at each STP PCPB for challenge and governance purposes. In addition, progress against workforce ambitions are reported as part of the monthly STP programme highlight reports as well as via assurance returns to NHSE on a regional basis (see Appendix 8 for full details of workforce metrics dashboard).
- For each new scheme/project the STP will ensure specific metrics/evaluation methods are included in the design phase and routinely monitored throughout implementation. This will be jointly developed by stakeholders to support the strengthening of cross organisation working.
- The STP will continually review its ambitions and trajectories on a regular basis ensuring that work is undertaken to analyse and predict future demand. Techniques such as the HEE GP supply tool forecasting model and business design methodologies will be used to analyse demand in primary care to support emerging PCNs workforce development plans.

The below diagram visualises our approach to how we structure our data for analysis and sharing:



Workforce Plan Monitoring – Data Sources

12.3 Monthly Assessment

Progress against the delivery of this strategy and key metrics will be reported on and assurance provided monthly on a local, regional and national basis to stakeholders.

Our reporting structure for the STP is shown in the below table:

Local (STP Level)	Regional Level (Midlands and East)	National Level
Monthly Programme Level Reporting to Primary Care Leads *(transitioning to Primary Care Programme Board)*	Monthly Programme Level Highlight Reports to the GPFV Transformation Board	NHSD SDCS GPFV Monitoring Survey – Quarterly Return
Monthly Primary Care Workstream Reports to Black Country & West Birmingham STP Delivery Board	Monthly Workforce Highlight Reports to the GPFV Transformation Board	STP Assurance Return on NHSE Assurance Statements (sent by NHSE Region)
Monthly Project Level Highlight Reports to Project Task and Finish Groups and fed into Programme Plan Highlights	General Practice Nursing Monthly highlight report	
STP Assurance Return on NHSE Assurance Statements – to STP PMO	STP Assurance Return on NHSE Assurance Statements (sent by STP PMO)	

STP Data and Reporting Structures

12.4 Accountability

The STP does and will continue to use assurance statements at the core of all its plans and to facilitate how it focuses reporting requirements and governance processes. This is in line with the issued guidance referenced in the below weblink.

https://www.england.nhs.uk/wp-content/uploads/2019/02/Annex-B-guidance-for-operational-and-activity-plans-assurance-statements-v2.pdf) and technical definitions (https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f

For each assurance statement the STP will develop a project plan and report progress against key milestones to:

- STP Primary Care Programme Board. (STP PCPB)
- Black Country and West Birmingham STP PMO (with subsequent reporting to the Health Partnership Board – see governance structure).
- NHSE regional teams.
- NHSE national teams.

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A metrics dashboard is under development to monitor and report progress against the assurance statements and ambitions. It is envisaged that this will go live across the STP by the end of 2019. This will be updated and reported via the governance processes on a regular basis, to the above Boards, committees and groups. This is to ensure there is visibility and give partners an opportunity to ensure any corrective action can be taken on if adverse variations to targets are seen.

As part of our ongoing monitoring of all the programmes of work we are delivering across the STP, we will ensure that any learning and outputs from these are considered. The above approaches and mechanisms we have detailed gives us a good opportunity to ensure that we embrace and mature a strong change culture and that we learn from outputs from programmes contained within the GPFV and Long-Term Plan.

12.5 Patient Participation

Across the STP there are extensive arrangements in place to engage patients and the public in the way that services are developed, delivered and evaluated. Each partner has mechanisms to involve our population in the way that services are commissioned and provided, and primary care is no different in this regard. Most of our practices have Patient Participation Groups (PPG) and we have great examples of the impact that these groups can have, not only on the way that GP practices operate but their role in empowering local people and communities more widely.

Based on feedback from the 2017/18 GP practice survey, we know that:

In Dudley, patients overall experience of their GP practice was very good. Local people are aware of online services that are offered at their GP practice, but many have not used them. Mental health and long-term conditions are recognised and supported well.

In Sandwell and West Birmingham, most patients rate their overall experience as good. Almost half surveyed were not aware of the online services offered at their practice and therefore did not use them. Most patients get a choice in date or time when booking a GP appointment.

In Walsall, the overall experience of GP practices is very good with most patients finding it easy to get through to their GP practice on the phone. Most patients were aware of online services, but a high proportion said they had not used these in the last 12 months. Their confidence and trust in staff providing services when their GP practice is closed was high.

Wolverhampton, most patients describe their overall experience of their GP practice as very good. There is a general awareness of online services locally, but most patients have not used them. There are also high levels of satisfaction with receptionists in practices and patients find it easy to use their GP practice website to look for information or access services. Satisfaction with appointment types was also high.

We also use digital solution to capture, on an ongoing basis, patient's view of the services we provide and the care they received. An example of this is shown below:

Patient Experience Measure

The information captured in this told us that across all our localities patients' perceptions of care received at their last GP appointment offered room for improvement, with them feeling like they are not treated with the right level of care or concern and that they are not given enough time.

Mechanisms like this are routinely employed and reviewed by individual organisations and within the STP structure so that we understand how we are performing and to help identify any areas for improvement. These are then brought into the planning and programme structure mentioned earlier.

It is also reasonable to say that whilst opinions expressed in the latest survey are consistent across the STP and positive in terms of how we benchmark with national results, there is some variation across results from practice to practice.

It is this variation that we want to tackle, so that people across the Black Country and West Birmingham recognise the level of service they can expect, regardless of the practice they visit.

We have used the knowledge from this national survey, ongoing place-based involvement work by local CCGs and specific engagement events on this strategy development to ensure that this strategy responds to the views of local populations.

The STP recognises the needs and expectations of the public are changing. We are living longer but we often require different, more complex care as a result. New treatment options are emerging, and we rightly expect better care closer to home. Our primary care services are there for people, often as the first port of call and when at its best, general practice plays a valuable role of coordinating care for those most frail and vulnerable.

Good access to general practice is something which all patients and the public want. For those living with long-term conditions they strive for not only good access but for continuity of care and want to feel able to influence their own care planning.

We know that having a sustainable primary care service and using new models of care such are networks, is very important for our population registering with a GP of choice. We know that our patients have a strong and emotive reaction to any suggested reduction in the local provision of primary care services.

Our population also recognises the challenges faced by primary care such as the issues with recruitment, many GPs reaching retirement age and increasing complexity of an aging patient population. From conversations we have had with our patients and service users we know they are open to exploring other options such as online access and being cared for by new types of workforce such as practice based pharmacists, paramedics in practice and social prescribers to address some of these challenges.

There is wide recognition and ambition across the STP to create a future where our residents have more choice and control over their own health. Care planning, which places the individual and what matters to them at the centre, is something that our residents support. It is also an area where our population have positive ideas on the role that they can play in supporting their own health.

Local people still need more information on the way in which primary care services are developing. They want to understand the new roles being introduced and understand the different ways that services can be accessed through, for example the new network structures.

As this strategy is mobilised and more plans for implementation are developed there is commitment across the STP to engage with patients and the public. We have structured this at the following levels:

- People – we will increase the choice and control that people have. Increasing opportunities for people to influence their own care, to set personalised goals, participate in shared decision making and for individuals to be seen as equal partners in their care planning.
- Practice – we will encourage each practice to have a Patient Participation Group and offer support to those practices who don't have one or for those groups who need some support to be the best they can be. This will offer all patients, registered with a practice in our STP, a chance to have a voice about how the care is provided in their practice.
- Place – each CCG has a forum for PPG leaders to come together at a PCN or Place level. Theses forums are a great way to hear about health developments, share ideas and influence commissioning decisions. Each CCG has PCCC with patient / public representatives (including Healthwatch) and these meetings are

held in public. These are key to us being open about the way in which decisions are made in relation to planning and buying (commissioning) primary care services.

- Partners – at an STP partnership level we will offer collective clarity about the direction of travel for primary care, we will ensure that there is consistency in the opportunities for people to be involved in decisions about that strategic direction and we will support this through the introduction of 'Black Country Voices'. A new citizen's panel for the STP which will be in place by April 2020 and will provide a mechanism for gathering insight and feedback on health and care issues. It will help the STP to reach an unrepresented demographic from across the four localities including those who are seldom heard and will complement existing engagement methods used across the footprint.

The STP has also committed to communicate in a way that is:

- Open and transparent – our communication will be as open as we can be, ensuring that when the information cannot be given or is unavailable, the reasons are explained.
- Consistent – There are no contradictions in the messages given to different stakeholder groups or individuals. The priority to those messages and the degree of detail may differ, but they should never conflict.
- Two-way – There are opportunities for open and honest feedback and people have the chance to contribute their ideas and opinions about issues and decisions.
- Clear – communication should be jargon free, to the point, easy to understand and not open to interpretation.
- Planned – communications are planned and timely rather than ad-hoc and are regularly reviewed to ensure effectiveness.
- Accessible – our communications are available in a range of formats to meet the needs of the target audience.
- High quality – our communications are high quality in relation to structure, content and presentation at all times.

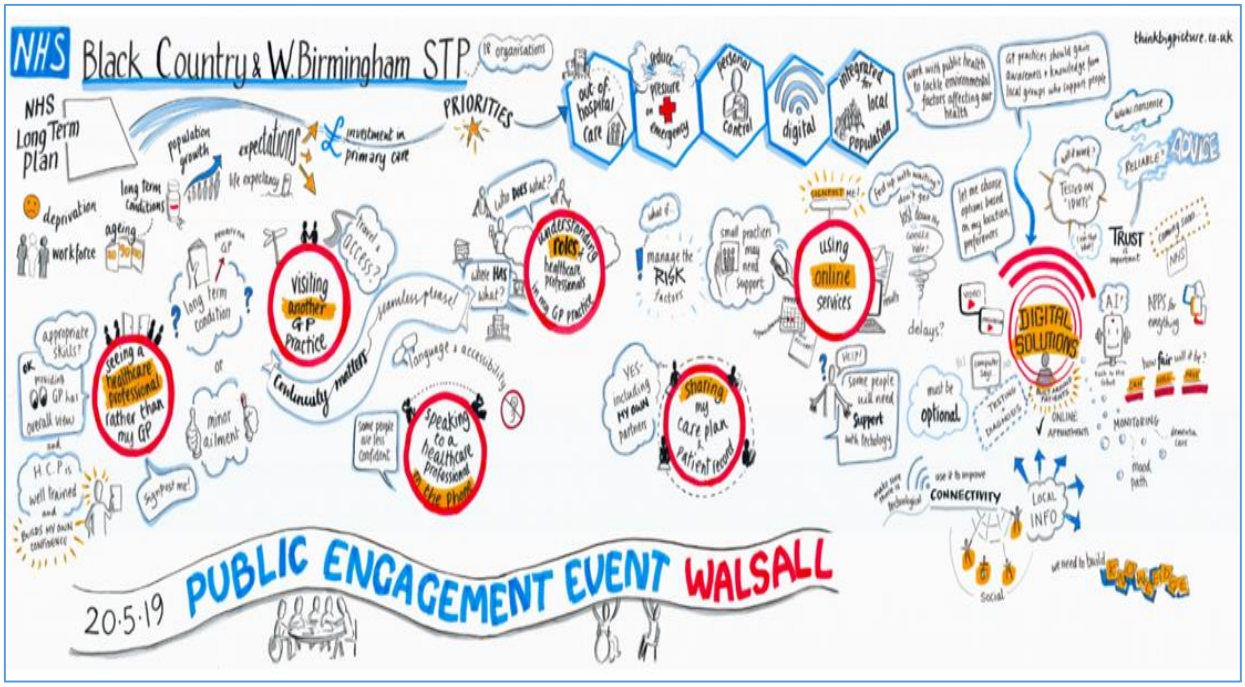
We will also ensure that there will be no service changes without adequate involvement and we will promote the ways in which local people can have their say.

12.6 Public Engagement on this Strategy

To help us identify what matters most to local people, we held four public engagement events across the STP footprint. The events encouraged people to have their say on primary care services and captured views and experiences based on a series of topical areas covering access, the development of new roles within primary care, the use of online services and the emergence of digital solutions.

The events led by primary care leads in each of the CCGs, highlighted the challenges faced by primary care, the opportunities of partnership working and how CCGs were working together to develop a system-wide Primary Care Strategy for how it will improve the care for people living in the Black Country and West Birmingham over the next five years.

A graphic recorder was commissioned to create a visual representation of the conversations that took place at each event. The visuals will be used to evidence the progress and direction of conversations in each of our four localities and will support CCGs to understand what matters most to local people – an example is included below:-



STP Public Engagement Event Feedback Example- Walsall – 20/5/2019

Across the four events, 118 local people attended. Attendees were predominately white, of retirement age and who were experiencing several long-term conditions. Some localities did get representation from BME communities including a representative from the Refugee and Migrant Centre, which covers Birmingham, Walsall and Wolverhampton and a representative from a mental health support group.

Generally, feedback we received from local people who attended the events was consistent across our four localities. Overall patients would be happy to see a variety of health professionals in primary care for minor ailments, provided they had the training required and were able to make easy onward referrals to their GP or other services. Patients with multiple long-term conditions were more hesitant to see alternative health professionals as they thought it was important that the health professional understood their history and they valued consistent, face-to-face care.

When discussing the digital agenda, most people felt they needed further education to understand the solutions being investigated and what this would mean in practice. They also felt that if results were made available electronically they may need support to understand them. Concerns were raised regarding data security and the level of information being made between groups, with a focus on voluntary sector organisations.

Representatives on behalf of refugee and migrant populations/mental health sector highlighted the difficulties that would arise for patients if they were required to attend alternative practices and see health professionals that they were not familiar with.

(See Appendix 9 for narrative and visual representation of the conversations that took place at each engagement event).

12.7 Future involvement

Going forward we will continue to run events with our local population to present the work that we are doing and to get input from public and patients on upcoming projects to ensure that it meets their needs. The outputs of events will be collated and taken to the STP Partnership Board for consideration.

12.8 The Role of the Primary Care Commissioning Committee

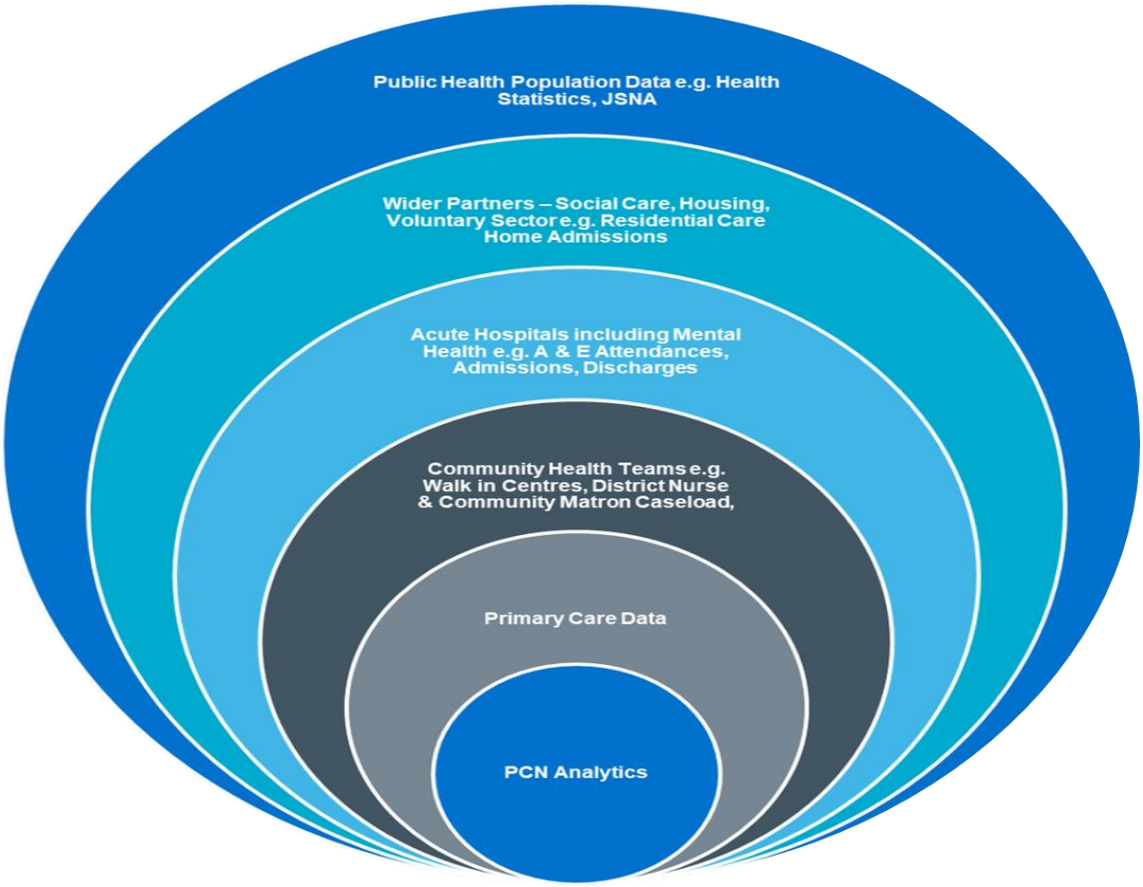
The PCCC oversees the commissioning of primary care and has established the Primary Care Operational Group to review and monitor contractual performance, quality and safety of primary medical care services.

12.9 Primary Care Network Analytics

One of the key benefits of PCNs will be their ability to apply the benefits of wider system integration to the specific local needs of the populations they serve. A key foundation to enable this to be as effective as possible is accurate, timely and easily accessible population information. As such the STP is committed to supporting the development of the data and BI functions that will enable this for the networks.

In order that PCNs can make the right decisions based on the data available, Business Intelligence will need to focus on the following areas:

- Infrastructure (the technology that will support the data gathering).
- Analytics (the way in which the data is used to create information for networks and their clinical directors to utilise).
- Intelligence led Intervention (how the information is then used to inform service changes). An overview of our vision for PCN Analytics is included below:-



Primary Care Networks Analytics

Infrastructure

Across the STP there are already systems in place throughout primary care where information is collected, stored and analysed. However, these systems and processes are not consistent across the emerging networks. Furthermore, different areas within the STP are currently at different stages in terms of data links, PCN wide information governance and analytical capability.

The STP knows that to move to a PCN business intelligence system that can support population health management, it will need a large pool of data and processing facilities with the capability of pulling data together. This data will need to be made anonymous when it is being analysed and location specific at practice and MDT levels. Linked data should include primary, secondary, community and mental health data as a minimum but the strategy will also include the ambition to link social care data to this data. When available the STP will use the national PCN dashboard to help understand the performance of its networks.

There are a number of options that the STP will consider in creating this data system, with the ultimate decision making and design to be co-produced with clinical directors and their networks. These options may include:

- Procurement of new sets of systems.
- Utilising existing capability such as commissioning support units (who provide business intelligence support)
- Using a combined approach with different parts of the system responsible for the different pieces data we are looking at.

PCNs already have or are working on Information Governance (IG) agreements as part of their network development and these will all be in place over the coming months.

Analytics

Currently there are different analytical teams across PCNs analysing different data sets (clinical, operational, financial, performance). The STP will work towards drawing these together either physically of virtually so that a) the data user has the full picture and b) so that advanced analysis can take place. The analytics capability will need to cover risk stratification tools for issues such as obesity, school readiness or social isolation. It will also require the ability to look at cause and effect modelling for decision making. To gain this improved analysis, the PCN analytics capability will need to tap into expertise from public health, social care, commissioning support units and population health academies.

Intelligence Led Intervention

Integrated networks and forums for population health management will be developed drawing in primary care, secondary care, social care, public health teams and the voluntary sector to create a joined-up approach to data analysis for PCNs. Ongoing analysis and use of data in care design, case management and direct care interactions to support proactive and personalised care will be key to making the right improvements in the PCNs. This may require us to make changes to the current structures in place and we will need to look at specialist roles to translate the data analysis into improvements.

13 Finance

13.1 Current Levels of Expenditure

The four CCGs submitted financial plans for the 2019/20 financial year on 15th May 2019 and all are planning to spend in-line with their allocation for primary medical care services, which totals £204.5m across the STP. The level of funding is set to increase by 4-5% per year to £244.8m by 2023/24.

CCGs will be working up 5-year financial plans for submission in autumn 2019, but an initial draft 5-year plan for primary care spend based on the current model of care is included in the following tables. It is assumed that if nothing changes, CCGs will plan to spend in-line with the published primary medical care allocations for 2019/20 to 2023/24.

STP	2018/19 FOT at M11 £000	2019/20 Plan £000	2020/21 Plan £000	2021/22 Plan £000	2022/23 Plan £000	2023/24 Plan £000
Primary Care Co-Commissioning						
General Practice - GMS	121,655	127,149	132,539	138,331	144,810	152,201
General Practice - PMS	2,626	2,666	2,792	2,925	3,071	3,237
Other List-Based Services (APMS incl.)	16,401	14,290	14,902	15,561	16,299	17,140
Premises cost reimbursements	23,261	22,269	23,212	24,226	25,363	26,660
Primary Care NHS Property Services Costs - GP	-	1,561	1,619	1,682	1,754	1,837
Other premises costs	191	213	221	230	241	253
Enhanced services	18,081	19,326	20,108	20,954	21,904	22,993
QOF	14,891	15,501	16,179	16,907	17,718	18,641
Other - GP Services	271	398	424	449	475	504
Delegated Contingency	-	567	591	616	645	678
Enhanced Services - PCN DES	-	548	568	591	616	645
Sub-total - Primary Care Co-Commissioning	**197,378**	**204,487**	**213,156**	**222,473**	**232,897**	**244,788**
PMC Allocation	**197,950**	**204,487**	**213,156**	**222,473**	**232,897**	**244,788**
(Adverse) / Favourable to Allocation	**572**	**(0)**	**-**	**-**	**-**	**-**

Draft 5-year Primary Care Financial Plan (STP)

NHS Dudley CCG	2018/19 FOT at M11 £000	2019/20 Plan £000	2020/21 Plan £000	2021/22 Plan £000	2022/23 Plan £000	2023/24 Plan £000
Primary Care Co-Commissioning						
General Practice - GMS	27,793	27,766	28,800	29,926	31,203	32,676
General Practice - PMS	-	-	-	-	-	-
Other List-Based Services (APMS incl.)	2,099	531	551	572	597	625
Premises cost reimbursements	4,486	3,093	3,208	3,334	3,476	3,640
Primary Care NHS Property Services Costs - GP	-	1,561	1,619	1,682	1,754	1,837
Other premises costs	75	94	97	101	106	111
Enhanced services	6,860	7,529	7,809	8,114	8,460	8,860
QOF	149	141	146	152	158	165
Other - GP Services	545	1,488	1,544	1,604	1,673	1,752
Delegated Contingency		216	224	232	242	254
Enhanced Services - PCN DES		548	568	591	616	645
Sub-total - Primary Care Co-Commissioning	**42,007**	**42,967**	**44,566**	**46,309**	**48,285**	**50,564**
PMC Allocation	**41,842**	**42,967**	**44,566**	**46,309**	**48,285**	**50,564**
(Adverse) / Favourable to Allocation	**(165)**	**0**	**-**	**-**	**-**	**-**

Draft 5-year Primary Care Financial Plan (Dudley CCG)

NHS Sandwell and West Birmingham CCG	2018/19 FOT at M11 £000	2019/20 Plan £000	2020/21 Plan £000	2021/22 Plan £000	2022/23 Plan £000	2023/24 Plan £000
Primary Care Co-Commissioning						
General Practice - GMS	50,289	53,014	55,237	57,637	60,326	63,397
General Practice - PMS	710	750	782	815	854	897
Other List-Based Services (APMS incl.)	5,280	5,442	5,670	5,916	6,192	6,508
Premises cost reimbursements	9,009	9,518	9,918	10,349	10,831	11,383
Primary Care NHS Property Services Costs - GP	-	-	-	-	-	-
Other premises costs	49	51	54	56	58	61
Enhanced services	9,326	9,853	10,267	10,713	11,212	11,783
QOF	6,938	7,330	7,638	7,970	8,342	8,766
Other - GP Services	(1,677)	(4,000)	(4,168)	(4,349)	(4,552)	(4,784)
Delegated Contingency		-	-	-	-	-
Enhanced Services - PCN DES		-	-	-	-	-
Sub-total - Primary Care Co-Commissioning	**79,923**	**81,959**	**85,397**	**89,107**	**93,264**	**98,012**
PMC Allocation	**79,419**	**81,959**	**85,397**	**89,107**	**93,264**	**98,012**
(Adverse) / Favourable to Allocation	**(504)**	**0**	**-**	**-**	**-**	**-**

Draft 5-year Primary Care Financial Plan (Sandwell & West B'ham CCG)

NHS Walsall CCG	2018/19 FOT at M11 £000	2019/20 Plan £000	2020/21 Plan £000	2021/22 Plan £000	2022/23 Plan £000	2023/24 Plan £000
Primary Care Co-Commissioning						
General Practice - GMS	21,265	21,752	22,674	23,668	24,789	26,066
General Practice - PMS	-	-	-	-	-	-
Other List-Based Services (APMS incl.)	6,495	6,524	6,801	7,099	7,435	7,818
Premises cost reimbursements	6,949	6,840	7,130	7,443	7,795	8,197
Primary Care NHS Property Services Costs - GP	-	-	-	-	-	-
Other premises costs	67	67	70	73	77	81
Enhanced services	1,009	1,058	1,102	1,151	1,205	1,267
QOF	4,003	4,228	4,407	4,601	4,818	5,067
Other - GP Services	59	741	772	806	844	887
Delegated Contingency		207	216	225	236	248
Enhanced Services - PCN DES		-	-	-	-	-
Sub-total - Primary Care Co-Commissioning	**39,847**	**41,416**	**43,172**	**45,066**	**47,199**	**49,631**
PMC Allocation	**40,137**	**41,416**	**43,172**	**45,066**	**47,199**	**49,631**
(Adverse) / Favourable to Allocation	**290**	**(0)**	**-**	**-**	**-**	**-**

Draft 5-year Primary Care Financial Plan (Walsall CCG)

NHS Wolverhampton CCG	2018/19 FOT at M11 £000	2019/20 Plan £000	2020/21 Plan £000	2021/22 Plan £000	2022/23 Plan £000	2023/24 Plan £000
Primary Care Co-Commissioning						
General Practice - GMS	22,309	24,618	25,829	27,100	28,493	30,062
General Practice - PMS	1,916	1,916	2,010	2,109	2,218	2,340
Other List-Based Services (APMS incl.)	2,527	1,792	1,881	1,973	2,075	2,189
Premises cost reimbursements	2,817	2,817	2,956	3,101	3,260	3,440
Primary Care NHS Property Services Costs - GP	-	-	-	-	-	-
Other premises costs	-	-	-	-	-	-
Enhanced services	887	887	931	976	1,026	1,083
QOF	3,802	3,802	3,989	4,185	4,400	4,642
Other - GP Services	1,343	2,169	2,276	2,388	2,511	2,649
Delegated Contingency		144	151	159	167	176
Enhanced Services - PCN DES		-	-	-	-	-
Sub-total - Primary Care Co-Commissioning	**35,601**	**38,145**	**40,021**	**41,991**	**44,149**	**46,581**
Grand Total	**89,353**	**94,913**	**101,552**	**109,284**	**117,500**	**126,306**
PMC Allocation	**36,552**	**38,145**	**40,021**	**41,991**	**44,149**	**46,581**
(Adverse) / Favourable to Allocation	**951**	**-**	**-**	**-**	**-**	**-**

Draft 5-year Primary Care Financial Plan (Wolverhampton CCG)

13.2 Forecast of Expenditure

As shown and stated in 12.1 the CCGs have prepared a draft plan to spend in-line with the primary medical care allocation for 2019/20 based on the current models of care and will be working up detailed 5-year financial plans to 2023/24 for the submission due in autumn 2019.

CCGs have also planned to spend £1.50 per registered patient to support transformation and maintenance of PCNs, which will be funded recurrently from the CCGs' core allocations.

STP	2019/20 Plan £000	2020/21 Plan £000	2021/22 Plan £000	2022/23 Plan £000	2023/24 Plan £000
Practice Transformation Support/PCN Development					
NHS Dudley CCG	482	487	492	497	501
NHS Sandwell and West Birmingham CCG	864	872	881	890	899
NHS Walsall CCG	431	436	440	445	449
NHS Wolverhampton CCG	441	509	556	599	639
Total	**2,218**	**2,304**	**2,369**	**2,430**	**2,488**

STP PTS / PCN Development spend

CCGs have also included a GPIT plan as follows, but this has not been updated for the potential impact of any digital technology schemes relating to the new models of care:

STP	2019/20 Plan £000	2020/21 Plan £000	2021/22 Plan £000	2022/23 Plan £000	2023/24 Plan £000
GP IT Costs					
NHS Dudley CCG	1,516	1,289	1,313	1,337	1,361
NHS Sandwell and West Birmingham CCG	1,876	1,992	2,115	2,246	2,385
NHS Walsall CCG	1,054	1,059	1,059	1,059	1,059
NHS Wolverhampton CCG	788	817	849	881	914
Total	**5,234**	**5,157**	**5,336**	**5,523**	**5,719**

STP GP IT Costs

13.3 STP Financial Position

The STP is continuing to work up plans and quantify the total financial impact of the new models of care to 2023/24 to include:

- Inflationary pressures in future years.
- Additional workforce requirements.
- Capital and revenue consequences of the local primary care estates strategies.
- Other enables, such as digital solutions.

Workforce

Using the HEE modelling techniques, the STP requires 790 FTE GPs by March 2023 to meet predicted demand. Comparing this to the baseline FTE as at 1st April 2019 and adjusting this baseline for predicted recruitment and retention rates and predicted retirements the STP will need 47 additional FTE GPs by March 2023. This is an additional £5.2m recurrent cost based on an estimate of £110k per FTE.

Modelling is being undertaken to forecast the capacity required to meet the case for change to the end of 2023/24 for all key staff groups, such as:

- GPs.
- General practice nurses.
- Physician associates.
- Pharmacists.
- Administrative staff including social prescribers.
- Direct patient care (e.g. HCA, nursing associate and phlebotomist).

Estates

Local primary care estates strategies have been prepared for each CCG and work is being undertaken to understand the planned and proposed developments and improvements to quantify the capital and revenue implications.

The revenue impact has been calculated using a guide measure, which is based on a review of current expenditure levels for each practice and identifying the point at which appropriate quality and capacity indicators were achieved. For example, this would equate to an additional £2m p.a. for Walsall CCG and £2.4-3m for Sandwell and West Birmingham CCG.

Further work is being undertaken to quantify the capital and revenue consequences of the local primary care estates strategy.

Digital

Current resource for primary care IT is ring-fenced and these budgets are fully committed to existing obligations such as GP clinical systems provision and support. Additional funding opportunities are provided through the ETTF and HSLI which are co-ordinated across the Black Country and West Birmingham.

Work is ongoing to quantify the impact of digital requirements as an enabler to the new models of care.

Funding Increased Expenditure

It is highly likely that the revenue cost of the new models of care will be over-and-above the level of allocation for the period to 2023/24 and therefore the STP is also considering other funding sources and the release of savings by re-providing care out of hospital, for instance.

13.4 Associated Risks

The STP is in the process of modelling the additional staffing requirements and the capital and revenue impact of estates plans and other enablers (e.g. digital and any other support/oversight).

It is likely that the STP will need to identify a way of funding the cost impact of the investments into the new models of care and this remains a significant risk.

14 Useful Data Sources

The table below includes data sources that may be useful in completing the plan. [This section may be removed or amended in the final version of the plan].

National general practice profile from PHE can be useful source of demographics info and mapping solutions.	https://fingertips.phe.org.uk/profile/general-practice/data#page/8
Weighted populations and allocations	https://www.england.nhs.uk/allocations/
GP practices data	https://digital.nhs.uk/services/organisation-data-service/data-downloads/gp-and-gp-practice-related-data and https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice
Workforce data	https://www.nwrs.nhs.uk/
GP Patients survey	http://www.gp-patient.co.uk/

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15 Appendices

15.1 Appendix 1: Black Country & West Birmingham Sustainability and Transformation Partnership (STP) Implementation Plan & Aspirations for Primary Care 2019-2024

15.2 Appendix 2: Black Country & West Birmingham Sustainability and Transformation Partnership (STP) Clinical Strategy

15.3 Appendix 3: Black Country & West Birmingham Sustainability and Transformation Partnership (STP) GPN Strategy

15.4 Appendix 4: Case Studies

15.5 Appendix 5: The Black Country and West Birmingham Memorandum of Understanding, Version 5

15.6 Appendix 6: The Black Country and West Birmingham STP CCG Primary Care Programme Board Terms of Reference

15.7 Appendix 7: The Black Country Health and Social Care Principle Digital Roadmap

15.8 Appendix 8: The Black Country and West Birmingham STP GPFV Workforce Metrics

15.9 Appendix 9: The Black Country and West Birmingham Sustainability and Transformation Partnership Public Engagement events

15.10 Appendix 10: Workforce Retention Plan 2019-2020

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