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

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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.

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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.

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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

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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

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- 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

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- 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

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- 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

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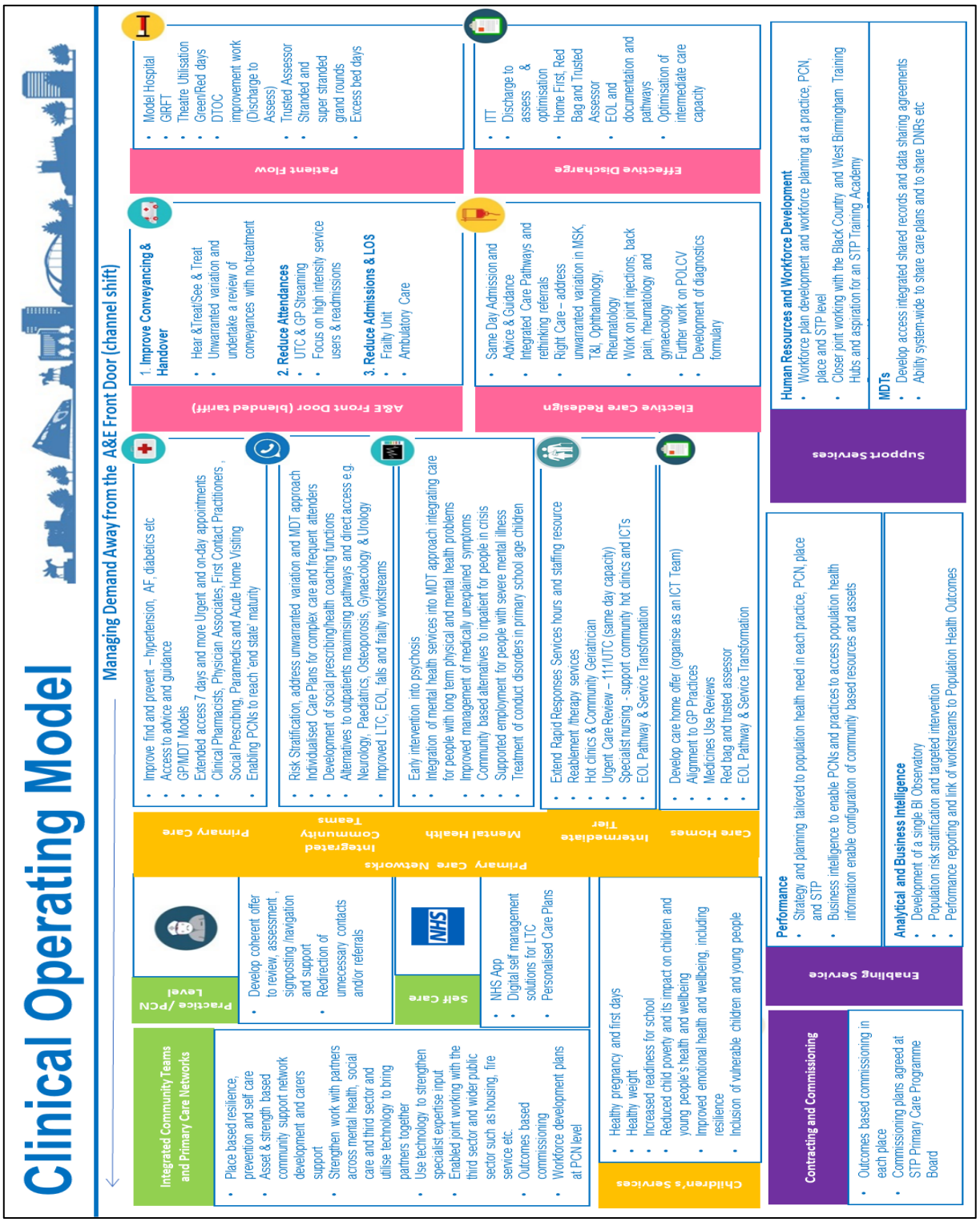
3.3 Wider Primary Care Services

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

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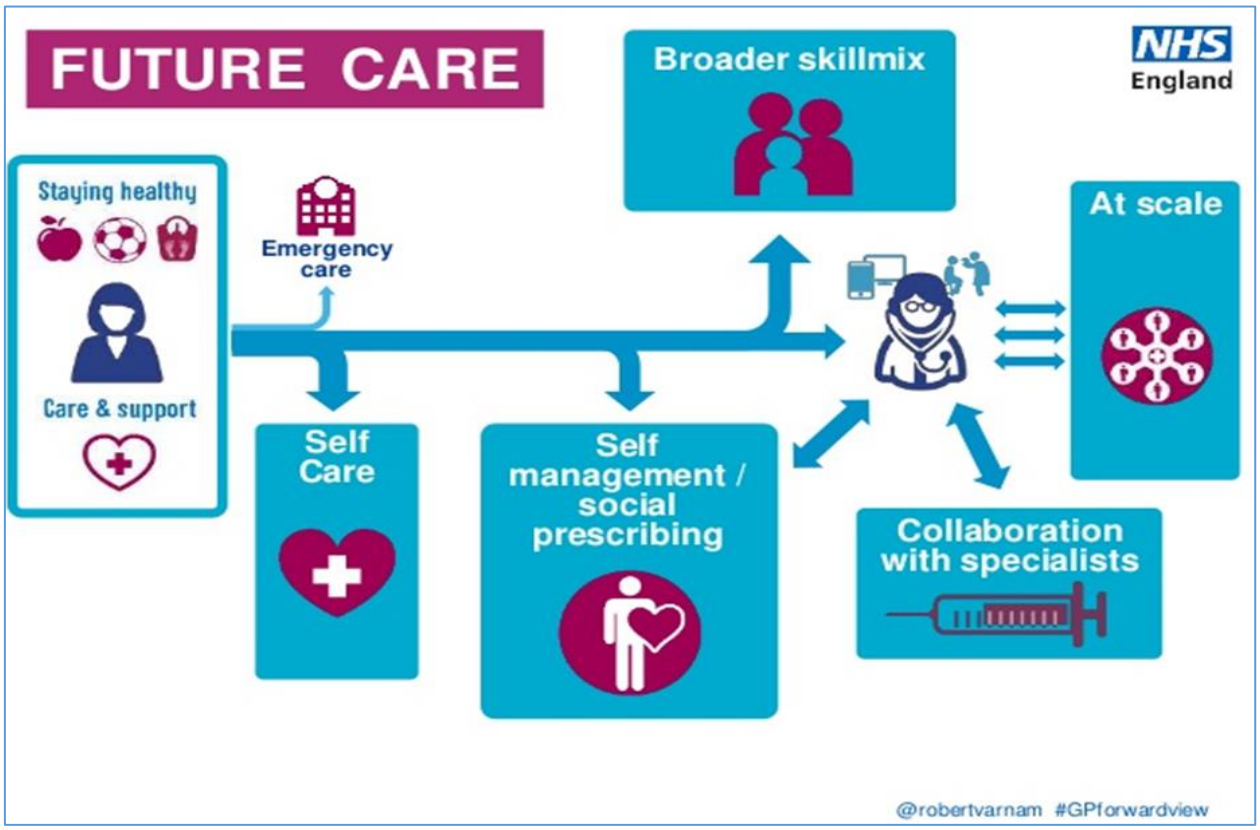
3.5 Future Model of Care

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

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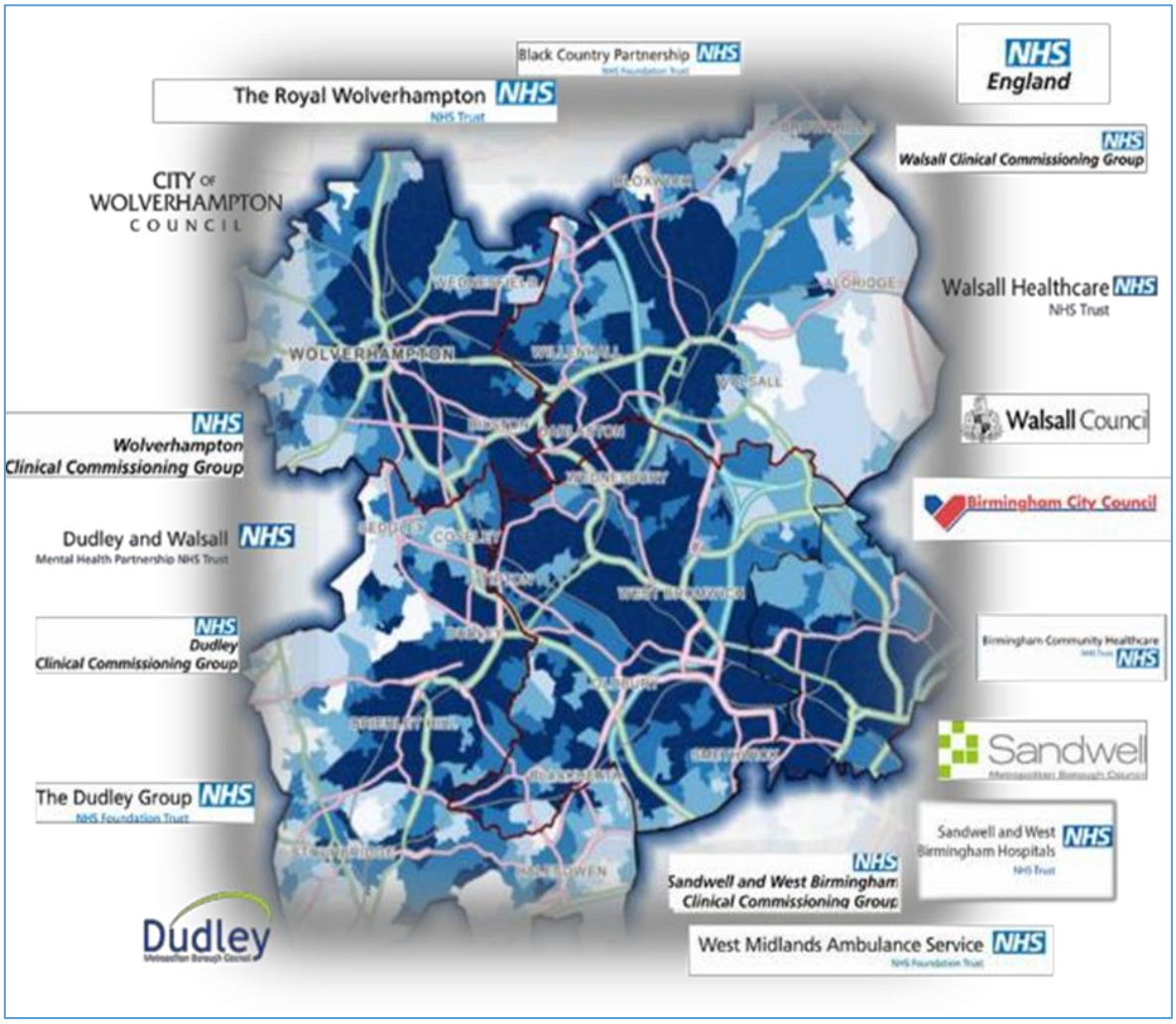
4 Introduction

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.

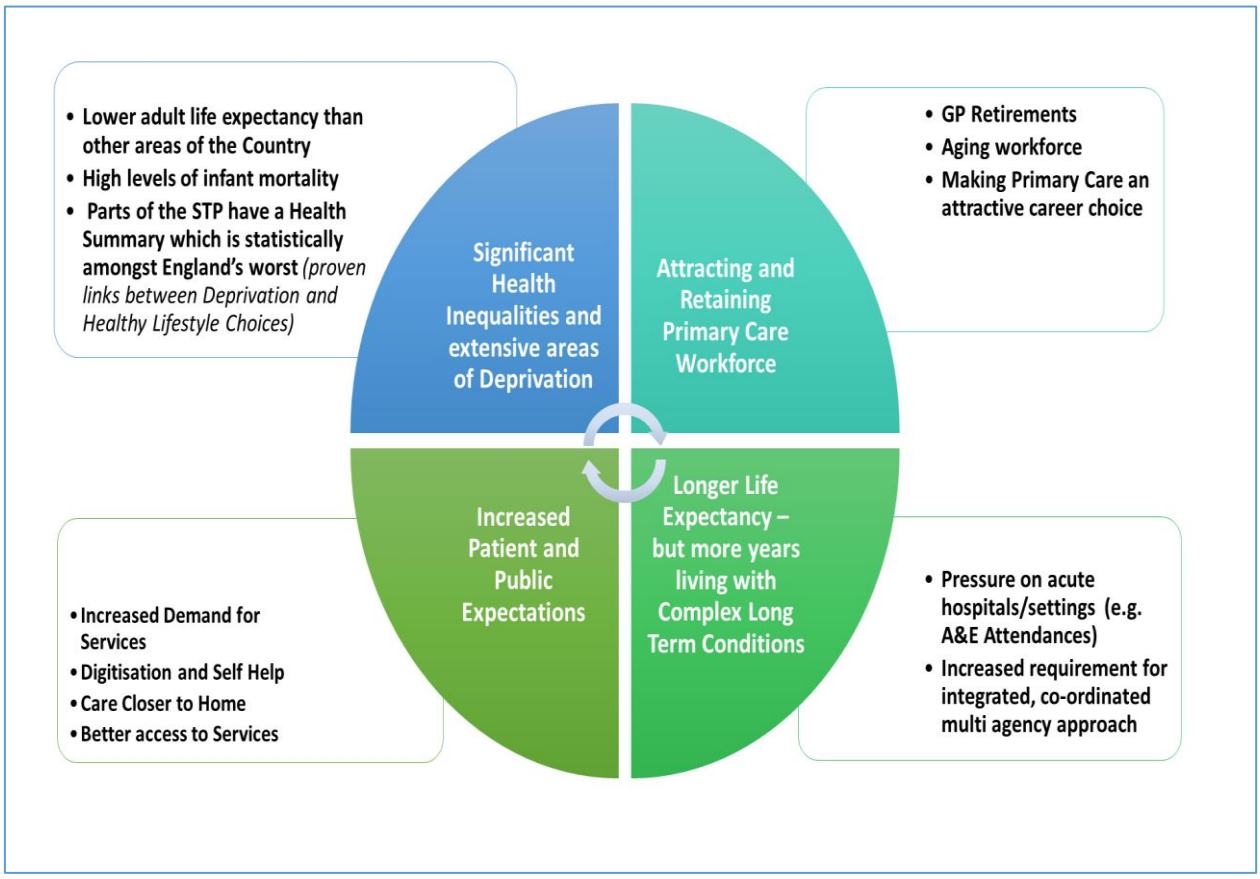
The predicted population growth across the STP footprint is expected to be in line with the national avenge but weighted towards these BME populations and particularly South Asian groups. About 4% of Black Country households have no one who has English as their main language.

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

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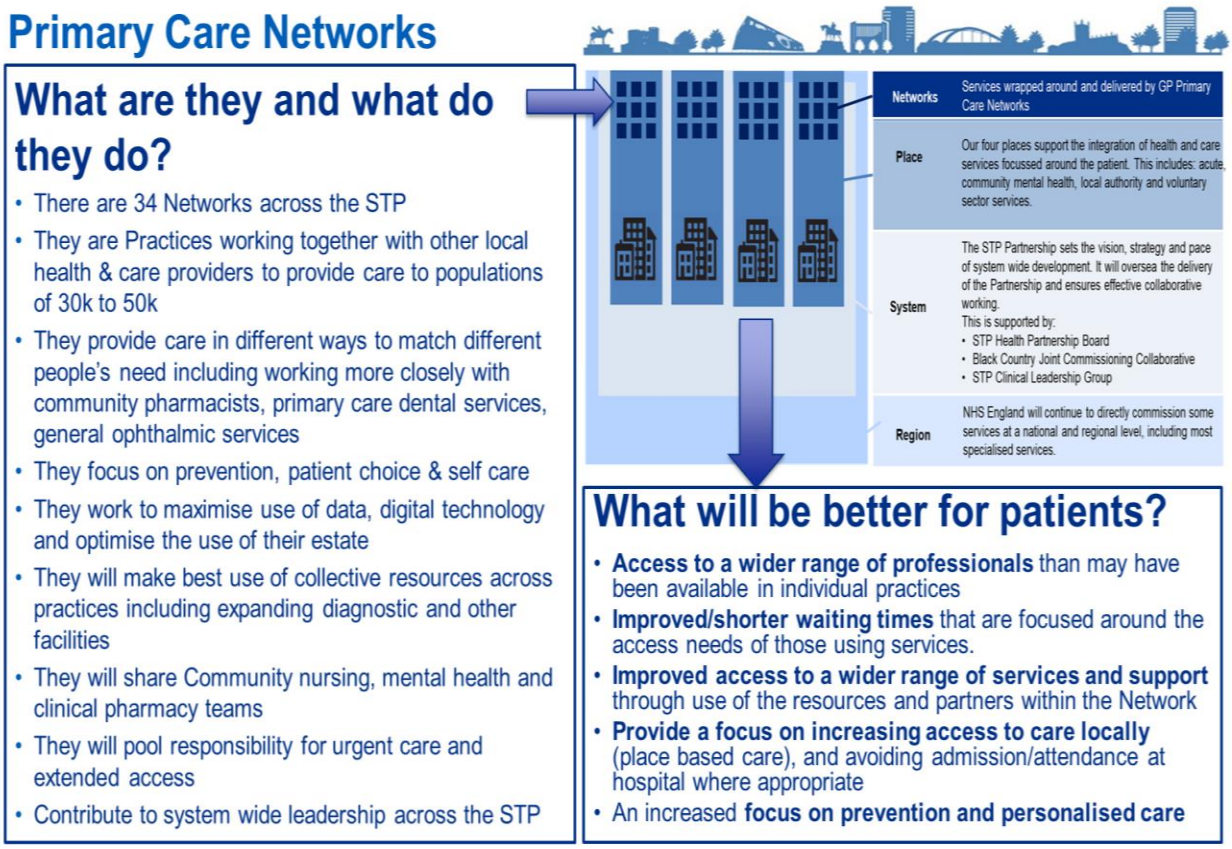
Some of these challenges are a function of changes in: population need and growing complexity of care; deprivation resulting in poor health and wellbeing; how we organise and provide services; the fact that quality of the care we offer varies unnecessarily from place to place; and the way we engage with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

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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*

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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

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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):

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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.

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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

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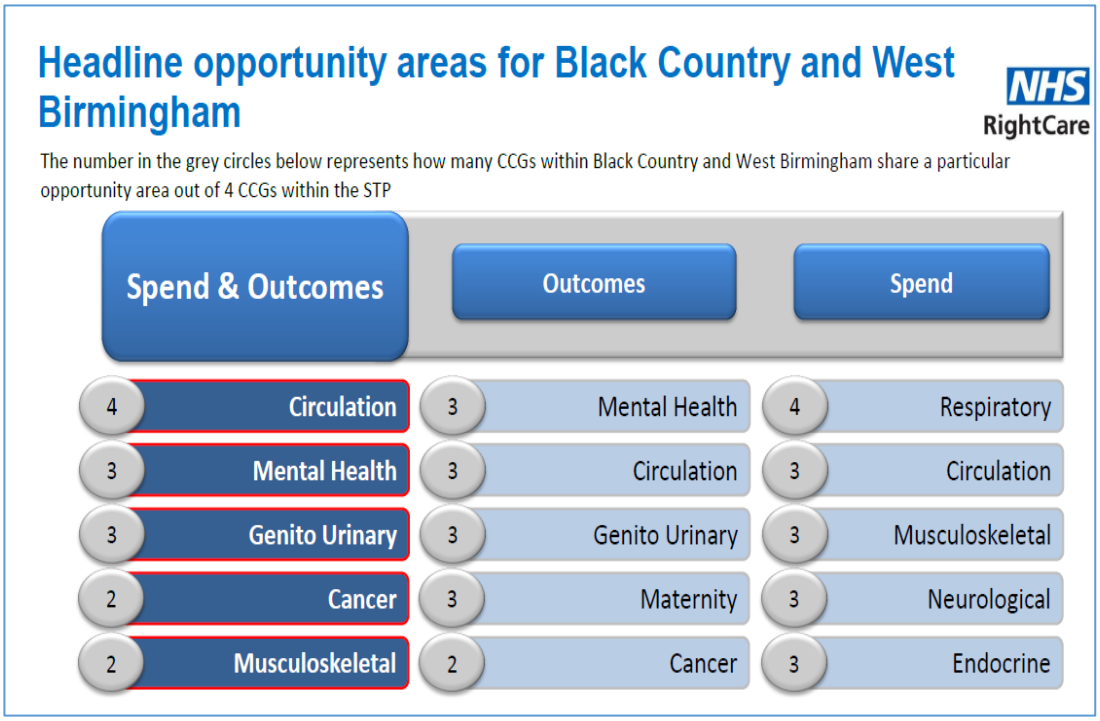
kidney disease, chronic heart disease, depression and dementia. This is demonstrated in the table below:

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.

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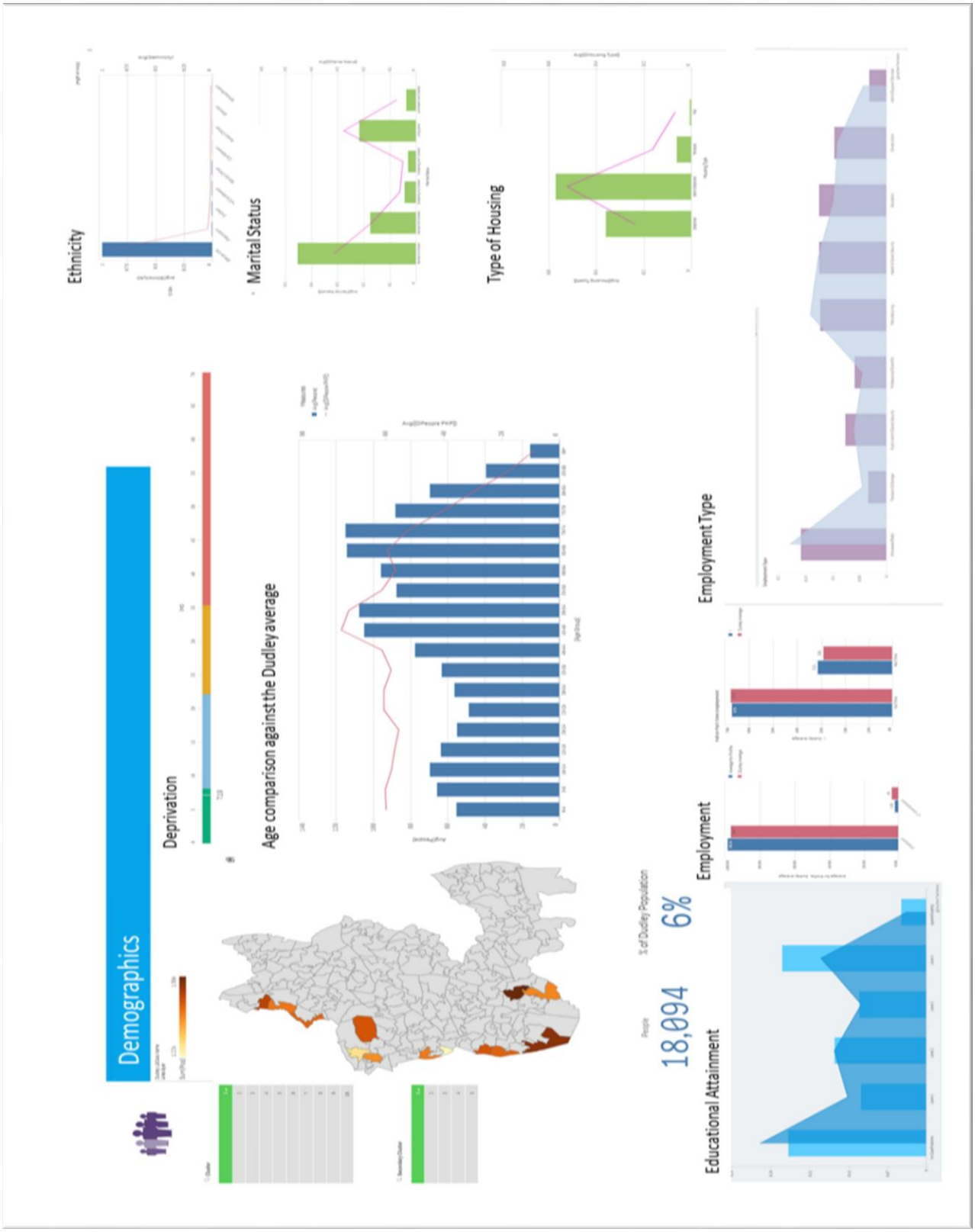
5.2 Primary Care Network Demographics

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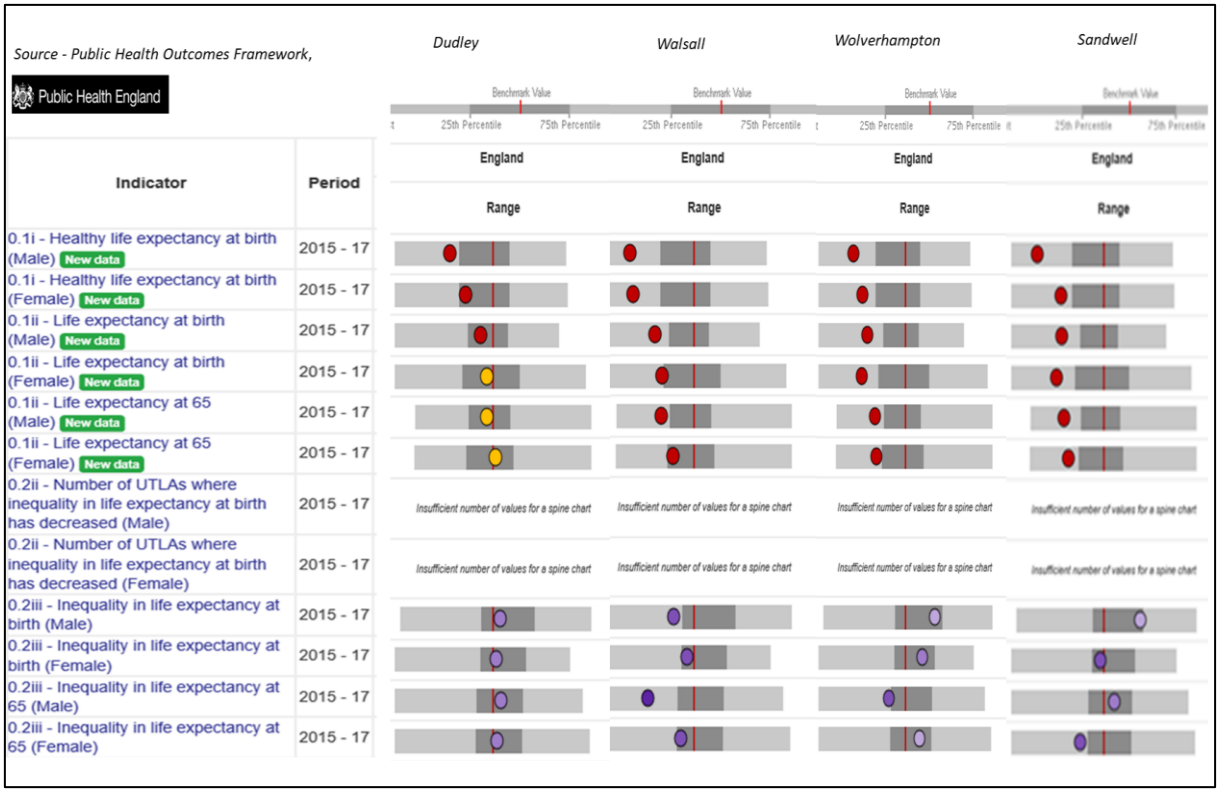
The STP recognises that PCN level analytics are at a very early stage and will continue to be developed and refined across the STP and provided to PCNs and STP Governance forums alike to both inform commissioning decisions (STP and Local) and as a mechanism to assess the impact of PCNs over time.

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; England; Range	Benchmark Value; 25th Percentile; 75th Percentile; England; Range	Benchmark Value; 25th Percentile; 75th Percentile; England; Range	Benchmark Value; 25th Percentile; 75th Percentile; 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.

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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

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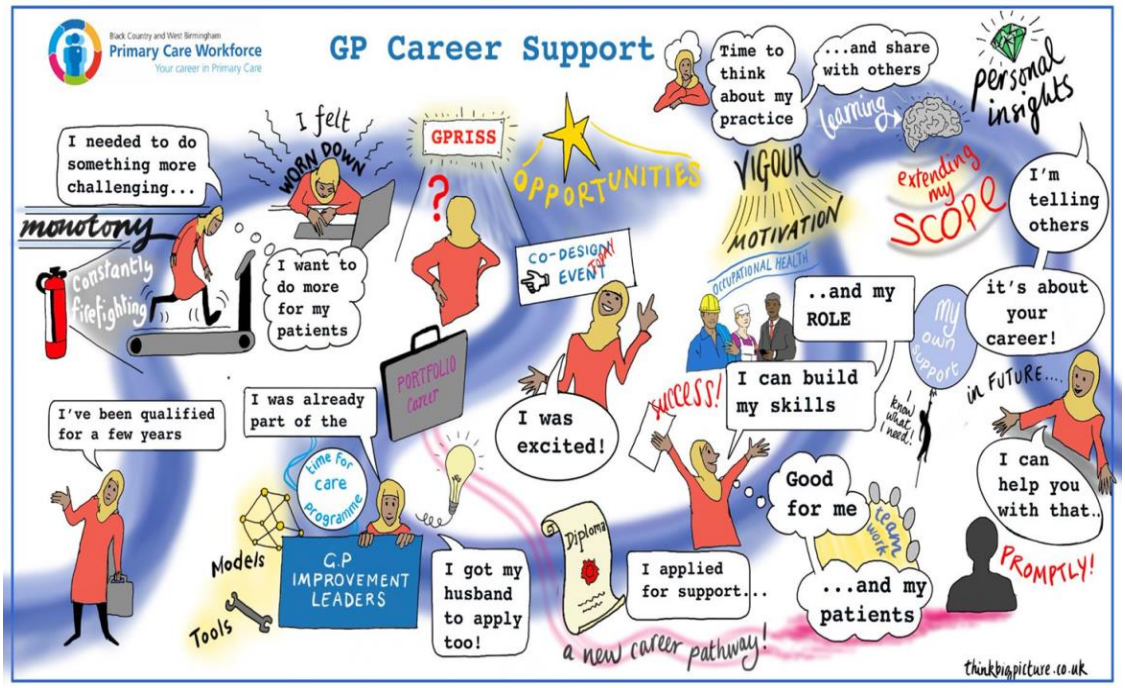

Case Study Example – GP Portfolio Careers

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.

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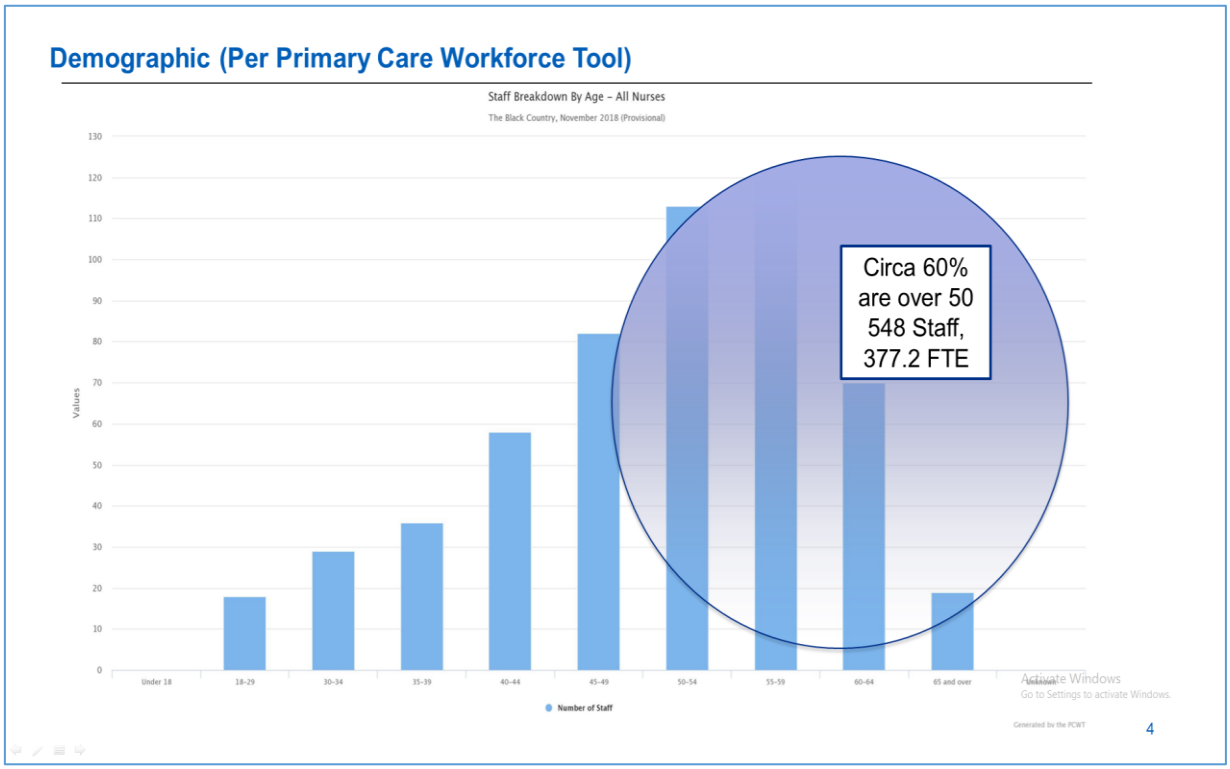
5.5 General Practice Nursing

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.

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- 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.

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- 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.

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- 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.

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- 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:*

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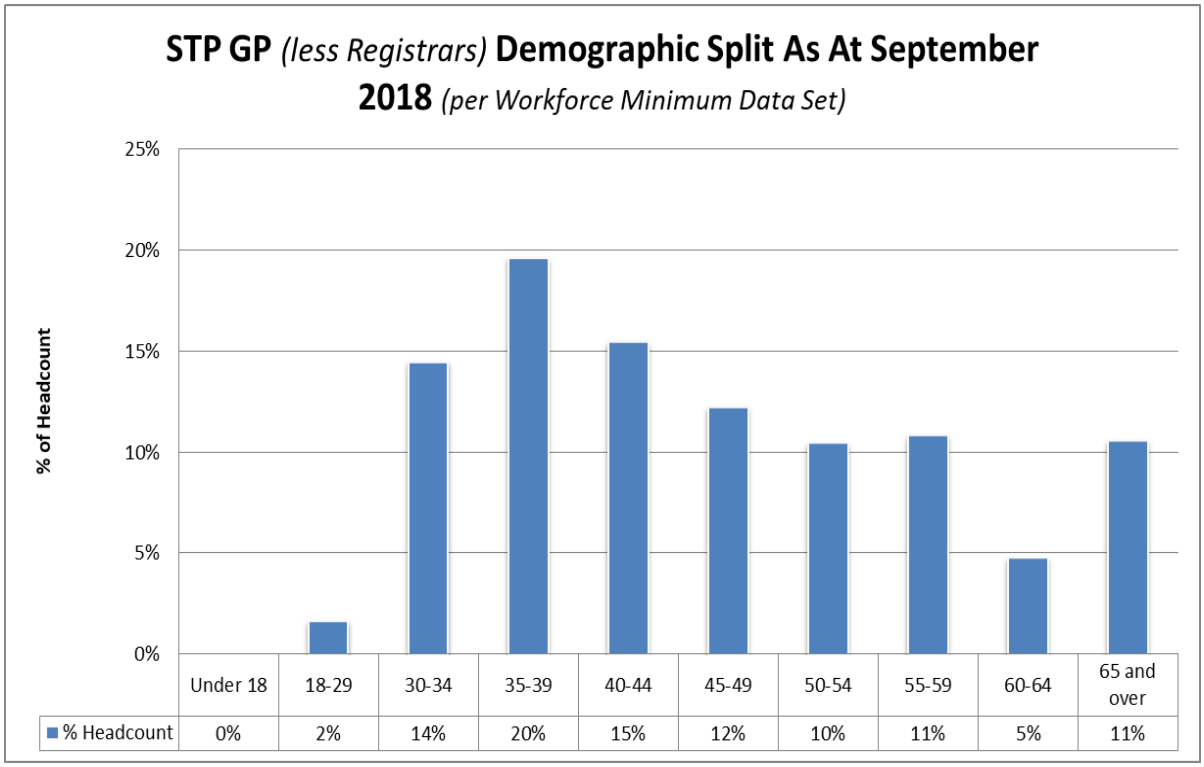

STP GP Demographics

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.

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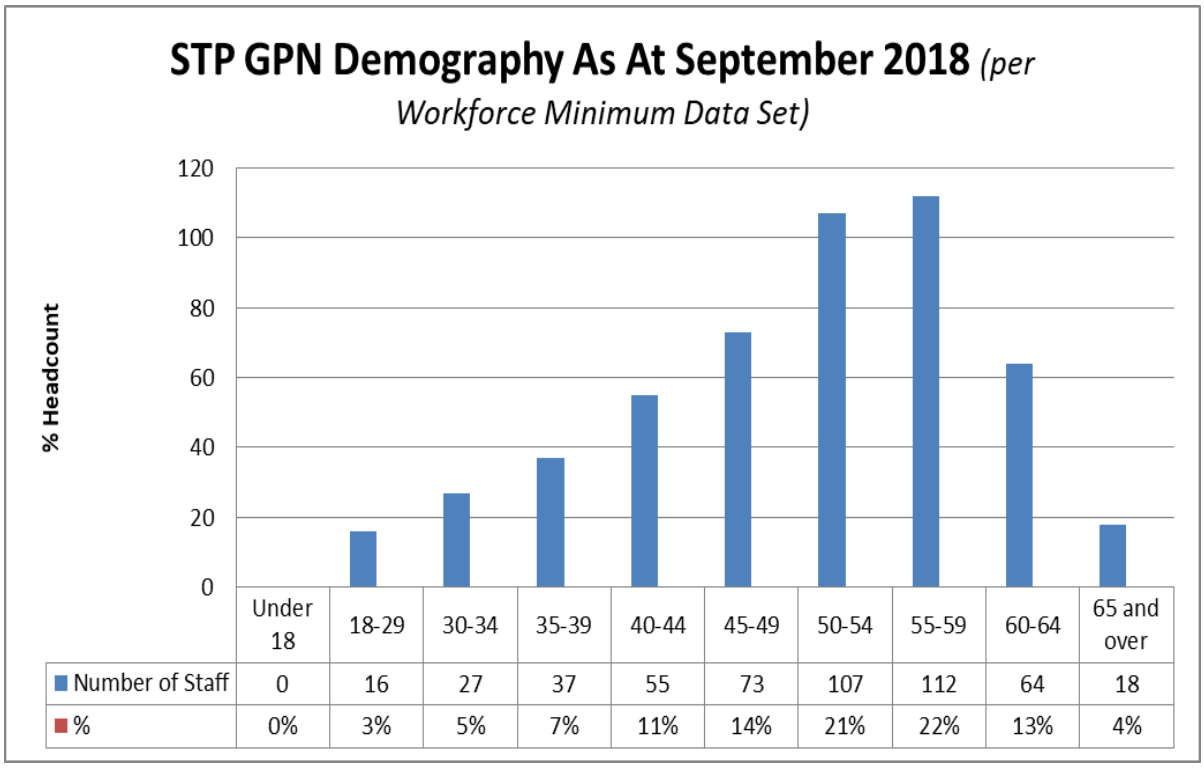

STP GPN Demographics

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

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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.

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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.

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- 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

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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.

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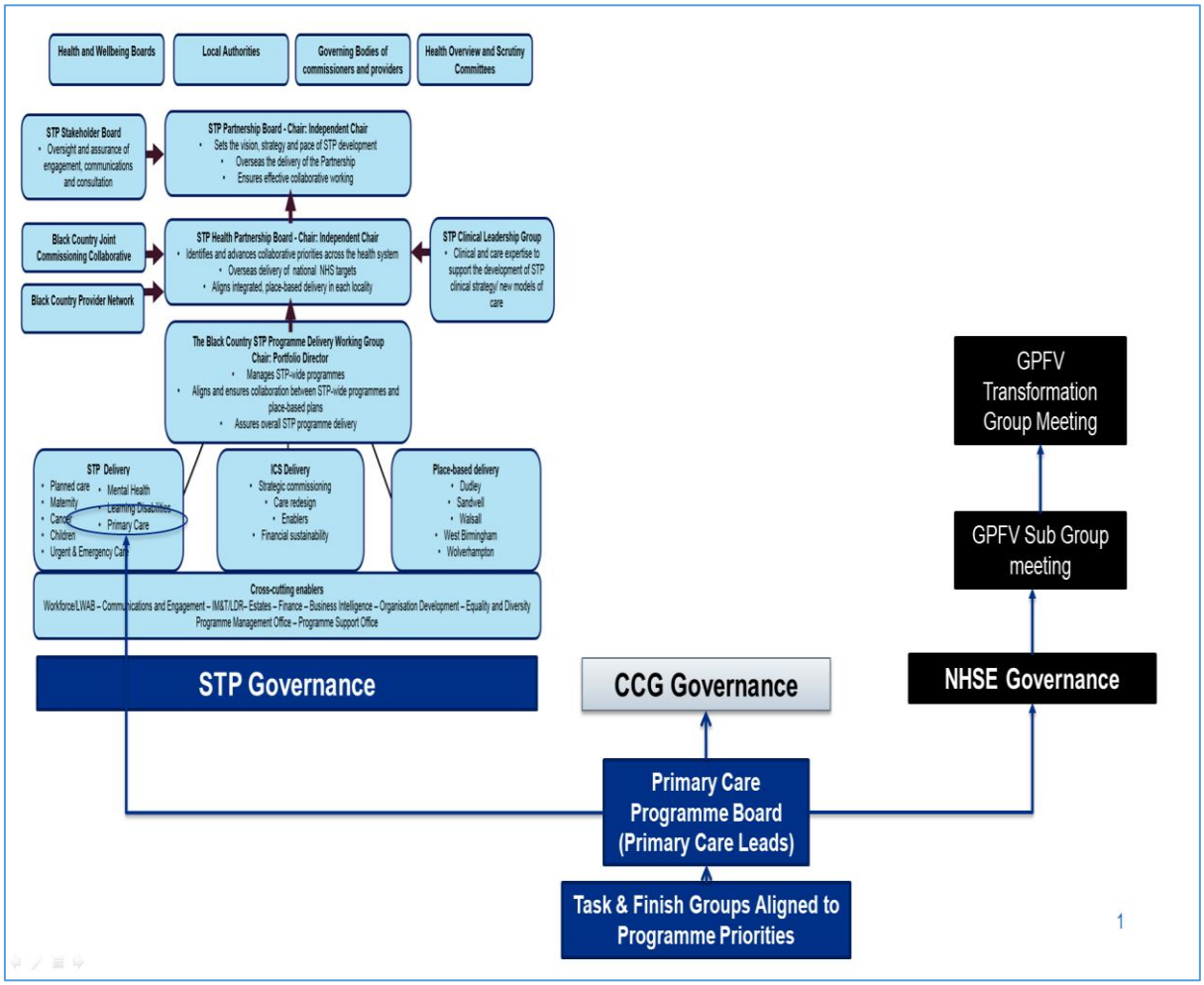
6 Fulfilling the NHS Long Term Plan

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*



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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.

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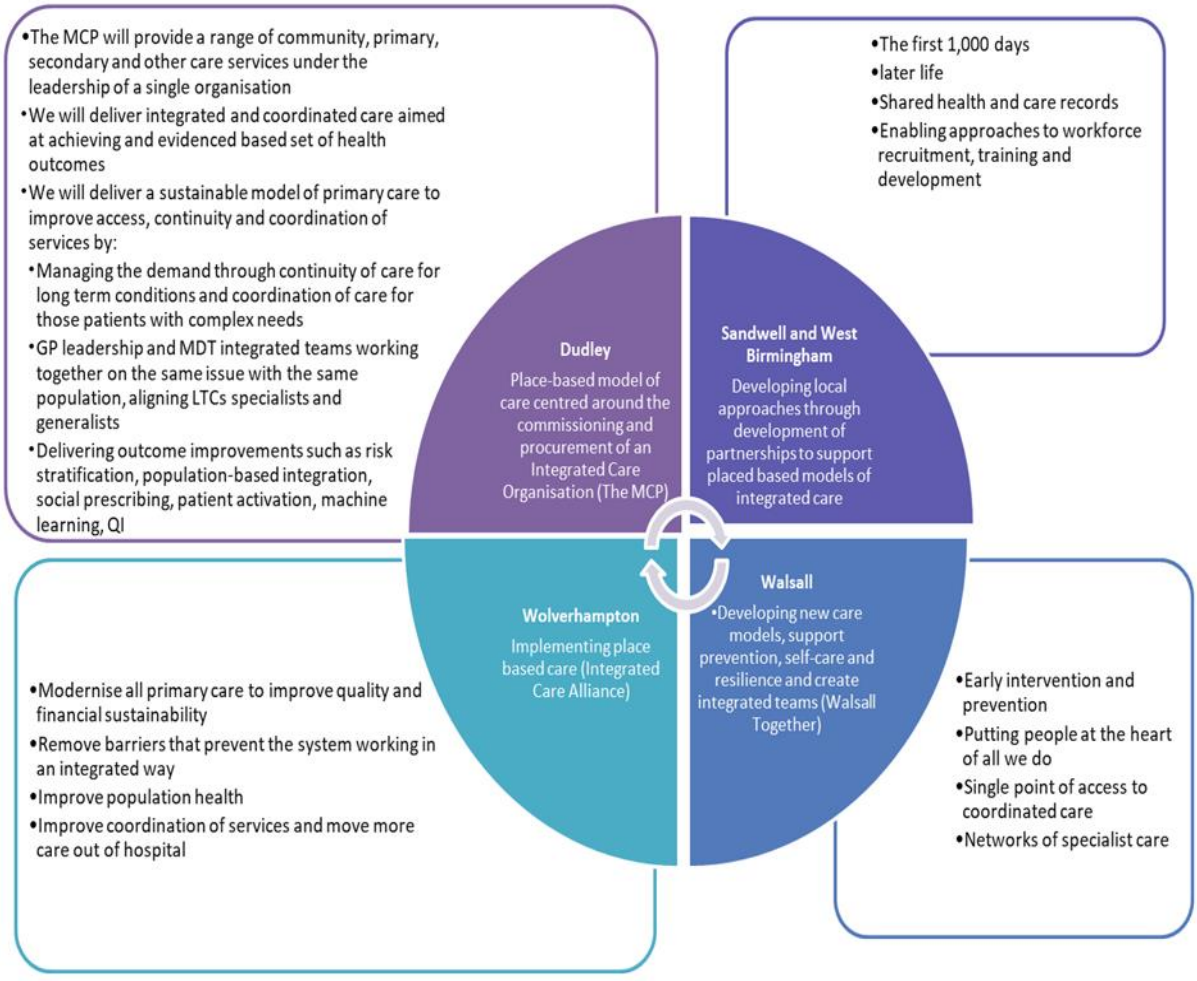
7 Key element 1 - We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services

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

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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,

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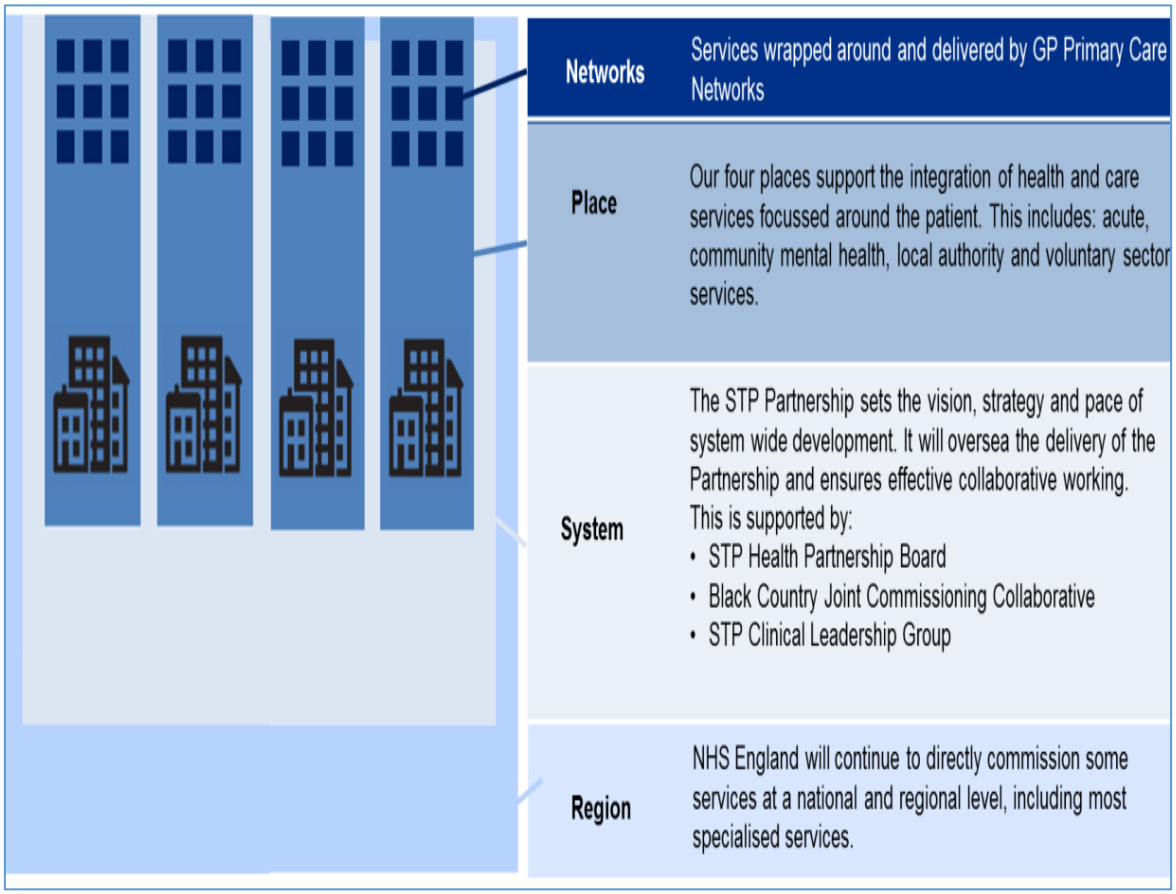
community and intermediate care teams this will increase the capacity and responsiveness of our services to those who need it.

- 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.

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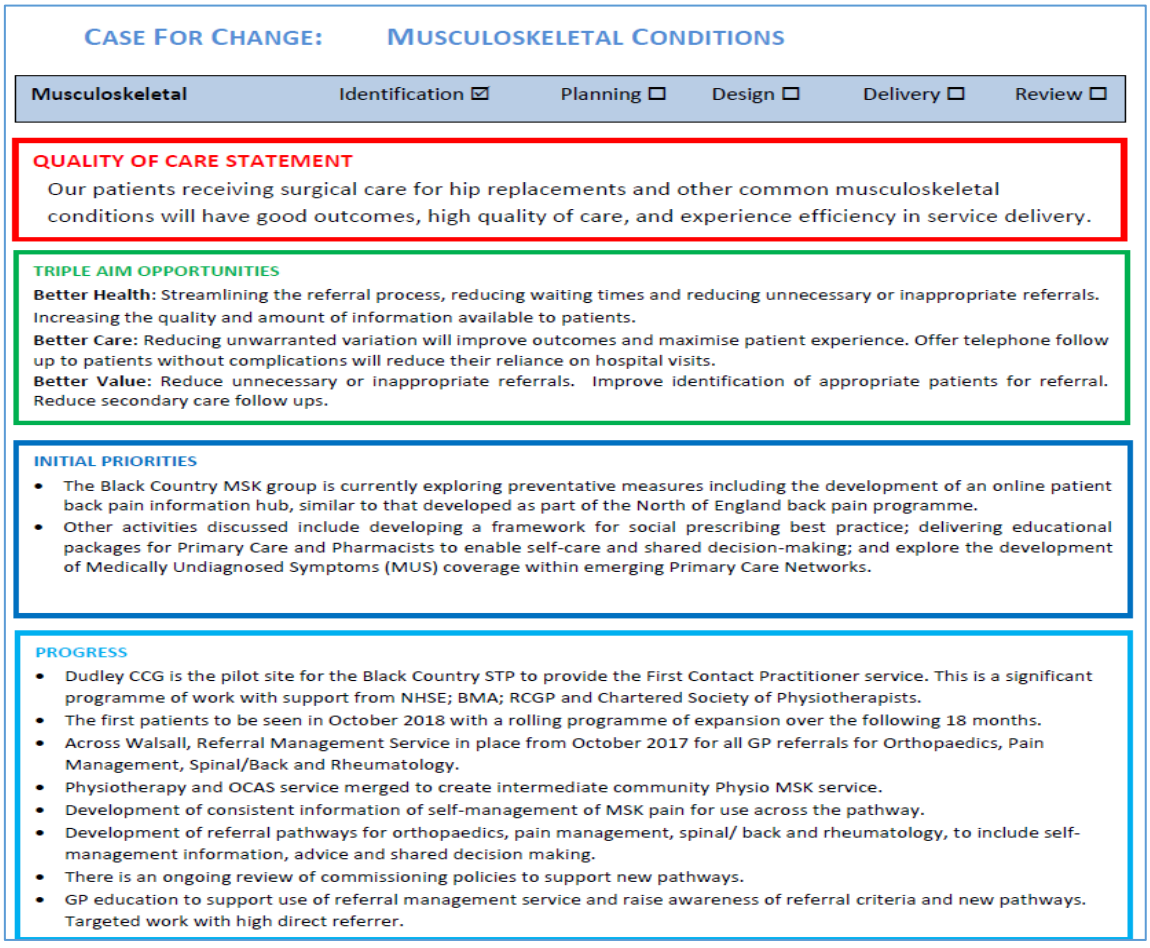
- Education and delivery of public health programmes.
- Screening and immunisation provision.
- Managing and supporting long-term conditions.
- Positive lifestyle changes.
- Health promotion, protection and screening.
- Travel advice.
- Management of risks (drugs, alcohol, weight management, smoking 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

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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.

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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.

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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.

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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.

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- 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.

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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.

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9 Key element 3 - People will get more control over their own health and more personalised care when they need it

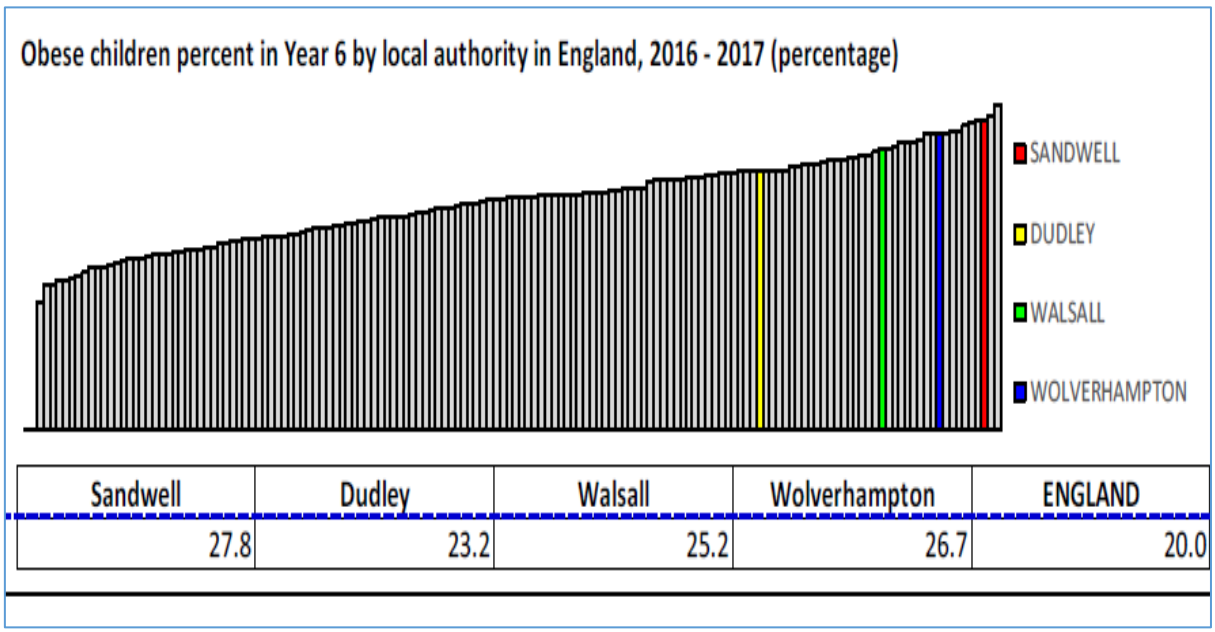
9.1 Current Situation

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.



% Obese Children Compared to National Average

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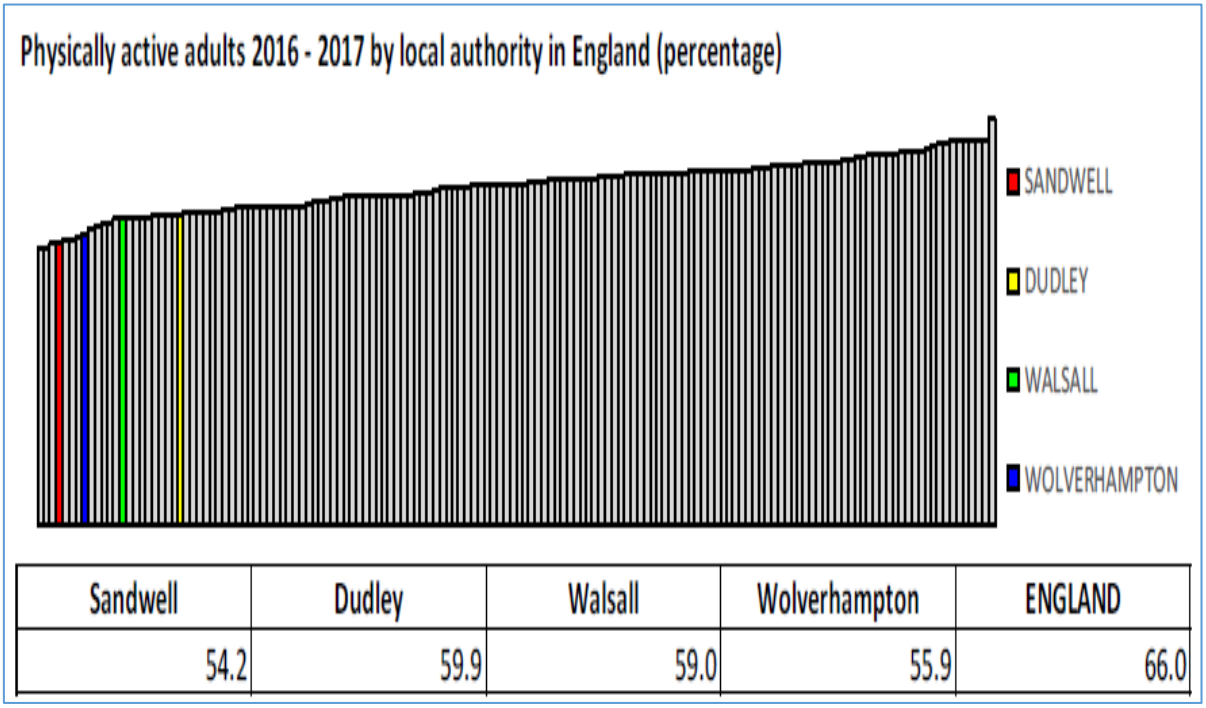

Sandwell	Dudley	Walsall	Wolverhampton	ENGLAND
54.2	59.9	59.0	55.9	66.0

% 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).

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- 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.

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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.

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- 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.

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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

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- **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).

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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.

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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.

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- 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.

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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.

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Integration Approaches across the STP

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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.

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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.

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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.

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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.

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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

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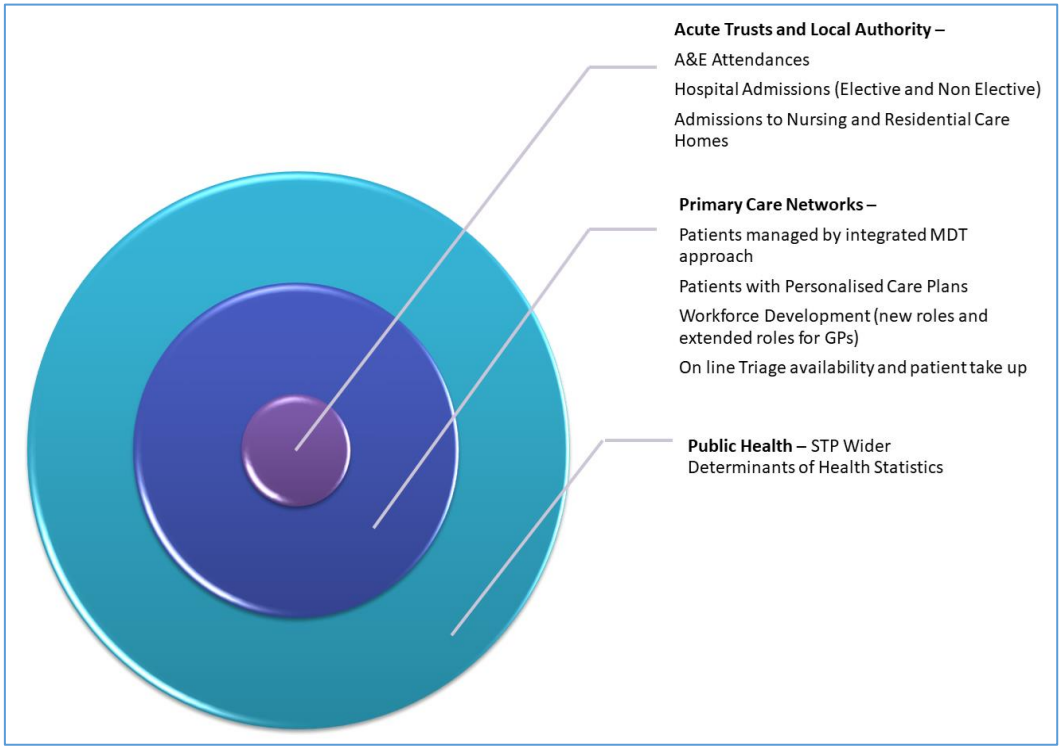
As the integration model associated with PCNs takes shape, baselining and managing the impact of the change will encompass more data sources, partners, systems and processes than ever before.

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

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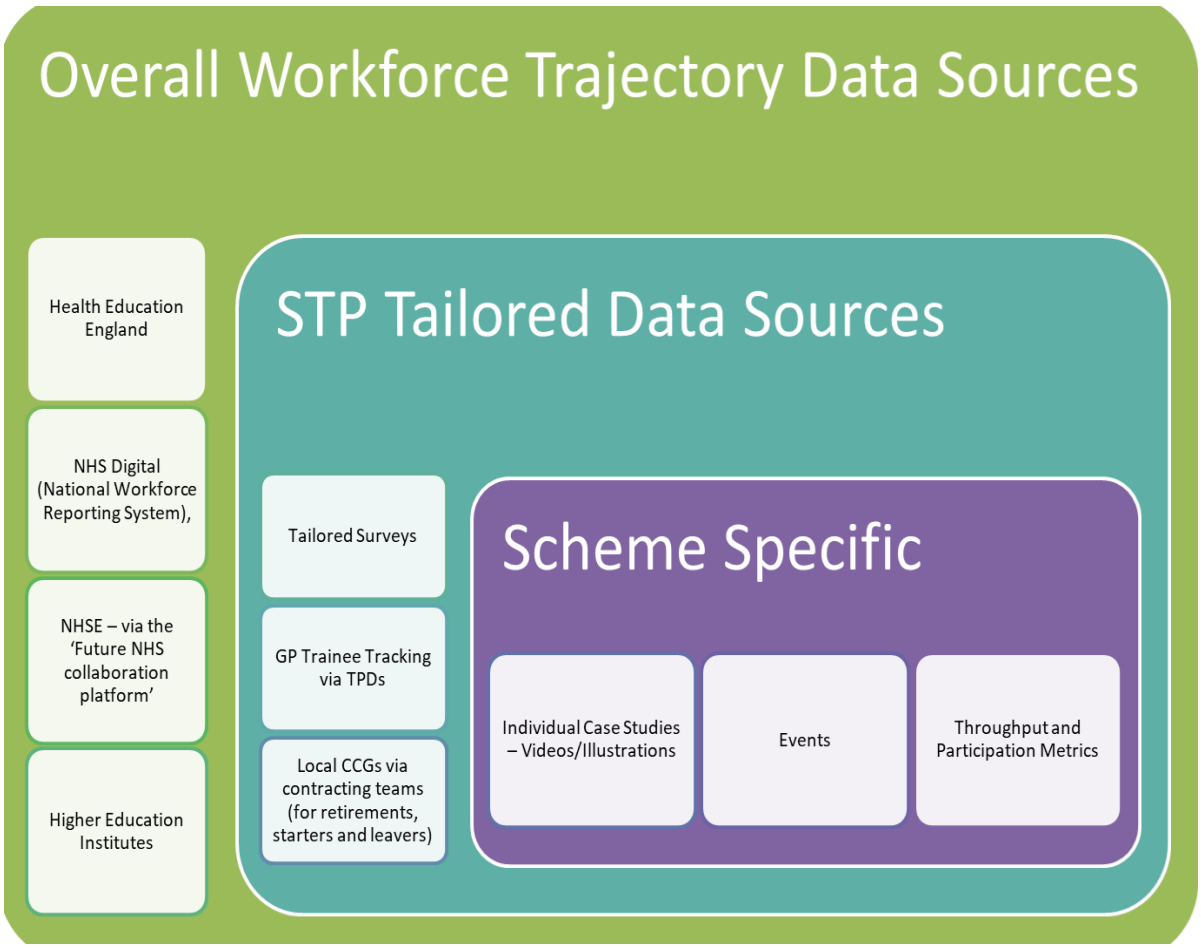
and local sources via CCG contracting teams (for retirements, starters and leavers).

- 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

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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:

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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.

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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

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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.

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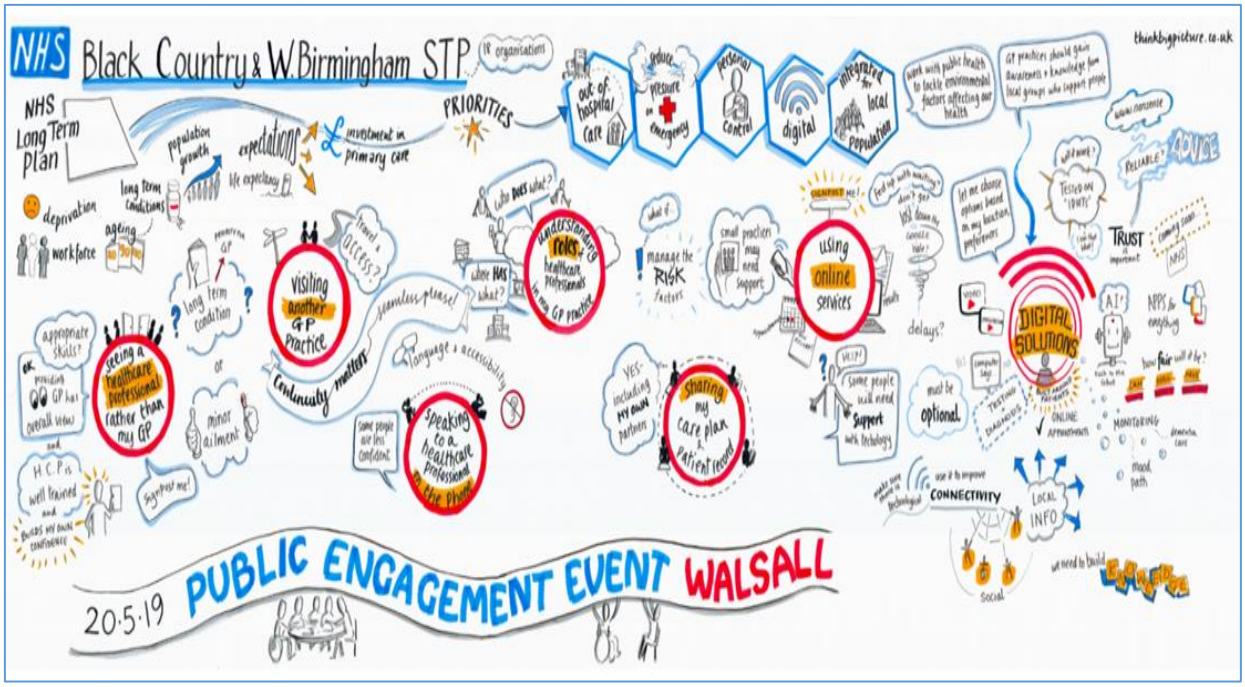
12.6 Public Engagement on this Strategy

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.

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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:-

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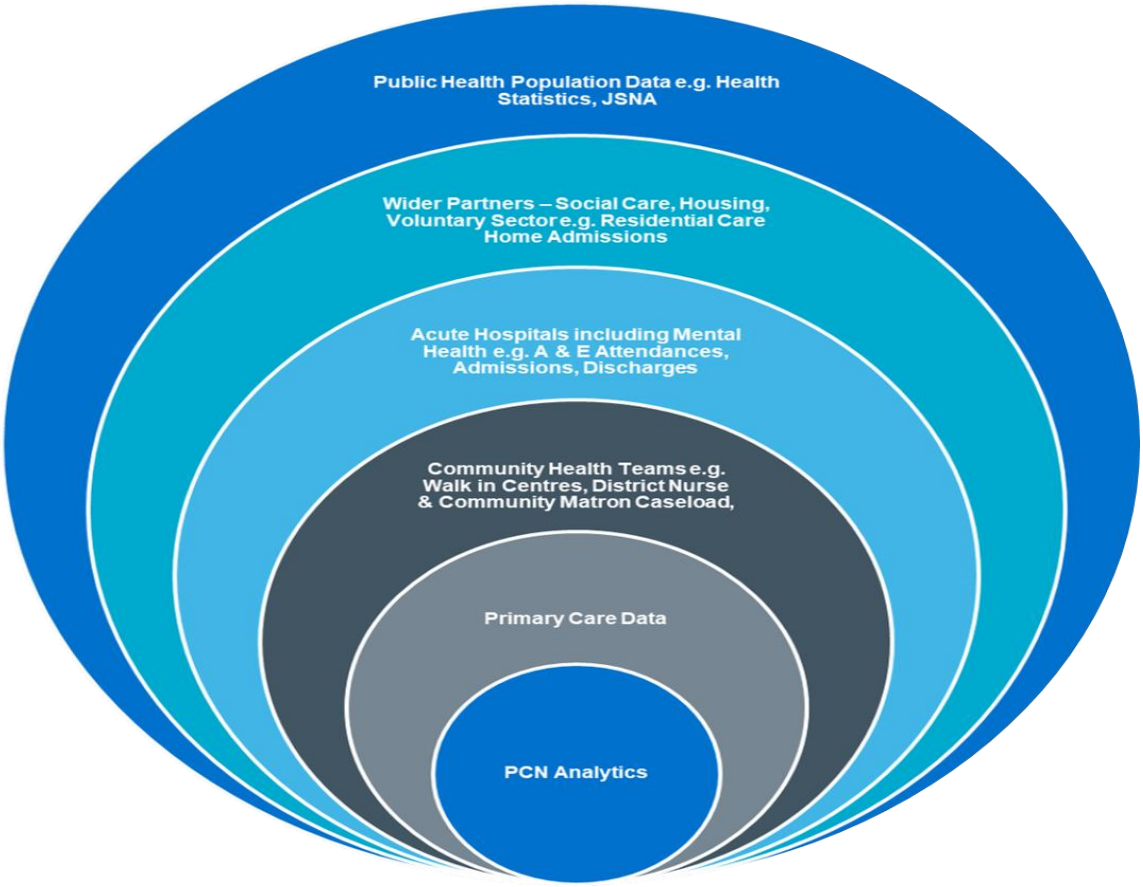

Primary Care Networks Analytics

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.

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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.

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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)

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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)

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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.

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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.

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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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