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<td>Apologies</td>
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<td>Questions from the Public</td>
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<td>Minutes of meetings held on Friday 31 May 2019</td>
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<td>Mrs H Mosley</td>
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<td>Matters Arising/Action Log</td>
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<td>Report from the Primary Care Operational Group</td>
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<td>Mrs J Robinson</td>
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<td>Risk Register</td>
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<td>Mr D King</td>
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<td>GP Engagement Scheme</td>
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<td>Mrs J Taylor</td>
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<td>STP GPN Strategy</td>
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<td>STP Draft Primary Care Strategy</td>
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<td>Quality &amp; Safety Report</td>
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<td>Mrs C Brunt</td>
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<td>Finance Report</td>
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<td>Mr P Cowley</td>
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<td>2:40pm</td>
<td>Primary Care Commissioning Committee Financial Planning Update</td>
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<td>Mr P Cowley</td>
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<td>Update from the Primary Care Development Group and GP Forward View</td>
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<td>Mrs J Taylor</td>
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<td>Primary Care Networks Update</td>
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<td>On-line Solution</td>
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<td>Mrs J Taylor</td>
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<td>STP Primary Care Programme Board Update</td>
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<td>Mr D King</td>
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<td>Future Committee Arrangements</td>
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<td>Philip</td>
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<td>Senior Finance Manager – Primary Care</td>
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<td>Andrea</td>
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<td>Dr</td>
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<td>Matthew</td>
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<td>Tim</td>
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<td>Johnson</td>
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<td>Lay Member – Patient &amp; Public Involvement</td>
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<td>Mrs</td>
<td>Anna</td>
<td>Nicholls</td>
<td>Interim Deputy Head of Commissioning (Primary Care) NHS England (West Midlands)</td>
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| Dr David   | Public Health Representative - Primary Care Commissioning Committee | Primary Care Commissioning Committee Member at Dudley CCG  
Consultant in Public Health Medicine, Dudley MBC  
Wife is a Consultant Obstetrician at Heart of England Foundation Trust  
Occasional Church organist fees received for giving recitals or playing for services |
| Mrs Julie  | Primary Care Contracts Manager         | None                                                                               |
| Mr David   | Patient Opportunity Panel Representative | Non-Executive Director - Black Country Partnership NHS Foundation Trust  
Volunteer, Healthwatch Dudley                                                   |
| Mrs Joanne | Primary Care Commissioning Manager     | Other: Daughter works at Moss Grove Surgery                                         |
| Mr Thomas  | Dudley Local Pharmaceutical Committee Representative | Dudley LPC Member  
Royal Pharmaceutical Society Member                                               |
| Mr James   | Head of Quality Assurance              | None                                                                               |
DUDLEY CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

MINUTES OF THE MEETING HELD IN PUBLIC ON
FRIDAY 31 MAY 2019
T051, 3RD FLOOR, BRIERLEY HILL HEALTH AND SOCIAL CARE CENTRE, VENTURE WAY, BRIERLEY HILL, DY5 1RU

Quorum:
A meeting of Committee will be quorate provided that at least four voting members are present of which one must be either the Chair or Vice Chair of Committee and one must be the Chief Finance Officer/Deputy Chief Finance or Chief Nursing Officer/ Head of Membership Development & Primary Care.

ATTENDEES:

Voting Members
Prof C Handy  Non-Executive Director, Quality and Safety, Dudley CCG (Chair)
Dr D Pitches  Consultant in Public Health, Dudley MBC
Mr A Johnson   Secondary Care Clinician, Dudley CCG
Mrs H Mosley  Non-Executive Director for Patient and Public Involvement, Dudley CCG
Mrs C Brunt  Chief Nurse, Dudley CCG

Non-Voting Members
Mr D King  Head of Membership Development & Primary Care, Dudley CCG
Dr T Horsburgh  Clinical Executive for Primary Care, Dudley CCG/LMC Representative
Mr D Stenson  Patient Opportunity Panel Representative

In Attendance
Mrs J Robinson Primary Care Contracts Manager, Dudley CCG
Mrs A Nicholls  Interim Deputy Head of Commissioning (Primary Care), NHS England (West Midlands)
Mrs J Taylor   Primary Care Commissioning Manager, Dudley CCG
Mr M Gamage   Head of Financial Management, Dudley CCG (Deputy for Mr P Cowley)

Minute Taker:
Miss T Fear   PA to Head of Membership Development & Primary Care, Dudley CCG

The meeting was also attended by 2 members of the public.

1.0 APOLOGIES FOR ABSENCE

Apologies were received from

Voting Members
Mr T Allen  Non-Executive Director for Governance, Dudley CCG

Non-Voting Members
Mrs A Crew  Chief Officer, Healthwatch Dudley
Mr T Thomik  Dudley LPC Representative

In Attendance
Mr P Cowley Senior Finance Manager, Dudley CCG (Mr M Gamage deputy)
Mr B Dhami  Senior Contracts Manager (Primary Care), NHS England (West Midlands)
Mrs S Nicholls  Deputy Chief Nurse
2.0 DECLARATIONS OF INTEREST

To request members to disclose any interest they have, direct or indirect, in any items to be considered during the course of the meeting and to note that those members declaring an interest would not be allowed to take part in the consideration or discussion or vote on any questions relating to that item.

The Chair confirmed that a review of the Conflict of Interest checklist and any potential Conflict of Interest from the agenda items had taken place.

Resolved:
1) No changes were made to those listed.

3.0 QUESTIONS FROM THE PUBLIC

Prof. Handy noted that there were no questions submitted to Committee prior to the meeting.

Resolved:
1) Committee noted that there were no questions submitted prior to the meeting.

4.0 MINUTES OF THE LAST MEETING

The minutes of the meetings held on Friday 15 March 2019 and Friday 26 April 2019 were submitted to Committee.

Committee noted that the minutes relating to the meeting held Friday 15 March 2019 were agreed as an accurate record of the meeting.

Committee noted that the minutes relating to the meeting held Friday 26 April 2019 were agreed as an accurate record of the meeting.

Resolved:
1) Committee agreed that, the minutes of the meeting held on the 15 March 2019 were an accurate record of the meeting.
2) Committee agreed that, the minutes of the meeting held on the 26 April 2019 were an accurate record of the meeting.

5.0 MATTERS ARISING/ACTION LOG

The action log was discussed and updated accordingly with the following points noted:

PCCC/MAY/2019/6.0 Primary Care Networks
The slides were circulated to the members of Committee.
Action closed.

PCCC/MAY/2019/9.0 2019/20 Financial Plan
The Primary Care budget was reported to the CCG’s governing body. A further update would be given to Primary Care Commissioning Committee in July 2019 as part of the Finance report.
Action closed.

PCCC/MAY/2019/10.0 Interpretation Services
A task and finish group had been set up which would look at translation issues. A piece of work had been produced which analysed by practice the most utilised non-English language across Dudley and provided clarity to those languages which were not currently being recorded. It was expected that a report would be considered at Committee in August 2019.
Action closed.
A further point was discussed in relation to the Committee’s delegation to agree the STP Primary Care Strategy which was referenced within the minutes of April’s Committee. Committee were informed that the item was discussed at the May Governing Body where it was agreed the Primary Care Commissioning Committee would have delegated authority to agree a draft Primary Care Strategy.

6.0 RISK REGISTER

Mr. King spoke to this item to provide the Committee with an updated risk register.

Committee reviewed the current status of the risks and recommendations made by the Primary Care Operational Group (PCOG).

Risk 135 - “There is a risk that the provision of Primary Care Medical Services are adversely affected partially or fully due to individual performer issues.” The risk to remain the same

Risk 136 – “There is a risk that the provision of Primary Care Medical Services are adversely affected partially or fully due to insufficient workforce”. The risk to be reviewed quarterly.

Risk 137 – “There is a risk that the provision of Primary Care Medical Services are adversely affected partially or fully due to unplanned loss of Estates or IT infrastructure” The risk to remain the same

Risk 138 – “There is a risk that the provision of Primary Care Medical Services are adversely affected partially or fully due to Financial issue”. The risk to remain the same

Risk 139 – “There is a risk that there is insufficient workforce and appropriately skilled workforce within the primary care team and wider CCG support teams to deliver the delegated Primary Care Commissioning functions, projects such as the GP Forward View Plan and Dudley Quality Outcomes for Health”.

PCOG had made a recommendation to Committee in relation to closing Risk 139 from the Primary Care Commissioning Committee Risk Register and create a new risk on the Remuneration & Human Resources Committee Risk Register. It was noted the risk would need to be reviewed regarding whether organisational capacity exists in the CCG to deliver the corporate objectives. Committee accepted the recommendation made by PCOG to close Risk 139.

Action: Non-Executive Directors

Resolved:
1. Committee reviewed the current status of the risks.
2. Committee accepted the recommendations made by the Primary Care Operational Group for Risk 139 to be closed from the Primary Care Committee Risk Register and create an additional risk on the Remuneration & Human Resources Committee Risk Register.

7.0 QUALITY AND SAFETY REPORT

Mrs Brunt spoke to this item to provide on-going assurance to Committee regarding quality and safety in accordance with the CCG’s statutory duties.

Committee were advised that follow up visits had been scheduled for the practices who had already received CQC reports following recent inspections. The visits would discuss methods of support for the domains that were rated as “Require Improvement”.

It was noted that work was on-going in relation to Dudley’s Immunisations. A review of data had demonstrated that the uptake of childhood vaccinations in Dudley had fallen when compared to previous years, although Dudley is better than the national average.

Dr Pitches noted that there was a rise in cases of measles and mumps in young people who missed
immunisations during the “MMR scares” of the 1990s. Patients who were not vaccinated were still able to do so providing they didn’t have contra-indications.

General discussions took place in relation to campaigns relating to immunisations. It was felt that more work could be done to encourage vaccination for the benefit to the patient and to the wider community. It was suggested whether campaigns would be launched locally however it was noted that this would be more beneficial if promotion was managed nationally and at STP level.

Committee had previously noted its concerns in relation to length of time it had taken to close a serious incident logged within the Quality & Safety report which had been managed by NHS England. Committee were advised that the Serious Incident had now been closed.

There were 18 patients on the Special Allocation Scheme (SAS). Following a review panel meeting 6 patients had been successfully removed from the scheme and were now receiving general medical services within GP practices. Committee were advised that a further review panel had met and it was expected that a paper on potential changes would be reported to the next.

Committee were asked to note the report for assurance.

Resolved:

1. Committee noted the report for assurance.

8.0 FINANCE REPORT

Mr Gamage spoke to this item on behalf of Mr Cowley to present baseline budgets for the financial year 2018/19.

The budget reported to Committee for the full financial year totaled £45.601m

An underspend of £35,000 was reported in respect of budgets reported to Committee for the full financial year.

One further budget change was reported in month 12, with £39,000 received from NHS England in respect of diabetes transformation.

Within the overall figure, small underspends against Co-commissioned Primary Care services (£9,000) and Core Commissioning budgets (£29,000) were partially offset by an overspend of £9,000 in respect of GP Forward View allocations.

Clarification was given in relation to the £35,000 underspend, it was noted that the figure would not carry forward to the next financial year however would contribute to the CCG’s overall surplus control total.

Committee queried the figures within the report in relation to the “GP with special interest”. It was felt that the figures were significantly high for a 0.5 whole time equivalent post. It was suggested that there could be more than one GP with a special interest however it was agreed that Mr. Gamage would seek clarity on the matter.

Action: Mr. Gamage

Committee was asked to note the reported financial position for assurance.

Resolved:

1. Committee noted the reported financial position for assurance.
2. Committee requested clarification in relation to the figures given for the GP’s special interest.
Mrs Robinson spoke to this item to update Committee following the Primary Care Operational Group (PCOG) meeting held on 1 May 2019.

PCOG noted that version 2 of the NHS England Primary Medical Care Policy and Guidance Manual (PGM) had been published and that the Primary Care Contracts team would be reviewing the amendments and any internal policies would be amended accordingly. It was anticipated that the Special Allocation Scheme would require amendments. It was also noted that the CCG were expected to report to NHS England via the Primary Care Commissioning Activity Report that Committee had considered and reviewed the revised guidance. Committee were assured that they would have sight of any changes via a report from the Primary Care Operational Group.

The group reviewed the practice visit schedule and minor changes were agreed to improve overall effectiveness. It was also noted that an additional 2 practices were identified to receive a practice visit following recent CQC “Required Improvement” ratings either overall or in one or more of the domains and from analysis from the Primary Care Analysis Tool (PCAT).

The group also received a report detailing exception reporting reviews undertaken as part of the Dudley Quality Outcomes for Health (DQOFH) monitoring process. Committee were previously sighted on 11 practices that had been identified as requiring a practice visit. The group were assured that the practice visit had been carried out and all remedial actions had been completed. Committee were advised that no areas of concerns were highlighted from the practice visits however it was noted that a number of practices had protocols in place however they did not have anything formal in writing. The visits also highlighted a number of areas of good practice. It was expected that these would be shared with the Dudley Practice Managers Alliance (DPMA).

It was agreed that future Quality and Safety reports would include the number of IRIS (Identification and Referral to Improve Safety) referrals.

Committee were asked to note the actions of the Primary Care Operational Group for assurance.

Resolved:

1. Committee noted the actions of the Primary Care Operational Group for assurance.

Mr King spoke to this item to confirm Primary Care Network (PCN) registrations.

The Primary Care Operational Group met on 22 May to consider PCN registrations and received registration documents to establish 6 PCN’s. Committee were advised that the previous Kingswinford, Amblecote & Brierley Hill locality had split in two.

The Primary Care Operational Group provided assurance to the Committee that;

- All PCN registration requests were submitted by 15 May as required by the Directed Enhanced Service (DES)
- All PCN registration documents were completed with the information required for registration
- That 100% of the CCG population was included within a PCN
- The registration requests align with the NHS England requirements that the PCN footprint would “best support the delivery of services to their patients in the context of broader Integrated Care Systems (ICS)”

The Group also considered a request from Kingswinford and Wordsley PCN which included a registration request for Moss Grove Surgery, Kinver - a member practice of NHS South East Staffordshire and Seisdon Peninsula CCG (SESSP). The Primary Care Operational Group, in consultation with NHS England and SESSP agreed that a PCN registration for Moss Grove Surgery, Kinver to join Kingswinford and Wordsley PCN could not be confirmed. However it was noted that if the application for Moss Grove Surgery Kinver to
transfer into Dudley CCG was approved the request be supported at this time. Committee were advised that Moss Grove Kinver had already been made aware of PCOG’s recommendation.

Discussion took place in relation to a number of the PCN’s that had a total network list size above 50,000. Committee were assured that the applications were based on the geography of the practices, the population needs and were co-terminus with MCP configurations. NHS England confirmed their agreement with the 4 PCN’s having total network list size above 50,000.

Committee were then informed of the next steps of the registration process and were advised that subject to Committee approval the registration documents would be submitted to the STP for approval.

It was highlighted that there was one practice – Meadowbrook Road Surgery that decided not to participate in the DES but had confirmed that it was in agreement for the CCG to allocate the DES resources to the Halesowen PCN to ensure 100% coverage. The resource would be managed on behalf of Meadowbrook Road Surgery and therefore its patients would still receive the same level of service and would be organised and co-ordinated through the Halesowen PCN. General discussions took place in relation to the effect this would have on the patients, it was felt that there would not be an impact to patients in the first year however it was expected that patients may be effected in the second year of the DES. Committee were advised that Meadowbrook Road Surgery would be able to fully join the Halesowen PCN should they wish to do so.

Mrs Taylor advised Committee that the practice did not participate in the local extended access scheme, and their patients were already utilising other Halesowen practices to access the extended access scheme.

Discussions then turned to the appointment of the PCN Clinical Director roles. Committee were advised that the CCG had provided PCNs with a suggested job description and person specification using the sample template that had been published nationally however as the commissioner, Dudley CCG were not able to dictate the job description for the Clinical Director role. Committee were advised that each PCN had gone through a selection process to recruit Clinical Directors within each locality. PCNs went through either an election or appointment process to recruit to the position. It was also noted that NHS England had launched a national training programme which each clinical director would be expected to attend in order to develop their competencies and skills.

Committee requested that PCNs become a standing agenda item. Committee were advised that the update would form part of the PCOG update to Committee.

Committee were asked to:

- Note the contents of the report and its appendices
- Consider and approve the recommendations from the PCOG

  1. That the PCN registration requests were approved, excluding Moss Grove Surgery, Kinver from the Kingswinford and Wordsley PCN at this stage
  2. Support the registration and request to proceed with a PCN transfer of Moss Grove Surgery, Kinver subject to approval by NHS England of the application for the practice to join Dudley CCG

Resolved:

1. Committee noted the report and its appendices.
2. Committee considered and approved the Primary Care Network registrations excluding Moss Grove Surgery, Kinver from the Kingswinford and Wordsley PCN at this stage.
3. Committee approved the Primary Care Operational Group recommendation to support the registration and request to proceed with a PCN transfer of Moss Grove Surgery, Kinver subject to approval by NHS England of the application for the practice to join Dudley CCG.
4. Committee requested regular updates on Primary Care Networks as part of the Primary Care Operational group report to Committee.
Mrs Taylor spoke to this item to present to Committee the end of year process for 2018/19 and process for undertaking contractual visits, the final draft business rules for the 'Dudley Quality Outcomes for Health' (DQOFH) contract 2019/20 and the process for future review of DQOFH for ratification.

The DQOFH framework continues to be undertaken in 41 of our 43 membership practices.

Committee were advised that an original extraction had taken place at the beginning of April 2019. Practices were then given a period of time to rectify any coding errors. A further extraction had taken place at the beginning of May the results of the extraction would be used to calculate practices final payments. It was noted that any claw back of finances would be rectified in the May 2019 payment schedule.

Once the final extraction of practice achievements had been undertaken a full end of year report would be considered at Committee in July 2019.

The end of year face to face contractual visits would be based on a rolling program over a 3 yearly cycle to ensure all practices were monitored and would be a combination of targeted and random visits. It was noted that the visits would include the practices that worked to the National Quality Outcomes Framework (QOF). In addition practices would be monitored and audited with regard to the access requirements on an annual basis.

The targeted visits will be based on the following:
- Practices with outlying achievement on a wide range of indicators
- Practices with high levels (above 5% tolerance rate) of exception reporting
- Primary Care Analysis Tool (PCAT) - outliers
- Informed local intelligence
- CQC – where the inspection report raises issues of non-compliance

The associated DQOFH business rule had been updated to reflect any amendments to the final indicators for 2019/20. The business rules had been through a process of consultation with all relevant Clinical Leads.

Discussions then turned to the process for the future review of the DQOFH framework. Committee was advised that in accordance to the emerging PCN’s the CCG would request representation from the PCN Clinical Directors to be involved in the process and formal consultation will be sought from each PCN.

Committee were asked to approve:
- The end of year process and process for undertaking contractual visits;
- The final draft business rules for the DQOFH framework contract for 2018/19;
- The process for review of the DQOFH framework for 2020/21

Resolved:
1. Committee approved the end of year process and process for undertaking contractual visits.
2. Committee approved the final draft business rules for the DQOFH framework contract for 2018/19.
3. Committee approved the process for review of the DQOFH framework for 2020/21

Mrs Taylor spoke to this item to present to Committee the Dudley Practice Managers Alliance Training Budget Proposal 2019/20 for ratification.

Dudley Practice Managers Alliance (DPMA) had previously been given responsibility for producing a plan for approval by the CCG via the Primary Care Commissioning Committee. The DPMA had effectively managed the budget over the last 7 years on behalf of the CCG.
The NHS Long Term Plan gave an increasing role to Training Hubs in the future and in 2019/20 there will be a Training Hub established that would co-ordinate training at an STP level (Black Country and West Birmingham).

The CCG had agreed that the Training Hub would be responsible for co-ordinating and organising the training plan in line with the strategic direction.

The DPMA would still remain responsible for identifying the future training requirements of their practice staff.

The Training Hub would be responsible for evaluating, reporting and communicating training available to practice staff, DPMA and the CCG on a regular basis.

The Training Hub would co-ordinate and prepare the training plan on behalf of the DPMA which will be within the allocated budget and mutually agreed.

Committee requested regular updates in relation to this item and it was agreed that a 6 monthly report would be provided to Committee.

A query was raised by Committee in relation to whether the DPMA were effectively using the Bluestream training package. It was noted that there were previous issues with uptake, Mrs Taylor agreed to look into this and provide Committee with a report at the next meeting.

Action: Mrs Taylor

Committee were asked to approve the Dudley Practice training plan proposal 2019/20.

Resolved:
2. Committee requested that a 6 monthly report would be provided to Committee.

14.0 PRIMARY CARE COMMISSIONING COMMITTEE ANNUAL REPORT

Mrs Robinson spoke to this item to present the draft Annual Report 2018/19 for Committee approval and to provide assurance that Committee had discharged its responsibilities and had met its Terms of Reference.

The report considered at Committee summarised the work during the year and confirmed that Committee had fulfilled its statutory functions in relation to its delegated functions from NHS England relating to the commissioning and contracting of primary medical services.

Committee had fulfilled its delegated functions in accordance with scheme of delegation as set out in the CCG Constitution.

Committee had made significant progress in developing and improving the quality of primary medical services in Dudley.

Committee had made significant progress towards delivery of the GP Forward View plan.

It was highlighted that due to timescales of publishing the Annual Report, the finances were not up to date and would need to be amended for the final publication. Minor changes were also agreed to the engagement section.

Committee formally thanked the Primary Care team for the work that they undertake.

Resolved:
1. Committee were assured that the Committee has discharged its responsibilities
2. Committee approved the Primary Care Commissioning Committee Annual Report subject to the update of the finances and minor changes to the engagement section being updated for the final report.
15.0 DATE AND TIME OF THE NEXT MEETING

Friday 28 June 2019
1:00-3.00pm
T046/47 Brierley Hill Health & Social Care Centre
Venture Way, Brierley Hill, West Midlands DY5 1RU

MINUTES ACCEPTED AS A TRUE AND CORRECT RECORD

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### PRIMARY CARE COMMISSIONING COMMITTEE

**OUTSTANDING ACTION LIST – 26 July 2019**

<table>
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<tr>
<th>MEETING REFERENCE</th>
<th>ACTION</th>
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<th>STATUS</th>
<th>DEADLINE DATE</th>
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<tr>
<td>PCCC/MAY/2019/6.0</td>
<td>Risk Register – Risk 139</td>
<td>Non-Executive Directors</td>
<td>On-going</td>
<td>July 2018</td>
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<tr>
<td></td>
<td>Risk 139 from the Primary Care Commissioning Committee Risk Register would be closed and an additional risk be added on the Remuneration &amp; Human Resources Committee Risk Register.</td>
<td></td>
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<td>PCCC/MAY/2019/8.0</td>
<td>Finance Report – GP with special interest</td>
<td>Mr M Gamage/ Mr P Cowley</td>
<td>On-going</td>
<td>July 2018</td>
</tr>
<tr>
<td></td>
<td>Committee queried the figures within the report in relation to the “GP with special interest”. It was felt that the figures were significantly high for a 0.5 whole time equivalent post. It was suggested that there could be more than one GP with a special interest however it was agreed that clarification would be sought on the matter.</td>
<td></td>
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<tr>
<td>PCCC/MAY/2019/13.0</td>
<td>Dudley Practice Managers Alliance Training Budget</td>
<td>Mrs J Taylor</td>
<td>On-going</td>
<td>July 2018</td>
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<td></td>
<td>A query was raised by Committee in relation to whether the DPMA were effectively using the Bluestream training package. It was noted that there were previous issues with uptake, Mrs Taylor agreed to look into this and provide Committee with a report at the next meeting.</td>
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**TITLE OF REPORT:** Update from the Primary Care Operational Group (PCOG)

**PURPOSE OF REPORT:** To update Committee following the Primary Care Operational Group meetings held on 5 June 2019 and 3 July 2019

**AUTHOR OF REPORT:** Mrs J Robinson, Primary Care Contracts Manager

**MANAGEMENT LEAD:** Mrs C Brunt, Chief Nurse

**CLINICAL LEAD:** Dr T Horsburgh, Clinical Executive for Primary Care

**KEY POINTS:**

- Considered and supported an application from:
  - Wychbury Medical Group to include a new partner
  - Castle Meadows Surgery to include a new partner who will replace the existing non-clinical partner
  - Lion Health to remove a partner
- Reviewed the 2019 General Practice Annual Electronic Declaration (e-dec) and made a recommendation to NHSE for 2019 amendments
- Was assured by plans in place to roll out 111 direct booking into GP practice systems in line with the planning guidance
- Received information regarding delayed medical records from archive – NHSE are managing this matter, at the time of writing it was unknown how many Dudley practices may be affected
- Was assured by the DQOFH 2018/19 end of year report and agreed that a further review of the findings of the end of year position should be undertaken to identify practices that will receive a practice visit. Achievement against the indicators are within the allocated budget
- Received an update regarding Advice and Guidance and noted that its use is incentivised by the GP engagement scheme
- Supported the draft Post Payment Verification Process (PPV) for approval by Committee (appendix1)
- Recommend approval of the PCOG revised Terms of Reference (appendix 2)
- Recognised the rationale and supported changes to the NHS Health Checks Program and recommended further engagement with the Primary Care Networks
- Received the quality and safety matters set out in the report to Committee – the full dataset is presented to Committee in the private section of the meeting
- Reviewed the Committee risk register and make recommendations under agenda item 7
<table>
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<th>RECOMMENDATION:</th>
<th>Committee is asked to:</th>
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<tbody>
<tr>
<td></td>
<td>• Note the actions of the Primary Care Operational Group for assurance</td>
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<tr>
<td></td>
<td>• Approve the contractual changes recommended by the group as follows:</td>
</tr>
<tr>
<td></td>
<td>o Addition of 1 partner to the Wychbury Medical Group GMS Contract</td>
</tr>
<tr>
<td></td>
<td>o Addition of 1 partner to the Castle Meadows Surgery GMS Contract</td>
</tr>
<tr>
<td></td>
<td>o Removal of 1 partner from the Castle Meadows Surgery GMS Contract</td>
</tr>
<tr>
<td></td>
<td>o Removal of 1 partner from the Lion Health GMS Contract</td>
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<tr>
<td></td>
<td>• Approve the Post Payment Verification Process</td>
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<td></td>
<td>• Approve the revised Primary Care Operational Group Terms of Reference</td>
</tr>
<tr>
<td></td>
<td>• Review the current status of risks and accept the recommendations made by PCOG</td>
</tr>
</tbody>
</table>

| FINANCIAL IMPLICATIONS: | Not applicable |

| WHAT ENGAGEMENT HAS TAKEN PLACE: | Not applicable |

| ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE: | No conflicts of interest were declared in advance. |

| ACTION REQUIRED: | ✓ Decision  
|                 | ✓ Assurance |
1.0 INTRODUCTION

1.1 This report provides an update from the Primary Care Operational Group (PCOG) following its meetings held on 5 June 2019 and 3 July 2019.

2.0 CONTRACTUAL

Contract Variations

2.1 The group considered and supported the following partnership changes for approval by Committee.

<table>
<thead>
<tr>
<th>Practice</th>
<th>Action</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>Wychbury Medical Group</td>
<td>Addition of 1 partner</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>(subject to all signatories to the contract)</td>
<td></td>
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<tr>
<td>Castle Meadows Surgery</td>
<td>Addition of 1 partner (ANP)</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Castle Meadows Surgery</td>
<td>Removal of 1 non-clinical partner</td>
<td>1 July 2019</td>
</tr>
<tr>
<td>Lion Health</td>
<td>Removal of 1 partner</td>
<td>31 July 2019</td>
</tr>
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</table>

Review of 2019 General Practice Annual Electronic Declaration (e-dec) - Data Collection

2.2 GP practices are required to complete an annual e-Declaration, the outcome is useful to the CCG to support monitoring of delegated contractual functions.

2.3 The CCG has an opportunity to propose any changes to this year’s data collection. PCOG agreed with the feedback already provided to NHS England that included ensuring that the e-dec reflects changes to the GP contract and Primary Care Networks.

111 Direct booking

2.4 The integration of 111 with GP practice systems is a directive outlined in the NHS Long Term Plan. For 2019/20 this becomes a contractual obligation and practices, where functionality exists, must make available a minimum of one appointment per whole 3,000 patients per day for direct booking from NHS 111. In addition to this obligation the CCG has set a target, within the planning guidance submitted to NHS England, of 100% achievement by January 2020.

2.5 There is a plan to enable the integration with 111 and GP practice systems and the group was assured that they delays experienced by the pilot practice were being addressed and monitored to ensure compliance within the timescales.

3.0 DELAYED MEDICAL RECORDS - PRIMARY CARE SUPPORT ENGLAND (PCSE)

3.1 The group was provided with information regarding delayed medical records in PCSE archive where an error in the way data was processed had resulted in 160,000 patient records, in England, being retained in archive.
3.2 The group was advised that the bulk of these records had been delayed in archive between 6 to 18 months and some records dated back 3 years.

3.3 PCSE has already returned around 90,000 records. In the West Midlands there were 5,709 delayed records across 560 practices. At the time of the meeting, the number of Dudley practices effected was unknown.

3.4 Any adverse findings would lead to the practice being asked to inform the patient under the NHS duty of candour. Practices will be asked to report any such cases to NHS England using a dedicated mailbox. A pilot suggests that it is unlikely that there has been any patient harm.

3.5 A briefing note has been received from NHS England to support the communications management and to assist the CCG with any queries that may be received.

4.0 PRIMARY CARE COMMISSIONING

Post payment Verification Process (PPV)

4.1 PPV provides assurance to the CCG that claims submitted by practices for a selection of enhanced services and local improvement schemes accurately reflect the levels of service provided. PPV was previously part of routine PCT business.

4.2 PPV also supports practices in ensuring that they are accurately claiming for all services being provided and Identifies potential under-claims as well as over-claims.

Findings may result in:
- recovery of inappropriate payments, sanction, breach or remedial notice against the contract or
- Increase in payments if under-claimed

4.3 PCOG recommend that Committee approve the draft overarching PPV process (appendix 1).

Dudley Quality outcomes for Health (DQOFH) 2018/2019

4.4 The group was assured by the DQOFH 2018/19 end of year report. The report included the final year position for each practice and reported achievement against: all indicators; compliance with access requirements; exception reporting and compliance with audits.

4.5 The report demonstrated that there had been an increase in achievement against indicators compared to 2017/18.

4.6 With the exception of one practice, where there was outstanding data, all practices achieved the access target of 75 contacts per 1000 patients.

4.7 With the exception of one practice that had experienced IT issues, there was full compliance against the submission of audits required under DQOFH.

4.8 The group approve the recommendation of the report that a focus group should be set up to undertake a further review of the findings of the end of year position to identify practices that will receive a practice visit.

4.9 The DQOFH achievements generated payments of 94.2% of the achievable value, equating to £6.12m against the total available budget of £6.50m

4.10 The practice achievements are set out in table 1 below:
Advice and Guidance

4.11 The group received an update regarding the use of Advice and Guidance. There is not a contractual requirement or specific targets set by NHS England however the CCG is required by NHS England to promote and encourage its use. To support this and to achieve the QIPP target Advice and Guidance has been incorporated into the GP engagement scheme.

5.0 PRIMARY CARE OPERATIONAL GROUP TERMS OF REFERENCE

5.1 The Terms of Reference have been revised to include monitoring arrangements for Dudley Quality Outcomes for Health and Quality Outcomes Framework.

5.2 The group make a recommendation to Committee that the proposed changes to the Primary Care Operational Group Terms of Reference should be approved (appendix 2).

6.0 NHS HEALTH CHECKS

6.1 The NHS Health Checks program is a national program to identify people aged between 40 and 70 with no pre-existing history of heart disease, stroke or high cholesterol.

6.2 Dudley Council is the Commissioner of the mandated service and Dr D Pitches presented proposed changes to the group.

6.3 The group recognised the rationale behind the proposed changes and supported the decision to prioritise invitations based on patient needs and the need to reduce inequalities.

6.4 The group recommended further engagement with the Clinical Directors of the 6 Primary Care Networks to gain their support, to establish how the proposal would be communicated to patients and to establish if the delivery model within the deprived areas would need to be changed.

7.0 PRIMARY CARE QUALITY & SAFETY

7.1 PCOG received the primary care quality and safety matters that are set out in detail in the quality and safety report to Committee. The full Primary Care Analysis Tool (PCAT) dataset will be presented to Committee as a private agenda item.

The group discussion included:

- Follow-up visits had been arranged for the two practices who had received a Requires Improvement rating in one or more domains and that Annual Regulatory Reviews (ARRs) will be undertaken between July and September, CQC have identified 12 practices for a review.
The general practice flu plan questionnaire had been sent to practices with 36 responses received to date. Initial review of the information highlighted a variation in the return and this will be followed through with practices.

The Childhood immunisations waiting list data was discussed and it was agreed that there should be a further review of the data.

It was noted that the first of the infection, prevention and control audits under the new schedule had been carried out.

A further review of the patients included in the Special Allocation Scheme (SAS) had been held and had resulted in 10 patients being successfully removed from the scheme.

The group was assured that there was no risk to patients following identification by CQC that there was a large number of documents waiting to be scanned into the patient records at one practice. Confirmation had been received that although these documents remained in the workflow each document had been reviewed.

A full review of the PCAT dataset was carried out with particular attention being given to 2 practices that had moved into the red of the overall performance indicator. The group noted that practices can slip into the red due to improvement by other practices and therefore the group decided that practices will be monitored by the amount a Z score may have decreased.

A summary of complaints was provided and in particular, focus was given to a complaint received that had been considered by the NHS England Professional and Practice Information Gathering Group (PPIGG). The CCG pharmacy team has visited the practice and the outcome of investigations will be provided back to the group.

A review of preventing future deaths reports relevant to primary care was discussed and it was agreed that any key themes identified should be reported to PCOG to provide an opportunity of shared learning with GP practices and providers.

8.0 RISK REGISTER

8.1 PCOG reviewed the Committee risk register and make recommendations set out under agenda item 7.

9.0 RECOMMENDATION

Committee is asked to:

- Note the actions of the Primary Care Operational Group for assurance
- Approve the contractual changes recommended by the group as follows:
  - Addition of 1 partner to the Wychbury Medical Group GMS Contract
  - Addition of 1 partner to the Castle Meadows Surgery GMS Contract
  - Removal of 1 partner from the Castle Meadows Surgery GMS Contract
  - Removal of 1 partner from the Lion Health GMS Contract
- Approve the Post Payment Verification Process
- Approve the revised Primary Care Operational Group Terms of Reference
- Review the current status of risks and accept the recommendations made by PCOG
POST PAYMENT VERIFICATION PROCESS

DATE ISSUED: TBC
DATE TO BE REVIEWED: TBC (12 months)
AMENDMENT HISTORY

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<td>5.6.19</td>
<td>First Draft for internal review by Primary Care Operational Group</td>
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<td>V1.0</td>
<td>29.1.19</td>
<td>Final version to PCCC</td>
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APPROVALS
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<td>V1.0</td>
<td>29.1.19</td>
<td>Primary Care Commissioning Committee - Delegated Responsibility for CCG Board</td>
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<td>Senior Finance Manager, Phil Cowley</td>
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ENGAGEMENT
This document has been presented for comments at the following forums:
Local Medical Committee – July 2019
Dudley Practice Managers Alliance – June 2019
Post Payment Verification Process

1.0 Introduction
Under fully delegated co-commissioning arrangements, Dudley CCG has to discharge its responsibility of seeking and confirming contractual compliance of all primary medical contracts that fall under its governance.

The CCG must make sure that there is evidence of well-maintained documentation and a robust governance system in place for all Enhanced Services (ES) and Local Improvement Schemes (LIS) that substantiates the validity of payments. PPV supports practices in ensuring that they are accurately claiming for all services being provided and identifies potential under-claims as well as over-claims.

In order to fulfil this responsibility In accordance with the service specifications, GMS regulations and the Statement of Financial Entitlement the Primary Care Team will carry out Post Payment Verification (PPV) of the ES and LIS provided by Contractors.

2.0 Structure of PPV
The PPV visits will be carried out by CCG representatives from the Primary Care Team. The visiting team may need intermittent access to individual practice staff throughout the visit. As much as possible of the PPV will be carried out remotely. The content of the review to determine compliance against the ES or LIS specification will depend upon which enhanced service or local improvement scheme is being reviewed an example may include:

- Review of any evidence submitted such as monthly and quarterly returns
- Review of audit
- Retrospective checks on the appointment system
- Patient records check to ensure the consultation took place on the day the appointment was booked
- Compliance against the relevant ES or LIS service specification will be assessed
3.0 Criteria for Choosing GP practices for visits
The selection will be at the CCGs discretion – being selected for a PPV visit does not imply any suspicion of wrong doing.

The selection criteria may differ depending upon which enhanced service or local improvement scheme is being reviewed and could include identified outliers in terms of over and under performance compared to similar membership practices. The CCG may determine that a random selection may be appropriate.

4.0 Notification and frequency of the PPV visit
The Contractor will be given 2 weeks’ notice prior to any visit. It is intended that the verification of claims visits will be carried throughout the year (April to March) thereafter focussing on different claim types on an annual rolling programme.

5.0 PPV Outcome

Draft Report
A draft report will be sent to practice for comment on the factual accuracy for return to the CCG within 2 weeks.

Final Report
A copy of the final report will be sent to the Primary Care Operational Group for review and once signed off, the final report will then be issued to the Contractor.

Any serious findings or where there is recovery of inappropriate payments will be reported to the Primary Care Commissioning Committee who may discharge their delegated powers to apply a sanction, breach or remedial notice against the contract.

In the event that there is disagreement over the final report the NHS England Dispute Resolution Policy will apply and may be used by the Contractor.

In the event of suspected fraud or other illegality being uncovered the CCG will involve the NHS Counter Fraud Authority.
The Regulations that apply

The NHS (General Medical Services Contracts) Regulations 2004 as amended

Provision of information

77.—(1) Subject to sub-paragraph (2), the contractor shall, at the request of Board, produce to the Board or to a person authorised in writing by the Board or allow it, or a person authorised in writing by it, to access—

(a) any information which is reasonably required by the Board for the purposes of or in connection with the contract; and

(b) any other information which is reasonably required in connection with the Board’s functions.

(2) The contractor is not required to comply with any request made in accordance with paragraph (1) unless it has been made by the Board in accordance with directions made by the Secretary of State under section 98A (exercise of functions) of the 2006 Act relating to the provision of information by contractors.”.

Annual return and review

81.—(1) The contractor shall submit an annual return relating to the contract to the Board which shall require the same categories of information from all persons who hold contracts with that Trust.

(2) Following receipt of the return referred to in sub-paragraph (1), the Board shall arrange with the contractor an annual review of its performance in relation to the contract.

(3) Either the contractor or the Board may, if it wishes to do so, invite the Local Medical Committee for the area of the Board to participate in the annual review.

(4) The Board shall prepare a draft record of the review referred to in sub-paragraph (2) for comment by the contractor and, having regard to such comments, shall produce a final written record of the review.

(5) A copy of the final record referred to in sub-paragraph (4) shall be sent to the contractor.

Compliance with legislation and guidance

125. The contractor shall—

(a) comply with all relevant legislation; and

(b) have regard to all relevant guidance issued by the Board or the Secretary of State or Local Authorities in respect of the exercise of their functions under the 2006 Act.”

The delegation agreement between NHS England and Dudley Clinical Commissioning Group

Schedule 2 – Delegated Functions

Part 1: Delegated Functions: Specific Obligations

1.0 Primary Medical Services Contract Management
Primary Care Operational Group
(Sub-Committee of Primary Care Commissioning Committee)

Terms of Reference – Version 3.43

AMENDMENT HISTORY

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<td>First draft of TOR</td>
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<td>V2.0</td>
<td>October 2015</td>
<td>Revised and updated</td>
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<td>V3.1</td>
<td>January 2017</td>
<td>Revised and updated to reflect the change of chair responsibility and update the membership</td>
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<td>V3.2</td>
<td>June 2017</td>
<td>Revised to reflect comments of the group</td>
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<td>V3.3</td>
<td>September 2018</td>
<td>Membership revised</td>
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<td>3.4</td>
<td>May 2019</td>
<td>Revised to include monitoring arrangements for Dudley Quality Outcomes for Health and Quality Outcomes Framework</td>
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REVIEWERS

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<td>Julie Robinson</td>
<td>January 2017</td>
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<td>Emma Smith</td>
<td>January 2017</td>
<td>Governance Support Manager</td>
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<td>Caroline Brunt</td>
<td>May 2017</td>
<td>Chief Nurse</td>
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<td>Joanne Taylor</td>
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APPROVALS

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<tr>
<td>V3.3</td>
<td>Primary Care Commissioning Committee</td>
<td>28 September 2018</td>
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NB: The version of this policy posted on the intranet must be a PDF copy of the approved version.

Please note that any changes to these Terms of Reference must be done in line with the Terms of Reference Development Guidance. Changes must be agreed at Committee. The Governance Team must be included in any revision to ensure that the statutory duties are unaffected and in line with the CCGs Constitution.
Primary Care Operational Group – Terms of Reference

1. Introduction & Purpose

1.1 This Primary Care Operational Group (the ‘Group’) is a group which reports to the CCG Primary Care Commissioning Committee and the CCG Quality and Safety Committee.

1.2 These terms of reference set out the membership, remit and responsibilities of the Group. The Group will review its terms of reference annually. Any resulting changes to the terms of reference will be approved by the Primary Care Commissioning Committee.

2. Membership

2.1 The members of the group will be made up of:

- Head of Membership Development and Primary Care (Chair)
- Primary Care Commissioning Manager (Vice Chair)
- Primary Care Contracts Manager
- Clinical Executive for Primary Care
- LMC Representative
- CCG Performance Manager or deputy
- Clinical Executive for Quality and Safety
- GP Engagement Lead
- Pharmaceutical Advisor
- Practice Manager CCG Lead
- Head of Quality Assurance
- Senior Finance Manager – Primary Care
- Healthwatch Chief Officer
- Representatives from NHS England

2.2 The Group can also co-opt additional members from time to time as business dictates.

2.3 The Group may invite other individuals or non-members to attend a meeting to contribute to its discussions where relevant and appropriate i.e.

- GP Mentorship Lead
- Practice Nurse Mentorship Lead
- Practice Manager Mentorship Lead
- Chief Nurse
- Designated Nurse for Safeguarding Vulnerable Adults
- Representatives from The Office of Public Health, Dudley MBC
- CCG Lay Member
- CQC Primary Medical Services Inspector
- Primary Care Contracts Support Officer
- Primary Care Commissioning Support Officer

3. Secretary

3.1 A named individual will be responsible for supporting the Chair in the management of the Committee’s business and for drawing members’ attention to best practice, national guidance and other relevant documents as appropriate.

4. Quorum
4.1 A meeting of the Group will be quorate provided that four members are present, of which:

- One must be a GP member
- One must be a CCG Manager:
  - Head of Membership Development and Primary Care
  - Primary Care Commissioning Manager
  - Primary Care Contracts Manager
  - Head of Quality Assurance
  - Senior Finance Manager – Primary Care

5. Frequency of meetings

5.1 The Group will meet at least monthly. No unscheduled or rescheduled meetings will take place without members having at least one week's notice of the date. The agenda and supporting papers will be circulated to all members at least five working days before the date the meeting will take place.

5.2 The CCG Primary Care Commissioning Committee or the CCG Quality and Safety Committee and/or the Group reserve the right to call a meeting at any time if an urgent matter arises.

6. Remit Duties and Responsibilities

6.1 The overall purpose of the Group is to provide a forum for the CCG to review and monitor contractual performance and quality and safety in primary care.

6.2 The group will exercise its duties and responsibilities in accordance with the delegation agreement made between NHS England and the CCG in March 2015

6.3 The specific duties of the group are as follows:

- To make recommendations to the Primary Care Commissioning Committee in relation to all practice contract variations i.e. partnership changes, retirements, practice list closures in accordance with the delegation agreement

- To determine and recommend a process for the contract review of all GMS practices to the Primary Care Commissioning Committee

- To make recommendations to the Primary Care Commissioning Committee in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices

- To make recommendations to the Primary Care Commissioning Committee in relation to the approval of practice mergers

- To make recommendations to the Primary Care Commissioning Committee in relation to the management of poorly performing GP practices. To decide whether the practice is in breach of contract.

- To consider information relating to performance of the practice to enable the group to make recommendations; this will include but not be limited to the outcome of contract review visits, primary care web tool, local quality dashboard, complaints, CQC inspections.

- To make recommendations to the Primary Care Commissioning Committee in relation to the performance of Dudley Quality Outcomes for Health (DQOFH) and Quality Outcomes
Framework (QoF). This will include receiving a quarterly update, annual end of year report and making recommendations for face to face contract visits.

- To report to and receive feedback from the Professional & Practice Information Gathering Group (PIGG) of NHS England (The PIGG receive, assess and triage concerns about an individual performer) where contractual issues give concern regarding the performance and competency of individual performers.

- To review and discuss any issues or concerns relating to the quality and safety of patient care in general practice.

- To receive the results of quality audits and inspections in general practice including CQC.

- To share information on incidents and serious incidents relating to general practice and associated learning.

- To report on trends in complaints including Friends and Family Test.

- To consider reports and information arising from practice visits outside of contract review visits i.e. GP engagement and mentorship practice visits.

- To support the CCG Primary Care Commissioning Committee and the Quality and Safety Committee to determine the key indicators by which performance and quality will be monitored within the Primary Care Assurance Tool (PCAT) and review this annually.

- To discuss concerns relating to the ability of practices to maintain the provision of their GMS contract. (Note that concerns will not necessarily be as a result of poor performance but issues that might lead to a reduction in the quality of services or put patient care at risk if no intervention is taken to mitigate the problem. For example, practices who may have key staff with significant health problems or practices with recruitment issues and who may benefit from an agreed support package).

- To report to the Primary Care Commissioning Committee identification of risks to consider for addition to the risk register.

- To discuss and agree local communication messages in relation to primary care.

7. Membership Reporting Process

- To co-ordinate the activities of membership support to practices with a view to identifying and acting upon issues to avoid practices being in breach of contract.

- To report to the Quality and Safety Committee on issues impacting on the quality of service provision in General Practice.

- To report to the Committee on the uptake and provision of enhanced services.

- To produce a report to the Primary Care Commissioning Committee following each meeting to summarise the issues and themes without disclosing practice specific details.

- To provide assurance to the Primary Care Commissioning Committee and Quality and Safety Committee that the CCG has a process to identify and manage contractual performance and quality issues by involving and escalating as appropriate to other Committee’s and organisations where necessary.
8. Managing Conflicts of Interest

8.1 Conflicts of interest are a common and sometimes unavoidable part of the delivery of healthcare. The CCG is required to manage any conflicts of interest through a transparent and robust system. Members of the Group are encouraged to be open and honest in identifying any potential conflicts during the meeting.

8.2 It is imperative that CCGs ensure complete transparency in any decision-making processes through robust record-keeping. If any conflicts of interest are declared or otherwise arise in a meeting, the chair must ensure the following information is recorded in the minutes; who has the interest, the nature of the interest and why it gives rise to a conflict; the items on the agenda to which the interest relates; how the conflict was agreed to be managed and evidence that the conflict was managed as intended.

9. Relationship with the Governing Body

9.1 The Group will provide a written summary of the key matters covered by the meeting, including any actions and decisions taken to report to the Primary Care Commissioning Committee and Quality and Safety Committee where necessary.

9.2 The minutes of each meeting of the Group, will be agreed at the subsequent meeting.

10. Review of Committee Effectiveness

10.1 The Group will annually self-assess and report to the CCG Primary Care Commissioning Committee and Quality and Safety Committee on its performance in delivery of these terms of reference.

10.2 These terms of reference will be reviewed at least annually to ensure they remain fit for purpose.
Schedule 1 - Membership

Voting Members
Head of Membership Development and Primary Care
Primary Care Commissioning Manager
Primary Care Contracts Manager
GP governing body member holding the position of LMC representative
Clinical Executive for Quality and Safety
GP Engagement Lead
Pharmaceutical Advisor
Practice Manager CCG Lead
Head of Quality Assurance
Senior Finance Manager – Primary Care
Representatives from Healthwatch
Representatives from NHS England
### Board Assurance Framework & Risk Register (BAF & RR) for Primary Care Commissioning Committee

**Date of Meeting:** 26 July 2019  
**Report:** Board Assurance Framework & Risk Register  
**Agenda item No:** 7.0

<table>
<thead>
<tr>
<th><strong>TITLE OF REPORT:</strong></th>
<th>Board Assurance Framework (BAF) &amp; Risk Register (RR) for Primary Care Commissioning Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PURPOSE OF REPORT:</strong></td>
<td>To provide the Committee with an updated BAF &amp; RR</td>
</tr>
<tr>
<td><strong>AUTHOR OF REPORT:</strong></td>
<td>Mr D King - Head of Membership Development &amp; Primary Care</td>
</tr>
<tr>
<td><strong>MANAGEMENT LEAD:</strong></td>
<td>Mrs C Brunt, Chief Nurse</td>
</tr>
<tr>
<td><strong>CLINICAL LEAD:</strong></td>
<td>Dr T Horsburgh, Clinical Executive for Primary Care</td>
</tr>
<tr>
<td><strong>KEY POINTS:</strong></td>
<td>Risks assigned to Primary Care Commissioning Committee and reviewed by the Primary Care Operational Group on 3 July - attached</td>
</tr>
<tr>
<td><strong>RECOMMENDATION:</strong></td>
<td>Committee is asked to review the current status of risks and accept the recommendations made by the Primary Care Operational Group, highlighted in red</td>
</tr>
<tr>
<td><strong>FINANCIAL IMPLICATIONS:</strong></td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>WHAT ENGAGEMENT HAS TAKEN PLACE:</strong></td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:</strong></td>
<td>No conflicts of interest were declared in advance.</td>
</tr>
<tr>
<td><strong>ACTION REQUIRED:</strong></td>
<td>✓ Decision Assurance</td>
</tr>
<tr>
<td>ID</td>
<td>Original Date</td>
</tr>
<tr>
<td>-----</td>
<td>---------------</td>
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<tr>
<td>135</td>
<td>26/06/2019</td>
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<tr>
<td>136</td>
<td>26/06/2019</td>
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<tr>
<td>137</td>
<td>26/06/2019</td>
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<tr>
<td>138</td>
<td>26/06/2019</td>
</tr>
<tr>
<td>139</td>
<td>26/06/2019</td>
</tr>
</tbody>
</table>

**Notes:**
- **PMS Premium:** Reinvestment of PMS Premium due to Financial issues.
- **Dudley CCG Estates Strategy:** Development and implementation of Dudley CCG Estates Strategy.
- **Primary Care Commissioning:** Helen Mosley, Caroline Brunt.
**TITLE OF REPORT:** GP Engagement Scheme 2019/20

**PURPOSE OF REPORT:** To inform the Committee of changes to the way in which the CCG engage with Member practices, and agree the GP Engagement Scheme for 2019/20.

**AUTHOR OF REPORT:** Mrs J Taylor, Primary Care Commissioning Manager

**MANAGEMENT LEAD:** Mrs C Brunt, Chief Nurse

**CLINICAL LEAD:** Dr T Horsburgh, Clinical Executive for Primary Care

**KEY POINTS:**

- The GP Engagement Scheme exists to support Membership engagement through locality meetings, membership events, and practice involvement in the commissioning agenda

- It has always been divided into 3 component parts
  - Part A: attendance at meetings (locality, membership and Dudley Practice Management Alliance (DPMA))
  - Part B: Prescribing Incentive Scheme
  - Part C: Commissioning – support towards the QIPP agenda and other engagement related activities

- The GP Engagement Scheme has been reviewed as result of changes to the Dudley Quality Outcomes for Health Framework (DQOFH) and the introduction of Primary Care Networks (PCNs)

- The outcome of the review is as follows

  **Part A: Meetings**
  - Locality meetings will cease and be replaced with monthly meetings between the CCG elected GP board members and the PCN Clinical Directors
  - Membership meetings will continue, with the format to be amended for greater discussion and interaction, to be led by CCG GP elected board members
  - DPMA meetings will cease to be funded by the CCG, will continue as standalone DPMA members meetings with the CCG in attendance by invite only

  **Part B: Prescribing Incentive Scheme**
  - The Committee has previously agreed to include this scheme in the DQOFH.
  - This element of the scheme becomes what was previously Part C and is focussed in the practice achieving specific targets that will contribute to the delivery of the QIPP programme. This component will be focussed on
development of an action plan and the CCG providing practices with QIPP performance information on a regular basis.

**RECOMMENDATION:**
The Committee are asked to **note**
- Membership meetings will continue and be led by GP elected board members. The format and content will change to allow for greater interaction in localities/PCNs.
- GP Collaborative Steering Group updates will be undertaken through PCN meetings rather than membership meetings.
- Locality meetings will be cease – they will be replaced with a new PCN and CCG review group.
- DPMA meetings will continue independently with CCG attendance by invite only.

The Committee are asked to **approve**
- The GP engagement scheme for 2019/20

**FINANCIAL IMPLICATIONS:**
The cost proposed scheme is £230,000

**WHAT ENGAGEMENT HAS TAKEN PLACE:**
- Clinical Forum
- Clinical Executive Team
- GP Collaborative Steering Group
- Primary Care Network Clinical Directors
- Senior Management Team
- Primary Care Team

**ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE**
To note that any GP members of the Committee may be conflicted with Agenda Item 12.0. These members are not voting members therefore will not be included in the decision but may be involved in the discussion.

**ACTION REQUIRED:**
Decision X
Approval X
Assurance
1.0 PURPOSE

1.1 To inform the Committee of changes to the way in which the CCG engage with member practices, and agree the GP Engagement Scheme for 2019/20.

2.0 BACKGROUND

2.1 The mechanism in which the CCG engages with Member practices has been reviewed in light of the introduction of the new PCN Direct Enhanced Service (DES) and the proposed changes to the CCG constitution (moving from 10 elected GP board members to 5).

2.2 The recommendations contained within this paper have been made following discussion with the following groups:
- Clinical Forum
- Clinical Executive Team
- GP Collaborative Steering Group
- PCN Clinical Directors
- Senior Management Team
- Primary Care Team

3.0 PROPOSED CHANGED AND RATIONALE

3.1 The table below sets out the engagement activities undertaken at present and the agreement reached by those consulted.

<table>
<thead>
<tr>
<th>Engagement Activity</th>
<th>Change</th>
<th>Rationale</th>
<th>Agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members meetings</td>
<td>Continue and change</td>
<td>Still required</td>
<td>Yes</td>
</tr>
<tr>
<td>GP engagement practice visits</td>
<td>No change</td>
<td>Still required to discuss the how the practice is reviewing and achieving its QIPP targets.</td>
<td>Yes</td>
</tr>
<tr>
<td>Dudley Practice Management Alliance (DPMA) meetings</td>
<td>Continue and change</td>
<td>CET view the DPMA as a standalone group. DPMA members to continue with meetings but should not continue to be funded by the CCG. The CCG</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Locality Meetings – Option One
Continue in addition to PCN meetings.  
Dismissed by CET and PCN Clinical Directors. Problems with timetabling, meeting congestion, time consumption and funding.  
No

### Locality Meetings – Option Two
Locality meetings 'bolted on' to PCN meetings  
Dismissed by CET and PCN Clinical Directors. Problems with CCG representation, meeting size, meeting length, funding and accommodating KAB locality with 2 PCNs. PCNs need all the time in year one to focus on PCN development.  
No

### Locality Meetings – Option Three
5 elected GP Board members and 6 PCN CDs to meet monthly to formally review and discuss the PCN DES (required as part of PCN DES contract).  
Supported by CET and PCN CDs.  
Yes

### 4.0 RECOMMENDATIONS FOR THE GP ENGAGEMENT SCHEME 2019/20

#### 4.1 The GP engagement scheme is previous years has operated in 3 parts
- **Part A – attendance at meetings**
- **Part B – Prescribing Incentive Scheme**
- **Part C – QIPP, audit and other engagement activities determined by the PCCC**

#### 4.2 Part A: Recommendations
- GPs will continue to receive payment for attending membership meetings at £74 per hour, for 2 hours per meeting. This will be paid for each practice attending a minimum of 6 membership meetings per annum.
- There will be no payment for locality meetings, as these will not be continuing. The budget for this element of the scheme will be used to reimburse PCN Clinical Directors attending PCN review meetings with the CCG GP elected board members.
- There will be no payment for DPMA meetings, these are standalone run by DPMA members and the CCG will continue to attend by invite only.
- The PCN Clinical Directors will be reimbursed £74 per hour, for 2 hours, per month for a minimum of 10 meetings per year.
4.3 **Part B - Recommendations**

- The Prescribing Incentive Scheme has been moved into the DQOFH – as previously agreed by the Committee.
- Part B becomes a scheme for practices to achieve targets which contribute to the delivery of the QIPP programme as follows:
  - Each practice will have a target for the 3 QIPP areas identified by the CCG and develop an action plan for delivery
  - Each practice to participate in a meeting with the GP engagement lead to discuss performance against their delivery plan and actions required to deliver
  - The practice will be paid based on the achievement of its QIPP plan
  - The full details of the GP engagement scheme and proposal for 2019/20 are appended to this paper.

5.0 **BUDGET IMPLICATIONS**

5.1 The table below sets out the financial commitments of the GP engagement scheme as a result of the proposed changes:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (£'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A - Q1 localities</td>
<td>20</td>
</tr>
<tr>
<td>Part A - Members Meetings</td>
<td>39</td>
</tr>
<tr>
<td>Part B - QIPP Delivery</td>
<td>160</td>
</tr>
<tr>
<td>CCG/PCN Review Group</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>230</strong></td>
</tr>
</tbody>
</table>

5.2 Funding in respect of Part B, the prescribing incentive scheme, has transferred into the DQOFH framework, and the remaining scheme cost of £230,000 will be funded non-recurrently during 2019/20 as follows:

- £30,000 from project slippage in core CCG budgets.
- £200,000 from the remaining value of the DQOFH provision made during the year-end process, which assumed 100% achievement compared to actual achievement of 94.2%.

5.3 Recurrent funding would need to be identified to support these schemes in future years, and further evaluation of the requirement for the scheme should be undertaken in light of developments in the PCN contract. In particular, the QIPP element of the scheme may
be overtaken by the shared savings scheme included in the GP contract, which NHS England envisages being part of Primary Care Network Entitlements from 2020/21 onwards.

6.0 MEMBERSHIP MEETINGS

6.1 The agenda for the membership meetings will be determined by the 5 CCG elected board members and agreed through the Clinical Executive Team (CET) 6 weeks in advance of each meeting.

6.2 The membership meeting will no longer be used as a mechanism for GP collaborative steering group updates – which will be undertaken through the PCN meetings.

6.3 The membership meetings will be supported by the primary care and communications and engagement team who will organise and promote the events, provide facilitator plans, facilitators, and capture and report feedback from the meetings.

6.4 The agenda will be set by CCG elected board representatives and agreed at the Clinical Executive Team meeting. The meetings will be chaired and led by the CCG elected board representatives. The events will be developed to become more interactive, and be organised by sitting members in their respective PCN groups.

7.0 CCG AND PCN CLINICAL DIRECTORS REVIEW GROUP

7.1 The CCG will have a responsibility to contractually review the PCN DES. The CCG will also need to have a mechanism to engage and consult PCNs on a range of issues historically discussed with locality meetings i.e. commissioning developments, delivery of QIPP, public consultations, feedback into the STP etc.

7.2 The review group would be required to meet monthly, and the PCN Clinical Directors would be re-imbursed by the CCG to attend these meetings re-imbursed £74 per hour, for 2 hours, per month for a minimum of 10 meetings per annum.

7.3 The review group will determine its terms of reference and way in which they work together in 2019/20 in preparation for the when the PCN effectively goes live in 2020/21 (with the addition of Nationally defined service specifications to deliver clinical outcomes).

8.0 RECOMMENDATIONS

8.1 The Committee are asked to note

- Membership meetings will continue and be led by GP elected board members. The format and content will change to allow for greater interaction in localities/PCNs.
- GP Collaborative Steering Group updates will be undertaken through PCN meetings rather than membership meetings.
• Locality meetings will cease and will be replaced with a new PCN and CCG review group.
• DPMA meetings will continue standalone with the CCG in attendance by invite only.

8.2 The Committee are asked to approve
• The GP engagement scheme for 2019/20.
To: GPs and Practice Managers

Dear Colleague

PRACTICE ENGAGEMENT SCHEME 2019/20

The Practice Engagement Scheme is an important programme of work which will strongly contribute to enabling the CCG to deliver its Commissioning Strategy, strengthen quality assurance and meet both national and local obligations for the commissioning of primary care.

The CCG recognise that 2019/20 is a transitional year, in which PCNs will begin to develop, the MCP begins to mobilise, and CCGs in the Black Country will be determining how we organise the commissioning of services.

The CCG continues to place a great importance on the engagement of member practices. The scheme this year reflects the importance of continuing that engagement whilst recognising the need to reduce duplication of meetings, and set some realistic and measurable outcomes that can be achieved to contribute to the delivery of our QIPP programme.

The Practice Engagement Scheme is made up of two parts:-

Part A

Part A of the scheme is the remuneration for attendance at key meetings and dissemination of the information internally within the practice; these meetings along with the addition requirements of the scheme are set out below:

<table>
<thead>
<tr>
<th>Meeting Type</th>
<th>Requirement</th>
<th>Remuneration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locality Meetings which occurred April – June 2019</td>
<td>One GP / Practice Manager from each practice to attend 3 locality meetings which occurred in Quarter 1</td>
<td>£444</td>
</tr>
<tr>
<td>Membership Events</td>
<td>One GP from each practice to attend 6 events per year</td>
<td>£888</td>
</tr>
<tr>
<td><strong>Total Remuneration</strong></td>
<td></td>
<td><strong>£1332</strong></td>
</tr>
</tbody>
</table>

The remuneration received for Part A of the Engagement Scheme is based on attendance and paid at a rate of £74 for a GP and £37 for a Practice Manager. It is essential that attendees sign the register for the meeting as this will be used as the basis for payment.

Notes:

- The payment will reflect attendance at locality meetings that have taken place in Quarter 1 (April – June 2019)
- Adjustments may be mutually considered to facilitate transition across the year as required to support PCN development
Part B

Part B of the scheme requires the Practice to contribute towards delivery of the CCG’s QIPP programme.

- The CCG have identified improvement targets for each of the 3 QIPP schemes outlined in the table below.
- The targets have been identified and agreed by the relevant Commissioner and Commissioning Development Committee.
- The practice will put in place an action plan to achieve the targets which they are expected to achieve by 31st March 2020.
- The practice will be provided with a report on a monthly basis showing performance to date, and projected performance and payment against the target.
- The CCG will provide advice and guidance on the actions and tasks that can be undertaken by practices to achieve the 3 improvement targets.
- In order to achieve payment the practice must achieve all three targets. For the avoidance of doubt, there is no pro-rata payment for partial achievement.

<table>
<thead>
<tr>
<th>QIPP Scheme</th>
<th>Detail of opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Advice and Guidance</td>
<td>The practice is expected to fully utilise Advice and Guidance for assessment before referral to Outpatient services.</td>
</tr>
<tr>
<td></td>
<td>During Q3-4 2019/20, each practice is expected to reach a target of advice and guidance utilisation being at least 90% of GP-referred first outpatients (excluding Urgent Referrals and 2 Week Waits) in the following specialties:</td>
</tr>
<tr>
<td></td>
<td>• Clinical Haematology</td>
</tr>
<tr>
<td></td>
<td>• Endocrinology</td>
</tr>
<tr>
<td></td>
<td>• Gastroenterology</td>
</tr>
<tr>
<td></td>
<td>• Neurology</td>
</tr>
<tr>
<td></td>
<td>• Ophthalmology</td>
</tr>
<tr>
<td></td>
<td>• Respiratory Medicine</td>
</tr>
<tr>
<td></td>
<td>• Rheumatology</td>
</tr>
<tr>
<td></td>
<td>These specialties have been chosen as those which have shown the ability to provide guidance within the best practice 2-day turnaround target:</td>
</tr>
<tr>
<td></td>
<td>This target will be measured as the number of advice and guidance requests in these specialties in the period as a percentage of GP referred first outpatients (excluding 2WW/Urgent referrals).</td>
</tr>
<tr>
<td></td>
<td>For example, if the practice submits 90 A&amp;G requests and there are 100 GP-Referred Outpatients, the practice will achieve 90%.</td>
</tr>
<tr>
<td>2. Implementation of Dudley Prescribing Policy</td>
<td>The practice is expected to participate in the implementation of Dudley Prescribing Policy.</td>
</tr>
<tr>
<td></td>
<td>Each practice is expected to reduce their expenditure of products included in the prescribing policy by at least 50% by March 2020.</td>
</tr>
<tr>
<td></td>
<td>This will be monitored via EPACT2 prescribing data.</td>
</tr>
<tr>
<td></td>
<td>This should be evidenced by completing and submitting action plan monitoring template on a quarterly basis</td>
</tr>
</tbody>
</table>
3. Prescribing Cost Improvement Plan in line with work plan objectives

The practice is expected to participate in the implementation of the locally agreed Prescribing Cost Improvement Plan.

Each practice is expected to implement all product switches with an expected achievement of at least 80% by March 2020.

This will be monitored via EPACT2 prescribing data.

This should be evidenced by completing and submitting action plan monitoring template on a quarterly basis.

Remuneration - £0.50 registered list size (using list sizes as at 1st April 2019)

The practice is required to sign and return the attached agreement. In doing so, the practice commits to undertake the requirements of this Practice Engagement Scheme and understands that, if you do not adhere to the requirements of this scheme, payments could be reclaimed.

Yours sincerely

Joanne Taylor
Primary Care Commissioning Manager

2019/20 PRACTICE ENGAGEMENT SCHEME AGREEMENT

The Practice commits to undertake the requirements of this Practice Engagement Scheme and understands that, if they do not adhere to the requirements of this scheme, payments could be reclaimed.

Signature:

Name:
PLEASE RETURN COMPLETED APPLICATION BY 31ST JULY 2019 TO:
Dudleyccg.primarycare@nhs.net
DUDLEY CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE

Date of Report: 26 July 2019
Report: GPN Strategy and Supplementary Documents
Agenda item: 9.0

| TITLE OF REPORT: | To present to Committee the Black Country and West Birmingham Sustainability and Transformation Partnership (STP) GP Nurse (GPN) Strategy and supplementary documents |
| PURPOSE OF REPORT: | GPN Strategy and supplementary documents: |
| | • A career progression framework aligned to the Health Education England (HEE) career and education framework for GPNs |
| | • A competency framework based on the RCGP GPN framework |
| | • An induction and preceptorship framework based on existing programmes e.g. Capital Nurse |
| AUTHOR OF REPORT: | Mrs. J Taylor, Primary Care Commissioning Manager |
| MANAGEMENT LEAD: | Mrs. C. Brunt, Chief Nurse |
| CLINICAL LEAD: | Dr. T Horsburgh, Clinical Executive for Primary Care |
| KEY POINTS: | **General Practice Nurse Strategy** |
| | **Aim** |
| | The aim of this strategy and supporting documents is to provide a forward view for general practice nursing for the Black Country. |
| | **Objectives** |
| | • Align the strategy content to reflect and support the actions within national and STP documents such as |
| | o 10 Point Action Plan for GPNs |
| | o GP Forward View |
| | o NHS Long Term Plan |
| | o STP Clinical, Workforce and Primary Care strategies |
| | • To provide an outline of good practice using the principles of compassionate care |
| | • To provide a suite of companion documents that offer: |
| | o A career progression framework aligned to the HEE career and education framework for GPNs |
| | o A competency framework based on the RCGP GPN framework |
| | o An induction and preceptorship framework based on existing programmes e.g. Capital Nurse |
| | o Guidance around Clinical Supervision for GPNs |
| | o A retention strategy for GPNs |
Strategy Overview
The General Practice Nurse Strategy provides a framework for a STP-wide nursing plan through seven domains and partners within the STP have agreed to:

- Support excellence in care through learning in association with patients, their families and service users.
- Increase focus on quality and continually seek to improve the care provided.
- Encourage the best nurses to join practices within the Black Country STP footprint and embrace diversity through skilled appointments.

Responsibility for each domain will lie with relevant teams within each CCG and with the STP, with support from NHSE and HEE.

Seven domains and six priority areas have been identified to support the implementation of the strategy and its companion documents, these have been aligned to a number of national work programmes:

- GPN 10 Point Action Plan
- GP Forward View
- NHS Long Term Plan
- Compassionate Care
- NMC Standards of Proficiency for Registered Nurses
- HEE General Practice Nursing Services Education and Career Framework
- RCGP GPN Competency Framework
- RCGP General Practice Advanced Nurse Practitioner Competencies
- QNI Transition to General Practice Nursing Resource
- QNI Voluntary Standards for General Practice Nurses

These domains are not exhaustive and each CCG will have different priorities and workforce needs that will be identified locally and led by the local clinical leads.

The strategy also provides an overview of key deliverables across the STP, and guidance around:

- Competencies for nursing staff in general practice
- Education framework
- Induction and preceptorships

This is guidance for practice staff and should be used across the career lifespan in conjunction with mandatory training, NMC revalidation, apprenticeships and local training and induction.

RECOMMENDATION:
Committee is asked to Approve:

- The Black Country and West Birmingham Sustainability and Transformation Partnership (STP) GP Nurse (GPN) Strategy and supplementary documents

FINANCIAL IMPLICATIONS: N/A
| WHAT ENGAGEMENT HAS TAKEN PLACE: | This strategy and supporting documents have been sent out for consultation across the Black Country to:  
- Practice Nurses  
- Clinical Leads and Senior Nurses  
- GPs  
- Practice Managers  
- LMC |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE</td>
<td>None</td>
</tr>
</tbody>
</table>
| ACTION REQUIRED: | Decision  
Approval ✓  
Assurance |
DOCUMENT STATUS:

DATE ISSUED:

DATE TO BE REVIEWED:

AMENDMENT HISTORY

<table>
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<tr>
<th>VERSION</th>
<th>DATE</th>
<th>AMENDMENT HISTORY</th>
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<tbody>
<tr>
<td>1.2</td>
<td>30/7/2019</td>
<td>Overarching strategy extracted from competency framework and circulated to local CCG and STP colleagues for consultation including nurses</td>
</tr>
<tr>
<td>1.3</td>
<td>12/11/2018</td>
<td>Amendments made re-sent to previous stakeholder group for consultation</td>
</tr>
<tr>
<td>1.4</td>
<td>28/1/2019</td>
<td>Amendments made re-sent to previous stakeholder group for consultation</td>
</tr>
<tr>
<td>1.5</td>
<td>28/1/2019</td>
<td>Slight amendment made and document re-sent</td>
</tr>
<tr>
<td>1.6</td>
<td>14/2/2019</td>
<td>Amendments made re-sent to previous stakeholder group including LMC for consultation</td>
</tr>
<tr>
<td>1.7</td>
<td></td>
<td>Final amendments made for approval</td>
</tr>
</tbody>
</table>

REVIEWERS

This document has been reviewed by:

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE/RESPONSIBILITY</th>
<th>DATE</th>
<th>VERSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally Roberts</td>
<td>Chief Nurse Wolverhampton CCG</td>
<td>12/3/2019</td>
<td>All</td>
</tr>
<tr>
<td>Sarah Southall</td>
<td>Head of Primary Care Wolverhampton CCG</td>
<td>12/3/2019</td>
<td>All</td>
</tr>
<tr>
<td>Sara Bailey</td>
<td>Deputy Chief Nurse Walsall CCG</td>
<td>13/2/2019</td>
<td>All</td>
</tr>
<tr>
<td>Sarah Shingler</td>
<td>Chief Nurse Walsall CCG</td>
<td>13/2/2019</td>
<td>All</td>
</tr>
<tr>
<td>Caroline Brunt</td>
<td>Chief Nurse Dudley CCG</td>
<td>13/2/2019</td>
<td>All</td>
</tr>
<tr>
<td>Joanne Taylor</td>
<td>Commissioning Manager Dudley CCG</td>
<td>13/2/2019</td>
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<tr>
<td>Pauline Billingham</td>
<td>Nurse Mentor Dudley CCG</td>
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<tr>
<td>Michelle Carolan</td>
<td>Sandwell and West Birmingham CCG</td>
<td>13/2/2019</td>
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<tr>
<td>Alyson Hall</td>
<td>Training Hub Coordinator Sandwell and West Birmingham CCG</td>
<td>13/2/2019</td>
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<tr>
<td>Jayne Hawkins</td>
<td>GPN Facilitator Futureproof Health (Dudley Training Hub)</td>
<td>13/2/2019</td>
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<td>Katie Welborn</td>
<td>Matron for Vertical Integration and Sexual Health The Royal Wolverhampton Hospitals NHS Trust</td>
<td>13/2/2019</td>
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<tr>
<td>Heidi Mitchell</td>
<td>Health Education England</td>
<td>13/2/2019</td>
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<td>Phil Turner</td>
<td>Bilston Family Practice</td>
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<td>Therese McMahon</td>
<td>Sandwell and West Birmingham CCG</td>
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<tr>
<td>Lisa Clarke (original author of strategy)</td>
<td>Senior Lecturer University of Wolverhampton</td>
<td>13/2/2019</td>
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</tr>
<tr>
<td>Salma Reehana</td>
<td>GP Partner Health and Beyond</td>
<td>13/2/2019</td>
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<td>David King</td>
<td>Equality and Human Rights Manager NHS Arden and GEM</td>
<td>13/2/2019</td>
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<tr>
<td>Kelly Huckvale</td>
<td>IG Lead NHS Arden and GEM</td>
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<tr>
<td>Sukhdip Parvez</td>
<td>Patient Safety Manager Wolverhampton CCG</td>
<td>13/2/2019</td>
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<tr>
<td>Mike Hastings</td>
<td>Director of Operations Wolverhampton CCG</td>
<td>14/2/2019</td>
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<tr>
<td>Paul Aldridge</td>
<td>GP Forward View Development Manager Black Country STP</td>
<td>19/3/2019</td>
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<tr>
<td>Della Burgess</td>
<td>Health Education England (LWAB)</td>
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**APPROVALS**

This document has been approved by:

**GROUP/COMMITTEE** | **DATE** | **VERSION**
-------------------|----------|---------
Workforce Task and Finish Group Wolverhampton CCG | 15/1/2019 | 1.3
10 Point Action Plan Group | 13/2/2019 | 1.5
Wolverhampton Primary Care Commissioning Committee | 2/4/2019 | 1.7

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Comments from STP Chief Nurse – Sally Roberts

Introduction to the Strategy

This strategy has been developed at a time of significant change both nationally and locally across the Black Country. The true value and essence of high quality nursing care has not changed since nursing was first founded as a vocation and a profession. General Practice Nursing (GPN) is a role that is unique because as a profession it works across the whole age span with patients and the public to optimise the health of the practice population within the community, provides health advice and promotion and manages acute events.

To be a nurse is an amazing role, we are allowed in to the most personal and intimate episodes of people’s lives and entrusted to take care of those who are at their most vulnerable. This is why we joined our profession – to help and make a difference to those who need us most, to value people and make them feel like human beings at all times. This is what marks out our professional intervention and contribution.

Whilst we can all articulate these true and important reasons sadly we hear on an all too regular basis of failings in nursing care in all settings. Therefore nurses are not perfect or immune to factors and influences which can compromise the care that they give. It is for this reason a nursing strategy is essential; this will be provided via this overall strategy document and a additional suite of documents to support:

- Induction of new staff
- Preceptorship
- Competencies
- Skills and education
- Clinical supervision

The aim of this strategy is to define our values for all our nurses, fellow professionals, patient’s carers and the public we serve. To make a clear statement that regardless of your discipline or specialism of nursing, your work setting or location across the Black Country that delivering high quality, safe and personal care is at the heart of what you do.
The recent announcement of a Primary Care Network contract as part of the initiatives within the NHS Long term Plan offers a fantastic opportunity for the role of GPN to flourish and grow even further, the advancement of new roles to Primary care is even more exciting and we look forward as a nursing community to working collaboratively for the benefit of our local population.

As part of this strategy we ask GPN’s to benchmark their competencies, this tool allows the nurse to provide evidence of existing competencies that are utilised to support safe and effective care delivery; whilst identifying continuing professional development requirements. Learning objectives can then be set and discussed within individual appraisal by utilising Appendix 2: Personal Development Plan. Ensuring that nurses have the right skills at the right time to deliver the right care. The completion of the competency framework will also assist with identifying evidence for revalidation (NMC, 2015).

“General practice is an opportunity to see another side of community that I’d not experienced, and I love it, I love the variety, I love how you get to know your patients.”

“I worked at the surgery for 14 years as a receptionist then HCA; 9 years as HCA I did the NVQ 3 and worked my way up.”

“It a really autonomous role you’re using your skills in communication and assertiveness to develop a rapport with the patients, their health is at the heart of everything I do. Empowering the patients to look after their own health is really important, face to face discussion around things like smears to reassure patients and encourage them to participate, when the patients thank you afterwards and that’s really satisfying.”

“It’s that patient journey, they come back to you, for example leg ulcer dressings, it’s amazing seeing someone and being part of the journey and seeing them heal – it’s great. My colleague is dealing with people that she immunised years ago, she’s immunising their children now. It amazes me that the GPs know who the family is and it helps with your role.”

“Having a background as a HCA in general practice has really helped with my communication and nursing skills and I’ve been able to build on this further. It’s opened up a lot of opportunities for me, the extended role is a benefit to the practice it’s good for the skill mix, I can pick up a lot of things that the nurses were doing which will allow them to concentrate on long term conditions and more complex things.”

“General Practice Nursing”

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GPN Strategy – Plan on a Page

Domain 1: Having the right staff in place
Domain 2: Team structure
Domain 3: Education and development
Domain 4: Excellence in care
Domain 5: Digital technology
Domain 6: Research and innovation
Domain 7: Communication

STP GPN Competency Framework
National, STP and local:
- Workforce plans
- Communication and Engagement plans
- Digital technology strategies

STP GPN Education and Career Framework

STP GPN and HCA Induction Framework

Local Clinical Supervision Frameworks

Priority area 1: Maximising health and wellbeing
Priority area 2: Providing a positive experience
Priority area 3: Delivering care and measuring impact
Priority area 4: Building and strengthening leadership
Priority area 5: Ensure the right staff with the right skills are in place
Priority area 6: Supporting positive staff experience

- GPN 10 Point Action Plan
- NMC Standards of Proficiency
- GPN Education and Career Framework (HEE)
- RCGP GPN and ANP competency frameworks
- QNI Transition to GPN
- QNI Voluntary Standards
- HEE ACP Framework

Page 8 of 47
GPN Progression Pathway

The diagram below offers an overview of what basic qualifications are needed, and a progression timeline at entry level for each of the following:

• Level 2 HCA
• Level 3 HCA
• Nursing Associate/Associate Practitioner
• General Practice Nurse
• Advanced Nurse Practitioner

This list is not exhaustive and the nurse would be expected to develop their clinical and leadership skills throughout the lifetime of their career in general practice using a suitable CPD framework such as that developed for this strategy. Staff can enter the pathway at any level and move through the levels by attaining appropriate training and qualifications, progression points at each level are shown in the diagram below. The timeline will depend on staff experience, opportunity, funding availability and timings of training programmes throughout the academic year.
<table>
<thead>
<tr>
<th>Entry Level Candidate</th>
<th>Level 2 Health Care Assistant</th>
<th>Level 3 Health Care Assistant</th>
<th>Nursing Associate</th>
<th>General Practice Nurse</th>
<th>Advanced Nurse Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal qualifications or experience required</td>
<td>Qualifications required: Level 2 diploma in Health and Social Care or Health Care</td>
<td>Qualifications required: Level 3 diploma in Health and Social Care or Health Care</td>
<td>Qualifications required:</td>
<td>Qualifications required:</td>
<td>Qualifications required:</td>
</tr>
<tr>
<td></td>
<td>Entry route via: Full-time college programme</td>
<td>Entry route via: Full-time college programme</td>
<td>Approved Level 5 Foundation Degree NMC registration</td>
<td>Approved RN training i.e. SRN; RGN or RN (Adult) via approved programme leading to DipHE, BSc or MSc</td>
<td>Approved RN training (as for GPN)</td>
</tr>
<tr>
<td></td>
<td>Apprenticeship</td>
<td>Apprenticeship</td>
<td>Maths and English at GCSE/equivalent</td>
<td>Self-funded/employer sponsored study</td>
<td>MSc Advanced Clinical Practice</td>
</tr>
<tr>
<td></td>
<td>Employer funded training</td>
<td>Employer funded training</td>
<td>Entry route via: Apprenticeship</td>
<td>Entry route via: Apprenticeship</td>
<td></td>
</tr>
</tbody>
</table>

Progression Points:
- Progression Point L2 to L3 HCA (15-18 months)
- Progression Point L3 HCA to AP (2 years)
- Progression Point L3 HCA to GPN (3 years full time 4 years part time)
- Progression Point L3 HCA to NA (2 years)
- Progression Point NA to GPN (2\(\frac{1}{2}\) years)
- Progression Point GPN to ANP (3 years)

A GPN would be expected to have a “reasonable” amount of post-registration experience before undertaking the Advanced Clinical Practice Master’s degree, this would depend on the nurse and their current and previous role but would generally be around 3-5 years.
General Practice Nurse Strategy

Aim
The aim of this strategy and supporting documents is to provide a forward view for general practice nursing for the Black Country.

Objectives
- Align the strategy content to reflect and support the actions within national and STP documents such as
  - 10 Point Action Plan for GPNs
  - GP Forward View
  - NHS Long Term Plan
  - STP Clinical, Workforce and Primary Care strategies
- To provide an outline of good practice using the principles of compassionate care
- To provide a suite of companion documents that offer:
  - A career progression framework aligned to the HEE career and education framework for GPNs
  - A competency framework based on the RCGP GPN framework
  - An induction and preceptorship framework based on existing programmes e.g. Capital Nurse
  - Guidance around Clinical Supervision for GPNs
  - A retention strategy for GPNs

Strategy Overview
The General Practice Nurse Strategy provides a framework for a STP-wide nursing plan through seven domains and partners within the STP have agreed to:
- Support excellence in care through learning in association with patients, their families and service users.
- Increase focus on quality and continually seek to improve the care provided.
- Encourage the best nurses to join practices within the Black Country STP footprint and embrace diversity through skilled appointments.
Responsibility for each domain will lie with relevant teams within each CCG and with the STP, with support from NHSE and HEE.
Seven domains and six priority areas have been identified to support the implementation of the strategy and its companion documents, these have been aligned to a number of national work programmes:

- GPN 10 Point Action Plan
- GP Forward View
- NHS Long Term Plan
- Compassionate Care
- NMC Standards of Proficiency for Registered Nurses
- HEE General Practice Nursing Services Education and Career Framework
- RCGP GPN Competency Framework
- RCGP General Practice Advanced Nurse Practitioner Competencies
- QNI Transition to General Practice Nursing Resource
- QNI Voluntary Standards for General Practice Nurses
- HEE ACP Framework

These domains are not exhaustive and each CCG will have different priorities and workforce needs that will be identified locally and led by the local clinical leads.

**The role of the GPN Lead Nurse**

The GPN 10 Point Action Plan recommends that each area should have access to a GPN Lead Nurse, who will support and guide the GPN strategy at both a strategic and operational level. There is currently a designated lead in each CCG and an overall GPN Lead Nurse for the STP. Each CCG area has different provision models for their GPN lead nurse which includes:

- Provision via Chief or Deputy Chief Nurse
- Designated GPN lead who may also have a patient safety function or work as a GPN and maintain the role part time
- Nurse mentor and facilitator who have an operational role and may also work as GPNs
- Clinical leads within practices and practice groups who also work with CCGs in an advisory role

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• GPN leads at regional level working with NHSE and HEE
Each role, although different provides support to the GPN workforce through collaboration with CCG and STP colleagues and at a regional level via the NHSE/HEE leads. Networking between strategic and operational colleagues facilitates the development and promotion of the GPN role and enables the GPN lead to provide appropriate support to colleagues.

**Domain 1: Having the right staff in the right place at the right time**
Providing good nursing care for patients relies on ensuring that there are the right staff, in the right place at the right time. In a diverse workforce such as general practice this requires flexibility and constant development. This domain should be considered in conjunction with the STP and CCG workforce plans and with the following supplementary document:
• The Black Country STP GPN Services Education and Career Framework

<table>
<thead>
<tr>
<th>The STP and CCGs will:</th>
<th>Aligns to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implement a workforce plan which focuses on recruitment and retention.</td>
<td>GPN 10 Point Action Plan – 1; 3; 4; 5; 7; 8; 9; 10</td>
</tr>
<tr>
<td>• Continue to develop workforce review and training needs analysis to ensure effective management of nursing resources and the development and placement of existing and new roles within primary care.</td>
<td>GPFV (section) – 2; 5</td>
</tr>
<tr>
<td>• Review the role of the HCA and GPN in practice taking into account new roles and the revised NMC standards.</td>
<td>NHS Long Term Plan (section) - 4</td>
</tr>
<tr>
<td>• Promote the GPN role via traditional local and regional marketing campaigns, the use of social media and engagement with schools, colleges and universities.</td>
<td>Compassionate Care – 1; 3; 6</td>
</tr>
<tr>
<td>• Develop and promote student placements to practices including placements for those on Return to Practice programmes, taking into account capacity in each site.</td>
<td>NMC Standards: Platforms 1; 4; 5</td>
</tr>
<tr>
<td>• Provide staff with the opportunity to develop their leadership skills at all levels from HCAs to ANPs.</td>
<td>QNI Voluntary Standards: Domain 2; 3; 4</td>
</tr>
<tr>
<td>• Promote the Return to Practice programme particularly those relevant to GPNs.</td>
<td></td>
</tr>
<tr>
<td>• Develop and promote opportunities for nurses to advance in their role at all levels, whilst emphasising that this is a personal choice.</td>
<td></td>
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</table>
- Support the development of Health Care Support Workers, including the promotion of level 2 and 3 Nursing Associate and Registered Nurse apprenticeships.
- Support the development of newer and multi-skilled roles for HCSWs e.g. Associate Practitioners and Medical Assistants to meet demand.
- Support the implementation of clinical supervision within general practice either via face to face or electronic means.

<table>
<thead>
<tr>
<th>Domain 2: Team Structure</th>
</tr>
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<tbody>
<tr>
<td>GPNs are part of a multidisciplinary team and local leadership structures are central to supporting the provision of quality oversight and good innovative care. This domain should be considered in conjunction with the STP and CCG workforce plans, and with:</td>
</tr>
<tr>
<td>- The Black Country STP GPN Services Education and Career Framework</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>The STP and CCGs will:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Define pathways to enable career development in line with the Health Education England Education and Careers Framework (2015).</td>
</tr>
<tr>
<td>- Set aspirational targets to deliver high quality care, measured against national and international standards.</td>
</tr>
<tr>
<td>- Undertaking peer review and support between colleagues and teams.</td>
</tr>
<tr>
<td>- Offer nurses at all levels the opportunity to participate in quality improvement and service and clinical developments.</td>
</tr>
<tr>
<td>- Develop shared governance to engage staff and enable them to influence patient care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Aligns to:</th>
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<tbody>
<tr>
<td>GPN 10 Point Action Plan – 2; 4; 6; 7; 8; 9</td>
</tr>
<tr>
<td>GPFV (section) – 2; 5</td>
</tr>
<tr>
<td>NHS Long Term Plan (section) - 4</td>
</tr>
<tr>
<td>Compassionate Care – 1; 3; 6</td>
</tr>
<tr>
<td>NMC Standards: Platforms 1; 3; 5; 6</td>
</tr>
<tr>
<td>QNI Voluntary Standards: Domain 2; 3</td>
</tr>
</tbody>
</table>
**Domain 3: Education and Development**

Education is key to the development and maintenance of skills and workforce development, it also supports the foundations for a “home-grown” workforce of the future. This domain should be considered in conjunction with the following supplementary documents:

- The Black Country STP GPN Competency Framework
- The Black Country STP GPN and HCA Induction Framework
- The Black Country STP GPN Services Education and Career Framework

These documents provide in-depth details of the education and development for GPNs and HCAs working in primary care.

<table>
<thead>
<tr>
<th>The STP and CCGs will:</th>
<th>Aligns to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop and support local GPN education forums.</td>
<td>GPN 10 Point Action Plan – 2; 4; 6; 7; 8; 9</td>
</tr>
<tr>
<td>• Develop mentors and increase student placement opportunities in primary care taking into account capacity.</td>
<td>GPFV (section) – 2; 5</td>
</tr>
<tr>
<td>• Invest in the future workforce through engagement with apprenticeships at all levels from HCA to Registered Nurse.</td>
<td>NHS Long Term Plan (section) - 4</td>
</tr>
<tr>
<td>• Support access to HEE sponsored programmes in advanced clinical practice and specialist nursing.</td>
<td>Compassionate Care – 1; 3; 6</td>
</tr>
<tr>
<td>• Ensure that nurses at all levels receive a strong induction, with on-going preceptorship where possible and have the support and opportunity to develop their careers. This will be implemented via the Induction Framework and the Retention Programme</td>
<td>NMC Standards: Platforms 1; 3; 5; 6</td>
</tr>
<tr>
<td>• Develop new ways of working to help nurses to develop within the profession and retain nurses in general practice.</td>
<td>QNI Voluntary Standards: Domain 2; 3</td>
</tr>
<tr>
<td>• Develop and maintain links with the Black Country Training Hub to ensure wider provision of free and accessible training to nurses at all levels.</td>
<td></td>
</tr>
</tbody>
</table>
Domain 4: Excellence in care
Facilitating provision of the best care possible is central to everything the STP does. Continual improvement requires care to be underpinned by best practice evidence, research with measurable outcomes, ensuring right thing is done at the right time. This domain should be considered in conjunction with STP and CCG patient and carer engagement programmes and local work around patient safety and improvement.

<table>
<thead>
<tr>
<th>The STP and CCGs will:</th>
<th>Aligns to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Listen to, value and learn from patient opinions and their experiences.</td>
<td>GPN 10 Point Action Plan – 2; 4; 6; 7; 8; 9</td>
</tr>
<tr>
<td>• Encourage nurses and HCAs to be actively involved in programmes that promote</td>
<td>GPFV (section) – 2; 5</td>
</tr>
<tr>
<td>the patient and carer voice e.g. Friends and Family Test, Patient Participation</td>
<td>NHS Long Term Plan (section) - 4</td>
</tr>
<tr>
<td>Groups, “Friends of” groups</td>
<td>Compassionate Care – 1; 3; 6</td>
</tr>
<tr>
<td>• Continually listen and involve patients to help inform our own learning needs e.g.</td>
<td>NMC Standards: Platforms 1; 3; 5; 6</td>
</tr>
<tr>
<td>via patient testimonial for revalidation.</td>
<td>QNI Voluntary Standards: Domain 2; 3</td>
</tr>
<tr>
<td>• Encourage engagement with local and national guidelines e.g. NICE as examples</td>
<td></td>
</tr>
<tr>
<td>of best practice</td>
<td></td>
</tr>
<tr>
<td>• Promote engagement with research and development in primary care to improve</td>
<td></td>
</tr>
<tr>
<td>services and care.</td>
<td></td>
</tr>
<tr>
<td>• Ensure that all patients have their communication needs met appropriately.</td>
<td></td>
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</table>

Domain 5: Digital Technology
New technology is central to the delivery of care within general practice. This domain is supported by STP and local digital technology plans such as those implemented as part of the GPFV.

<table>
<thead>
<tr>
<th>The STP and CCGs will:</th>
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<tbody>
<tr>
<td></td>
<td>GPN 10 Point Action Plan – 1;</td>
</tr>
<tr>
<td></td>
<td>GPFV (section) – 2; 5</td>
</tr>
</tbody>
</table>
• Encourage nurses to engage with digital technology and to become Digital Champions where appropriate enabling them to promote electronic services to patients and carers.

• Promote the use of new patient focused technologies to deliver nursing care that enhance safe care delivery e.g. on-line consultations, use of health apps and telemedicine where locally appropriate.

• Encourage engagement with digital platforms such as NHS futures to link with peers and enhance delivery of care.

• Consider the use of platforms such as Skype and WhatsApp to connect with peers responsibly.

• Develop the responsible use of social media platforms to engage with patients and carers.

NHS Long Term Plan (section) – 1; 5
Compassionate Care – 1; 3; 5
NMC Standards: All platforms
QNI Voluntary Standards: All domains

Domain 6: Research and Innovation
Nursing care relies on access to a good evidence base, promoting critical dialogue and research is central to this agenda.

• The Black Country STP GPN Competency Framework
• The Black Country STP GPN and HCA Induction Framework
• The Black Country STP GPN Services Education and Career Framework

Consideration should also be given to work undertaken by the West Midlands Academic Health Science Network and the National Institute for Health Research to promote research and innovation in primary care and within the nursing profession. This domain will be a major focus within the new Bachelor of Nursing programmes currently under development locally.

The STP will:
• Develop a culture where research becomes a normal part of clinical practice and nurses can develop confidence in participating in and leading research in primary care.

• Develop local research which underpins safe, effective and high quality care.

Aligns to:
GPN 10 Point Action Plan – 2; 7; 8
GPFV (section) – 2; 5
NHS Long Term Plan (section) – 1; 4
Compassionate Care – 1; 3; 6
• Grow links with local acute trust Research and Development teams and universities to support the development of research in general practice by practice nurses.

NMC Standards: Platforms 1; 3; 4; 5; 6
QNI Voluntary Standards: Domain 3; 4

**Domain 7: Communication**
The General Practice Nurse Strategy and accompanying documents can be used to implement and measure performance and milestones. It is important that staff and STP leads are kept informed and we share progress. This should be considered in conjunction with STP and CCG communication and engagement strategies and the following supplementary documents:
- The Black Country STP GPN Competency Framework
- The Black Country STP GPN and HCA Induction Framework
- The Black Country STP GPN Services Education and Career Framework

Therefore the STP have agreed to:

<table>
<thead>
<tr>
<th>The STP will:</th>
<th>Aligns to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop current communication methods available locally, including intranet web pages and global communication emails.</td>
<td>GPN 10 Point Action Plan – All action points</td>
</tr>
<tr>
<td>• Develop a STP wide Nursing Newsletter and promote the responsible use of social media to ensure that we all know what is happening.</td>
<td>GPFV (section) – 2; 3; 4; 5</td>
</tr>
<tr>
<td>• Hold monthly forums on a local level to update you on topics.</td>
<td>NHS Long Term Plan (section) – 1; 3; 5</td>
</tr>
<tr>
<td>• Work with the Black Country Training Hub to widen the reach of current communication methods.</td>
<td>Compassionate Care – All priority areas</td>
</tr>
<tr>
<td></td>
<td>NMC Standards: All platforms</td>
</tr>
<tr>
<td></td>
<td>QNI Voluntary Standards: All domains</td>
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</tbody>
</table>
## Key Deliverables

The key deliverables for this programme include, but are not limited to the following activities. These deliverables are based on current activity and activity that is in development, a timeline for implementation of key deliverables is shown below, other deliverables are on-going. The dates below are provisional **implementation dates and are subject to change** as the GPN agenda develops in line with the NHS Long Term Plan and work will be going on relating to these projects up to these dates.

<table>
<thead>
<tr>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
<th>On-going</th>
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<tbody>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Development of GPN retention programme</td>
<td>Training needs analysis and review of GPN</td>
<td>Co-design of formal induction programme</td>
<td>Development of Nurse Bank (Local or national)</td>
</tr>
<tr>
<td>Mapping exercise for HCA to ANP</td>
<td>Work experience programme</td>
<td>Facilitating access to training through PLP</td>
<td>Development of &quot;Step into Practice&quot; programme</td>
</tr>
<tr>
<td>Facilitation of access to HEE sponsored courses</td>
<td>Facilitation of access to HEE sponsored courses</td>
<td>Facilitation of access to HEE sponsored courses</td>
<td>Promoting development of mentorship</td>
</tr>
<tr>
<td>Promote Queen’s Nurse programme</td>
<td>Development of initial clinical supervision programmes</td>
<td>Promote Queen’s Nurse programme</td>
<td>Promote Queen’s Nurse programme</td>
</tr>
</tbody>
</table>
Promotion of leadership skills training

Promotion of digital nurse champion role

Development of Marketing framework

Workforce Analysis
- All CCGs will work with STP partners to collate:
  - Funding and training needs analysis for primary care nursing
  - Skills and function mapping for staff
  - Review of general practice nursing
  - Work with Primary Care Networks, practice and locality groups to identify current and expected gaps
  - Plan recruitment, retention and CPD according to identified needs

Recruitment
- CCGs, Training Hub and practices to co-design a sustainable programme to attract students before they enter the higher education system through:
  - Work experience for Year 12/equivalent
  - Events in schools and colleges supported by local HEIs and Training Hubs

- CCGs within the STP to consider engaging in a formal “Step in to General Practice” programme with STP partners, practices, Training Hubs and local universities and colleges that:
  - Targets student nurses and Health and Social Care diploma students that are about to qualify
  - Matches candidates with available nursing jobs in Primary Care
  - Promotes a supported pathway directly into local career development programmes such as Fundamentals of General Practice Nursing and Nursing Associate/Registered Nurse apprenticeships
• Training Hub to promote the Primary Care Nurse champion role within practices across the STP to support the recruitment and retention agenda

• All partners to collaborate to co-design of a formal induction programme for new GPNs/HCAs that includes:
  o Formal induction plan
  o Preceptorship
  o Care Certificate for new HCAs
  o Access to free numeracy and literacy level 2 key skills for those that do not have it

• CCGs and Training Hub to establish a marketing framework that includes:
  o Social media and digital marketing
  o Hard-copy media
  o Face to face events

Retention
• All partners to co-design of a formal retention plan that includes:
  o Succession planning through up-skilling existing staff and encouraging the recruitment of new staff before existing staff leave
  o Promotion of working as groups to share staff, increase the skill mix and offer variety
  o Promotion of portfolio careers such as clinical specialities, research, education
  o Encouraging staff to reduce hours not leave
  o Ensuring new staff are supported and encouraged to develop
  o Safeguarding funding and opportunities for training and up-skilling of staff

• Training Hub to engage in the national or a local GPN nurse bank pilot and share learning, to include:
  o Retired staff who may wish to maintain their professional registration
  o Staff that prefer the flexibility of bank working
  o Staff working in leadership and strategic roles who may wish to maintain their clinical skills
  o Staff working in other areas who may wish to develop their skills in primary care with a view to moving into a GPN role
Assurances around indemnity

Student Placements
- All partners to continue close partnership working with universities, acute trust and practices to ensure that placements are available including for apprentices:
  - Regular contact with universities
  - Access to the register of mentors
  - Feedback
- All partners to ensure staff are aware of changes to mentorship with new NMC standards makes process easier including the role of other professions and HCAs in supervising student nurses

Leadership Skills
- CCGs to maintain a GPN leadership role within the STP footprint through:
  - Training Hub GPN Facilitator
  - GPN mentors
  - GPN leads within all CCG areas including an overall STP GPN lead
- CCGs and Training Hub to facilitate access to formal leadership programmes through promotion and support practices to release staff to attend programmes such as:
  - NHS Leadership Academy programme e.g. Edward Jenner
  - RCN leadership programme for GPNs
  - Specialist Practice Programme (General Practice Nursing) – HEE sponsored programme
  - Level 5 Diploma in Leadership for Health and Social Care apprenticeship
- CCGs and Training Hub to promote and encourage annual applications to the QNI Queen’s Nurse programme and develop an STP footprint Queen’s Nurse network
- All partners to encourage GPNs to undertake educator programmes and identify where staff already have educator skills e.g.:
  - Mentorship awards
- Practice Educator awards
- Teaching qualifications
- Assessment qualifications (formerly A1/D32)

Encourage staff to utilise these skills and their clinical expertise to support students, new staff members and participate in the training and development of existing staff

- All partners to encourage staff to participate in clinical supervision and for senior staff to develop facilitation roles

**Career Development Pathways**

- CCGs and Training Hub to promote apprenticeships at all levels as a viable option for career development in primary care allowing practices to promote existing staff and recruit new staff at all stages of the GPN “life-cycle”:
  - HCA apprenticeships at levels 2 and 3
  - Nursing Associate apprenticeships/Associate Practitioner apprenticeships
  - Registered Nurse Apprenticeships

- CCGs and Training Hub to promote and provide support for practices to access apprenticeships at all levels through incentives such as:
  - Funding of 10% top-up required for non-levy payers through direct funding or levy-sharing
  - Employers incentives and full funding available for 16-18 year olds
  - Central engagement of apprenticeship providers
  - Support with recruitment of NA and RN candidates
  - Support for NA and RN candidates during their course

- All partners to enable access to HEE sponsored programmes:
  - Fundamentals of General Practice Nursing
  - Specialist Practice – General Practice Nursing
  - Advanced Clinical Practice
• CCGs to enable practices to release staff for training as part of a career development pathway through various support mechanisms e.g.:
  - Backfill and protected learning time
  - Development of a nurse bank
  - Sharing of staff across Primary Care Networks, groups and localities

• All partners to support the Return to Practice programme by identifying staff who may have lapsed registration through established and novel routes e.g.:
  - Existing staff working as HCAs or in non-clinical roles
  - Those who may have taken early retirement but now wish to return
  - Those who have moved to other professions but may be interested in returning to nursing including those in executive roles within the NHS
  - Carers and parents who may have changed circumstances
  - Enrolled Nurses who may wish to return and may wish to use this as a pathway to convert to Registered Nurse

Work with local practices to identify possible training sites for RtP candidates and promote the small financial incentive included.

• CCGs and practices to ensure there is access to a robust programme of training developed in conjunction with the Training Hub and local HEIs to enable staff to up-skill and maintain skills in line with national guidance:
  - Clinical skills
  - Long-term condition management
  - Non-medical prescribing

Advanced Practice
• CCGs and Training Hub to work with PCNs, practice groups, local HEIs and HEE to promote access to Advanced Clinical Practice roles through:
  - Identifying priority areas
  - Facilitating access to HEE sponsored programmes
  - Promoting the role of the ANP and the benefits to the practice as outlined in the GPFV
• CCGs and Training Hub to work with PCNs, practice groups and local HEIs to identify and promote research opportunities for nurses through:
  o Championing the role of the GPN in research
  o Encourage all levels of staff to take part in local service evaluation and audit as an on-going process
  o Encouraging GPNs to consider research as a viable portfolio career opportunity
  o Liaise with local Research and Development teams around opportunities for nurses to work on existing projects and develop their own projects
  o Scope training opportunities for staff interested in research e.g. research methods, Good Clinical Practice, research ethics etc.

Career Pathway Definition
• STP leads to undertake an exercise to map the development of an individual from new entry HCA to Advanced Nurse Practitioner as defined by the HEE framework within primary care including:
  o Skills and qualifications needed to attain each stage
  o Potential costs at each stage
  o Timescales for training

Peer Review
• CCGs to develop the peer review process for GPNs through:
  o Developing the group clinical supervision process to encourage dialogue between nurses and peer review of care
  o Continued development of local GPN forums to include topics where training needs have been identified e.g. introduction of new NICE guidance, contractual changes

Service Development
• All partners to encourage and support individual nurses and those working collectively within PCNs and practice groups to identify service development opportunities through:
  o Providing information and access to innovation funding including access to bid writing training
  o Working collectively to identify health needs and addressing service gaps
○ Membership of organisations that encourage networking and sharing of innovation such as Patient Safety Collaborative Q Community and Queen’s Nursing Institute

Quality Improvement
• All partners to encourage and support individual nurses and those working collectively within PCNs and practice groups to identify quality improvement opportunities through:
  ○ Active involvement in patient engagement.
  ○ Participation in formal processes for measuring and improving the patient experience such as Friends and Family Test and GP Survey
  ○ Active involvement in quality assurance processes such as contract visits, serious incident and complaint investigation
  ○ Celebration of quality improvement innovation through GPN newsletters and bulletins

Education and Development
• Each CCG area to continue to develop their local nurse education forums.

• Ensure there is access to a robust programme of training developed in conjunction with the Training Hub and local HEIs to enable staff to up-skill and maintain skills in line with national guidance:
  ○ Clinical skills
  ○ Long-term condition management
  ○ Non-medical prescribing

Research and Development
• Work with PCNs, practice groups and local HEIs to identify and promote research opportunities for nurses through:
  ○ Championing the role of the GPN in research
  ○ Encourage all levels of staff to take part in local service evaluation and audit as an on-going process
  ○ Encouraging GPNs to consider research as a viable portfolio career opportunity
  ○ Liaise with local Research and Development teams around opportunities for nurses to work on existing projects and develop their own projects
o Scope training opportunities for staff interested in research e.g. research methods, Good Clinical Practice, research ethics etc.
Compassionate Care

The Department of Health published Compassion in Practice (2012)\(^3\) which includes the future vision for nurses, midwives and care staff. Through the development stages of Compassion in Practice GPN’s have developed their own representation of the 6 C’s and areas of action. The way, in which NHS services are delivered and used needs to change, we need to do things differently in the future, and see a move towards community based care. Some of this change is happening now and we have been involved in avoiding hospital admissions with the ‘care closer to home’ agenda. The move from an acute setting to care at home will require robust primary care services to meet the challenge of an ageing population and the increase in long term conditions associated with this. This again requires nurses to be up-skilled in long term conditions.

<table>
<thead>
<tr>
<th>Culture of Compassionate Care (DH, 2012)</th>
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</thead>
<tbody>
<tr>
<td>1. <strong>Care</strong>: caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.</td>
</tr>
<tr>
<td>2. <strong>Compassion</strong> is how care is given through relationships based on empathy, respect and dignity. It can also be described as intelligent kindness and is central to who people perceive their care.</td>
</tr>
<tr>
<td>3. <strong>Competence</strong> means all those in caring roles must have the ability to understand an individual’s health and social needs. It is also about having the expertise clinical and technical knowledge to deliver effective care and treatments based on research and evidence.</td>
</tr>
<tr>
<td>4. <strong>Communication</strong> is central to successful caring relationships and to effective team working. Listening is as important as what we say and do. It is essential for “no decision without me”. Communications is key to a good workplace with benefits for those in our care and staff alike.</td>
</tr>
<tr>
<td>5. <strong>Courage</strong> enables us to do the right thing for the people we care for, to speak up when we have concerns. It means we have the personal strength and vision to innovate and to embrace new ways of working.</td>
</tr>
<tr>
<td>6. <strong>Commitment</strong> to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients.</td>
</tr>
</tbody>
</table>

\(^3\) Department of Health (2012) Compassion in Practice: Nursing, Midwifery and Care Staff Our Vision and Strategy. DH: London.
To make Compassion in Practice happen nurses at all levels across all services will need to take the lead on these 6 Priority Areas:

1. Maximising health and Wellbeing. Helping people to stay independent
2. Working with people to provide a positive experience
3. Delivering care and measuring impact
4. Building and strengthening leadership
5. Ensuring we have the right staff, with the right skills in place
6. Supporting positive staff experience

These principles should apply to all nursing staff whether or not they hold professional registration.

**Priority Area 1 – Maximising Health and Wellbeing, Helping People to Stay Independent**

GPN’s have a unique role to play in improving the health and well-being of the population by making every contact count. Supporting people to manage their own health and well-being more effectively by ensuring that individual needs are identified and that appropriate support is in place is a key priority. GPN’s within the Black Country will co-ordinate and support their practice team to deliver care and support in primary care settings. Individual practice populations health will be optimised through:

- Mental health and wellbeing
- Contraceptive and sexual health advice
- Education and delivery of public health programmes
- Screening and immunisation provision
- Managing and supporting long term conditions
- Positive lifestyle changes
- Health promotion, protection and screening
- Travel advice
- Management of risks (drugs, alcohol, weight management, smoking cessation)
- Managing acute events
- Long term conditions including exacerbations and continuing care
- Medicines management
- Triage
• Minor illness and minor injury management
• Management of emergencies (acute asthma attack, chest pain etc.)
• Preventing premature deaths

**Key Deliverables:**
• Develop innovative ideas to support management of long term conditions
• Use and develop knowledge and skills to support and care for individuals and maximise their health and wellbeing
• Effective management of chronic disease to reduce acute episodes and reduce unavoidable hospital admissions
• Provide accessibility and flexibility in service delivery
• Provide patient led services
• Deliver public health programmes such as immunisations, screening i.e. cervical cytology, NHS Health Checks advice and health promotion

**Evidence of Good Practice:**
• Nurses across the STP provide weight management clinics, smoking cessation, over 75 checks, health education for long term conditions, NHS Health Checks, travel health and sexual health screening.
• Patients are signposted to social prescribing, lifestyle services, social services, counselling and support services.
• Staff are working at a strategic level with partners to develop and improve care pathways.

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**Priority Area 2 – Working with People to Provide a Positive Experience**

A positive patient experience is defined as:
"Getting good treatment in a comfortable, caring and safe environment, delivered in a calm and reassuring way; having information to make choices, to feel confident and feel in control: being talked to and listened to as an equal; and being treated with honesty, respect and dignity”,

A positive experience is for everyone:

No-one should receive a poorer experience because of age, disability, gender, ethnicity, cognitive difficulties, sexual orientation, religion or belief or any other individual characteristic. Those who need help to articulate their experiences will be given adequate and appropriate support (DH, 2005). The culture and ethos of NHS care has changed significantly over recent years. The focus is on working with patients and carers to enable them to manage their care and to have choice and control over the care they receive. This requires a shift in models of nursing practice which requires support and effective leadership

**Key Deliverables**

Nurses will:
• Listen to patients and treat them as an individual with respect, sensitivity and a positive attitude
• Seek out the patient’s, relatives and carer’s experience of care in whatever means suits the individual including patient participation groups.
• Actively involve patients in discussions around their Care Planning and Care Decisions including End of Life Care. There will be evidence of a care plan within the patients records which demonstrates person centred care through engagement where appropriate
• Have in place, and participate in a formal process for measuring and improving the patient experience.
• Ensure comments and complaints from patients are listened to, acted upon and feedback given to the individual, ensuring positive learning outcomes is achieved.
• Audit changes in practice to ensure they remain effective
• Demonstrate a reduction in the number of complaints received around the patient experience
• Ensure patients are represented on forums which influence health care services and the practice
• Publicise good patient experience

Examples of good practice include:
• Personalised care plans
• Increased access to services such as late night and weekend openings
• Joint working as part of the practice team with patient participation groups, developing increased skills to be able to offer services nearer to home.
• Role development e.g. Nurse prescribing, spirometry, warfarin clinics, sexual health services including implant insertion, advanced clinical practice, Triage.
• HCAs developing in their roles and taking on extended skills, HCAs training as Nursing Associates and associate practitioners and moving on to RN apprenticeships.

Priority Area 3 – Delivering Care and Measuring Impact

Everybody deserves to receive the highest quality of compassionate care from nursing staff. It is essential to a person’s health, well-being and dignity. It is what our patient’s value the most and it is the nursing intervention that we value the most.
Care and the values of caring are more than just words and must be at the centre of how each practice is run.
GPN’s will use intelligence available within the practice to learn, improve and highlight positive impact care provided has had for the people they care for.

Key Deliverables
• All nursing and support staff will know what high quality personalized care actually is and will deliver it with compassion, confidence and pride.
• All job descriptions for nursing and support posts will have an essential requirement for the delivery of high quality personalized care.
Recruitment of new nursing and support staff will include assessment of caring and compassion.
Practice nurses will be the champions and guardians of high quality personalized care in their practice, providing role modelling and visible leadership.
All nursing and support staff will be expected to uphold these values and to raise concern to their manager for an instance when care does not meet these standards.
Nurses will build and maintain relationships by listening, supporting others, gaining trust and showing understanding during all professional interactions
Nurses will actively encourage participation by creating an environment where others have the opportunity to contribute
Nurses will commit to working in inter-agency contexts in order to deliver measurable outcomes and improve services.
Use professional judgement to influence commissioning decisions
Use data to target care groups within practice population
Have an audit program
Deliver evidenced based care

### Examples of good practice include:
- Some practices across the borough have implemented:
  - Structured delivery of care for patients with long term conditions against evidence based targets.
  - Audit of care provision for example cervical cytology audits, x-ray referral audits, prescribing audits, infection prevention audits.
  - Partnership working with wider health economy to meet local and national targets e.g. admission avoidance, public health targets such as immunisation and cervical cytology.
  - Case management of vulnerable people for example ward rounds and structured care for patients who can attend appointments at the surgery.

### Priority Area 4 - Building and Strengthening Leadership
The foundations to achieving excellence in nursing practice and all of the outcomes in this strategy lie in effective professional leadership. Leadership in nursing is crucial to the quality of patient care and to the development of the professions. Strong leadership drives high quality care by fostering a caring and compassionate culture.
Leaders need to be confident, competent, well-motivated, self-aware, and socially skilled. They need to be team players who are able to work with others across professional and organisational boundaries. In short good leaders make positive, visible changes to the delivery of care.

### Key Deliverables
### At an Individual Level:
- Every nurse should set an example of excellence for others.
- Each nurse will be prepared to lead and be accountable for improvements in patient care.
- Nurses will facilitate the professional and personal development of others, demonstrating leadership, reflective practice, supervision, quality improvement and teaching skills.

Every nurse should reflect on their code of conduct.

### At a Practice Level:
- Emphasis is placed on leadership development within the Practice.
- Actively seeking out those with potential.
- Actively using the skills of good leaders.

The CCG Lead Nurses and Training Hub Nurse Facilitator will:
- Promote programmes of leadership training.
- Drive implementation of this strategy and provide expert advice guidance and influence for all nurses in primary care.
- Build upon the leadership and facilitation skills of practice nurses to influence practice through positive role modelling, sharing best practice and encouraging improvements in patient/client care.
- Nurture and develop nursing leadership ability.

**Examples of good practice include**
- Mentorship for pre-registration and post –registration nurses.
- Supporting training of medical students, FY2 and GP registrars.
- Participation in the development and delivery of training sessions for the health economy such as asthma training.
- Partnership working with local community to develop services based on community need, (Young Persons Info Centre work).
- Partnership working with local commissioning group to influence service delivery.
- Pilot projects to evidence the cost effectiveness and safety of new ways of working such for both Primary Care and the Health Economy such as Spirometry, anti-coagulation services.
- Development of direct referral pathways rights for x-ray, admission and referral to consultant clinics.
- Leading on aspects of General Practice quality assurance frameworks, such as QoF, Qof+ and Dudley Quality Outcomes for Health.
Priority Area 5 - Ensure We Have the Right Staff, with the Right Skills in Place

Nurses have a wide range of knowledge and skills; however general practice nurses may require additional specific skills and competence when entering into general practice nurse roles. This strategy acknowledges that there is a requirement to support practice nurses and healthcare assistants to build upon existing knowledge and skills to become proficient and competent to deliver the healthcare agenda and nursing vision. This strategy recognises that there is a need to have a competency framework in place for practice nurses and healthcare assistants to support staff in their development. ‘The Future of Primary Care: Creating Teams for Tomorrow’ review acknowledges how services wrapped around General Practice need to transform with the existing workforce and be ready to work in different ways to deliver high quality care.

Key Deliverables

- Recognised training pathway and competency framework for General Practice nurses at all levels from Healthcare Assistants to Advanced Clinical Practitioners (levels one to eight).
- All staff will complete self-assessment section of the competency framework which will inform training provision and be reviewed by local mentors and supervisors at practice, network or locality level.
- Practices will have a skill mix that is safe and appropriate
- Appropriate delegation to healthcare assistants
- All nursing staff will have an appropriate job description
- All nursing staff will have access to a professional forum
- All nursing staff will have an annual appraisal and personal development plan
- All nursing staff will have access to clinical supervision
- All nursing staff will have access to union and legal representation
- Nurses to develop or update mentorship skills in preparation to support pre-registration nurses in primary care
- All nurses will ensure that they have the appropriate level of indemnity cover either through their employer or individual indemnity policies which is relevant to their skill level.

Examples of good practice include

- Appropriate skill mix within each practice
- Support the development of other roles within the practice for example developing admin staff to undertake a phlebotomy role
- Support the training and practice of HCA’s, student nurses, and post registration nurses undertaking developmental training.
- Supporting training of junior medical staff with medical colleagues
- Development of protocols to ensure safe evidence based care which can be delivered in the most appropriate and cost effective way,
Priority Area 6 – Supporting Positive Staff Experience

The shared vision for nursing and this strategy can only be achieved if staffs feel supported to do their job well. Staff wellbeing is closely linked to patient wellbeing and evidence supports the theory that good staff experience has a positive impact on the quality of care delivered. There are staff demonstrating compassion every day and delivering the highest quality care. This excellent work must be celebrated, more than that; these values must be continually reinforced through the commitment and actions of leaders, managers and employers.

**Key Deliverables**
- GPNs at all levels will take a leadership role towards feeling valued, respected and part of decision making within the practice.
- Access to a professional forum for general practice nurses facilitated by CCGs and Training Hub.
- GPNs at all levels will take a leadership role to ensure that they work in a healthy and safe environment.
- GPNs will contribute to ensuring good communication and information flows.
- Each practice will ensure GPNs and healthcare workers have clear expectations and objectives linked to local priorities.
- Each practice has relevant policies and standards and procedures to support staff in their day to day work.

**Examples of good practice include**
- Promoting a culture of “patient first” in practice.
- Induction packs for staff in training.
- Working as part of a team, valuing every one’s role.
- Supporting staff experiencing stress.
- Working with managers to ensure continuity of service under pressure.
Appendix 1: General Practice Nursing Ten Point Action Plan

The Ten Point Action Plan for General Practice Nursing\(^4\), describes the nursing element of the GP Forward View\(^5\). This helps nurses and health care support workers (HCSW) focus on demonstrating their contribution to reducing the three gaps identified in the Five Year Forward View - the health and well-being gap, the care and quality gap, and the funding and efficiency gap. Subsequently, the Next Steps on The Five year Forward View sets out how areas will recruit and train the workforce needed to meet the challenges ahead. This will mean more convenient access to care, and a stronger focus on population health and prevention. There will be more GPs and a wider range of practice staff will operate in more modern buildings. In addition there will be better integration with community and preventive services, hospital specialists and mental health care. The plan will also provide a useful framework for Sustainability and Transformation Partnerships (STPs) to build upon when developing their local workforce plans.

The action plan is shown below.

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\(^4\) Health Education England 2017 General Practice – Developing confidence, capability and capacity: A ten point action plan for General Practice Nursing. HEE: London

Ten point action plan

1. Extend leadership and educator roles.
   - Celebrate and raise the profile of general practice nursing and promote general practice as a first destination career.

2. Increase the number of pre-registration placements in general practice.

3. Establish inductions and preceptorships.

4. Embed and deliver a radical upgrade in prevention.

5. Improve access to ‘return to practice’ programmes.

6. Support access to educational programmes.

7. Increase access to clinical academic careers and advanced clinical practice programmes, including nurses working in advanced practice roles in general practice.

8. Develop healthcare support worker (HCSW), apprenticeship and nursing associate career pathways.

9. Improve retention.

10. Embed and deliver a radical upgrade in prevention.
Appendix 2: Standards of Proficiency for Registered Nurses

The Nursing and Midwifery Council have recently updated their standards of proficiency for RNs to include the following:

Platform 1. Being an accountable professional
Platform 2. Promoting health and preventing ill health
Platform 3. Assessing needs and planning care
Platform 4. Leading and managing nursing care and working in teams
Platform 5. Improving safety and quality of care
Platform 6. Coordinating care

The proficiencies in this document specify the knowledge and skills that registered nurses must demonstrate when caring for people of all ages and across all care settings. They reflect what the public can expect nurses to know and be able to do in order to deliver safe, compassionate and effective nursing care. They also provide a benchmark for nurses from the European Economic Area (EEA), European Union (EU) and overseas wishing to join the UK register, as well as for those who plan to return to practice after a period of absence. These elements should now be taken into account with any nursing workforce strategy and framework.

Further details can be accessed here.

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Appendix 3: General Practice Nursing Services Education and Career Framework (HEE, 20157)

The framework aims to standardise the training and education of practice and district nurses across England. The framework is split into two sections one for district and the other for practice nursing. Each section then splits further into 9 distinct levels; starting at apprentices and assistants at level 1-3 leading to advanced nurses at level 8-9. The levels relate then to underlying role descriptors. The document sets out the educational and professional requirements to progress through the levels. This offers nurses a clearer direction and more of an understanding of what is expected at each level. The evolving nature and rapid pace of change in 21st century healthcare requires nurses, midwives and allied health professionals to be able to respond flexibly to meet the changing needs of patients and their families. Adaptability, transferable skills and consistency across the different levels of the Career Framework are vital in meeting these needs.

This framework will be communicated to all practice nurses through the Nurse Forums. The organisation would like staff to engage with the framework and embed it into practice, benchmarking practice and mapping future training needs to support continuing professional development. It is hoped that through appraisal nurses will feel confident referring to the framework for their development with their line managers.

The interactive framework can be accessed online here and a Black Country Framework based on this is provided as part of this suite of GPN documents.

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<tr>
<th>Level</th>
<th>Role</th>
<th>Minimum professional and educational requirements for the role</th>
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</table>
| 8     | Advanced Nurse Practitioner/Clinical Academic | • NMC registration. Masters degree or PG diploma meeting ANP requirements and to include level 3 high intensity interventions; level 3 extended brief interventions (see NCE guidance)  
• V300 independent and supplementary prescribing; NMC mentorship or practice educator qualification.  
• Clinical academies will have or be working towards a research-based award at masters or PhD level. |
| 7     | Senior General Practice Nurse | • NMC registration; first degree working towards PG level qualification.  
• V300 independent and supplementary prescribing; NMC mentorship qualification; level 3 extended interventions. |
| 6     | General Practice Nurse | • NMC registration; first degree/relevant experience; NMC specialist practitioner qualification/relevant experience in primary care  
• NMC mentorship qualification; level 3 extended interventions. |
| 5     | General Practice Nurse | • NMC registration; working towards Fundamentals of General Practice Nursing  
• Level 3 extended interventions. |
| 4     | Nursing Associate/Associate Practitioner | • Nursing Associates will hold and approved Level 5 Foundation degree and be registered with NMC.  
• Associate Practitioners will hold or be working towards a relevant Higher Care Certificate or level 5 qualification. |
| 3     | Health Care Assistant | • Care Certificate; achieved a relevant Level 3 QCF qualification/Level 3 Apprenticeship; training for working in community settings and role specific skills; Maths and English at Level 2 (GCSE/Functional Skills)  
• Level 2 brief intervention training |
| 2     | Health Care Assistant | • Care Certificate; holding or working towards relevant Level 3 QCF qualification; training for working in community settings and role specific skills; holding or working towards Maths and English at Level 2 (GCSE/Functional Skills) |
Appendix 4: RCGP GPN Competency Framework

The RCGP General Practice Foundation General Practice Nurse Competencies framework will be adopted by Black County Sustainable Transformation Plan members to enable consistency in competence across all General Practice Nurses within Dudley, Sandwell, Walsall and Wolverhampton and inform future training requirements.

It is recognised that many Health Care Assistants (HCAs) and General Practice Nurses (GPN) will have a significant level of expertise in most areas, however the role and remit of a GPN can be wide and varied and new nurses entering into the field of GPN will have many transferrable skills but will require additional skills to proficiently carry out the role of the GPN. There are also a number of newer roles that need to be considered within this framework such as Nursing Associate and Associate Practitioner.

It is acknowledged that some nurses may become expert in a more specialist area of care in their practice. However, all should ensure they achieve and maintain a minimum level of competency across all areas of the generalist role. This competency framework is also supported by new care models developed by NHS England; Five Year Forward View⁸ and GP Forward View⁹ and more recently the District Nursing & General Practice Nursing Services Education & Career Framework (2015). This Framework, while differentiating the two roles; both of these nursing disciplines supports standardisation and also sets out their comparators and expectations for each level in both clinical skills and educational requirements which will assist with workforce planning and educational commissioning assisting to strengthen this local strategy. We would like our workforce to feel engaged in the decisions about healthcare delivery and encourage all to benchmark key skills and identify future learning needs by developing a personal development plan.

This competency framework will be delivered via a separate document aligned to the strategy.

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Appendix 5: Transition to General Practice Nursing Resource$^{10}$

The QNI offers a range of free online resources to support nurses who are new to community and primary care settings.

These resources are designed to be useful for student nurses, nurses who have recently started working in the community, or who are considering a career move. The resources are designed to be used with the help of a mentor.

The online resource can be accessed here. This designed to be used in conjunction with existing and proposed preceptorship, and programmes such as the HEE Fundamentals of General Practice Nursing and Return to Practice for General Practice and not as a stand-alone module.

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Appendix 6: Voluntary Standards for General Practice Nurses: Queens Nursing Institute 2015

The specialist expertise of the general practice nurse has now been recognised. The NMC specialist practice standards for General Practice Nursing were first published in 1994 and reissued in 2001. The role sits within the career framework at level 7; nurses working at this level will have advanced skills in clinical practice often leading minor illnesses and long term conditions and be an expert in general practice nursing with leadership and management skills. The QNI Voluntary Standards\textsuperscript{11} are mapped across 4 domains as identified below.

The aim of the QNI Standards is to:

- Provide patients and the public with a contemporary description of the role of the Senior General Practice Nurse (SGPN)
- Identify the key aspects of the SGPN role, grouping them under the four key domains that reflect the breadth of competence required for safe, high quality person centred care
- Support and guide HEI’s in developing education programmes which are focussed on agreed practice
- Enable SGPN to articulate their role within General Practice and new models of care
- Provide a framework for service commissioners, General Practitioners and other providers in planning primary care nursing services

\textsuperscript{11} Queen’s Nursing Institute/Queen’s Nursing Institute Scotland (2017) Voluntary Standards for General Practice Nursing Education and Practice. QNI: London
Objectives: at the end of an NMC approved educational programme mapped against the QNI Voluntary standards the SGPN will be able to:

**Domain 1 - Clinical Care**

- Demonstrate a broad range of evidence informed general practice nursing (GPN) clinical expertise that supports high quality, person centred care for individuals across the age range in the practice population including children and young people where appropriate. Evaluate therapeutic and other care management strategies, ensuring effectiveness and patient concordance.
- Use advanced assessment skills when assessing individuals with complex health care needs and associated multi-morbidity, using a range of evidence based assessment tools to enable accurate decision making; identifying variation in individuals with a diagnosis, ensuring correct referral and management pathways are followed and prescribing across a range of interventions within their scope of competence.
- Understand the connection between physical health and mental health issues, identifying patients with mental health issues and develop strategies to provide emotional support, mental health promotion and well-being with patients and their carers; collaborate with mental health professionals and General Practitioners (GPs) when identifying needs and mental capacity, using recognised assessment and referral pathways and best interest decision making.
- Engage in effective multidisciplinary and multiagency team working whilst recognising professional accountability, to ensure optimal patient care that supports transitions across health care and other agency boundaries that are smooth and meaningful to patients.
- Demonstrate advanced communication skills and be able to foster therapeutic relationships with patients, enabling patients to know they have been listened to with respect and compassion. Use creative problem solving, influencing and negotiation to enable shared decision making when developing care and management plans and anticipatory care.
- Demonstrate partnership approaches when undertaking consultations, fostering a culture of patient-centred practice, promoting the concept of self-care and patient led care where possible and providing appropriate health promotion, education and support.
- Facilitate behaviour change interventions for patients using extended brief interventions where appropriate and support the team to incorporate and evaluate behaviour change interventions in their consultations, including social prescribing.
- Engage and use digital technologies to support patient self-care and the efficiency and effectiveness of the General Practice Nursing team.
- Develop at least one area of specialist nursing practice interest, in accordance with the needs of the practice population.
• Assess, evaluate and articulate risks to both patients and staff using a range of tools, professional judgment and experience. Develop and implement risk management strategies that take account of people’s views and responsibilities, whilst promoting patient and staff safety and preventing avoidable harm.

Domain 2 – Leadership and management

• Demonstrate professional and clinical leadership of the general practice nursing team and clinically supervise, support and appraise the team in their delivery of nursing interventions in the practice. Use advanced communication skills to enable confident management of complex interpersonal issues and conflict management. In larger nursing teams, support and enable other team members to induct, appraise, support and develop junior members of the team.
• Manage the general practice nursing team within regulatory, professional, legal, ethical and policy frameworks. Promote and model effective team work ensuring staff feel valued and have opportunities for development and to enhance resilience but also create and implement strategies when performance needs to be addressed.
• Analyse the clinical caseload for the GPN team and GPN service, ensuring a safe and effective distribution of workload using delegation, empowerment, education skills and effective resource management. Where appropriate, contribute to workforce planning at service, local and regional levels.
• Demonstrate knowledge of social, political and economic policies and drivers that impact on the wider community and analyse how these may impact on the design and delivery of general practice nursing services to meet the needs of the practice population.
• Understand national and local public health strategies and how these are aligned to support the health of the practice population.
• Collaborate effectively with other disciplines and agencies to identify how the GPN team can lead and assist in the implementation of these strategies.
• Working with the wider health and social care team, third sector partners and others, engage in initiatives which build on community assets within the registered population of the locality to enhance health and wellbeing.
• Ensure every member of the GPN team is able to recognise vulnerability in adults and children and young people and understand their responsibilities and those of other organisations in terms of safeguarding legislation, policies and procedures.
• Confidently articulate the unique contribution and value of the general practice nursing team to both the business objectives of the Practice and to improved health outcomes for patients, whilst maintaining a strategic system wide perspective.
• Apply a range of change management strategies to respond flexibly and innovatively to changing contexts of care and the need for amended service provision.
• Analyse the practice population to ensure all patients with long term conditions are identified, undertaking risk stratification, where appropriate, to ensure evidence based pathways of care are followed and there is effective case management of patients with complex needs across the new models of primary care.

Domain 3 – Facilitation of learning
• Complete an NMC approved mentorship award/programme (if not previously achieved), supporting and facilitating the development of placements within General Practice for nurses and other health care professionals.
• Create positive teaching and learning environments and mentorship and preceptorship schemes that enhance the development of nursing student’s, nursing staff and other professions learning about care in General Practice and the wider community. Evaluate the impact of educational interventions for students, staff and patients.
• Develop systems to assess the learning and development needs of the GPN team and negotiate strategies with the Practice to meet these needs.
• Take responsibility for the practice assessment of nurses undertaking “foundation/fundamental” or NMC approved “specialist practice” general practice nursing courses and ensure excellent liaison with approved education institutions.
• Role model non-judgemental and value based care in practice creating a culture of openness and recognition of the duty of candour, promoting these values in other members of the GPN team.
• Support registered nurses in the team in the revalidation process, acting as a confirmor as necessary.

Domain 4 – Evidence, Research and Development
• Source and discern between different forms of evidence, engaging with the development of evidence based guidelines for the Practice or new models of primary care. Support staff to ensure all care is evidence informed and based on best practice.
• Contribute to the development, collation, monitoring and evaluation of data relating to service provision and development, quality assurance and improvement. Analyse this information for benchmarking of GPN services, where appropriate, in the local area.
Identify trends that may impact on the GPN service and, where appropriate, produce data-informed business/operational plans to support service development and innovation.

- Participate in the development of systems, including face-to-face engagement, valuing considered, honest and reflective patient feedback that enables patients to share their experiences of care confidentially. Develop processes for the systematic improvement of service in response to patient feedback.
- Ensure governance systems are in place for GPN staff that ensures patient follow up, referrals, correspondence and safety alerts are actioned.
AMENDMENT HISTORY

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REVIEWERS

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<td>12/3/2019</td>
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<tr>
<td>Katie Welborn</td>
<td>Matron for Vertical Integration and Sexual Health The Royal Wolverhampton Hospitals NHS Trust</td>
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<td>Therese McMahon</td>
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<tr>
<td>Lisa Clarke (original author of strategy)</td>
<td>Senior Lecturer University of Wolverhampton</td>
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<tr>
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<td>GP Partner Health and Beyond</td>
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Equality and Human Rights Manager NHS Arden and GEM  
Version 1.2

Kelly Huckvale  
IG Lead NHS Arden and GEM  
Version 1.2

Sukhdip Parvez  
Patient Safety Manager Wolverhampton CCG  
Version 1.2

**APPROVALS**
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RCGP Competency Framework

The RCGP General Practice Foundation General Practice Nurse Competencies framework\(^1\) has been adopted by Black County Sustainable Transformation Plan members to enable consistency in competence across all General Practice Nurses (GPNs) and Health Care Assistants (HCAs) working in primary care within Dudley, Sandwell, Walsall and Wolverhampton and inform future training requirements.

It is recognised that many HCAs and GPNs will have a significant level of expertise in most areas, however the role and remit of a GPN can be wide and varied and new nurses entering into the field of GPN will have many transferrable skills but will require additional skills to proficiently carry out the role of the GPN. There are also a number of newer nursing-based roles that need to be considered within this framework such as Nursing Associate and Associate Practitioner and the competencies within this can easily be mapped to meet their CPD needs.

It is acknowledged that some nurses may become expert in a more specialist area of care in their practice. However, all should ensure they achieve and maintain a minimum level of competency across all areas of the generalist role. This competency framework is also supported by new care models developed by NHS England; Five Year Forward View\(^2\) and GP Forward View\(^3\) and more recently the District Nursing & General Practice Nursing Services Education & Career Framework (2015). This Framework, while differentiating the two roles, supports standardisation and also sets out comparators and expectations for each level in both clinical skills and educational requirements which will assist with workforce planning and educational commissioning assisting to strengthen this local strategy. We would like our workforce to feel engaged in the decisions about healthcare delivery and encourage all to benchmark key skills and identify future learning needs by developing a personal development plan.

This competency framework will be delivered via a separate document aligned to the strategy.

Completing the Competency Framework

All relevant staff are expected to complete the initial self-assessment of the competency framework and identify additional training requirements. Any identified learning needs should be discussed with the line manager and a personal development plan created, the PDP will then be used as a mechanism for further review and documentation of competencies. **The competency framework is not designed to be used as an annual PDP document, but as an on-going framework to map CPD and career development that stays with the nurse in the long-term.**

Sections 1-7 are considered core competencies and it is expected that all staff will complete these sections, thereafter sections 8 – 22 should be completed where relevant to the individual practitioner’s role or where the staff member has identified through a personal development review the need for further professional development to meet the needs of the practice.

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All sections shaded in grey relate to activities that would generally be **undertaken by registered nurses only**, however due to changes in professional registration, for example the NMC regulating the new Nursing Associate role, it is possible that these activities may apply to other professionals too in the future.

Following recommendations made by the NMC in January 2019 guidance for nurses who are non-medical prescribers is now provided by the Royal Pharmaceutical Society⁴ and is beyond the scope of this document. Click here view the [Prescribing Competency Framework](https://www.rpharms.com/resources/frameworks/prescribers-competency-framework).

A copy of the completed self-assessment and personal development plan should be returned to the practice manager; this can be either hard copy or electronic; the information that is sent will be kept confidential and collated to ensure that subsequent training provision meets the needs of local practitioners. The relevant local lead may also request to view this as part of an on-going audit process.

**Revalidation**

Revalidation is the process that all nurses and midwives in the UK and nursing associates in England will need to follow to maintain their registration with the NMC. It took effect from April 2016, revalidation aims to help the nurse, midwife or nursing associate demonstrate that they practice safely and effectively. It encourages them to reflect on the role of the Code in their practice and demonstrate that they are ‘living’ the standards set out within it.

This document is designed to support the revalidation process and not replace it, nurses and nursing associates will need to revalidate every three years to renew their registration. They need to submit their application for revalidation online, so an NMC Online account is required.

**Acknowledgements**

Original document prepared for Walsall CCG by Lisa Clarke, Yvonne Higgins and Sally Roberts.

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GPN Competency Framework (based on RCGP GPN Framework 2015)

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<td>Communication with Patients</td>
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<td>Manage routine consultations with patients including:</td>
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<td>o Initiating the session/time management</td>
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<td>o Using a holistic approach gather information and receive a history</td>
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<td>o Identifying problems appropriate for management within own scope of competence</td>
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<td>o Clinical reasoning: identifying possible courses of action for you to undertake or the level and speed of referral</td>
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<td>o Being able to assist the patient to make decisions in a style appropriate to their wishes</td>
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<td>o Planning and exploration</td>
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<td>o Closing the session</td>
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<td>o Being aware of potential barriers to communication, being mindful of needs of specific groups</td>
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<td>Manage clinical risk within consultations including:</td>
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<tr>
<td>o Recognising signs and symptoms which may indicate the presence of serious medical</td>
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conditions (‘Red flags’) and taking appropriate action e.g. NEWS2 scoring –
- NEWS Score on RCP website
- Working at all times within personal professional and clinical boundaries

Respond appropriately and communicate effectively with patients who have specific needs including:
- Children and Adolescents
- Learning Disability and Difficulty
- Physical Disability
- Mental Illness including those with memory loss
- Bereavement
- Terminal illness
- Distressed or angry patients
- Difficulty in communicating and understanding the English Language

Have an understanding of the ethical issues and clinical audit that impinge on general practice including:
- The responsibilities and obligations of the General Data Protection Regulation regarding patient confidentiality
- The requirements of Information Governance
- Clearly representing the patient’s viewpoint to others
- Guide to data protection - ICO

**Communication within teams**
- Communicate effectively with other disciplines to enhance patient care
- Work effectively in your team and support structures that are in place for the smooth running of the practice

Be able to delegate clearly and appropriately including assessment of clinical risk and application of the principles that underpin delegation to unregulated health care support workers:
- Please see Royal College of Nursing (2017) “Accountability and Delegation: A Guide for the Nursing Team”

**SECTION 2 Personal and People Development**

- Recognise and promote the wide remit practitioners working within Primary Care
  - Please see NMC Standards for Nursing Associates

- Apply clinical governance principles and practice to your work

- Recognise and understand the roles of individuals working within the Primary Health Care team and understand how the roles of other practitioners and agencies interface with yours

- Appreciate and work with the changing structures of health care provision and understand the key issues as they affect your practice such as:
  - The contractual arrangements
- How Quality and Outcomes are measured, monitored and rewarded
  - Local and National Quality improvement strategies and approaches
  - General Practice Forward View
  - Five Year Forward View

- Have an understanding of how the current NICE guidelines and other national and local policies impact on your work.
  - Understand how these are communicated and implemented within the work place
  - For more information see NICE

Be aware of the Legal and Professional issues pertinent to working within your own sphere of practice:

- Accountability and delegation
- Consent including Young People’s Competency to Consent
- Mental Health and Capacity requirements.
- Safeguarding children and vulnerable adults including statutory child health procedures and local guidance
- Access to Health Records
- Notification of Infectious Diseases (NOIDs)
- Professional
- Duty of care
- Vicarious liability
- Record keeping
- GDPR/information governance
- Use of clinical guidelines/protocols/patient group directions/ patient specific directions
- Further information available from the NMC
Understand the benefits of clinical supervision for the individual, the organisation and the service:
- Identify sources of provision within your area and ensure you are involved in it

A separate clinical supervision document is available

Use the principles of reflective practice to support and maintain your own personal portfolio and professional development plan whilst working with senior team members to participate in effective assessment and training support

- Identify specific training and support as required for your continuing professional development and work with the practice to access this.
- Under direction, if qualified to do so, act as a mentor/teacher/assessor to others in a clinical situation.
- **NMC Standards for Student Supervision and Assessment**

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<tr>
<td>Have a working knowledge of Health and Safety requirements within the workplace, including fire procedures. Follow procedures to report any concerns identified.</td>
</tr>
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</table>

<p>| |</p>
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<tbody>
<tr>
<td>Work with patients and colleagues in adopting sound infection control measures</td>
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</table>

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<tbody>
<tr>
<td>Be able to identify, and if appropriate take action on the risks to health of microbiological and chemical hazards within the working environment according to COSHH regulations (2015)</td>
</tr>
</tbody>
</table>
Further support available from Health and Safety Executive

Vaccines and Drugs:
- Ensure cold chain, safe storage, vaccine stability, rotation and disposal of drugs
- Where appropriate oversee the monitoring, stock control and documentation of controlled drug usage according to legal requirements
- Vaccine storage guidance available from PHE

Emergency situations:
- When appropriate, be able to manage the emergency response and treatment using local guidelines.

Infection control:
- Apply infection control measures within the practice according to local and national guidelines including:
  - Hand washing
  - Universal hygiene precautions
  - Collection and handling of laboratory specimens
  - Segregation and disposal of waste materials
  - Decontamination of instruments and clinical equipment
  - Reporting and treatment of sharps injuries
  - Dealing with blood and body fluid spillages

Recognise and manage situations where specific training is a requirement in order to work within scope of practice
### Mandatory Training:
Be aware of and undertake mandatory training and updates in:
- Anaphylaxis
- Basic Life Support
- Safeguarding Children
- Manual Handling
- Fire Safety
- Infection control
- Safeguarding Adults
- Chaperoning

Know how to use the personal security systems within the workplace

### Practice Policies:
Be aware of and abide by:
- Procedures and systems
- Health and safety documentation
- The monitoring and reporting of the state of equipment and furniture
- Current recommendations for the safe use of VDU screens

Work with others as appropriate on the development of current and new services and initiatives

### Audit:
- Know the audit policies of local general practice
- Understand how they are developed
- Contribute to the preparation of local guidelines, protocols and standards
- Be involved in clinical audits

Be aware of and promote the current approaches to patient involvement and experience in service design and delivery

### SECTION 4 Quality and Service Improvement

Be familiar with current national and local policies, procedures and initiatives relating to quality maintenance and improvement

**Personal practice and development**

- Through reflective practice and training, ensure your work is aligned with current evidence based practice
- Recognise and work within your own competence and current professional code as regulated
- Contribute to team development with suggestions based on your own clinical experience
- Give and receive useful feedback professionally
- Attempt to defuse challenging situations using problem resolution skills to reduce potential for formal complaints. Ensure these situations are reported to the appropriate individuals
- Be able to manage your own time effectively

For areas within own responsibility:

- Be aware and manage situations of potential risk using the principles of clinical governance
- Recognise and report any significant, adverse and seriously adverse events
- Facilitate access for patients to appropriate professionals in the practice team and beyond
- Know and implement practice policies: including the policy regarding ‘whistle blowing’
- Ensure your working area is maintained and stocked appropriately for yourself and other colleagues using the area

Be aware of and understand the cost implications of the work undertaken, ensuring compliance with local prescribing policies

### SECTION 5 Equality and Diversity

Know the demographics of your practice population and locality in order to actively promote equality and diversity in your work

- [https://fingertips.phe.org.uk/](https://fingertips.phe.org.uk/)

Understand and implement with patients, patient’s relatives and colleagues the latest guidelines issued by professional bodies such as the NMC 2018

Relevant areas include:
- Prioritise People
- Practice Effectively
- Preserve Safety
- Promote Professionalism and Trust
- [NMC Professional standards of practice and behaviour for nurses, midwives and nursing associates](https://www.nmc.org.uk"

Being aware of additional guidance around professional behaviour relating to:
<table>
<thead>
<tr>
<th>Ensure within your own clinical practice adherence to local chaperoning policies</th>
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<tbody>
<tr>
<td>Recognise the signs of and adhere to local policies demonstrating the ability to effectively follow up concerns relating to:</td>
</tr>
<tr>
<td>- Domestic violence</td>
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<td>- Adults at risk of harm</td>
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<tr>
<td>- Addiction and dependency</td>
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<tr>
<td>- Child protection</td>
</tr>
<tr>
<td>- Female genital mutilation</td>
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<tr>
<td>- Prevent guidance</td>
</tr>
<tr>
<td>Know the local contact and access information for voluntary and statutory services that may be useful to patients. Guide and support patients in accessing these as appropriate.</td>
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<tr>
<td>- Wolverhampton Information Network</td>
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<td>- Dudley Community Information Service</td>
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<td>- Sandwell Information Point</td>
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</table>

**SECTION 6 Health & Well-Being**

**Assessment:**

Follow guidelines for, undertake and record the following tasks following appropriate training:

- Urinalysis and preparation of specimens for Path lab investigation
- Blood pressure
- Pulse rate and rhythm
- Respiratory rate
- Temperature
- Height and Weight
- Waist Circumference
- Visual acuity
- Legs prior to prescribing of support hosiery
- ECGs and ambulatory blood pressure monitoring (ABPM).
- Blood glucose monitoring
- Venepuncture
- Identifying and using the Body Mass Index
- Patients inhaler techniques and undertaking peak flow readings
- Spirometry (only in appropriate training has been undertaken as per ARTP guidelines)

**Obtaining samples:**
- Following recommended processes, be able to obtain samples and/or swabs from patients as a delegated task or based on clinical presentation (for example: ear, Chlamydia, high vaginal swabs). Taking into account communication and legal issues ensure that patient is fully informed and understands:
  - The background and rationale for the test
  - The process for obtaining and communicating results

### SECTION 7 Management of Emergency Situations

Following practice protocols and evidence based treatment and national guidance be competent to assess the degree of urgency and take necessary action in the following situations:
- Collapse
- Asphyxia
- Anaphylaxis
- Vasovagal Syncope
- Acute chest Pain
- Cerebrovascular episode
- Convulsions
- Head Injury
- Hyper and Hypoglycaemia
- Acute respiratory problems
- Haemorrhage
- Poisoning
- Burns
- Fractures

**Sepsis:**
Awareness of the signs and symptoms of sepsis in infants, children and adults and be competent to manage or signpost any patient with suspicion of sepsis for further treatment.
- New altered mental state/behaviour
- Respiratory rate
- Heart rate
- Blood pressure
- Urine output
- Mottled or ashen appearance
- Cyanosis of skin, lips or tongue
- Non-blanching rash of skin
- Recognise the signs and symptoms that indicate moderate to high risk of severe illness or death.
- Recognise signs and symptoms in infants and children.
- Recognise when to transfer to an acute setting.
- Awareness of the role of NEWS2 in assessing risk
Useful information:
- NICE Sepsis Pathway
- NHS England Sepsis guidance
- PHE guidance on sepsis in England
- RCP NEWS 2 Score guidance
- RCGP Sepsis Toolkit
- The Sepsis Trust
- eLFH Sepsis E-learning programme

Therapeutic Monitoring:
- Use a holistic patient approach to check concordance with and adherence to prescribed treatments
- Be able to identify abnormalities such as drug reactions, side effects and contraindications.
- Have knowledge of and work within local and practice guidelines to monitor and advise patients on the review processes for the following conditions:
  - Hypothyroid
  - Hyperthyroid
  - Rheumatoid arthritis
  - Iron deficiency anaemia
  - Pernicious anaemia
  - Epilepsy
  - Mental health disorders
  - Anticoagulant therapy

Ear Care:
- Have a working knowledge of anatomy and physiology of the ear
- Display an understanding of the need for preventative care including patient education and advice
- Demonstrate safe and proficient use of aural care instruments for the removal of cerumen, aural toilet and irrigation
- Undertake aural toilet based on knowledge of the latest evidence based practice in relation to ear care.
- Recognise the specific needs of patients with hearing loss including provision of advice for patients on safe ear care in accordance with national guidelines.
- Additional guidelines and resources from the [Ear Care Centre](#)

**ROLE SPECIFIC SECTION**

**SECTION 8 Wound Management**

Be able to:
- Undertake initial assessment of patients presenting with injuries
- Demonstrate knowledge of wound classification
- Demonstrate knowledge of your local formulary
- Demonstrate knowledge and understanding of the healing process and factors that inhibit wound healing
- Assess and care for uncomplicated wounds
- Select appropriate treatments based on knowledge of dressing types and properties
- Apply a range of dressings according to assessed need
- Assess pain using an appropriate using a recognised tool and recommend self-management or refer
- Undertake suture removal
- Be aware of current guidelines on tetanus prophylaxis
- Educate the patient in wound self-care and monitor as appropriate
- After having completed appropriate training undertake Doppler Assessment and compression bandaging for leg ulcer management
- After further training, assess and care for more complex wounds

Additional Resources:
- Simple Wound Management and suturing guidance
- NICE Clinical Knowledge Summaries, Venous Leg Ulcers
- NICE CKS, burns and scalds

### SECTION 9 Minor Surgery

- In relation to Minor Surgical Procedures recognise the role of the GPN in assisting with the provision of minor surgery
- Provide appropriate support for the Patient before during and after the procedure including dealing with emergencies
- Work within the medico-legal and professional requirements relating to the provision of minor surgery in general practice
- Guidance around minor surgery in primary care

**Pre Operatively:**
- Based on sound knowledge and understanding be able to prepare and check
- Documentation
<table>
<thead>
<tr>
<th>Infection control procedures</th>
<th>Surgical instruments and appropriate suturing material</th>
<th>Personal protective equipment</th>
<th>The clinical environment including lighting and other equipment</th>
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<tbody>
<tr>
<td>Intra operatively:</td>
<td>Support and assist practitioner and patient as appropriate</td>
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<td>Post operatively:</td>
<td>Undertake post-operative care of patient and management of the wound</td>
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<td>Provide verbally and where appropriate in writing after care instructions for the patient</td>
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<td>Ensure safe decontamination of instruments and safe disposal of hazardous waste</td>
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<td>Ensure histo-pathological specimens and paperwork is effectively managed in accordance with local procedures.</td>
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<td>Ensure effective record keeping in accordance with local and national policies.</td>
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**SECTION 10 Health Promotion**

Demonstrate:
- Assessment skills with regard to patients' readiness to change
- Awareness of screening, its effectiveness and potential limitations, and the willingness to undertake training to perform cervical screening
- Ability to deliver safely primary prevention interventions such as vaccination and immunisation
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<td>o The ability to identify determinants of health in the local area</td>
<td>o A knowledge of public health issues in the local area including health inequalities</td>
<td>o An awareness of both local and national health policy</td>
<td>o An insight into issues which have a bearing on the wider health economy</td>
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<tr>
<td>o An ability to identify patients whose health could be at risk and offer brief, focused lifestyle advice including the ‘Brief Intervention’ and ‘Motivational Interviewing’ approaches</td>
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Additional resources -
- MECC e-learning - [https://www.elfh.org.uk/programmes/making-every-contact-count/](https://www.elfh.org.uk/programmes/making-every-contact-count/)
- [https://www.longtermplan.nhs.uk/areas-of-work/prevention/](https://www.longtermplan.nhs.uk/areas-of-work/prevention/)

Provide support and make referral where appropriate for:
- Smoking cessation
- Diet, overweight / obesity prevention and management in adults
- Exercise/activity
Be familiar with sources of reliable information on health promotion topics, nationally and in your locality.

**SECTION 11 Health Screening**

- Undertake new patient checks recognising health promotion opportunities
- Be aware of the factors that may contribute to health inequalities particularly in relation to screening uptake.
- Be sensitive to individual values of all patients and possible additional needs of patients with:
  - learning difficulties
  - language and communication barriers including patients of other ethnicities

Be familiar with the National Health Cancer Screening Services including, Breast Cancer, Cervical Cancer, Bowel Cancer and Prostate Cancer Risk Management, Abdominal Aortic Aneurysm, especially regarding local implementation and the national and local call and recall system.

- **PHE Screening Additional information**
- **NHS Screening information**

**SECTION 12 NHS Health Check**

- Undertake NHS Health Checks in accordance with PHE guidance.
- Be aware of risk factors for vascular disease and of individual risk reduction strategies.
- Be able to articulate vascular risk to patients in a meaningful way.
- Be able to promote behaviour change in those with risk factors.

- Patient information - [https://www.nhs.uk/conditions/nhs-health-check/](https://www.nhs.uk/conditions/nhs-health-check/)
- Professional guidance - [https://www.healthcheck.nhs.uk/](https://www.healthcheck.nhs.uk/)
- NHS Health Check training - [https://www.healthcheck.nhs.uk/commissioners_and_providers/training/](https://www.healthcheck.nhs.uk/commissioners_and_providers/training/)

### SECTION 13 Cervical cytology

Understand and be able to explain the rationale for Human Papilloma Virus (HPV) screening and the consequent recall and follow up processes. Perform, after undertaking appropriate training and updates, cervical smear taking according to NHSCSP standards including:

- Preparation of the patient, equipment and environment
- Management of the consultation including:
  - Good communication skills
  - Appropriate history taking
  - Record keeping
- Correct evidence based procedure for sample taking, including assessment of cervix and awareness of contraindications to procedure
- Management of the sample
- Explanation of procedure for obtaining results
- Comply with requirements regarding personal and practice audit
### Additional Resources
- PHE Cytology programme information
- Training programmes for cytology
- Screening programme e-learning

### SECTION 14 Immunisation of children* and adults (*registered professional only unless HCA is providing nasal LAIV)

- Be able to give accurate information regarding contra-indications and side effects and to address parents’ concerns appropriately
- Be aware of up to date UK childhood immunisation schedule and know who to consult if there is any uncertainty about which vaccines are needed or timing of vaccines
- Ensure correct handling and reconstitution of vaccines
- Apply medico- legal principles of informed consent
- Ensure access to emergency equipment

**Demonstrate:**
- Understanding the importance of maintaining the cold chain and what to do if a breach is suspected
- Knowledge of vaccine preventable diseases covered by UK immunisation schedule
- Knowledge of management of anaphylaxis
- Knowledge of differences between intramuscular and subcutaneous injections
- Correct vaccination technique, including choice of needle, angle, and site of administration
- Understanding of adverse events, knowledge of system for reporting adverse events
- Assess and if appropriate, administer injections under an individualised prescription or Patient Group Direction (child and adult)
- Dispose of sharps appropriately and safely
- Recognise the importance of and apply principles of excellent record keeping to this situation
- Contribute to the development of practice guidelines

**Additional Resources**
- Your local Health Protection Team - [https://www.gov.uk/health-protection-team](https://www.gov.uk/health-protection-team)
- E-learning programme - [https://www.e-lfh.org.uk/programmes/immunisation/](https://www.e-lfh.org.uk/programmes/immunisation/)

### SECTION 15 Travel Health (HCAs may provide some travel health advice)

Supported by senior colleagues, assess travel health needs of patients and provide a holistic approach and comprehensive advice for patients prior to travel. Where appropriate after training this will include:
- Vaccinations and medications
- Malarial prophylaxis and bite avoidance
- Safe sex/sexual health
Food hygiene
Sun protection
First aid and emergency medication
Risk of travel/need for health insurance
Fit to fly certification
Appropriate written information
Self-care measures
Provide guidance in accordance with guidelines and identify any potential problems for the patient.
Administer injections as appropriate according to local guidelines and policies.

Additional Resources
- National Travel Health Network and Centre (NaTHNaC) - [www.nathnac.org](http://www.nathnac.org)
- International Travel and Health WHO - [http://www.who.int/ith/en/](http://www.who.int/ith/en/)
- Immunisation e-learning tool - [https://www.e-lfh.org.uk/programmes/immunisation/](https://www.e-lfh.org.uk/programmes/immunisation/)
- Jane Chiodini Travel Health Specialist Nurse resource site - [https://www.janechiodini.co.uk/](https://www.janechiodini.co.uk/)

**SECTION 16 Mental Health and Learning Disability**

Be aware of risk factors and recognise early signs of mental health problems for the following conditions and have a basic understanding of their management in General Practice:
- Depression
- Generalised anxiety disorders
- Suicide awareness
- Self-Harm
- Bipolar disorder
- Post-partum affective disorders
- Schizophrenia
- Dementia
- Substance abuse
- Eating disorders

- Demonstrate awareness of the importance of promoting mental health
- Recognise and if necessary take a proactive and appropriate approach to meeting the physical health needs of patients with mental health problems.
- Provide care and support for patients and carers in accordance with the NSF for Mental Health.
- Acknowledge and reflect on potential barriers that may impact on care provision in this area.

- Administer appropriate prescribed therapies and monitor for side effects contraindications and adverse drug reactions.
- Understand the role of the key worker and communicate as required.

Additional guidance and information –
- [https://www.longtermplan.nhs.uk/areas-of-work/mental-health/](https://www.longtermplan.nhs.uk/areas-of-work/mental-health/)
- [https://www.nhs.uk/oneyou/every-mind-matters/](https://www.nhs.uk/oneyou/every-mind-matters/)
Be aware of health and wellbeing issues relating to learning disability and have a basic understanding of their management in General Practice via knowledge of the Learning Disability Health Check:

- Diet and weight management
- Smoking
- Alcohol intake
- Sexual health including contraception
- Immunisation status
- Cancer screening (cytology, mammography and bowel screening)
- Long term conditions
- Physical health assessment
- Continence and constipation
- Skin assessment
- Epilepsy
- Behaviour
- Hearing
- Communication
- Mobility

Additional guidance and information:

### SECTION 17 Men’s Health

Be aware of the morbidity and mortality statistics relevant to Men’s Health. Provide support, advice and if appropriate manage or be involved in care for patients presenting with or for:
- Well man checks
- Sexual health problems
- Testicular cancer
- Prostate disease, including cancer
- Breast cancer
- Libido problems
- Erectile dysfunction
o Mental health concerns

Additional Resources -
- https://www.menshealthforum.org.uk/
- https://uk.movember.com/
- Urogenital conditions - https://pathways.nice.org.uk/pathways/urogenital-conditions
- Prostate cancer - https://www.cancerresearchuk.org/about-cancer/prostate-cancer
  https://prostatecanceruk.org/
  https://pathways.nice.org.uk/pathways/prostate-cancer
  https://www.nhs.uk/conditions/testicular-cancer/

SECTION 18 Women’s Health

Provide support, advice and if appropriate make an initial assessment, be involved with care for patients referring if necessary for patients presenting with:
- Vaginal discharge
- Urinary incontinence
- Abnormalities of menstruation, including pre-menstrual syndrome, the effects of the menopause
- Management of symptoms of menopause
  - HRT, osteoporosis, the effects of a hysterectomy
- Infertility and pre-conceptual issues
- Teach and encourage patients to be ‘breast aware’.
- Encourage women to have cervical screening (age appropriate) and promote the HPV vaccine in girls

**Additional Resources**

- Women’s Health Concern - [https://www.womens-health-concern.org/](https://www.womens-health-concern.org/)
- The British Menopause Society - [https://thebms.org.uk/](https://thebms.org.uk/)
- Polycystic ovary syndrome NHS Choices - [https://www.nhs.uk/conditions/polycystic-ovary-syndrome-pcos/](https://www.nhs.uk/conditions/polycystic-ovary-syndrome-pcos/)
- Endometriosis - [https://www.nhs.uk/conditions/endometriosis/](https://www.nhs.uk/conditions/endometriosis/)
  - [https://www.endometriosis-uk.org/](https://www.endometriosis-uk.org/)
  - [https://pathways.nice.org.uk/pathways/endometriosis](https://pathways.nice.org.uk/pathways/endometriosis)
- Cervical cancer - [https://www.jostrust.org.uk/](https://www.jostrust.org.uk/)
- Breast cancer - [https://www.cancerresearchuk.org/about-cancer/breast-cancer](https://www.cancerresearchuk.org/about-cancer/breast-cancer)
- Urinary incontinence - [https://www.nhs.uk/conditions/urinary-incontinence/](https://www.nhs.uk/conditions/urinary-incontinence/)
SECTION 19 Family Planning and Sexual Health

Be aware of, implement and provide advice on:
- Protocols and PGDs for dispensing emergency contraception
- Local agencies providing advice for unwanted pregnancies
- Referral for insertion of IUDs/IUS including emergency contraception
- Local HIMP policies for reducing teenage pregnancies
- Local infertility guidelines and referral pathways
- STIs – local referral pathways and associate life style risk factors
- Local HIV/AIDS policies and referral pathways
- Local Genito-Urinary medicine (GUM) clinical service provision

Further information –
- https://www.nhs.uk/conditions/sexually-transmitted-infections-stis/
<table>
<thead>
<tr>
<th>Be able to advise on precautions and contraindications regarding: o Oral contraception o Emergency contraception o Natural methods o Barrier Methods/condoms o Male and female sterilization o Long acting reversible contraception including hormone o injections, implants, intrauterine devices and systems (IUDs/IUSs)</th>
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<tr>
<td>Provide appropriate signposting and support for people from the LGBTQIA community, including cervical cytology advice for trans men who still have a cervix.</td>
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<tr>
<td>Additional resources –</td>
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</table>
- https://www.nhs.uk/common-health-questions/sexual-health/should-trans-men-have-cervical-screening-tests/

### SECTION 20 Care of Patients with Long Term Conditions
#### Care of Patients with Long Term Conditions: Diabetes

- **Areas of knowledge and skills should include:**
  - Primary Prevention and screening
  - Signs and symptoms including differentiation between type 1 and type 2
  - National and Local Guidelines
  - Recommendations for management in Primary Care including targets for metabolic control and reduction of CVD risk factors
  - Current treatments
  - Nutrition
  - Blood glucose monitoring
  - Hypoglycaemia
  - Hyperglycaemia
  - Microvascular and macrovascular complications
  - Other complications
  - Patient education and self-care
  - Concordance and adherence to treatment
### Care of Patients with Long Term Conditions: Chronic Obstructive Pulmonary Disease (COPD) and Asthma

Areas of knowledge and skills should include:
- Primary Prevention and Lung Health
- Patient Education and self-care
- Concordance and adherence to treatment
- National and Local Guidelines
- Signs and symptoms
- Asthma triggers
- Diagnostic criteria
- Recognition and management of acute exacerbations
- Pharmacological and non-pharmacological management for current treatments
- Inhaler devices and inhaler technique
- Pulmonary rehabilitation
- Complications

### Additional Resources

- **NHS Diabetes** - [https://www.nhs.uk/conditions/diabetes/](https://www.nhs.uk/conditions/diabetes/)
- **Diabetes UK** - [https://www.diabetes.org.uk/](https://www.diabetes.org.uk/)
- **Relevant NICE pathways** -
### Additional Resources

- British Thoracic Society - [https://www.brit-thoracic.org.uk/](https://www.brit-thoracic.org.uk/)
- NICE asthma guidelines - [https://pathways.nice.org.uk/pathways/asthma](https://pathways.nice.org.uk/pathways/asthma)
- British Lung Foundation - [https://www.blf.org.uk/](https://www.blf.org.uk/)
- Global Initiative for Asthma - [https://ginasthma.org/](https://ginasthma.org/)
- Global Initiative for COPD - [https://goldcopd.org/](https://goldcopd.org/)

### Care of Patients with Long Term Conditions: Hypertension

**Areas of knowledge and skills should include:**

- Primary Prevention and lifestyle measures
- Diagnosis and classification
- Monitoring Blood Pressure
- Understanding targets
- National and Local Guidelines
- Current treatments
- Patient education and self-care
- Concordance and adherence to treatment
- Complications

### Additional Resources

- British Hypertension Society - [https://bihsoc.org/](https://bihsoc.org/)

### Care of Patients with Long Term Conditions: Cardiovascular Disease
### Areas of knowledge and skills should include:
- Primary and secondary prevention and modifiable and non-modifiable risk factors
- Tools for risk assessment
- Cardiac Arrhythmias including atrial fibrillation
- Diagnoses within CVD including:
  - Angina, Stroke, Transient Ischaemic Attack (TIA) and Heart Failure
  - Signs and symptoms
  - Investigative procedures
  - Current Treatments
  - Cardiac Rehabilitation
  - National and Local Guidelines
  - Patient education and self-management
  - Concordance and adherence to treatment
- [https://www.longtermplan.nhs.uk/areas-of-work/stroke/](https://www.longtermplan.nhs.uk/areas-of-work/stroke/)

### NICE guidance –
- [https://pathways.nice.org.uk/pathways/chronic-heart-failure](https://pathways.nice.org.uk/pathways/chronic-heart-failure)
- [https://pathways.nice.org.uk/pathways/atrial-fibrillation](https://pathways.nice.org.uk/pathways/atrial-fibrillation)
- [https://pathways.nice.org.uk/pathways/familial-hypercholesterolaemia](https://pathways.nice.org.uk/pathways/familial-hypercholesterolaemia)
- [https://pathways.nice.org.uk/pathways/chest-pain](https://pathways.nice.org.uk/pathways/chest-pain)
- [https://pathways.nice.org.uk/pathways/stroke](https://pathways.nice.org.uk/pathways/stroke)
- British Heart Foundation - [https://www.bhf.org.uk/](https://www.bhf.org.uk/)

### Care of Patients with Long Term Conditions: Cancer

Cancer care review – be able engage or signpost to the following:
- Face to face review
- Providing dedicated appointments
- Engagement with carers/significant others
- Provision of information
- Patient understanding of treatment
- Use of appropriate template

Further information –
- Cancer Research UK Health Professionals Page - [https://www.cancerresearchuk.org/health-professional](https://www.cancerresearchuk.org/health-professional)
- Macmillan Cancer Support - [https://www.macmillan.org.uk/about-us/health-professionals](https://www.macmillan.org.uk/about-us/health-professionals)
- [https://www.longtermplan.nhs.uk/areas-of-work/cancer/](https://www.longtermplan.nhs.uk/areas-of-work/cancer/)

Cancer recovery package:
- Holistic needs assessment and care planning
| o Treatment summary  
| o Health and wellbeing  

Further information –  

**Cancer screening – for example:**  
| o Breast  
| o Cervical  
| o Bowel  
| o Prostate cancer awareness  
| o Skin cancer  

| o Additional information  
| - [https://www.gov.uk/topic/population-screening-programmes](https://www.gov.uk/topic/population-screening-programmes)  
| o [https://www.nhs.uk/conditions/nhs-screening/](https://www.nhs.uk/conditions/nhs-screening/)  
| o [https://www.cancerresearchuk.org/about-cancer/screening](https://www.cancerresearchuk.org/about-cancer/screening)  

**Care of Patients with Long Term Conditions: Other Conditions**  
In addition have a working knowledge of the following conditions, their impact upon patients and carers and the ways in which they may manifest in Primary Care and assist in diagnosis monitoring and treatment as appropriate:

**Chronic Kidney Disease:**  
Be able to provide screening, monitoring and advice around:  
| o Risk of CKD
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<th><strong>Monitoring</strong> (e.g. in diabetes and hypertension)</th>
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Further information -
| o NICE guidance - [https://pathways.nice.org.uk/pathways/neurological-conditions](https://pathways.nice.org.uk/pathways/neurological-conditions) |
| o NHS fibromyalgia - [https://www.nhs.uk/conditions/fibromyalgia/](https://www.nhs.uk/conditions/fibromyalgia/) |
### Musculoskeletal conditions:
Monitoring and management of:
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis

**NICE guidance** -
- [https://pathways.nice.org.uk/pathways/osteoarthritis](https://pathways.nice.org.uk/pathways/osteoarthritis)
- [https://pathways.nice.org.uk/pathways/osteoarthritis](https://pathways.nice.org.uk/pathways/osteoarthritis)

### Endocrine disorders:
An awareness of:
- Thyroid Disease

**NICE guidance** -

### Care of Patients with Long Term Conditions: Frailty
Address the common “frailty syndromes”:
- Falls
- Immobility
- Delirium
- Incontinence
- Medicines optimization
- Multimorbidity

Further information –
- [https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/frailty-resources/](https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/frailty-resources/)
- [https://www.bgs.org.uk/topics/frailty](https://www.bgs.org.uk/topics/frailty)
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<td>o Deterioration</td>
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<td>o End of Life</td>
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<tr>
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<tr>
<td>o Care planning</td>
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<td>o Support for carers</td>
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<td>o <a href="https://www.alzheimers.org.uk/">https://www.alzheimers.org.uk/</a></td>
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<td>Care planning</td>
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<tr>
<td>Support for carers</td>
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<td>o <a href="https://www.longtermplan.nhs.uk/areas-of-work/ageing-well/">https://www.longtermplan.nhs.uk/areas-of-work/ageing-well/</a></td>
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- Register of patients on EOL register, PC MDT place based model of care, monitoring and assessment/evaluation of care.
- EPaCC system.
- ReSPECT focus (i.e. plans for emergency care and treatment, not just making decisions related to CPR), will be a positive step forward to help improve communication and ultimately patient care.

Further information:
Please refer to local End of Life pathways, guidance and programmes.

- [https://www.nhs.uk/conditions/end-of-life-care/](https://www.nhs.uk/conditions/end-of-life-care/)

E-learning:

### SECTION 2 Information and Knowledge

Ensure accurate documentation/record keeping procedures in line with practice policies and guidance from NMC and other regulatory bodies

- [https://www.nmc.org.uk/standards/code/record-keeping/](https://www.nmc.org.uk/standards/code/record-keeping/)
Use a computer and manage files

Record, retrieve and access information

Review and process data using accurate read codes about patients, in order to ensure easy and accurate retrieval for monitoring and audit purposes, for example Calculating Quality Reporting System (CQRS) including the appointment system

Be able to access and send emails including attachments

- Manage information searches using the internet and local library databases for example the retrieval of relevant information for patients on their condition/diagnosis.
- Understand the nature and hierarchy of medical evidence.
- [https://patient.info/doctor/different-levels-of-evidence](https://patient.info/doctor/different-levels-of-evidence)

Understand and be able to describe role of the Caldicott Guardian / Personal Data Guardian, knowing the name of your local nominated health professional

---

**SECTION 23 General – Learning and Development**

Contribute to the provision of learning opportunities for colleagues
Act as a mentor/coach for more junior staff (e.g. pre-registration nurses or HCAs) if appropriately qualified assessing competency against set standards as requested

- Disseminate learning and information gained to other team members in order to share good practice and inform others about
- Current and future developments (e.g. courses and conferences)
- As requested undertake specific training exercises such as observed clinical practice and shadowing of role

**SECTION 24 General – Development and Innovation**

Critically evaluate and review innovations and developments that are relevant to your own area of work

Keep up to date with new developments locally and nationally identifying those that will enhance your team’s work. Influence other team members to undertake trials of changes in care delivery
Personal Development Plan (PDP)

This form needs to be filled in during your Personal Development Review (PDR)

Name: ___________________________  Name of Reviewer: ___________________________  Date of Review: _____________

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**DATE TO BE REVIEWED:**

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<td>Sally Roberts</td>
<td>Chief Nurse Wolverhampton CCG</td>
<td>12/3/2019</td>
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<tr>
<td>Sarah Southall</td>
<td>Head of Primary Care Wolverhampton CCG</td>
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<td>Sara Bailey</td>
<td>Deputy Chief Nurse Walsall CCG</td>
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<td>Sarah Shingler</td>
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<tr>
<td>Caroline Brunt</td>
<td>Chief Nurse Dudley CCG</td>
<td>13/2/2019</td>
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<td>Joanne Taylor</td>
<td>Commissioning Manager Dudley CCG</td>
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<tr>
<td>Pauline Billingham</td>
<td>Nurse Mentor Dudley CCG</td>
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<td>Michelle Carolan</td>
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<td>Alyson Hall</td>
<td>Training Hub Coordinator Sandwell and West Birmingham CCG</td>
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<td>Jayne Hawkins</td>
<td>GPN Facilitator Futureproof Health (Dudley Training Hub)</td>
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<td>Katie Welborn</td>
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<td>Lisa Clarke (original author of strategy)</td>
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<td>David King</td>
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**APPROVALS**
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**GROUP/COMMITTEE** | DATE       | VERSION |
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Part 1 - HCA/GPN Induction Framework
Introduction

To ensure the best possible start for any nurse working in general practice regardless of their prior experience, a quality orientation, induction programme is essential, as is education and ongoing continuing professional development (CPD). For nurses new to general practice, additional support through preceptorship and training such as the Fundamentals to General Practice Nursing programme is important. A framework for this journey is displayed below.

The General Practice Nursing 10 Point Action Plan (2017) has a focus on engaging and developing a new GPN workforce through inductions and preceptorships. The plan states that commissioners and the Royal Colleges should be working to ensure all nurses new to general practice have access to an approved employer-led induction programme and a continuous professional development (CPD) plan that includes the GPN foundation or fundamentals standards. As a minimum, HCAs will have access to the care certificate training standards.

The role and remit of a HCA or nurse working in primary care can be wide and varied and new staff entering into the field of GPN will have many transferrable skills but will require additional skills to proficiently carry out the role.

The RCGP General Practice Foundation General Practice Nurse Competencies framework has been adopted by Black County Sustainable Transformation Plan members to enable consistency in competence across all General Practice Nurses within Dudley, Sandwell, Walsall and Wolverhampton and inform future training requirements.

This induction framework is also supported by new care models developed by NHS England; Five Year Forward View (NHS England, Five Year Forward View, 2014) and GP Forward View (NHS England, 2016) and more recently the General Practice Nursing Education and Career Framework (Health Education England, District Nursing and General Practice Nursing Services Education and Career Framework, 2015) and QNI Transition Frameworks (Queen's Nursing Institute, 2016) . This Framework, supports standardisation and also sets expectations in both clinical skills and educational requirements which will assist with workforce planning and educational commissioning assisting to strengthen this local strategy. We would like our workforce to feel engaged in the decisions about healthcare delivery and encourage all to benchmark key skills and identify future learning needs by developing a personal development plan.

This framework will be delivered as part of the Black Country GPN strategy and should be used in conjunction with the following documents:

- Black Country GPN Strategy
- Black Country GPN Competency Framework
- Black Country GPN Education and Career Framework
- Clinical Supervision Guidelines

A preceptorship programme has also been developed as part of this framework and can be seen in part 2 of this document.
Acknowledgements

Amendments have been made to this document to reflect the new NHS England General Practice Nursing Induction Template (2019) which has been developed as part of the 10 Point Action Plan.

This document was developed with additional insight from:
Queen’s Nursing Institute – Transition to General Practice Nursing
Capital Nurse Programme
Sheffield University GPN Induction Programme
West Suffolk CCG GPN Training Programme
Manchester CCG GPN Training Programme

Suggested elements for the Practice Orientation and Induction

Every practice large or small is likely to have an orientation and induction programme. It should provide all the information that a new employee needs, without overwhelming or diverting them from the essential process of integrating into the existing team.

Review Job Description
GPN will sign a contract of employment within the first few days of their new appointment. Most employers within Primary Care are independent businesses and the responsibility lies with the practice for recruiting and developing their own employees, which may differ from processes within the NHS. Probationary periods may vary with different guidance and stipulations around performance as an independent employer.

Orientation
This may be a tour of the building, meeting new colleagues and becoming familiar with the IT system; all new starters should have this.

HEE suggests that practice orientation includes the following elements:
- Tour of the building/site
- Health and safety requirements and responsibilities
- Meeting other members of the team
- Contracts and terms of employment
- Set up of NHS.net account

Induction
Induction aims to acclimatise staff to their new job and working environment, helping the new staff member work out their role and how they fit into the team.

The length and nature of an induction depends on the complexity of the job and the background of the new employee; this may need to be adapted to suit. A standardised induction programme is unlikely to comprehensively meet anyone’s needs, nursing
staff may often have had experience in other roles in other settings; HEE suggests a practice induction should include the following elements.

**Mandatory Training**
- Basic Life Support
- Equality and Diversity
- Fire Safety
- Infection Control
- Information Governance
- Mental Capacity Act
- Moving and Handling
- Safeguarding Children
- Safeguarding Adults
- Prevent
- Chaperoning

**Practice Administration and Management**
- Primary care structure and funding
- Practice IT applications
- Electronic record keeping procedures and processes
- Audit and information collation/analysis
- Care Quality Commission (CQC) regulations and outcomes
- Equipment ordering and stock management
- Quality Outcomes Framework (QOF) – Introduction

**Communications and Relationships**
- Team working responsibilities (internally) and MDT collaboration
- Importance of developing and working with patients, carers and their families
- Effective primary care consultations and using appropriate communication skills
- Support for conflict management and managing difficult conversations
- Supervision, appraisal and on-going professional development

**Education to Support New GPNs and HCAs**

A new GPN or HCA will be unfamiliar with general practice, and may also be a newly qualified nurse or new HCA with little or no previous experience. Although GPNs will be autonomous and accountable, and may have several years of prior experience in another setting, they will not have all the knowledge and skills needed for running clinics from day one. They will need additional knowledge and skills beyond their initial nurse training and local induction.

By ensuring that a newly appointed GPN/HCA has access to educational support during the first 18 months of employment in general practice, will endeavour to enable the best possible support in their primary care career.

By accessing educational support, a new GPN/HCA will;
- Gain the knowledge, skills and competencies required for general practice nursing
- Enhance their existing skills of self-reflection, critical thinking and clinical judgement
Be in the best position to understand and respond to the current and potential demand for nursing services within primary care

Examples of training and update schedules are shown in Appendix 2.

The Care Certificate

The Care Certificate is a free programme with an identified set of standards that health and social care workers adhere to in their daily working life. This programme is aimed at the non-regulated workforce i.e. HCAs in order to build confidence through standardised introductory skills, knowledge and behaviours that promote compassionate, safe and high quality care. The Care Certificate is based on 15 standards and can be seen at the link below:

The Care Certificate

A range of guidance and workbooks are available to support candidates and assessors, no specific training is required to support a staff member through the process and the standards have been mapped to this document and the GPN Competency Framework.

General Practice Education and Career Framework

HEE has developed a District Nursing and General Practice Education and Career Framework (2015). This framework sets out comparators and expectations for both DN and GPN knowledge and skills at different levels of responsibility, this has been adapted for use in the Black Country GPN Education and Career Framework. It is envisaged that this framework will:

- Enable practitioners to plan and develop their careers by providing a visualisation of what skills, knowledge and competencies at different levels of responsibilities across general practice nursing are suggested
- Assist practices, Training Hubs and CCGs to identify organisational learning needs in terms of current and future workforce requirements (in terms of skills and knowledge) – which will enable them to better plan for the number of appropriately skilled staff to deliver a high-quality care
- Enable practices to work collectively to state their nursing education needs.
- To enable CCGs and Training Hubs to in turn commission appropriate educational opportunities to support practice needs.

This framework has been adapted into an induction programme document that can be seen in Appendix 1, this is not prescriptive, and can be modified to suit the needs of the nurse and the practice.

Delivered within practice

- Accountability and Responsibility
- Transferable skills
- Managing Risk
- Record keeping and IT
- Quality Outcomes Framework (QOF)
- Health Policy, law and ethics
- Partnership working
- Communications Skills
- CQC

**Clinical Management**

- Holistic assessment
- Anticipatory care and risk
- Supporting patient self-care
- Multiple pathology
- Deteriorating patient
- End of Life care
- Contraception and sexual health advice
- Health promotion and 'Making Every Contact Count'
- Minor Illness
- Minor Injury
- Spirometry
- Palliative care and symptom control
- Dementia care
- Long Term Conditions (LTC) and co-morbidities management
- Vaccinations & Immunisations
- Cervical
- Ear care
- Smoking Cessation
- Tissue viability
- ECG
- Oral Anticoagulation Management

**Further Development**

- Pharmacology and medicines management
- Prescribing
- Mentor preparation
- Appraisal of others
- Audit, review, research
- Leadership and management

**Continuing Professional Development**

The Nursing and Midwifery Council (NMC) is the legal regulator of nurses and Midwives in the UK. All nurses and midwives must register with the NMC in order to work. Since 1995, in order to remain on the NMC register all nurses must undertake a minimum of 35 hours of CPD every three years. Under revalidation guidelines that came into force in 2015, nurses must continue to undertake at least 35 hours of CPD every three years. However, 20 hours of this will have to be committed to participatory learning activities, such as seminars, learning workshops, shadowing other colleagues, etc. Nurses are required to ensure that when they do undertake any CPD-related learning that they are able to evidence learning outcomes which are directly relevant to their specialty.
Black Country STP is committed to supporting primary care workforce development, education and training. As part of this commitment and the on-going development and application of the framework, local CCGs will work in collaboration with each other, the local Training Hub, local Higher Education Institutions and Health Education England to ensure that GPNs can access high quality CPD.

A range of CPD opportunities are available across the STP footprint including:

- Nurse education forums
- Training workshops
- Apprenticeships
- Accredited training such as spirometry
- Pharmaceutical industry sponsored events
- Higher education programmes and modules

This list is not exhaustive

**Fundamentals of General Practice Nursing**

The Fundamentals of General Practice Nursing course was originally developed from work carried out by HEE and is designed to meet the CPD needs of RNs new to working in general practice and aims to provide a mix of theoretical and clinical skills relevant to current clinical practice and the changing context of primary care. The course is underpinned by the RCGP General Practice General Practice Nurse Competencies (2015) where appropriate and supports nurses in working towards and assembling evidence to demonstrate achievement of this with a focus on work-based learning.

Course content varies between instructions but generally includes:

- Clinical skills relevant to general practice e.g. cytology, venepuncture and LTC management
- Leadership
- Management

Local course providers include:

- [University of Wolverhampton](#)
- [Birmingham City University](#)
- [Staffordshire University](#)
Part 2 - General Practice Nurse Preceptorship Programme
Introduction

“A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning.” (Department of Health, 2010, p. 11)

This preceptorship framework is a resource for health and care organisations across the Black Country to support the practice of nurses new to Primary Care, these nurses may also be newly qualified. This recommended “best practice” approach to preceptorship has been adapted from the London based CapitalNurse Framework (2017) which was developed through an extensive stakeholder engagement exercise involving practitioners from organisations across London, representing all fields of practice and settings across acute, community and primary care.

Background

The aim of this preceptorship standard is to facilitate a decrease in variation in initial support for new GPNs and HCAs (and also potentially other staff members such as Physicians Associates, Clinical Pharmacists, Paramedics and Mental Health Workers) to reduce attrition and to retain staff ensuring the right number of professionals with the rights skills in the right place at the right time.

Nurse preceptorship was introduced as part of Project 2000 nurse training reforms in 1986 and evidence shows that the time period when transitioning from student to registered nurse is valuable and critical (Health Education England, "Raising the Bar: Shape of Caring": Health Education England’s response, 2016). Health Education England (2015) published preceptorship standards for organisations to clarify the requirements of preceptorship as part of the Shape of Caring Review (2016). This outlines areas of best practice and includes 14 required elements.

Odelius et al (2017), undertook a literature review evaluating the value of implementing nursing preceptorship. The findings show that the majority of preceptees benefit from increased competence and confidence through a preceptorship programme. A minority find it less useful either because they are in a specialist area or due to poor relationship with their preceptor. The study identified different approaches offering different benefits.

The conclusions drawn showed that organisational commitment and culture were essential in establishing, implementing and sustaining effective preceptorship programmes. The benefits of a standardised approach were identified through this literature review.

HEE’s national Reducing Pre-registration Attrition and Improving Retention (RePAIR) (2018) project is scheduled to report in the Spring of 2018; this work focuses on the fields of nursing, midwifery and therapeutic radiography. The focussed group work, with students, has highlighted just how important the model of preceptorship is. Many students who have the option to choose where they work immediately post-registration, are influenced by the preceptorship model on offer, and the commitment
of the employer to this programme. RePAIR also includes work with preceptorship leads from the project case study sites and the early evidence is that students and preceptorship leads value a programme that is a minimum of 12 months' duration. A review of preceptorship programmes examining preceptorship (Currie & Watts, 2012) concluded that organisational commitment was essential and outlined the key role requirements to support successful preceptorship.

**What is Preceptorship?**

Newly qualified nurses (NQN) become accountable as soon as they are registered and this transition from student to accountable practitioner is known to be challenging (Higgins, Spencer, & Kane, 2010). The purpose of preceptorship is to provide support during this transition. Preceptorship programmes may include classroom teaching and attainment of role-specific competencies, however the most important element is the individualised support provided in practice by the preceptor. The goal of preceptorship is for the newly registered nurse to develop their confidence and autonomy.

Currently the NMC states that as best practice, a new registrant on a preceptorship programme should have learning time protected in their first year of qualified practice and access to a Preceptor with whom regular meetings are held. They also strongly recommend that all new registrants should have a formal period of preceptorship of about four months but this may vary according to individual need. The NMC has launched [new guidance on pre-registration nurse training](#) and the supervision of students in practice. This will bring new challenges for the preceptorship period and the preceptors supporting this “future nurse”. This preceptorship framework will be reviewed in 2020 to reflect those changes and acknowledge the needs of a new registrant.

**A Preceptorship programme provides:**

- Integration of prior learning into practice
- Application in accordance with evidence-based practice
- Development of confidence
- Adherence to the Codes of Professional Conduct
- Update and enhance knowledge and clinical skills
- Adherence to policies and procedures
- Reflective practice
- Giving and receiving feedback
- Advocacy
- Interpersonal skills
- Clinical Risk Management and Governance
- Equality and Diversity
- Negotiation and conflict resolution
- Leadership and management development
- Develop a strategy for Continued Professional Development
- Team working within the multidisciplinary team
- Clinical judgement and decision making
- Enhancement of self-awareness: Provides training and education around use of medical devices, medicines management, documentation and electronic systems
Preceptorship is not
- Intended to replace mandatory training programmes
- Intended to be a substitute for performance management processes
- Intended to replace regulatory body processes to deal with performance
- An additional period in which another GPN takes responsibility and accountability for the newly registered practitioner’s responsibilities and actions (i.e. it is not a further period of training)
- Formal coaching (although coaching skills may be used by the preceptor to facilitate the learning of the newly registered practitioner)
- Mentorship
- Statutory or clinical supervision
- Intended to replace induction to employment
- A distance or e-learning package for a newly registered practitioner to complete in isolation

Preceptorship Standards

The following set out the basic preceptorship standards, which are expected of all GP surgeries in the Black Country STP area.

Who is the programme for?
The overall aim of a preceptorship programme is to develop confident and competent practitioners, therefore preceptorship should be available to all nurses new to General Practice, and may also be relevant to Allied Health Professionals (AHP). For the purposes of this programme preceptorship is conceptualised as applicable to a NQN or a nurse new to general practice, although the programme can be applied to any nurse or AHP.

Preceptorship can also be applied to new Health Care Assistants, Nursing Associates and Associate Practitioners, these staff groups may include apprentices and it is important that there is robust workplace-based support as part of the apprenticeship contract.

Preceptor/preceptee charter
This sets out the responsibilities and expectations for both preceptor and preceptee. This is available in Appendix Two.

Length of programme
The recommended length of a preceptorship programme for a NQN is 12 months from the date of joining the organisation and a minimum of 6 months, this may be applied to any nurse (or AHP) new to general practice, but may vary depending on role and previous experience.

During the programme there will be certain expectations of both the preceptor and preceptee in terms of engagement in the programme, development of the professional relationship and completion of defined competences (which are outlined in the complementary induction document). These should comply with HEE Standards and
examples of indicative content of a preceptorship programme can be found in Appendix One.

Ideally a programme should include a minimum supernumerary period of two weeks to cover induction and orientation to the organisation; however some environments, organisations or individuals may require more than two weeks. This should be agreed locally with the preceptor and line manager and the expected outcomes of the supernumerary period made explicit.

**Protected time**

As best practice, protected time should be allocated for both the preceptor and the preceptee, which should be supported by the employer. The purpose of this protected time is to support the nurse, build confidence and competence, consolidate learning and build resilience. This can be achieved through a combination of working directly with a preceptor, reflection, action learning, supervision and work-based learning. The provision and format of this protected time may vary depending on the working environment and the practice team.

<table>
<thead>
<tr>
<th>The recommended requirements are:</th>
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<tr>
<td>• The preceptee and the preceptor should work alongside each other at least four working days in the first month.</td>
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<td>• Regular formal meetings during the preceptorship period.</td>
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<tr>
<td>• Half-day initial training workshop for preceptors – blended learning approach (to be developed)</td>
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</table>

**Meetings between Nurse and Preceptor**

It is recommended that there are formal review meetings between the preceptor and preceptee at regular intervals during the preceptorship period: Initial meeting – to set expectations and learning plan. Interim meetings to monitor progress, share reflection and further consider development needs should be held at 3, 6 and 9 months. A final meeting to establish competence and sign off should be held after 12 months (this can be done earlier if all standards and requirements have been completed).

The purpose of these meetings is to provide a supportive safe place for the preceptee to reflect on their progress and experience. Meetings should be documented briefly, and this record dated and signed by both the preceptor and preceptee. Templates to help guide the meetings can be found in Appendix Four. The timing of preceptorship meetings may be amended and outcomes shared with the appropriate manager, in order to inform decisions about the probationary period.

**Preceptee**

The preceptee is responsible for engaging fully in the preceptorship programme. This involves a number of activities including completing induction and other required training, attending regular meetings with their preceptor, actively seeking feedback, escalating concerns, reflecting on their professional practice and taking ownership of their own development.
Preceptees should be encouraged to utilise their preceptorship period, and develop their portfolio towards NMC revalidation. It should be recognised that although formal study days are important, learning is achieved in a variety of ways including observation, workplace learning, e-learning, experiential learning, reflection and working with others. The preceptee should be encouraged to make full use of all of these opportunities for learning.

**Preceptors**

Preceptors require no specialist qualification, but should be nurses with a minimum of 1 years’ experience working as a registered nurse and ideally 1 year in general practice. They may volunteer or be asked to undertake the role by their lead nurse, or practice manager. Evidence suggests that the best preceptors are those who are volunteers, demonstrate supportive behaviours, share knowledge and build trust (Ferguson, 2010).

A preceptor should have no more than two preceptees at any one time. Some practices may adopt a team preceptorship model or may provide preceptorship within their practice or locality group, providing support across a number of practices.

The role of the preceptor is to provide guidance to the preceptee by facilitating the transition into their new role; supporting the preceptee to gain experience and apply learning in a clinical setting during the preceptorship period. A role descriptor for a preceptor can be found in Appendix Four.

**Preceptor Support and Development**

Preceptors should be prepared for their role and the offered some development in understanding the preceptorship programme and skills required. Ongoing support for preceptors should be available from the organisation leads. An approach to preceptorship development is currently being developed by NHSE and further information will be provided in due course.

**Preceptorship Lead**

Each CCG and/or Training Hub should have an appointed preceptorship lead who is responsible for overseeing the preceptorship programme which may include:

- Identifying preceptors, knowing who they are and providing links to appropriate level of preparation and support
- Identifying all nurses requiring preceptorship and others for whom preceptorship is deemed beneficial
- Allocating or delegating the responsibility for identifying preceptors in time for the preceptees start date
- Monitoring and tracking completion rates for all preceptees
- Performing regular checks that the preceptor/preceptee relationship is working satisfactorily
- Identifying any development/support needs of preceptors or preceptees
- Measuring the effectiveness and impact of preceptorship programmes on retention and staff engagement
- Ensuring preceptorship is operating within the DH framework (2010)
CCGs/Training Hubs will be responsible for monitoring the programmes and measuring success against key performance indicators, which could include:
  - Retention of GPNs after one year
  - Retention of GPNs after two years
  - Staff engagement – general or specific groups, i.e. preceptees and preceptors
  - Patient/service user feedback
  - CQC ratings against key criteria of safe, effective, caring, responsive and well-led

**Preceptee Development**
Preceptees should be provided with learning opportunities, including study days/sessions, over the first year, in addition to the supernumerary period. The content, frequency and running of these study days/sessions will depend on needs, however the purpose is to ensure that the preceptee is able to meet the required clinical and professional competences by the end of their preceptorship period.

Areas should include the nine domains of the Preceptorship Career Framework, which incorporates the fourteen elements outlined in the HEE standards, as referenced in appendix one.
References

Appendix 1: HCA/GPN Induction Framework Documentation

This Induction Framework is for all new nursing staff – this can be adapted for use by Registered Nurses, HCAs, Nursing Associates and Allied Health Professionals such as Physician’s Associates.

Staff may be at different levels of experience and may have worked in general practice before, this framework is not prescriptive and can be adapted to suit needs.

It should be used in conjunction with the following documents:
- GPN Competency Framework
- GPN Education and Skills Framework
- GPN Preceptorship Programme

### Orientation Programme

<table>
<thead>
<tr>
<th>Practice Orientation</th>
<th>Signed Practitioner</th>
<th>Signed Supervisor</th>
<th>Date</th>
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<td>Tour of the building/site</td>
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<td>Health and safety requirements and responsibilities</td>
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<td>Meeting other members of the team</td>
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<td>Contracts and terms of employment</td>
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<td>Occupational health clearance</td>
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<td>Set up of NHS.net account</td>
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<td>DBS clearance</td>
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<td>Set up Immform account</td>
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### Induction Programme

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<td>Basic Life Support</td>
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<td>Equality and Diversity</td>
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<td>Infection Control</td>
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<td>Information Governance</td>
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<td>Prevent/WRAP</td>
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<td><strong>Practice</strong></td>
<td><strong>Administration and Management</strong></td>
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<td>Set up local training account e.g. eLFH</td>
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<td>Location of practice policies</td>
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<td>How primary structure and funding</td>
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<td>Practice IT applications</td>
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<td>Electronic record keeping procedures and processes</td>
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<td>Audit and information collation/analysis</td>
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<td>Clinical system searches</td>
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<td>Quality Outcomes Framework (QOF) – Introduction</td>
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<td>Register for Open Exeter for cytology access*</td>
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<td>Team working responsibilities</td>
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(internally) and MDT collaboration

Importance of developing and working with patients, carers and their families

Effective primary care consultations and using appropriate communication skills

Support for conflict management and managing difficult conversations

Supervision, appraisal and ongoing professional development

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<th>Clinical Skills</th>
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<td>Mentorship*</td>
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*Registered Nurses only
### Appendix 2: Training Guidance

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<thead>
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<th>Mandatory Training</th>
<th>Update requirement</th>
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<tbody>
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<td>Basic Life Support and AED</td>
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<tr>
<td>Conflict Resolution</td>
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<td>COSHH</td>
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<td>Equality and Diversity</td>
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<td>FGM</td>
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<td>Fire Safety Awareness</td>
<td>Annually</td>
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<tr>
<td>Health and Safety</td>
<td>Annually</td>
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<td>Infection Prevention Control including Hand Hygiene</td>
<td>Annually</td>
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<td>Information Governance</td>
<td>Annually</td>
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<td>Manual Handling</td>
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<td>Safeguarding Children (Level 1, 2 and 3)</td>
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</tr>
<tr>
<td>Safeguarding Adults and the Mental Capacity Act (Level 1, 2, and 3)</td>
<td>initial course plus at least 3 yearly update</td>
</tr>
<tr>
<td>PREVENT</td>
<td>Once</td>
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Additional training is required prior to undertaking any of the following services

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<tr>
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<th>Update requirement</th>
<th>Provider</th>
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<tr>
<td>Asthma</td>
<td>Accredited course</td>
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<tr>
<td>Cervical Cytology</td>
<td>Initial course then 3 yearly updates</td>
<td>Birmingham Women’s Hospital</td>
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<tr>
<td>Childhood Immunisations</td>
<td>Initial course then annual updates</td>
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</tr>
<tr>
<td>CHD</td>
<td>Accredited course</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>Accredited course</td>
<td></td>
</tr>
<tr>
<td>Contraception</td>
<td>Initial workshop then 3 yearly updates</td>
<td>Faculty of Sexual and Reproductive Healthcare</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Accredited course</td>
<td></td>
</tr>
<tr>
<td>Ear Care</td>
<td>Initial course and 3 yearly update</td>
<td></td>
</tr>
<tr>
<td>End of Life</td>
<td>Initial workshop</td>
<td></td>
</tr>
<tr>
<td>Spirometry</td>
<td>Initial course and 3 yearly reaccreditation</td>
<td>ARTP</td>
</tr>
<tr>
<td>ECG</td>
<td>Initial course and 3 yearly update</td>
<td></td>
</tr>
</tbody>
</table>
**Appendix 3: Preceptorship Standard Domains**

The following provides additional description for the nine domains of the Preceptorship Career Framework to inform preceptee development programmes to be completed over the programme.

<table>
<thead>
<tr>
<th>Preceptorship Standard Domain</th>
<th>What it means – behaviours and outcomes</th>
</tr>
</thead>
</table>
| **Clinical Practice**        | o Delivering person-centred, safe and effective care  
                                 o Assessing and managing risks in delivering safe effective care to patients  
                                 o Maintaining own skills and competence |
| **Communication**            | o Sharing of health and care related information between a nurse and those in their care with both participants as sources and receivers. Information may be verbal or non-verbal, written or spoken.  
                                 o Understanding techniques to facilitate courageous conversations  
                                 o Understanding ways of managing conflict, taking ownership and using effective communication in difficult situations |
| **Teamwork**                 | o Working effectively as part of a team to achieve value-added patient, staff and organisational outcomes  
                                 o Working with colleagues and other multi-disciplinary professionals to provide a cohesive approach to patient care  
                                 o Understanding the components of effective teamwork |
| **Leadership**               | o Effectively utilising personal skills and attributes to inspire people to achieve a common goal  
                                 o Taking ownership and responsibility for self and practice. Acting as a role model for others  
                                 o Understanding role as a leader, reflect on leadership styles and qualities of a good leader |
| **Professionalism and Integrity** | o Demonstrating a strong sense of professionalism through values, behaviours and relationships in line with NMC Code of Conduct (2015) Understanding range and remit of roles and scope of own responsibility.  
                                 o Understanding professional accountability surrounding delegation |
| **Research and Evidence**    | o Contributing to the body of nursing knowledge and using evidence to inform safe and effective practice  
                                 o Understanding quality measures i.e. KPIs, friends and family, patient experience  
                                 o Seeking out ways to develop and improve quality of practice and care |
### Safety and Quality
- Reducing the risk of harm and ensuring the best possible health outcomes for those receiving care
- Taking active measures to reduce the risk of harm and ensure the best possible health outcomes for people receiving care.
- Understanding risks and safe levels of staffing
- Knowing how and with whom to raise issues
- Understanding the appropriate policies

### Facilitation of learning
- Creating an environment for learning and engaging in teaching and assessment
- Learning with and from others, teaching others to improve patient care and collaboration
- Understanding each other’s professional roles and their contribution to the patient journey
- Actively reflecting on positive and difficult situations and learning from these to improve practice
- Providing preceptees with the opportunity to reflect on their practice, individually and with peer support

### Development of self and others
- Helping self and others to identify learning needs and opportunities to achieve agreed goals
- Taking an active part in own professional, personal and clinical development with PDP in place and planned learning activities
- Understanding NMC revalidation requirements
- Using emotional intelligence to work for, rather than against, promoting good working relationships
- Finding ways to manage stress and develop resilience
- Identifying support networks and how to access help

* Content included in the Preceptorship domains aligns to the key elements outlined in the HEE Standards.
## Appendix 4: Preceptorship Charter

Charter between the preceptor and the preceptee

**Preceptee I, ________________________________** commit to fulfilling my responsibilities as a newly registered practitioner and preceptee.

This includes:
- Completing all organisation and local induction, statutory and mandatory training
- Attending study days and doing all required training to complete my preceptorship
- Observing and adhering to organisation values
- Participating fully in the preceptorship programme by preparing for and attending meetings as scheduled with my preceptor
- Working collaboratively with my preceptor to share my reflections and identify learning and development needs
- Seeking feedback from others to inform my progress
- Owning my learning and development plan

Signature:  ________________________________________________________  
Date:   _________________

**Preceptor I, ________________________________** commit to fulfilling my responsibilities as a preceptor.

This includes:
- Providing support and guidance to the newly registered nurse
- Acting as a role model and critical friend
- Facilitating introductions and promoting good working relationships
- Participating in all preceptorship activities including completing required training, preparing for, attending and documenting regular scheduled meetings
- Providing timely and appropriate feedback to the preceptee
- Liaising with manager about preceptee’s progress as appropriate
- Advising on learning and development needs, facilitating a supportive learning environment and signposting learning resources

Signature:  ________________________________________________________  
Date:  ____________________
Appendix 5: Preceptorship Meeting Templates

The following templates are suggested formats for formal review meetings to be completed by both preceptor and preceptee, signed, and dated and each maintaining a copy.

**Initial Meeting (within first 3 months)**

<table>
<thead>
<tr>
<th>Preceptee Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptor Name:</td>
<td></td>
</tr>
<tr>
<td>Date of Meeting:</td>
<td></td>
</tr>
</tbody>
</table>

**Expectations:**

**Induction Checklist:**

**Study days / eLearning Planned:**

**Development plan:**

Objectives should be SMART – Specific, Measurable, Achievable, Realistic and Time-bound
<table>
<thead>
<tr>
<th>Comments / Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Next Meeting Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preceptee Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preceptor Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
## Interim Meeting (6 months)

<table>
<thead>
<tr>
<th>Preceptee Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptor Name:</td>
<td></td>
</tr>
<tr>
<td>Date of Meeting:</td>
<td></td>
</tr>
</tbody>
</table>

### Expectations:

```

```

### Induction Checklist:

```

```

### Study days / eLearning Planned:

```

```

### Development plan:

```

```

**Objectives should be SMART – Specific, Measurable, Achievable, Realistic and Timebound**

### Comments / Notes:

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<table>
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<tr>
<th>Next Meeting Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptee Signature:</td>
</tr>
<tr>
<td>Preceptor Signature:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>
## Final Sign-Off Meeting (9 months)

<table>
<thead>
<tr>
<th>Preceptee Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptor Name:</td>
<td></td>
</tr>
<tr>
<td>Date of Meeting:</td>
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</table>

**Expectations:**

**Induction Checklist:**

**Study days / eLearning Planned:**

**Development plan:**

Objectives should be SMART – Specific, Measurable, Achievable, Realistic and Timebound

**Comments / Notes:**
Next Meeting Date:  
Preceptee Signature:  
Preceptor Signature:  
Date:  

**Preceptorship Sign-Off Declaration (12 months)**

This is to confirm that the preceptee has completed all aspects of the preceptorship programme satisfactorily

<table>
<thead>
<tr>
<th>Preceptee Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td></td>
</tr>
<tr>
<td>Preceptor Name:</td>
<td></td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
</tr>
<tr>
<td>Organisation Lead Name:</td>
<td></td>
</tr>
<tr>
<td>Date of completion:</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6: Role Descriptor for a Preceptor

Role Overview
To provide guidance to the graduate nurse by facilitating the transition from student to registered nurse by gaining experience and applying learning in a clinical setting during the preceptorship period.

Responsibilities

The role of the Preceptor is to:
1. Possess a good understanding of the preceptor framework requirements and communicate these to the newly registered nurse clearly and concisely
2. Ensure induction has been completed and check that the NRN is fully aware of local ways of working and appropriate policies
3. Facilitate introductions for the newly registered nurse to colleagues, multidisciplinary staff and others, promoting effective working relationships
4. Guide in assessing learning needs and setting achievable goals with regular and confidential review with the newly registered nurse
5. Use coaching skills to enable the newly registered nurse to develop both clinical and professionally and to develop confidence
6. Facilitate a supportive learning environment by signposting resources and actively planning learning opportunities for clinical, professional and personal growth of the newly registered nurse
7. Give timely and appropriate feedback to newly registered nurse on a regular basis
8. Act as a critical friend and advocate
9. Liaise with the line manager to monitor progress and address areas of poor performance or areas requiring further development through objective setting and regular review
Black Country STP

General Practice Nurse Education and Careers Framework (incorporating HEE Framework for GPNs)

V1.2 March 2019
DOCUMENT STATUS: 

DATE ISSUED: 

DATE TO BE REVIEWED: 

AMENDMENT HISTORY

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<td>12/7/2019</td>
<td>Circulated to local CCG and STP colleagues for consultation including nurses</td>
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<td>1.1</td>
<td>21/1/2019</td>
<td>Amendments made re-sent to previous stakeholder group for consultation</td>
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<td>1.2</td>
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<td>Final amendments made for approval</td>
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REVIEWERS

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<td>Sally Roberts</td>
<td>Chief Nurse Wolverhampton CCG</td>
<td>12/3/2019</td>
<td>All</td>
</tr>
<tr>
<td>Sarah Southall</td>
<td>Head of Primary Care Wolverhampton CCG</td>
<td>12/3/2019</td>
<td>All</td>
</tr>
<tr>
<td>Sara Bailey</td>
<td>Deputy Chief Nurse Walsall CCG</td>
<td>13/2/2019</td>
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<tr>
<td>Sarah Shingler</td>
<td>Chief Nurse Walsall CCG</td>
<td>13/2/2019</td>
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<tr>
<td>Caroline Brunt</td>
<td>Chief Nurse Dudley CCG</td>
<td>13/2/2019</td>
<td>All</td>
</tr>
<tr>
<td>Joanne Taylor</td>
<td>Commissioning Manager Dudley CCG</td>
<td>13/2/2019</td>
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<tr>
<td>Pauline Billingham</td>
<td>Nurse Mentor Dudley CCG</td>
<td>13/2/2019</td>
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</tr>
<tr>
<td>Michelle Carolan</td>
<td>Sandwell and West Birmingham CCG</td>
<td>13/2/2019</td>
<td>All</td>
</tr>
<tr>
<td>Alyson Hall</td>
<td>Training Hub Coordinator Sandwell and West Birmingham CCG</td>
<td>13/2/2019</td>
<td>All</td>
</tr>
<tr>
<td>Jayne Hawkins</td>
<td>GPN Facilitator Futureproof Health (Dudley Training Hub)</td>
<td>13/2/2019</td>
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<tr>
<td>Katie Welborn</td>
<td>Matron for Vertical Integration and Sexual Health The Royal Wolverhampton Hospitals NHS Trust</td>
<td>13/2/2019</td>
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<tr>
<td>Heidi Mitchell</td>
<td>Health Education England</td>
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<td>Phil Turner</td>
<td>Bilston Family Practice</td>
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<tr>
<td>Lisa Clarke</td>
<td>Senior Lecturer University of Wolverhampton</td>
<td>13/2/2019</td>
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<tr>
<td>Salma Reehana</td>
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<tr>
<td>David King</td>
<td>Equality and Human Rights Manager NHS Arden and GEM</td>
<td>13/2/2019</td>
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<tr>
<td>Kelly Huckvale</td>
<td>IG Lead NHS Arden and GEM</td>
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<tr>
<td>Sukhdip Parvez</td>
<td>Patient Safety Manager Wolverhampton CCG</td>
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<tr>
<td>Paul Aldridge</td>
<td>GP Forward View Development Manager Black Country STP</td>
<td>19/3/2019</td>
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<tr>
<td>Della Burgess</td>
<td>Health Education England (LWAB)</td>
<td>13/2/2019</td>
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**APPROVALS**
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**GROUP/COMMITTEE**

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<td>3.</td>
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General Practice Nursing Services Education and Career Framework (HEE, 2015\textsuperscript{1})

The framework aims to standardise the training and education of practice and district nurses across England. The framework is split into two sections one for district and the other for practice nursing. Each section then splits further into 9 distinct levels; starting at apprentices and assistants at level 1-3 leading to advanced nurses at level 8-9. The levels relate then to underlying role descriptors. The document sets out the educational and professional requirements to progress through the levels. This offers nurses a clearer direction and more of an understanding of what is expected at each level. The evolving nature and rapid pace of change in 21st century healthcare requires nurses, midwives and allied health professionals to be able to respond flexibly to meet the changing needs of patients and their families. Adaptability, transferable skills and consistency across the different levels of the Career Framework are vital in meeting these needs.

This framework will be communicated to all practice nurses through the Nurse Forums. The organisation would like staff to engage with the framework and embed it into practice, benchmarking practice and mapping future training needs to support continuing professional development. It is hoped that through appraisal nurses will feel confident referring to the framework for their development with their line managers.

The interactive framework can be accessed online here. This tool is designed to be used in conjunction with the STP GPN Strategy and the STP GPN Competency Framework documents.

This document is aimed at Nurses, Nursing Associates, Associate Practitioners and Health Care Assistants.

### CAREER AND EDUCATION ILLUSTRATION (Based on HEE Framework Illustration)

<table>
<thead>
<tr>
<th>Level</th>
<th>Minimum professional and educational requirements for the role</th>
</tr>
</thead>
</table>
| 8     | - NMC registration. Masters degree or PG diploma meeting ANP requirements and to include level 8 high intensity interventions; level 3 extended brief interventions (see NICE guidance)  
       | - V309 independent and supplementary prescribing; NMC mentorship or practice educator qualification.  
       | - Clinical academics will have or be working towards a research-based award at masters or PhD level. |
| 7     | - NMC registration; first degree working towards PG level qualification.  
       | - V309 independent and supplementary prescribing; NMC mentorship qualification; level 3 extended interventions. |
| 6     | - NMC registration; first degree/relevant experience; NMC specialist practitioner qualification/relevant experience in primary care  
       | - NMC mentorship qualification; level 3 extended interventions. |
| 5     | - NMC registration; working towards Fundamentals of General Practice Nursing  
       | - Level 3 extended interventions. |
| 4     | - Nursing Associates will hold and approved Level 5 Foundation degree and be registered with NMC.  
       | - Associate Practitioners will hold or be working towards a relevant Higher Care Certificate or level 5 qualification. |
| 3     | - Care Certificate; achieved a relevant Level 3 QCF qualification/Level 3 Apprenticeship; training for working in community settings and role specific skills; Maths and English at Level 2 (GCSE/Functional Skills)  
       | - Level 2 brief intervention training |
| 2     | - Care Certificate; holding or working towards relevant Level 2 QCF qualification; training for working in community settings and role specific skills; holding or working towards Maths and English at Level 2 (GCSE/Functional Skills) |

**Level M** Minimum professional and educational requirements for the role.
<table>
<thead>
<tr>
<th>Entry Level Candidate</th>
<th>Level 2 Health Care Assistant</th>
<th>Level 3 Health Care Assistant</th>
<th>Nursing Associate</th>
<th>General Practice Nurse</th>
<th>Advanced Nurse Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal qualifications or experience required</td>
<td>Qualifications required: Level 2 diploma in Health and Social Care or Health Care</td>
<td>Qualifications required: Level 3 diploma in Health and Social Care or Health Care</td>
<td>Qualifications required: Approved Level 5 Foundation Degree/ NMC registration</td>
<td>Qualifications required: Approved RN training i.e. SRN, RGN, or RN (Adult) via approved programme leading to DipHE, BSc or MSc</td>
<td>Qualifications required: Approved RN training (as for GPN) MSc Advanced Clinical Practice</td>
</tr>
<tr>
<td>Entry route via:</td>
<td>Full-time college programme</td>
<td>Entry route via:</td>
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<td>Entry route via:</td>
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<tr>
<td>Apprenticeship</td>
<td>Apprenticeship</td>
<td>Apprenticeship</td>
<td>Apprenticeship</td>
<td>Self-funded/employer sponsored study</td>
<td>Apprentice</td>
</tr>
<tr>
<td>Employer funded training</td>
<td>Employer funded training</td>
<td>Employer funded training</td>
<td>Apprentice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Progression Point L2 to L3 HCA (15-18 months)
- Progression Point L3 HCA to NA (2 years)
- Progression Point NA to GPN (2½ years)
- Progression Point L3 HCA to AP (2 years)
- Progression Point L3 HCA to GPN (3 years full time 4 years part time)

A GPN would be expected to have a "reasonable" amount of post-registration experience before undertaking the Advanced Clinical Practice Master’s degree, this would depend on the nurse and their current and previous role but would generally be around 3-5 years.
NHS Career Descriptors

The elements below were identified by General Practice and Community Colleagues as fundamental to clinical practice, links to educational programmes will reflect local provision, but other providers are available regionally and nationally.

Health Care Assistant – Skills for Health Level 2 and 3

The requirements of this role are likely to vary in organisations and may require one single skill to be applied in a range of settings such as phlebotomy. Staff in this role work under the supervision of a registered practitioner but supervision may be remote or indirect. They will have achieved the basic competencies of the Care Certificate, but will need induction to working as part of the practice nursing team or in community settings. It is expected that level 2 staff would proceed to level 3 as a minimum when working in primary care. HCAs undertake responsibility for routine clinical and non-clinical duties as delegated by a registered practitioner including defined clinical or therapeutic interventions within the limits of their competence. Their work is guided by standard operating procedures, protocols or systems of work but the worker may be expected to respond to patient questions and report these back to assist in patient care evaluation. They will be expected to demonstrate key behaviours consistent with the values identified for delivering compassionate care. If they are highly skilled in a specific clinical activity such as phlebotomy they may be asked to support the development of this skill in other staff.

<table>
<thead>
<tr>
<th>Level 2 HCA Qualifications</th>
<th>Skills</th>
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</thead>
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<tr>
<td>• <a href="#">Care Certificate</a> (highly recommended) to include, or have as an addition, training for working alone in community settings and specific skills needed for the role</td>
<td>• Works under direct or indirect supervision in a structured context.</td>
</tr>
<tr>
<td>• Hold or working towards <a href="#">level 2 QCF Diploma/Apprenticeship</a> in Clinical Healthcare Support or equivalent</td>
<td>• Demonstrates self-directed development and practice.</td>
</tr>
<tr>
<td>• <a href="#">Maths</a> and <a href="#">English</a> functional skills qualification</td>
<td>• Presents themselves in a credible and competent manner.</td>
</tr>
<tr>
<td></td>
<td>• Works to agreed protocols and procedures in stable, structured work areas.</td>
</tr>
<tr>
<td></td>
<td>• Solves routine problems using simple rules and tools, escalates when necessary.</td>
</tr>
<tr>
<td></td>
<td>• Makes judgements involving straightforward work-related facts or situations.</td>
</tr>
</tbody>
</table>
- Has responsibility for care of equipment and resources used by themselves or others.
- Supports change management.
- Contributes to the effectiveness of teams.

<table>
<thead>
<tr>
<th>Qualifications</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2 brief intervention training (see <a href="#">NICE guidelines</a>)</td>
<td>Underpinning knowledge of key interventions and conditions cared for in general practice settings.</td>
</tr>
<tr>
<td>QCF level 3 diploma/Apprenticeship in Clinical Healthcare Support or the equivalent</td>
<td>Recognise factors that impact on health and be able to offer simple health advice and support strategies for patients and carers.</td>
</tr>
<tr>
<td></td>
<td>Must understand the concepts of accountability and responsibility and be confident to accept delegation, ensuring they have undergone the necessary preparatory training.</td>
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<tr>
<td></td>
<td>Will be expected to understand basic reflective techniques to enhance their self-awareness and to develop resilience when facing adverse situations. They must be able to report back on any difficult situations encountered to enable support and guided learning to be offered.</td>
</tr>
<tr>
<td></td>
<td>Will offer a range of care to patients in a variety of community and general practice settings. e.g.</td>
</tr>
<tr>
<td></td>
<td>simple dressings</td>
</tr>
<tr>
<td></td>
<td>Preparing patients for complex dressings</td>
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<tr>
<td></td>
<td>Administering eye drops,</td>
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<tr>
<td></td>
<td>Undertaking new patient checks in general practice.</td>
</tr>
<tr>
<td></td>
<td>Must understand the principles of team working and actively contribute to the team.</td>
</tr>
<tr>
<td></td>
<td>Will follow the care plan, undertaking defined clinical procedures or therapeutic interventions, recording care given appropriately and reporting back progress or deterioration to the registered practitioner.</td>
</tr>
<tr>
<td></td>
<td>Will exercise a degree of autonomy as they are working alone whilst recognising the limits of their competence.</td>
</tr>
<tr>
<td></td>
<td>Must have an understanding of the concept of risk and be aware of how risk is assessed and managed and ensure any change in</td>
</tr>
</tbody>
</table>
risk status is reported promptly according to agreed policies and protocols.

- Must be skilled in communicating with patients and carers, acting as advocates when necessary and recognising how to support brief intervention behaviour change and self-management for patients or refer on if this is beyond their competence.
- Must role model the values identified in Compassion in Practice, and evaluation of care should identify positive experiences of care from patients, families and carers.
- Within their delegated workload they will be able to prioritise, plan and organise their work.
- Where appropriate they must participate in the support and teaching of students, new members of staff and other HCAs.
- Must have knowledge of a broad range of resources available in the community along with an understanding of the other agencies and professionals that support patients at home to ensure that these services are accessed and utilised appropriately.
- Are able to work effectively in a team that may include disciplines other than nursing and participate in team development, design and development of service improvements and a range of quality assurance activities, including involvement with audits.

**Nursing Associate/Associate Practitioner – Skills for Health level 4**

Staff in the [NA or AP role](#) work under the supervision of a registered healthcare practitioner but have received a level of educational preparation to enable them to take responsibility for delegated activity including defined clinical or therapeutic interventions. Nursing Associates will have completed an accredited programme that will allow them entry onto the NMC register. Their work is guided by standard operating procedures, protocols or systems of work but within this the worker will be expected to work alone in a variety of community and general practice settings and make decisions whilst reporting back objectively to assist in patient care evaluation and in broader service development and quality assurance activities. Depending on the skill mix of the team they may allocate work to
other HCAs of a lower grade and may supervise, develop, teach, mentor and assess other HCAs and may take a role in supporting students experiencing community placements and the roles within the nursing teams.

| Level 4 Nursing Associate/Associate Practitioner – in addition to level 2 and 3 skills |
| Qualifications                                                                 | Skills                                                                                                                                                                                                 |
| • Nursing Associates must hold an NMC approved QCF level 5 Foundation degree  | • Have underpinning knowledge of basic anatomy and physiology, key conditions cared for in community and general practice settings, organisational structures and resources available across health, social and third sector organisations. They must be able to recognise factors that impact on health and be able to offer health advice and support strategies for patients and carers. |
| • Associate Practitioners may hold or working towards Foundation degree at level 5 or QCF level 5 diploma | • Must understand the concepts of accountability and responsibility and be confident to accept delegated responsibility from a registered practitioner and be accountable for the care provided, ensuring they have undergone the necessary preparatory training. |
|                                                                                                                                                                        | • Will be expected to use reflection to enhance their self-awareness and to develop resilience when facing adverse situations. |
|                                                                                                                                                                        | • They must recognise the personal impact on them of any difficult situations and have strategies to enable personal learning and development, recognising the limits of their competence and personal strengths. |
|                                                                                                                                                                        | • Level 4 staff will offer a range of care to patients in a variety of community and surgery settings. Examples may include phlebotomy, non-complex wound dressings, supporting and developing staff in residential homes to enhance basic care of patients, supporting patients in lifestyle and behaviour changes to meet agreed care plans, teaching patients to administer eye drops, and supporting the development of level 3 HCAs. |
|                                                                                                                                                                        | • Will follow the care plan, undertaking defined clinical procedures or therapeutic interventions, recording care given appropriately and reporting back progress or deterioration to the registered practitioner. |
• Must have an understanding of the concept of risk and be aware of how risk is assessed and managed within patients’ homes and other settings and ensure any change in risk status is reported promptly according to agreed policies and protocols.
• Must be skilled in communicating with patients and carers, acting as advocates when necessary and recognising how to use and support level 2 brief intervention behaviour change and self-management for patients.
• Must role model the values identified in Compassion in Practice (NHSE 2014) and evaluation of care should identify positive experiences of care from patients, families and carers.
• Within their delegated workload they will be able to prioritise, plan and organise their work.
• Will be able to assess patients’ and carers’ learning needs and implement or support the implementation of teaching strategies to enable better understanding and management of their conditions for patients and carers and utilise basic behaviour change techniques.
• Where appropriate, they must participate in the support and experience of students, new members of staff and other HCAs.
• Must have knowledge of a broad range of resources available in the community along with an understanding of the other agencies and professionals that support patients at home to ensure that these services are accessed and utilised appropriately.
• Be able to work effectively in a team that may include disciplines other than nursing and participate in team development, design and development of service improvements, and a range of quality assurance activities, including involvement with audits.
• Will exercise a degree of autonomy as they are working alone whilst recognising the limits of their competence.
Registered Nurse (newly qualified or new to primary care) – Skills for health level 5

For staff new to practice nursing; within the first 12 months of post there is an opportunity to access a foundation course delivered through local universities. This course provides an introduction to all aspects of General Practice and will provide all students with a solid foundation to work in general practice.

The NMC strongly recommends that all “new registrants” have a period of preceptorship on commencing employment, this applies to those newly admitted to the NMC Register who have completed a pre-registration programme in the UK for the first time, or have subsequently entered a new part of the register. New registrants also include those newly admitted to the register from other European Economic Area States and other nation states.

The role of the “preceptor” is to:
- Facilitate and support the transition of a new registrant.
- Facilitate the application of new knowledge and skills.
- Raise awareness of the standards and competencies that the new registrant is required to achieve and support to achieve these.
- To providing constructive feedback on performance.

A good preceptor will be someone who will support the consolidation of knowledge and skills, be a listening ear and be positive in their approach to ensure that there is a low attrition rate.

<table>
<thead>
<tr>
<th>Level 5 Registered Nurse Foundation Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application of health policy, law and ethics in the community – to include Care Quality Commission (CQC) regulations and outcomes</td>
</tr>
<tr>
<td>Enhanced Communication</td>
</tr>
<tr>
<td>Care planning, working in partnership with patients and their families</td>
</tr>
<tr>
<td>Principles of managing long term conditions and co-morbidities</td>
</tr>
<tr>
<td>Assessing patients in home care settings and Interagency working</td>
</tr>
<tr>
<td>Recognising and managing the deteriorating patient</td>
</tr>
</tbody>
</table>

• Dementia care
• Health promotion and MECC ‘Making Every Contact Count’ - principles of motivational Interviewing
• Introduction to caring for patients in the community with long term conditions and co-morbidities, such as – COPD, cardiovascular disease, Mental Health illness, Diabetes, hypertension
• Caring for patients in the community at the end of their life i.e., palliative care and/or with a terminal illness
• Introduction to Minor Illness

### Fundamentals of General Practice Nursing

<table>
<thead>
<tr>
<th>Programme</th>
<th>Length of study</th>
<th>Core components</th>
<th>Delivery and assessment</th>
</tr>
</thead>
</table>
| Introductory foundation programme **Fundamentals of General Practice Nursing:** | Flexible. To be determined by the needs of the practitioner and their employer – depending on their previous experience and level of competency against these elements | This should include:  
• Organisational structures and funding for primary and community care services.  
• Accountability and responsibility in the context of lone working and decision-making.  
• Electronic record keeping and IT applications used in these settings.  
• Developing partnership with patients and families and negotiation skills and supporting self-care  
• Recognising and managing risk in these settings.  
• Transferring skills to these settings  
• Inter-professional and interagency collaboration  
• Principles of managing long term conditions. | Work based learning  
Emphasis on work based learning  
Workbooks / electronic portfolios maybe considered to demonstrate progressive learning and reflective practice  
**Mentorship**  
Assigned mentor / assessor in practice required. The mentor will be required to work with the learner to teach and assess their competence.  
Assessment of competency This will be decided locally but most practical aspects will be assessed in practice |

The following resource is very useful to staff new to Practice Nursing.

Resource: **Transition to General Practice Nursing: QNI (2015)**

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• Holistic assessment in patient’s homes and surgery settings using a range of assessment tools
• Recognition of multiple pathology, depression, anxiety and frailty and referral systems.
• Principles of anticipatory care and identification and management of deteriorating patients.
• Immunisation

In addition nurses and working in General Practice are likely to need the following skills:
• Cervical sampling
• Information on the Quality Outcomes Framework
• Basic contraception and sexual health advice
• Childhood immunisation programme and travel health

Registered Nurse having completed introductory foundation programme– Skills for health level 5

Registered nurses entering primary and community care settings may come with a plethora of prior knowledge and skills. Some may come straight from qualifying whereas others may come from hospitals and other settings with varying experience and competencies in many fields of practice, potentially bringing highly transferable skills to the new setting. Whilst it is acknowledged that nursing in primary and community care requires skills not required in the hospital, given those entering this role will be at different levels of knowledge and competence, it is important to create a flexible pathway of learning to enable those new to primary and community care to focus on areas of need within the first year. Those entering the workplaces that are newly qualified can create with their employer and the education provider a structured pathway of learning mapped to suit the individual and practice needs.
Advanced assessment modules should prepare health professionals to undertake a competent and comprehensive health assessment of a patient. This includes development of the ability to take an in-depth history, conduct an appropriate physical examination and use clinical reasoning skills to formulate appropriate differential diagnoses. This should include comprehensive history taking, clinical problem solving (theory and practice), physical examination of the ENT, eye, lymphatic, respiratory, peripheral vascular, and cardiac, abdominal, musculoskeletal and neurological systems with an emphasis on clinical indications that warrant further assessment and/or appropriate onward referral. The module should also include mental health assessment in recognition of the importance of a holistic approach. Assessment strategy should include Objective Structured Clinical Examination and ideally practice based learning activities with a mentor qualified at this level.

### Level 5 Registered Nurse Post foundation year
- Quality Outcomes Framework (QOF) and service redesign
- Mentor preparation
- Appraisal of others
- Pharmacology and Medicines management
- Audit, review, research
- Leadership and management
- Palliative care and symptom control

### Registered Nurse: General Practice Nurse– Skills for health level 6

In addition to the level 5 requirements this role requires consolidation of specialist knowledge and skills in general practice nursing demonstrating a depth of knowledge, understanding and competence that supports evidenced informed, complex, autonomous and independent decision-making, and care in general practice and related settings. Those new to this role will need a period of preceptorship. This role will require personal resilience, management, clinical leadership and supervision and mentorship of others in the general practice nursing team and providing an effective learning environment for staff and students in the wider team. The role will require an innovative approach in supporting and developing new models and strategies for service delivery, usually
incorporating inter-professional and inter-agency approaches to monitor and improve care. GPN deliver care to the practice population, but also need to have an understanding of the public health profile and population needs in order to be proactive in ensuring services are, as far as possible, matched to need. This role requires the ability to work independently and collaboratively, using freedom to exercise judgement about actions while accepting professional accountability and responsibility.

<table>
<thead>
<tr>
<th>Level 6 General Practice Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Qualifications</strong></td>
</tr>
<tr>
<td>Registered on Part 1 NMC register</td>
</tr>
<tr>
<td>NMC Specialist Community Practitioner Qualification – Practice Nurse.</td>
</tr>
<tr>
<td>Mentorship qualification/preparation</td>
</tr>
<tr>
<td>Educated to degree level or have equivalent experience</td>
</tr>
<tr>
<td>Successful completion of post registration accredited foundation course in general practice nursing at level 6 or 7 and able to meet RCGP Practice Nurse competencies - courses should be at a minimum of degree level (level 6) but by 2020 all courses to be at postgraduate level (level 7). To include extended brief interventions level 3 (see NICE guidelines for descriptors of behaviour change interventions).</td>
</tr>
</tbody>
</table>

May work towards:
- Postgraduate level qualification
- Independent/Supplementary Nursing Prescribing – V300
- NMC practice teacher award
- RCGP Practice Nurse competencies
needs across the whole age range for the general practice population.

- **This requires:**
  - Ability to assess and manage the range of conditions encountered in general practice using a variety of assessment tools and consultation models appropriate to the patient and situation using physical and clinical examination skills to inform the assessment and decision-making for the ongoing management of the patient.
  - Advanced communication skills that include skills of influencing and negotiation to enable information to be delivered in understandable formats for patients and behaviour change supported where necessary.
  - Effective multidisciplinary and multi-agency team working, alongside the ability to work independently and accept professional accountability and responsibility for the delivery of whole episodes of care, and supporting and developing others in the general practice nursing team to collaborate effectively, ensuring nursing care is guided by precedent and clearly defined policies, procedures and protocols.
  - Delivery and co-ordination of evidence-informed, person-centred and negotiated care across the age spectrum.
  - Use of technology to support independence and patient self-care at home to improve self-care and reduce exacerbations
  - Role modelling and embodiment of non-judgemental, value-based care encompassing the 6 Cs in practice and expectation and promotion of these values in other team members.
  - Competence in delivering evidence-informed care across a wide range of minor acute and LTC, ensuring effective evaluation of therapeutic and other approaches to condition management alongside ability to assess patient concordance.
  - Actively contributing to a variety of professional networks and sharing learning from these.
  - Development of effective team systems for ongoing supervision and promotion of clinical reflection for all staff, preceptorship programmes and mentorship.
• Identify and support the learning needs of individuals or the team in response to personal development needs identified at appraisal or service need.
• Evaluate the impact of educational interventions.
• Where appropriate, participate in teaching and student selection in higher education institutions and/or other education organisations.
• Develop a positive learning environment for students and the staff team, giving and receiving feedback in an open, honest and constructive manner.
• Leads a mixed-skill team effectively.
• This requires:
  • Clinical leadership of the team, recognising the stressors encountered in general practice nursing and developing systems to ensure team members continue to build resilience.
  • Work effectively across professional and agency boundaries, actively involving and respecting others' contributions.
  • Role modelling of the values expected in Compassion in Practice (2014) and the values and behaviours of effective leaders.
  • Enhanced and advanced general practice nursing clinical expertise to guide the nursing team in the management of patients with complex needs.
  • Ability to manage the workload effectively and develop business cases where appropriate in response to changing demands.
  • Display an innovative approach to practice, encouraging other team members and, where possible, patients and service users, to contribute and, where appropriate, instigate and evaluate a managed change process.
  • Ensuring the team is risk aware when working with patients, and health and safety aware within the surgery. Develop regularly reviewed systems to ensure risk is managed safely and effectively. Develop a learning culture within the immediate team to improve patient safety and ensure staff are supported and can learn from and in future prevent untoward incidents.
• Awareness and application of appropriate legislation that informs nursing and healthcare delivery.
• Ability to work independently but also to co-ordinate, delegate and supervise team members for a designated group of patients.
• Undertaking performance management when appropriate. Management of the nursing team within ethical and policy frameworks and knowledge and application of human resource law to enable effective staff management.
• Ensuring care and service delivery meets quality requirements but be actively involved in quality improvement strategies and service development innovations.
• Ability to demonstrate political awareness and translate policy into practice, demonstrating knowledge and awareness of healthcare commissioning and contracting mechanisms and systems, awareness of health and social policy contexts and local variations, and be skilled in developing effective external relationships with a variety of health, social and third sector agencies, recognising the importance of working within a governance framework.
• Where appropriate take delegated responsibility for the management of a budget that may include the purchasing of assets, equipment or other resources and staff costs.
• Where appropriate participate in clinical trials and research projects.
• Ensure active management of the workload, taking into consideration public health priorities and local community health needs and changing demographics.
• Participate in public health strategies where these are aligned to the practice population and work collaboratively with others to undertake risk stratification, case management and other strategies developed to improve health or avoid hospitalisation.
• Demonstrates underpinning knowledge of contemporary general practice nursing and the application and integration of research and other evidence into practice.
• This requires:
• Ability to access databases and other information sources and critically appraise information.
• Contribution to the development of local guidelines and policy locally and regionally, and nationally where appropriate.
• Participation in research-related activity such as audit, data gathering and patient feedback.
• Sharing of information and practice development through a range of means including writing for publication.

<table>
<thead>
<tr>
<th>NMC Specialist Practitioner Qualification</th>
<th>Length of study</th>
<th>Key components that may be included in curricula</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Programme</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NMC Specialist Practitioner Qualification – General Practice Nursing, degree or post graduate diploma award.</td>
<td>Normally one year full time. 2-4 years part time.</td>
<td>PN SPQ courses should meet the QNI standards in addition to NMC approval. Nurses at this level will be expected to have an excellent body of clinical expertise so the focus of courses will be on: Advanced assessment and complex decision making Advanced communication skills Extended brief interventions level 3. Adaptability in unpredictable environments Utilising technology to support patient care Partnership working with patients with complex and palliative and terminal conditions. Developing positive learning environments Enhanced leadership and management skills (see HEE framework for requirements) Participation in public health strategies Service development and improvement</td>
</tr>
</tbody>
</table>

The nurse would require 120 level 5 credits to access this programme.

Students also require as a minimum a sign off mentor that supports through the course of the programme in order meet NMC requirements but preferably a Practice Teacher.
Participation in research related activity – audit, data gathering, and patient feedback. Leading on quality assurance activities

NB. V300 prescribing programme http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-proficiency-nurse-and-midwife-prescribers.pdf Provider services have to ensure that students are supported by Designated Medical Practitioners (DMP) and that the 78 hours in clinical practice with the DMP is supported. All students enrolling on a V300 Independent prescribing programme will need to have completed an advanced assessment course or its equivalent.

Senior General Practice Nurse – Skills for health level 7

In addition to level 6, key responsibilities of staff at level 7 are to consolidate skills of critical analysis and evaluation to enable knowledge pertaining to complex, contemporary general practice nursing practice to be critiqued. Level 7 staff must be able to use new knowledge in innovative ways and take responsibility for developing and changing practice in complex and sometimes unpredictable environments. They must recognise the complexity of operating in multi-professional and multi-agency environments and the need for interdependent decision-making and support staff to feel confident and competent in delivering care within these contexts. At this level the practitioner will be highly experienced in their field and either continue to develop this expertise for managing complex cases or supporting less experienced staff, or may have more management responsibilities for the general practice team whilst retaining a clinical component to their role. They will be expected to provide training, support and supervision to staff and to participate at local and national levels in relation to general practice nursing.

<table>
<thead>
<tr>
<th>Level 7 Senior General Practice Nurse</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifications</td>
<td>Skills</td>
</tr>
<tr>
<td>- Registered on Part 1 of NMC Register</td>
<td>- Able to undertake complex general practice nursing interventions for a wide range of general practice issues and teach and develop other staff to enhance their practice to manage future situations.</td>
</tr>
<tr>
<td>- First degree and working towards a Postgraduate qualification</td>
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</tr>
<tr>
<td>- Independent/ Supplementary Nursing Prescribing – V300</td>
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</tr>
</tbody>
</table>
- Mentorship qualification/preparation
- May work towards:  
  [Specialist Practice course](#)
  [Master’s Level Award including level 4 high intensity interventions](#)
  (see  [NICE guidelines for descriptors of behaviour change interventions](#)).

This will entail being able to demonstrate not only practical knowledge but also a critical understanding of the range of theories and principles that underpin the general practice nursing approach.

- Assess capacity for informed consent and support other staff to develop this skill.
- Highly developed specialist knowledge and understanding of LTC, health behaviours, minor illness and interventions to improve health outcomes, including the use of technologies to support patients at home.
- Advanced knowledge and skills in therapeutics to prescribe effective pharmacological and non-pharmacological approaches for the management of specific acute and LTC and assess patient concordance.
- Is able to respectfully challenge practice, systems and policies in an objective and constructive manner.
- Participate in opportunities to influence national and local policy.
- Is able to develop, deliver and evaluate training and education packages, for individual and groups, across a broad range of general practice nursing needs and in collaboration with other disciplines and agencies to facilitate interprofessional/agency learning.
- Build capacity and capability to support learning in practice settings and collaborate with education service providers and education commissioners to ensure workforce and student needs are met.
- Able to display originality of thought and utilise this in innovative service development and delivery and safe implementation of new policies and guidelines for practice.
- Demonstrate problem-solving skills underpinned from perspectives, for example in research processes, service and quality improvement techniques, educational theory, or leadership and management theory.
- Design, plan, implement and evaluate learning and development programmes.
• Focus on the improvement of patient safety by developing systems to disseminate learning from incidents and follow up to ensure best practice is embedded in delivery of care.
• Act as an experienced work-based learning educator/assessor by providing advice and support to other practitioners and build capability and capacity to support learning in practice settings.
• The size of the team being led will depend on local practice needs; however, the leadership and management requirements of this role over that of level 6 are:
• Able to assimilate information from a range of sources and ensure complex decisions reflect the analysis of these different perspectives even when limited information is available.
• Is able to participate in strategy development, presenting a positive role model for general practice nursing, and ensuring this translates into practice development to improve the quality of care.
• Able to apply the theoretical perspectives of change management to create an environment for successful change and practice development and utilise conflict management and resolution strategies where appropriate.
• Demonstrate an evaluative and outcomes-based approach to practice and develop strategies to share this with a wider audience.
• Is able to appreciate the broadest context of clinical governance and initiate and support others, including service users, to be involved in a range of quality assurance and monitoring activities. Ensure that quality and audit cycles are completed and results and learning are fed back into practice.
• Develop processes for monitoring clinical effectiveness and efficiency to enhance management of resources.
• Where required undertake significant event auditing (or equivalent) and be skilled in undertaking objective investigations and in writing objective reports following the completion of the investigation and in presenting this information orally if required.
• Able to work effectively with a wide range of professionals and agencies and participate in multi-professional/agency strategies.
- Oversee the appraisal process for the nursing team, ensuring organisational objectives are reflected in personal and team objectives.
- Develop at least one special area of expertise to be seen as a local expert and role model able to articulate the most contemporary evidence, approaches to practice and management.
- Identify and utilise skills and knowledge of staff to support or undertake research-related activity such as audit, valuation and wider research for the benefit of the organisation.
- Monitor impact of evidence utilisation.

<table>
<thead>
<tr>
<th>Programme</th>
<th>Length of study</th>
<th>Key components that may be included in curricula</th>
</tr>
</thead>
<tbody>
<tr>
<td>All programmes should be at academic level 7 leading to a Master’s award</td>
<td>Flexible</td>
<td>Staff at this level will be highly experienced clinicians therefore it is unlikely that a generic programme will meet their needs. Key components are likely to be: Clinical supervision Coaching Level 4 high intensity interventions for behaviour change Independent/Supplementary Nurse Prescribing V300 (if not already attained) Post Graduate practice educator qualification (PGCert) Advanced leadership and management Undertaking investigations and report writing.</td>
</tr>
</tbody>
</table>
Advanced Nurse Practitioner/Clinical Academic – Skills for health level 8

ANP

In addition to level 7 this level 8 role will have achieved and consolidated ANP status, demonstrating highly specialised knowledge in general practice nursing. The role may differ between organisations but is likely to entail key responsibilities with respect to research, advanced nursing practice, service development and improvement, and education. They will be expected to be at the forefront of developments in their field, usually undertaking original research or having responsibility for co-ordination and delivery of Research and Development in their organisation and the implementation of research and evidence into practice. As an ANP they will continue to have clinical patient contact and may specialise in one area of practice but may use this in a consultancy capacity.

### Level 8 Advanced Nurse Practitioner

- Registered on Part 1 NMC register
- NMC Specialist Community Practitioner Qualification
- Meet RCGP/RCN ANP competencies
- Postgraduate diploma to include level 8 high-intensity interventions (see NICE guidelines for descriptors of behaviour change interventions)
- Mentorship training
- Master’s degree/post-graduate diploma in Advanced Clinical Practice
- Independent/ Supplementary Nursing Prescribing – V300
- May go on to work towards:
  - Professional Doctorate (Clinical practice)
  - PhD (Research)
  - Educational Doctorate (Education).

- Able to work clinically acting in a consultancy capacity for complex general practice nursing interventions. This may be in a broad range of general practice nursing interventions or the level 8 staff may have specialised in a key area of general practice nursing and teach and develop other staff to enhance their practice to manage future situations. This will entail being able to demonstrate not only practical knowledge but also a critical understanding of the range of theories and principles that underpin the approach in general practice and the ability to assess patients presenting with undifferentiated, undiagnosed presentations and use advanced assessment, diagnostic reasoning skills and a range of other diagnostic support tools to manage, treat or refer these patients.
- Is able to respectfully challenge practice, systems and policies in an objective and constructive manner.
- Proactively develops opportunities to influence national and local policy and strategy.
- Is able to develop, deliver and evaluate training and education packages, for individuals and groups, across a broad range of community nursing needs and in collaboration with other disciplines and agencies to facilitate inter-professional/agency learning.
| Build capacity and capability to support learning in practice settings and collaborate with education service providers and education commissioners to ensure workforce and student needs are met. |
| Able to display originality of thought and utilise this in innovative service development and delivery and safe implementation of new policies and guidelines for practice. |
| Demonstrate problem-solving skills underpinned from perspectives, for example in research processes, service and quality improvement techniques, educational theory or leadership and management theory. |
| Collaborate proactively with public health agencies and local authorities to ensure general practice nursing is actively engaged in the health improvement strategies for the local community. |
| The management role of a level 8 practitioner will vary according to the employer expectations of the role: |
| Able to assimilate information from a range of sources and ensure complex decisions reflect the analysis of these different perspectives even when limited information is available. |
| Lead the development of strategy and ensures collaborative working with others to translate this into practice development to improve the quality of care. |
| Represent general practice nursing at local, regional and national political, strategic or policy events. |
| Able to apply the theoretical perspectives of change management to create an environment for successful change and practice development. |
| Demonstrate an evaluative and outcomes-based approach to practice and develop strategies to share this with a wider audience. |
| Able to lead on key aspects of quality assurance to develop robust outcome indicators for general practice nursing and other aspects of clinical governance. |
| Ensure others in general practice nursing recognise the importance of data collection and quality assurance and ensure |
that findings and other results are disseminated in meaningful ways to staff.

- Where required undertake significant event auditing (or equivalent) and be skilled in undertaking objective investigations and in writing objective reports following the completion of the investigation.
- Able to work effectively with a wide range of professionals and agencies and participate in multi-professional/agency strategies.
- Develop at least one special area of expertise to be seen as a local expert able to articulate the most contemporary evidence, approaches to practice and management.
- Involvement with review and monitoring of clinical policies to ensure they are based on contemporary evidence.
- Involvement in clinical policy and research communities to identify deficits in evidence and identification of potential funding sources for practice or research development.

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<tr>
<th>Programme</th>
<th>Length of study</th>
<th>Key components that may be included in curricula</th>
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| All programmes will be at least academic level 7 | 3 years part time | Typical modules include:  
- Health Assessment for Advanced Clinical Practice  
- Clinical reasoning for Advanced Clinical Practice  
- Leadership and Governance for Advanced Clinical Practice  
- Advanced pharmacology for non-medical prescribers  
- Advanced perspectives for non-medical prescribing practice  
- Advanced Inquiry for Nurses, Midwives and Allied Health Professionals  
- Evidence Based Practice Project |

The course philosophy is to acknowledge prior experience and knowledge as a health professional and subsequently enable the nurse to fulfil potential through the development of new understanding, critical insight and advanced level academic and clinical skills.

This programme will develop the nurse's knowledge and skills to work at an advanced level of clinical practice.

It is expected that on completion of this course the nurse will be a recognised Advanced
Clinical Practitioner with an expert knowledge base, complex decision-making skills and clinical competencies for expanded autonomous scope of practice, the characteristics of which are shaped by the context in which the individual practices.

Clinical Academic
Clinical Academics (CAs) are clinically active health researchers, undertaking academic roles whilst also providing clinical expertise within health and social care settings. The research questions formulated by CAs are informed by clinical experience and the reality of patient care. As active researchers in fields of relevance to their own practice, and working alongside their clinical colleagues, CAs are also in a strong position to critically appraise and utilise research findings in the development of evidence based clinical practice and patient care. As such, CAs are uniquely placed to make invaluable contributions to the development of optimum care and services for patients and the public.

Clinical research provides evidence to inform clinical decisions, which is vital for ensuring the best possible care for patients. Funded training to gain recognised qualifications, such as a Master’s degree or a PhD, is available from research councils, NHS, charitable and private organisations. It can be an academically stimulating career choice, including the opportunity to present at conferences and write articles for academic journals. Clinicians can make a real difference to patient care. There are opportunities in a variety of settings, including clinical positions with patients, as well as working in a research laboratory.
**Level 8 Clinical Academic**

Will work towards many if not all of the ANP skills, although they may have chosen a research or teaching route to this level rather than an advanced practice route

- Practice Educator award if role focused in education
- Professional Doctorate (Clinical practice)
- PhD (Research)
- Educational Doctorate (Education).

- Lead on the development and implementation of research projects related to general practice nursing and build effective working relationships between practice and higher education institutions.
- Contribute to the development of implementation of research and development strategies and applications for funding.
- Collaborate with local research partners and universities to understand new projects, developments and findings and ensure frameworks for research governance are applied appropriately.
- Where appropriate undertake research as a principal investigator.
- Support the development of staff in research and practice development activities.
- Present research findings in peer reviewed journals, at conferences and at other dissemination events or via electronic mechanisms.

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| All programmes will be at least academic level 7 and may be at academic level 8 leading to a doctorate level award | 3-7 years part time depending on level of study | Typical modules include:
  - Health Assessment for Advanced Clinical Practice
  - Clinical reasoning for Advanced Clinical Practice
  - Leadership and Governance for Advanced Clinical Practice
  - Advanced pharmacology for non-medical prescribers
  - Advanced perspectives for non-medical prescribing practice
  - Advanced Inquiry for Nurses, Midwives and Allied Health Professionals
  - Evidence Based Practice Project

This programme will develop the nurse's knowledge and skills to work at an advanced level of clinical practice.

Alternative qualifications may be...
It is expected that on completion of this course the nurse will be a recognised Advanced Clinical Practitioner with an expert knowledge base, complex decision-making skills and clinical competencies for expanded autonomous scope of practice, the characteristics of which are shaped by the context in which the individual practices.

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<th>Masters by Research</th>
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<td>PhD</td>
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<td>Professional or clinical doctorate</td>
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<tr>
<td>Doctor of Education</td>
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<tr>
<td>Post-doctoral qualifications e.g. DSc; DNursing</td>
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Where the Local office of HEE is funding the education a formal agreement between the LETB, employer, HEI and/or student is useful in identifying how the research or practice development will inform services with agreement of expected outcomes to support service transformation and improve patient outcomes.

Future Nurse Infographics

The Future Nurse Infographic has been developed by NHS Employers to illustrate routes into nursing.
## Qualifications and Credit Framework (QCF)

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**DUDLEY CLINICAL COMMISSIONING GROUP**  
**PRIMARY CARE COMMISSIONING COMMITTEE**

**Date of Report:** 26 July 2019  
**Report:** Black Country and West Birmingham Sustainability and Transformation Partnership (STP) Primary Care Strategy  
**Agenda item:** 10.0

<table>
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<th>TITLE OF REPORT:</th>
<th>Black Country and West Birmingham Sustainability and Transformation Partnership (STP) Primary Care Strategy</th>
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<tr>
<td>PURPOSE OF REPORT:</td>
<td>To share the final draft STP Primary Care Strategy for approval of the Committee</td>
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<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr D King, Head of Membership Development and Primary Care</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mrs. C Brunt, Chief Nurse</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr. T Horsburgh, Clinical Executive for Primary Care</td>
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**KEY POINTS:**
- NHS Long Term Plan required the STP to produce a Primary Care Strategy that articulates the vision and key priorities for the STP by 30th June 2019
- The STP GPFW Programme Director for Primary Care has co-ordinated and produced the Strategy supported by the Primary Care teams in each of the CCGs
- The Strategy reflects the existing plan and Strategies for each CCG within the STP
- The STP Strategy has been informed by a number of engagement events with the public that have been undertaken in each place
- The STP Strategy has reflects the significant engagement already undertaken in Dudley as part of the consultation into the development of the MCP
- The STP Strategy therefore reflects all they key issues and factors that people felt were most important – access, continuity and co-ordination for primary care services.
- The STP Strategy has been submitted in draft to NHS England who have approved it.
- The CCG Governing Body has the responsibility for approving the Strategy based on the recommendation of the Committee

**RECOMMENDATION:**
- The Committee is asked to
  - Recommend that the Governing Body approve the STP Primary Care Strategy
  - Note that there will be continuing engagement with the public through the CCG existing forums to discuss the implementation of the Strategy.

**FINANCIAL IMPLICATIONS:**
- Not applicable

**WHAT ENGAGEMENT HAS TAKEN PLACE:**
- Formal consultation on the development of the MCP
- Engagement events in each place (CCG) within the STP

**ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE**
None identified or registered.

**ACTION REQUIRED:**
Approval
1.0 BACKGROUND

1.1 The STP is required to produce a Primary Care Strategy that articulates the vision and key priorities for the STP. Two main component parts of this strategy must focus on Workforce and the development of Primary Care Networks across the footprint.

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

2.0 APPROACH

2.1 The Strategy has been produced based on plans developed within each place (CCG). The partners in the STP have agreed to work at an STP level on, specifically:-

- Governance (including financial reporting) and the development of a GPFV Programme Board
- Workforce and training hub future state – via a refreshed STP Workforce Strategy
- Digital – via a strong focus on on-line consultation and 111 inter-operability
- The development and support of Primary Care Networks
- Estates and Technology Transformation Fund (ETTF)

3.0 TIMESCALES

3.1 The timescale for producing the Strategy has been a challenge that has been met.

3.2 The STP as commissioned Arden and Gem Commissioning Support Unit (CSU) to produce the Strategy with input from members of the Primary Care team, and Communications and Engagement Team to ensure that the Strategy was submitted to NHSE by the 30th June deadline.

5.0 CONSULTATION AND ENGAGEMENT

5.1 Extensive engagement and consultation has taken place over the last few years to really understand patient and public perceptions and expectations around primary care services. This started with a formal consultation into the development of an MCP which demonstrated that access, continuity, co-ordination and communication were all key factors which people felt were most important. In addition there have been many discussions with patients and the public on the NHS Long Term Plan, The Five Year Forward View, The GP Five Year Forward View, extended hours, self-care, primary care hubs, workforce, population health, outcomes and much more.

5.2 The CCG has regular forums, such as the Patient Opportunity Panel, which are involved in strategic direction which includes reviewing the GP survey. The Primary Care Commissioning Committee has also reviewed the GP survey. The conversations continue to evolve through the implementation of the Strategy.
5.3 There have been several consultations over practice changes including branch closures, mergers and practice closures. These have all been highly emotive and contentious and have much public and wider stakeholder interest. This has highlighted that place based care and relationships hold resonance and importance to people. This has all helped us to build a really rich picture and narrative of what is important to Dudley people.

5.4 As we move forward with developing plans for primary care, we need to ensure that we continue to involve the public and wider stakeholders. This would be especially relevant to ensure that any proposed changes to primary care are discussed at an informative stage which is open to influence. This is particularly important when the CCG considers the estate strategy for primary care as this would be likely to generate high interest and concern. We need to ensure that any time frames allow for meaningful conversations to take place and views be taken into account and adhere to the Gunning principles.

6.0 RECOMMENDATION

6.1 The Committee is asked to

- Recommend that the Governing Body approve the STP Primary Care Strategy
- Note that there will be continuing engagement with the public through the CCG existing forums to discuss the implementation of the Strategy.
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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<td>Paul Aldridge</td>
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<td>26/6/2019</td>
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<td>Revised to incorporate NHSE feedback</td>
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<td>1.8</td>
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## Authorisation

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<tr>
<th>Date</th>
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<th>Position</th>
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<tr>
<td>June 2019</td>
<td>Sarah Southall</td>
<td>Programme Director – GPFV Black Country STP</td>
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1 Executive Summary

1.1 Executive Summary

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

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

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

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

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

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

However, there are significant challenges being faced by primary care provision and in particular general practice. We need to radically rethink primary care if we are to deliver sustainability beyond the current decade. This is due to the increase in workload with the uncertainty of future workforce and the need to manage increasing numbers of people with multiple and complex health needs.
Through innovation and creativity, our STP has begun to make progress against many of the challenges our primary care services face. This strategy describes our vision and illustrates how the STP will work together to support and enable primary care to; obtain the necessary skills, workforce and infrastructure to deliver an efficient, resilient and sustainable service for our population. Part of our vision is to commission integrated pathways of care that are firmly rooted in primary and community services.

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

2 National Context

2.1 National Context

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

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

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

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

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

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

‘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
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- 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

Our vision

Working together to improve the health, wellbeing and prosperity of our local population
3.2 What does success look like in 2024?

An integrated and proactive approach to Population Health Management

- Population segmentation is used regularly to identify the needs of the population and opportunities to invest in cost-effective preventive care.

- Health inequalities are mapped and reduced through specific services and engagements - the outcomes of these analyses are used to tailor services to the specific needs of the population.

- The STP is able to ensure that PCNs are able to identify, develop and invest in a range of preventive services to meet predicted future challenges in relation to the population’s health.

- Community activities/resources/assets are mapped and connected at PCN levels and regularly updated in a directory of support available to health and social care across the STP

- Community health and wellness initiatives are set up and delivered in collaboration with local communities

- PCNs are utilising community assets in each place to connect those most in need (lowest activation) with community resources.

- People with long term conditions are systematically identified and supported to take control of their own health and wellbeing.

Reduced Pressure on our Urgent Care Systems

- Risk stratification systems are used universally to proactively identify people who might benefit from anticipatory care to prevent exacerbations

- Once identified, those at-risk receive enhanced rapid response care provided by relevant disciplines in the MDT, including support from health, social care, voluntary and independent sector where appropriate

- Engagement and education programmes are in place. This includes outreach in schools and other community settings and care homes. Programmes are planned and delivered with community groups.

- The population is aware of the range of other options available for accessing urgent care and will understand how they can access these.

- There is functionally integrated service that incorporates NHS 111, primary care out of hours and ambulance care, minimising the number of hand offs.

- Processes are in place to minimise delays between NHS 111 receiving a call and a patient being assessed over the phone by an out of hours clinician

- Primary care out-of-hours (OOH) services have arrangements in place with NHS 111 to enable call-handlers to directly book appointments where appropriate.

- Shared systems allow NHS 111 and out of hours services to make appointments to in-hours general practice

- People may be referred to a range of services, including: support for self-care, referring to a specialist or dispatching an ambulance
Access to a person’s information is governed by appropriate information governance controls

All partners, including NHS 111, have access to update all special patient notes (SPNs) and advanced care plans (ACP), in 50% of calls to 111 or 999 that were transferred to a clinician, the patient had a Summary Care Record with consent to share.

Continuity of Care

People receive the same standard of care across the footprint, delivered according to the same care pathways.

People receive appropriate clinical services that include referral to primary care appointments, referring to specialists, referring to self-care services.

People can access non-urgent clinical services such as x-ray facilities, blood testing, ECGs etc. there are appropriately trained to staff to interpret testing and give advice as a result.

GP practices are working across practice boundaries with each other and with community service teams. This may include shared clinical governance, audit and improvement processes; shared professional development and HR; pooling of staff for resilience or improved access to expertise.

Primary care teams are using the 10 High Impact Actions to release time for care, and establish new ways of working, with a particular emphasis on technology enabled care and self-care.

Staff can access new opportunities to develop special interests, for example in a particular clinical speciality or skill, or in leadership, training and service improvement.

Shared working practices, processes and governance are in place, allowing for professionals to work as a single team in each PCN - even where they come from different settings originally.

A focus on responding to the small number of requests for an urgent home visit through a rapid assessment by a clinician, usually by phone to prioritise, with an opportunity to plan an alternative to a hospital admission.

A defined practice standard for the first time from first call/contact to initial assessment and referral. Performance is monitored against this standard.

A range of appointments for People to access same-day, including telephone consultations, e-consultations and walk in clinics, as well as face to face appointments. No patient is attending A&E because they cannot get an appointment with the GP.

Provide early morning appointments for children who have deteriorated during the night to avoid People attending A&E before visiting a GP.

Practices take part in the discharge planning of frail and vulnerable people to ensure easy transition and fast re-settlement of their patients back in the community.
• Practices have an operational model in place to ensure that continuity of care, particularly for the elderly and those with long term conditions or additional vulnerabilities, are cared for in a practical way.

• Personalised support and care for people with long-term physical and mental health conditions

• MDTs are operating in support of every PCN. The person is at the centre of their multi-disciplinary team and the person and carers are actively involved in decision making

• MDTs regularly review those persons that have been identified as being at the greatest risk of developing complex needs as well as those who already need high levels of support as well as a chance to offer support to team members. Clinical risk stratification in place to identify patients for MDT support

• MDTs have access to mechanisms that facilitate ongoing and unscheduled conversations remotely so that cases are discussed in real time and they can access support and advice in a timely and efficient manner. Consistent and effective procurement of mobile technology is in place to facilitate these discussions and there are clear reporting and clinical governance structures in place

• MDTs have access to shared electronic patient care records.

• All people with complex care needs have an integrated health and social care plan which anticipates their care needs and is accessible to all professionals working within the care model, including acute and urgent care providers and social care

• People and their carers co-produce and own the care plan with the MDT responsible for delivery against the care plan

• There is a structured, ongoing learning and development programme in place for the whole MDT in a shared environment / includes peer-to-peer learning

• There is a care coordinator (or similar) that is the link between the person and the core MDT that ensures continuous conversation / seamless transition of care

• MDTs covering health and social care use recognised business intelligent systems to systematically, proactively and regularly identify people for admission or discharge from case load

• Anticipatory care planning using business intelligent systems are in place across the STP to identify those most at risk from disease or deterioration. MDTs discuss care planning arrangements

• MDTs are involved in discharge planning before people are discharged - working with specialists and the person to co-design a care plan to support their transition into the community.

• Care Coordinator approach connects with social care / voluntary sector care to provide appropriate support on discharge from acute setting

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

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

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

3.4 STP Clinical Operating Model

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

The people in our Region have told us what matters to them most is continuity of care, delivered closer to home when they need it. They tell us that they don’t want to go to hospital unless it’s necessary and don’t want to keep repeating their story to a revolving door of professionals involved in their care be it GPs, Specialist Clinicians in acute settings, Community Health Professionals (such as District Nurses), Social Workers or other vital community based services.
The development of Primary Care Networks provides a structured and supported opportunity to make this a reality over the next 5 years – building on the foundations and learning from some great practice that have already been put in place across the our patch. Over the life of this Strategy our Primary Care Networks will:-

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

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

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

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

- Submitted agreements on form and function and early sight on what services will be provided by the networks (we achieved the 15th May 2019 submission deadline).

- Agreed staffing requirements e.g. clinical directors, practice pharmacists and social prescribers. Work is underway across each network to understand what other workforce models and configurations are needed in support of primary care (see the narrative throughout this strategy).

- Started conversations on identifying what’s included within each respective area’s Directed Enhanced Service (DES), contracts and made early steps on how the financial flows will work.

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

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

*Primary Care Network Delivery Milestones*
4.5 Primary Care Workforce Statistics

The current position of our primary care workforce is shown in the table below, along with the trajectory that has been agreed with NHSE for the year 2019/2020. 

*Source: General Practice Workforce Final 31 December 2018, Experimental Statistics, NHS Digital:*

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

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.

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

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.
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.

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

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

**STP Primary Care Funds**

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

5.1 Demographic Profile

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

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

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

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>England</th>
<th>West Midlands</th>
<th>Dudley</th>
<th>Sandwell</th>
<th>Walsall</th>
<th>Wolverhampton</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD: Recorded prevalence (all ages)</td>
<td>3.20%</td>
<td>3.40%</td>
<td>4.00%</td>
<td>3.50%</td>
<td>4.00%</td>
<td>3.50%</td>
</tr>
<tr>
<td>CKD: QOF prevalence (18+)</td>
<td>4.10%</td>
<td>4.60%</td>
<td>6.30%</td>
<td>4.60%</td>
<td>5.20%</td>
<td>4.40%</td>
</tr>
<tr>
<td>Diabetes: Recorded prevalence (aged 17+)</td>
<td>6.40%</td>
<td>7.30%</td>
<td>7.00%</td>
<td>8.60%</td>
<td>8.70%</td>
<td>8.10%</td>
</tr>
<tr>
<td>Hypertension: Recorded prevalence (all ages)</td>
<td>13.80%</td>
<td>14.80%</td>
<td>17.70%</td>
<td>15.50%</td>
<td>15.60%</td>
<td>15.20%</td>
</tr>
<tr>
<td>Number of adults with dementia known to GPs: % on register</td>
<td>0.74%</td>
<td>0.73%</td>
<td>0.76%</td>
<td>0.69%</td>
<td>0.77%</td>
<td>0.62%</td>
</tr>
<tr>
<td>Number of adults with depression known to GPs: % on register</td>
<td>7.30%</td>
<td>7.60%</td>
<td>8.60%</td>
<td>6.90%</td>
<td>7.80%</td>
<td>7.90%</td>
</tr>
<tr>
<td>Stroke: Recorded prevalence (all ages)</td>
<td>1.70%</td>
<td>1.80%</td>
<td>2.00%</td>
<td>1.70%</td>
<td>1.80%</td>
<td>1.80%</td>
</tr>
</tbody>
</table>

**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](image-url)
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:

<table>
<thead>
<tr>
<th>The population is growing</th>
<th>The population is becoming more diverse</th>
<th>More people are living alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>By 2031, ethnic populations will make up 15 per cent of the population in England and 37 per cent of the population in London</td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>After recent growth, the number of births each year is expected to level off</th>
<th>Life expectancy and healthy life expectancy are growing</th>
<th>The population is ageing</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>After a recent decline, the number of deaths each year is expected to grow</th>
<th>Health inequalities persist</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>The number of deaths each year is expected to grow by 13 per cent from 462,000 to 520,000 by 2032.</td>
<td>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.</td>
<td></td>
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</tbody>
</table>

*Kings Fund Population Growth Analysis, 2012*

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

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

Dashboard extract example of a PCN
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:

5.3 Primary Care Workforce

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

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

We are also in the process of working through our intentions for other roles such as primary care mental health nurse, nurse associates and paramedics.
The full timescales and rollout plans will be detailed in our STP nursing and workforce strategies however we envisage this to be from 2020 onwards. It’s fair to say that having a reshaped workforce, working across professional boundaries and ensuring staff are able to support delivery of high quality of care for our population is one of our highest priorities. Our Workforce Retention Plan 2019-20 with more information is included at Appendix 10

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

5.4 General Practitioners

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

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

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

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

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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:
In addition, we have also made a commitment to:

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

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

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

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

![Current GPN STP Demographic Profile](image)

Current GPN STP Demographic Profile

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

- There is significant variation in terms and conditions across the STP and a lack of transparency of career progression and opportunities. Most GPNs would favour standardised terms and conditions for the profession.
- There is not enough protected learning time to help support developing PCNs, peer support, sharing best practice, digesting key policy and to be actively involved in planning and leading transformation changes on the GPFV, Long-Term Plan and GPN 10-point action plan.
• There is not enough recognition of the role and functions performed from a health professional and public perspective.
• There needs to be more involvement of these staff groups in operational and strategic leadership within the STP and PCNs.
• There needs to be more time to invest in developing students and sharing their experiences, so they stay in the roles and area.
• There needs to be more time for front line care and clinical activity

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

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

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

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

• Continually develop their professional skill set and academic knowledge to enhance their own personal development and develop practice/PCN capability, efficiency and effectiveness.
• Develop pathways into direct patient care roles for those staff that want to do this, thus creating a primary care career pathway for these staff.
• Create and sustain supportive professional networks across the STP to share good practice, provide peer support and build key relationships that will enable PCNs to succeed.
• Support and encourage the learning and implementation of core business improvement techniques that enable continuous improvement to be introduced in the Practice and PCN environment.
• Continue to expand their roles to offer front line support to people to navigate/signpost to alternative and more appropriate care access points. The STP has well established models of active signposting and care navigation that have been implemented over the 18 months prior to the workforce strategy development. We are committed to expanding active signposting and care navigation services where there is opportunity identified by PCNs and support continuous improvement of the function.

• Share best practice and develop existing social prescribing models with PCNs. The STP has already-established models of social prescribing in place. These have a key function in many integrated locality-based MDTs. The STP will embrace the opportunity from the development of PCNs to increase the capacity of this function and implement in line with national guidance.

5.7 New Primary Care Roles

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

Social Prescribing Link Workers

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

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

Physician Associates

Physician Associates (PAs) work to the medical model in the diagnosis and management of conditions in general practice and hospital settings, under the supervision of medical practitioners (GPs, consultants). They can supplement and complement GPs and nursing staff and see a range of patients whose cases vary in complexity. This enables the GP to see more complex patients and frees up time for other tasks such as visiting or teaching. A PA can see both acute and chronic patients
and is able to undertake numerous tasks both clinical and managerial where appropriate. Studies from general practice in England and Scotland have shown PAs to be safe, effective and liked by patients.

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

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

Clinical Pharmacists

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

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

• Clinical pharmacists will take a central role in the clinical aspects of shared care protocols, clinical research with medicines, liaison with specialist pharmacists (including mental health and reduction of inappropriate antipsychotic use in people with learning difficulties), liaison with community pharmacists and anticoagulation.

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

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

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

The main activities we are undertaking to achieve this are:

• Producing plans outlining how the pharmacy workforce can be developed to support the NHS Long-Term Plan.

• Mapping out the current pharmacy workforce across the STP footprint to identify the gaps.

• Developing guidance and a support network for this new workforce to ensure they are deployed into the system with the right skills, knowledge and expertise.

• Align our plans to the workforce strategy, developing a framework and network to support the pharmacy workforce from undergraduate, post graduate, early career through to advanced career development. Adopt portfolio career pathways to support the pharmacy workforce. Look to sharing good practice and excellence from the local CCGs and trusts.

• Develop a pharmacy deanery approach to support the pharmacy workforce expanding. This is being driven through our workforce sub-group (and in collaboration with primary care teams).

Nursing Associates

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

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

As part of our plans to develop the PCN workforce the STP will work together to support recruitment to physiotherapy and community paramedic roles in line with national PCN guidance. As with all other roles being considered and introduced we will build on existing models within the current workforce and introduce these in PCNs and the wider system.
Mental Health
The overall strategy across the STP is to align Community Psychiatric Nurses (CPNs) to PCNs. These services will provide more specialist mental health support for those who require it but who do not need or are unable to access secondary care, or who have been discharged from secondary care because their mental health problem is stable. By working alongside networks mental health workers can ensure there is joined up physical and mental health support.

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

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

5.8 Development of an STP Training Academy

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

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

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

5.9 Monitoring Continuous Improvement

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

- Producing regular workforce dashboards by STP area as part of routine governance processes and reviews.
• Continuing to capture outcomes from schemes and initiatives e.g. case studies and working to continuously improve offers to the primary care workforce.

• Continuing to develop and work closely with PCNs and as an ICS to maximise workforce opportunities and blur the lines of primary and community care e.g. developing more portfolio career GPs, GPNs, post Certificate of Completion Training (CCT) fellowships and apprenticeships.

• Continue to develop and expand our training academies and hubs.

• Robust training needs analysis for our PCNs aligned to demand.

• Maximises funding opportunities.

• Delivery of operational and day to day work required for successful delivery of the STP primary care workforce retention plan.

• The STP will continue to understand what matters to our workforce and provide this insight to commissioners, partners and PCNs. This will help us to shape and invest resources into the right schemes and initiatives. We have also committed to continually innovate, improve and review best practice to develop the STP as a great place to have a career in primary care.

5.10 Anticipated Workforce Challenges

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

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

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

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

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

- That 60% of GP trainees currently due to complete training in the next 12 months in the Black Country and West Birmingham decide to transition into general practice in the STP (this assumption is based on HEE methodology). This equates to 60 additional full-time equivalent GPs.

- That HEE methodology for forecasting GP retirements is robust (that all GPs currently aged over 55 will retire over the next 5 years). This equates to 41 full time equivalents for the current year.

- That we manage to retain as many GPs through our retention schemes as planned (to help minimise early retirements) and to encourage those GPs that were thinking of leaving the area, UK or profession to stay and enjoy a rewarding career in the Black Country and West Birmingham.

- That we can access at least some IGPRs and maximise other schemes that increase full time equivalent GPs in the area such as the GP Retainer Scheme.

- That we continue to proactively promote and grow the wider workforce and embrace new role opportunities. This will include working in close partnership with system partners to maximise apprenticeship levy opportunities.

- That there will be enough vacant posts available and advertised in practices and networks to recruit to.
• 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.

<table>
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<tr>
<th>Drivers for Change</th>
<th>Estates Impact</th>
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<tbody>
<tr>
<td><strong>Population growth</strong></td>
<td>Additional GP practices incorporated within community health facilities wherever possible. Integration of GP and community care at scale, provided through multi-speciality centres</td>
</tr>
<tr>
<td><strong>The financial challenge across the health economy must be addressed, but the quality of service must also be maintained</strong></td>
<td>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</td>
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<tr>
<td><strong>Need to drive efficiencies via closer work with provider organisations</strong></td>
<td>Integrated, multi-specialty healthcare centres provide potential solution, including greater efficiencies in administrative services</td>
</tr>
<tr>
<td><strong>Pockets of multiple deprivation, with high levels of high-risk behaviours and multiple conditions</strong></td>
<td>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.</td>
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*STP Estates Drivers*
These estates strategies are scheduled to be completed and approved by the end of July 2019 and this will mark an important milestone in our journey to develop a robust primary care estate plan at ICS, place, PCN, locality and neighborhood level.

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

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

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

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

The STP has identified the following estate challenges:

- Updating the condition, suitability and utilisation database for our 260+ GP practice locations (includes a separate count for all practices working in shared buildings). The STP is in the process of seeking Estates and Technology Transformation Fund (ETTF) funding to commission surveys for our premises during 2019-20 to provide a consistent baseline database and to support the work already in progress to update the Shape estate database.

- Our existing primary care estate programme development costs are funded through a combination of the ETTF programme and business as usual funding. We face a significant challenge as a system to fund the circa 30 major improvement and development schemes both for primary care and for hub developments, where a financial commitment is required from multiple organizations. The STP will jointly prioritise and agree the funding for these in line with our estate strategies.

- The STP also has a strong financial and organisational responsibility to ensure the whole primary care estate is fit for purpose, has appropriate capacity and achieves the best possible value for money. To achieve this, the STP will promote smart, generic space design through its proactive project review and approval process.

- The size and configuration of premises will be directly influenced by: the current and projected patient numbers, need for generic clinical rooms, the changing nature of our primary care workforce and the drive to employ more GPs and other clinical and support staff.
This will significantly impact on the number and design of clinical rooms and other facilities in the future as, for example the length of consultations and patient flow through the new PCNs will increasingly vary as we move away from the traditional GP consultation model. To support us in managing this we will:

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

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

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

5.12 Digitisation

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

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

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

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

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

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<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Aligned to the aims of the STP</td>
<td>Technology and its application will be aligned to the operational aims and strategic direction of the STP</td>
</tr>
<tr>
<td>2. Standard Approach</td>
<td>We will wherever possible adopt a standard approach to the deployment and use of technology, re-using existing proven solutions wherever it makes sense to do so making best use of committed investment</td>
</tr>
<tr>
<td>3. Patient Centric</td>
<td>Solutions will be designed around the patient with their care and wellbeing at the heart of the design process</td>
</tr>
<tr>
<td>4. Interoperable</td>
<td>Systems should be capable of exchanging data electronically to facilitate a complete patient view by drawing data from all relevant sources</td>
</tr>
<tr>
<td>5. Secure</td>
<td>Systems must be secure and conform to all relevant IG Standards</td>
</tr>
<tr>
<td>6. Accessible</td>
<td>Access to data is to those who need it irrespective of location, device or time</td>
</tr>
</tbody>
</table>

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

- **Empowerment**: Using technology people can access and contribute to their health and care record.

- **Infrastructure**: A resilient infrastructure across the STP which enables access to information to support decision making (place-based working).

- **Integration**: With the enabling economy wide infrastructure, standards and principles being a fundamental requirement for the interlinking of systems. Standards adopted nationally with the appropriate information governance framework and agreements eliminate organisational and regional boundaries to wider digital interoperability.

- **Intelligence**: Development of robust business intelligence across the STP to support decision making and identification of best practice models leading to improved care.

- The below blueprint shows our areas of focus, across the digital agenda for the next 5 years. Delivery of each of these areas will be through the STPs programme and PMO structure.

**STP Digital Blueprint High Level Programmes**

Element 4 goes into further detail on our digital aspirations.
6 Fulfilling the NHS Long Term Plan

6.1 STP Memorandum of Understanding (MOU)

The STP leadership team has made a strong commitment, as both individual organisations and as the STP to support delivering the requirements for primary care as laid out in the Long-Term Plan. This commitment is enacted through the jointly agreed MOU which is based on the principle that the STP will ‘provide a mechanism for securing the Parties agreements and commitment to sustained…delivery of STP plans…to realise a transformed model of care across the Black Country and West Birmingham’.

The MOU’s purpose is clear; it binds the parties to the common purpose of delivering a clinically, socially and financially sustainable health and care system that will improve the health and wellbeing of the population and address inequalities. However as noted this requires the parties to recognise the scale of change required and that its impact may be differential on the parties. The MOU recognises the role of primary care and affirms its intention to work for the benefit of the whole system not simply that of partner and associate members (see Appendix 5 for full details of the MOU).

6.2 Governance

The STP has well established programme governance of which primary care is a key component. This is shown in the below diagram - Black Country & West Birmingham STP Governance Structure at May 2019
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 primary care programme Board financial plans for funding allocations are developed and decisions ratified by each CCG PCCC and/or Governing Body. Financial monitoring statements are prepared monthly and reviewed by the Board.

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

6.3 Transformation and Programme Development and Delivery

The STP has adopted a joint management and stakeholder approach to how it identifies cross-system programme areas and how it plans delivery of any associated programmes and projects.

This is important as it aligns STP partners to the outcomes expected for large scale change programmes such as implementing PCN’s. This helps to create an environment where service co-production can work and although one organisation might be the lead, it would be recognised that it is for the STP to support and align resources, if needed to take corrective actions.
7 Key element 1 - We will boost ‘out-of-hospital’ care, and finally dissolve the historic divide between primary and community health services

7.1 Current Situation

Our local place is a fundamental foundation in delivering an ICS across the Black Country and West Birmingham. Being able to define and articulate delivery and provision of care at the local place is critical to us in delivering the right structure across a larger setting.

We have in each of our STP areas developed and implemented local place-based models of care for example MCPs. These aim to deliver improved access to local services for our population, greater continuity of care for those with ongoing conditions and more coordinated care for those with the most complex needs. This work is consistent with the STP intention that integrated care will provide services that are delivered in the right place and at the right time to those who need them.

The main initiatives and their key priorities underway in each area to support integration and develop our primary care infrastructure are:

Integration Programmes by STP CCG
Each place based integration model across the STP will work to the same overarching principles and a consistent set of outcomes. These are shown below:

STP Aligned Principles

As partners we are working collectively to integrate services and through this dissolve traditional barriers between all sectors within the STP. However, this will not be achieved over night and will require all system partners to change. We have committed to use all the enablers we have at our disposal to make integration a reality:

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

- We have expanded our community MDTs which will align with PCNs, based on neighbouring GP practices. This will result in fully-integrated primary and community-based healthcare. People living in care homes will receive guaranteed NHS support and our population will jointly be supported to age well.

- Working with CCGs, local authority and other system wide partners, we will seek to make joint decisions based on shared intelligence and joint resource allocation. Artificial system barriers will be overcome to allow person centred care to be the focus of our approach.

### 7.2 How our Services will be integrated

As shown above there are various mechanisms being used to support integration. In addition there are strong governance and programme frameworks in place. Through these approaches we will plan system-wide services that are based on need and place and not on individual organisational pathways that often do not interconnect.

The diagram below shows how we see our networks working with and being supported by other partners/providers to enable integration:

**STP PCN Integration**

Within our network we will include traditional community (and some secondary) services so these can offer a greater range of service in primary care. This includes:

- Mental health and wellbeing.
- Contraceptive and sexual health advice.
• Education and delivery of public health programmes.
• Screening and immunisation provision.
• Managing and supporting long-term conditions.
• Positive lifestyle changes.
• Health promotion, protection and screening.
• Travel advice.
• Management of risks (drugs, alcohol, weight management, smoking cessation).
• Managing acute events.
• Long-term conditions including exacerbations and continuing care.
• Medicines management.
• Triage

An example of how we have begun to do this is through our STP Musculoskeletal steering group. This group has representatives from partner organisations across the Black Country and West Birmingham. This group has co-designed the new model of care starting at the beginning of the individual’s pathway i.e. prevention and lifestyles support through to, if needed surgical intervention. The case for change is shown below:

![Case for Change: Musculoskeletal Conditions](image)

Case for Change MSK
7.3 Workforce Configuration

As highlighted through this document we will develop a 10-year workforce strategy for the STP (2019/20). This will incorporate requirements for acute, community, mental health and primary care. It will reflect the requirements of new care models across the STP, such as the PCNs supported by additional investment in community and primary care services, as described in the STP’s medium term financial plans. The plan will also describe the STPs approach to:

- Recruitment of new workforce, both medical and non-medical.
- Training and education.
- Retention of current staff.
- International recruitment.
- Enhancing productivity.
- Leadership and talent management.

As also stated within this strategy we are investing heavily in developing our primary care workforce. This is through development of new roles, funding and STP wide training and development as described in earlier sections.

7.4 Service Delivery

Each of the four areas has a formal structure in place which supports them to deliver programmes seen as critical in shifting appropriate services out of hospitals. These structures also support integrated working (the above being one such example). These programmes report up through the STP governance structure, so the system can be assurance that progress is being made.

We have started to jointly plan service changes so, as an STP we can ensure that any proposals consider impacts and benefits on out of hospital care.

Each of our places aims to deliver an integrated, responsive and innovative primary and community care service.

This approach will enable stronger integration of primary care with other services, as our GPs are supporting co-ordination of the care provided to their patients in collaboration with other services. One of the main approaches that will enable this is the use of MDTs to co-ordinate a person’s care (see Appendix 4 for Case Studies: MDT Working).

Over the next 12 months we will continue to evolve and integrate teams to become part of the wider primary care health team and continue to mature our PCNs.

The CCGs are already working collaboratively within the STP, taking consistent approaches to the way in which we commission and develop primary and community care. Some examples of what we have undertaken are:

- Collaborative workforce planning.
- Bidding and securing additional resource to support training and development of primary care staff to manage more complex care.
- Joint working with the Black Country and West Birmingham training hub to implement our GPFV plans which supports appropriately diverting the flow of patients out of hospitals.
In 2019/20 we will:

- Contribute to the development of the STP primary care strategy including network formation and maturity.
- Contribute and lead on specific projects on behalf of the STP.
- Identify areas for a common approach to the commissioning or contracting of services across the STP.
- Identify and develop common approaches across care pathways and service developments. This includes how we further integrate the workforce.

We have identified that we need to employ other enablers to develop out of hospital care and further integration between services. We will use technology to achieve this. The Long-Term Plan identified a move towards improved access for patients, meaning patients will need (and have) better access to their health care records.

We will facilitate this through a number of solutions including:

- Deployment of integrated online triage solutions that are accessible via a number of pathways. They include the NHS app and other third-party apps available within each CCG.
- Directly through the patient access portal on the GP practices websites.
- Improving patient choice will be further expanded through the deployment of online video consultation solutions. This is being piloted in Wolverhampton and Dudley and will provide choice to patients in the type of consultation they receive. It will also support patients who struggle to access services at the practice but would be able to access them from home.

Driving improvements in patient care is at the forefront of our digitisation programme. Having a Shared Care Record (SCR) across the STP will allow health and social care professionals to give much better continuity of care as patients move between partner services.

### 7.5 Governance

Please see sections 6.2 for an overview of our governance structure. This will be applied to each key element within this section.

### 7.6 Resourcing

Please see section 13 for the detail on funding and resource issues and proposed, projected spend.
8 Key element 2 - The NHS will reduce pressure on emergency hospital services

8.1 Current Situation

Across the STP emergency admissions for frailty and ambulatory care sensitive conditions are amongst the worst in the country. In 2014/15, there were 28,530 admissions for ambulatory care sensitive conditions costing £57.6m (identifying potential QIPP opportunities, MLU Strategy Unit, 2015).

Although this pertains to a small cohort of patients, the current ways in which services are provided result in us spending a large proportion of our resources inefficiently. Effective care planning and considering the whole needs of the individual is essential. Ensuring all staff work together to plan and support an individual’s care brings with it a number of benefits. These include; helping people maximise the use of existing networks in their communities and reducing social isolation as we know these are drivers of hospital attendances. We have introduced a number of initiatives aimed at reducing emergency department pressure. These are:

Our A&E Delivery Board has developed and established a workstream which looks to reduce pressure on emergency hospital services. Workstream 2 - Pre-Hospital Urgent Care and Attendance Avoidance

The main interventions within this workstream are:

- Development of an MDT rapid response service.
- Continued implementation of the high intensity users and complex cases programme. This is reducing attendance at A&E by a cohort of patients who attend A&E most frequently.
- Extending the support of the care homes nursing support team to further reduce conveyances from care homes to the emergency department.
- Enabling ambulance crews to make contact with the NHS 111 Clinical Advice Service (CAS) to prevent avoidable conveyance to hospital.
- Engaging those GP practices whose patients have the highest utilisation rates of urgent and emergency care services to seek a reduction in unwarranted variation.
- Optimising the degree of flu vaccination implementation and up-take.
- Extending enhanced access to primary care.

Another major intervention we are working toward (to be implemented during 2019/20) will be a single point of access for urgent community response. This will clinically triage referrals from GPs, ambulance crews and the NHS 111 CAS, and co-ordinate the response of community resources. The aim of which is to prevent avoidable hospital admission.
We have been enhancing our primary care infrastructure through the introduction of networks and new finance and contracting models. For example, we support our networks to adopt additional, enhanced services (via DES and other mechanisms). These will improve primary care access and opening times and provide more traditional hospital specialist services that manage patients through MDTs, who have more complex health and social care needs.

We will also support this through a targeted programme of primary care investment. With our proposed extra investments of £25m to GP services by 2021 we will:

- Have an extra 25,000 primary care appointments a year made available.
- Ensure all children under 5 and adults over 75 will be guaranteed same day access to GP appointments, meaning 200,000 people will be able to see a family doctor when they need to.
- Change the flow of care so over 1,000 people a month, who turn up at A&E, will be able to have their problem assessed and treated by a GP, reducing waits and improving care.
- By 2021, over 100,000 people will be saved a trip to hospital for their outpatient care, with more treatment offered in PCNs.
- Collectively we have discussed and agreed common sense changes to the way our GPs, hospitals and care services work together. This will reduce the number of people visiting A&E by 3,000 a week by 2021 through adoption of new care models e.g. PCNs and partnerships meaning faster treatment and care for the most seriously ill.
- Recruitment of additional pharmacist support within practices and networks, addition of a repeat prescribing function and commissioning link workers has assisted practices in providing a strong social prescribing function.
- By 2021, instead of having to be admitted as an emergency to hospital, an extra 1,000 people each week will be cared for in their own home or local community by doctors, nurses and paramedics.

Having a strong primary care infrastructure so patients can access the care they need will help to reduce the pressures on hospital emergency departments.

8.2 The Role of Primary Care

The STP has (and continues to) actively promoted primary and community-focused alternatives to hospital for unplanned care (using models identified above). Within the STP there has been a planned diversion of resources into pathways designed to prevent hospital attendance and increase acute capacity for those requiring acute care. We have:

- Commissioned improved access over and above the General Medical Services contract.
- Developed MDT reviews in primary care of patients with long-term conditions.
- Introduced extended hours access to primary care across practices.
- Additional primary care sessions during bank holidays.
• Developed Urgent Treatment Centres (UTC) to more appropriately manage primary care patients who attend the acute site.

• Integrated NHS 111 with the UTC to allow direct booking of primary care appointments as an alternative to emergency department attendance.

• Established an MDT to support care and nursing homes through enhanced training and rapid support at times of exacerbation.

• Created a high intensity user service to support patients who frequently access the urgent care system, to identify services to meet their long-term needs.

• Commissioned community capacity for those requiring social care assessment for long-term needs, either to avoid admission to hospital or allow more rapid discharge.

• New community-based beds for patients who are unable to weight-bear but do not need to be in an acute bed.

8.3 Workforce

As highlighted through this document we will develop a 10-year workforce strategy for the STP (2019/20). This will incorporate requirements for acute, community, mental health and primary care. It will reflect the requirements of new care models across the STP, such as the PCNs supported by additional investment in community and primary care services as described in the STP’s medium term financial plans. The plan will also describe the STP’s approach to:

• Recruitment of new workforce, both medical and non-medical.

• Training and education.

• Retention of current staff.

• International recruitment.

• Enhancing productivity.

• Leadership and talent management.

As also stated within this strategy we are investing heavily in developing our primary care workforce. This is through development of new roles, funding and STP wide training and development as described in earlier sections.
8.4 Service Delivery

We are seeking to make a stepped-change in the way we commission emergency and urgent care services. We will do this through a focus on ambulance services, as the key shared connecting service that operates across the system and its interface with all other providers and, through the strengthening of our primary care services.

We commission ambulance services jointly across the West Midlands and, in partnership with them we intend to change the way this is undertaken in the future. However, as part of this we also intend to develop the Black Country and West Birmingham model for emergency and urgent care. This sets out how services will be able to interface with each local hospital and PCN to improve the experience of patients, reduce avoidable attendances and provide enhanced care to people in the community. To support this, we have so far:

- Improved the standards and the quality of primary care.
- Enabled patients to have better access to services, with better continuity and co-ordination of their care.
- Enabled primary care to develop and integrate with the MCP.
- Collaborated across the Black Country and West Birmingham to support sustainable and resilient primary care.
- Improved access to primary healthcare clinicians through PCN development.
- Reduced unplanned hospitalisation for chronic ambulatory care sensitive conditions.
- Reduced in hospitalisations for asthma, diabetes and epilepsy in under 19s.

We have, throughout the pages of this strategy rehearsed how our primary care services will change to support delivery of new models of care and the Long-Term Plan. In much the same way as key element 1 we have also implemented, through our STP clinical strategy, a programme of work focused on delivering better urgent and emergency care. The progress and outcomes for this programme and individual projects are managed within our overarching programme structure.

As previously stated we have an STP wide approach to how we use digitisation to support primary care. We will however ensure a focus in the next 12 months on enhancing access for patients through the NHS 111 service. The main priority within this key element is implementing IT systems that allow access to the NHS 111 service so that organisations can book patients directly into general practice appointments at practices avoiding an unnecessary attendance to an emergency department.

8.5 Governance

Please see section 6.2 for an overview of our governance structure. This will be applied to each key element within this section.

8.6 Resourcing

Please see section 13 for the detail on funding and resource issues and proposed, projected spend.
9 Key element 3 - People will get more control over their own health and more personalised care when they need it

9.1 Current Situation

Our public have told us they want:

- Services there when I need them most
- To have a say in my care
- To be able to help myself to manage my health
- To know where to go when I need help or advice
- To tell my story once

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 percent in Year 6 by local authority in England, 2016 - 2017 (percentage)

<table>
<thead>
<tr>
<th>Authority</th>
<th>% Obese Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandwell</td>
<td>27.8</td>
</tr>
<tr>
<td>Dudley</td>
<td>23.2</td>
</tr>
<tr>
<td>Walsall</td>
<td>25.2</td>
</tr>
<tr>
<td>Wolverhampton</td>
<td>26.7</td>
</tr>
<tr>
<td>ENGLAND</td>
<td>20.0</td>
</tr>
</tbody>
</table>

% Obese Children Compared to National Average
It cannot just be down to health and social care partners to manage patient’s health for them. However, we do need to create a system which gives the population opportunities to access the support they need, when they need it and in a way that is easy for them.

The STP has committed to achieving a positive step change in population health & outcomes. We will achieve this through integrated, standardised place-based services built around the registered list which deliver both patient-centred and population-centred care. These will also be commissioned based on outcomes not activity. Specifically:

- We will support patients taking control of their own health plans where possible, empowering patients to live a healthy life is vital to this.
- We will close the gap between life expectancy and disability free life expectancy, so our population can enjoy longer lives with less health-related problems.
- We will promote improved outcomes through clinical intervention and health and lifestyle improvements. We recognise there are a number of areas that are impacting on the health of our population. Some will be addressed by education, some by social change and some by lifestyle change.

9.2 Role of Primary Care

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

- Implementing social prescribing within PCNs (this has begun across the STP).
• Expanding on good practice models such as health coaching and programmes such as Make Every Contact Count.

• Introducing Shared Decision Making (SDM) with patients.

• Ensuring that patients have personalised care plans where appropriate concentrating on “what matters to me”.

• Ensuring a co-ordinated, multi-disciplinary approach to managing personalisation is in place at both a universal and targeted level.

As a system we also need to ensure we build on the learning we have undertaken to support how we drive personalisation. For example, Dudley CCG was chosen to be an NHS England demonstrator site for personalised care in 2018/19. This meant:

• All patients with long-term conditions having personalised care plans undertaken as part of the Dudley Quality Outcomes for Health Framework. This resulted in holistic reviews and care plans being undertaken for 15,000 patients by the end of 2018/19.

• Health coaching and Patient Activation Measures (PAM) being piloted in three of their practices.

• Dudley stroke association going live with PAM in April 2019 and Dudley MBC using PAM for their self-management programmes.

• Dudley is expecting to rollout health coaching and PAM to all the PCNs.

We need to spread the learning and adoption of what worked well across the wider system and learn from what we could have done better. These types of principles are how we see integration supporting us to create a better health and social care landscape across the STP.

9.3 Workforce

As highlighted through this document we will develop a 10-year workforce strategy for the STP (2019/20). This will incorporate requirements for acute, community, mental health and primary care. It will reflect the requirements of new care models across the STP, such as the PCNs supported by additional investment in community and primary care services as described in the STP’s medium term financial plans. The plan will also describe the STP’s approach to:

• Recruitment of new workforce, both medical and non-medical.

• Training and education.

• Retention of current staff.

• International recruitment.

• Enhancing productivity.

• Leadership and talent management.

As also stated within this strategy we are investing heavily in developing our primary care workforce. This is through development of new roles, funding and STP wide training and development as described in earlier sections.
9.4 Service Delivery

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

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

We have introduced a programme management structure to help drive delivery of the above evidence-based components. These programmes will be managed as per our programme delivery and governance structures. Examples of what we have delivered so far are:

- We have strengthened our focus on this agenda by appointing a senior STP executive to oversee this programme from Sandwell and West Birmingham Hospitals. This will ensure there is the seniority within the system to be able to challenge partners, agree decisions at the STP Board and act as an advocate and champion for this very important agenda.
- We are ‘choice’ compliant across all four CCGs as at February 2019 (SWB resubmitting self-assessment).
- We have PAM MOUs in place/soon to be in place at all CCGs with affiliate agreements planned/in place for 25 general practices who will be trained in health coaching.
- We have developed the Black Country and West Birmingham health coaching-training model and have 22 social prescribing link workers in place/being recruited/being secured through business case approval.
- Sandwell and West Birmingham has bid for funding to be made available through the Better Care Fund to further support our social prescribing aspirations. We have, as part of this, agreed that business cases can be shared to other sites to help them shape and develop their social prescribing offer.
- We have secured agreements that all four CCGs will offer Personal Healthcare Budgets (PHBs) as default for Continuing Healthcare patients from April 2019 and we continue to develop our PHB offers in Mental Health (as per section 117) and Personal Wheelchair Budgets (PWBs). We expect to see a growth in PHB numbers through the life of this strategy.

(See Appendix 4 for Case Studies: Social Prescribing)

We have, as highlighted above, implemented a number of projects to support our population across a number of aspects of prevention. Going forward our aim is that we:

- Progress Policing and Community Safety Partnerships (PCSP)/ health coaching training programme across the entire STP.
- Deliver two strategic co-production events for people across the STP so they are aware of the work we are undertaking to support them in managing their own health and well-being.

- Strengthen peer support offers by using outputs from peer support mapping and commission facilitation training for groups through the four local Community and Voluntary Services.

- Engage with commissioners over strategic direction and ensure contracts support on-going personalisation.

- Plan and deliver a training programme for health coaching and personalised care support through the year.

- Explore PHBs for high intensity users and integrated personal budgets for children and young people with Education Health and Care (EHC) plans. (See Appendix 4 for Case Studies: Health Coaching).

Recognising that digital solutions play an important part in patients managing their health and well-being we have, as part of our overarching digital strategy, identified several key initiatives we will implement over the next 2 years.

These are:

- Introduction of GP online consultations. This project is backed by national funding and has been deployed across all four STP Localities. This supports patient’s access services via apps and directly through their practice websites.

- We have piloted support for patients with diabetes within Wolverhampton through the rollout of freestyle libra. This monitors user’s insulin levels without the requirement to do pinprick tests. Dudley is supporting patients with long-term conditions through use of its health app. Moving forward the NHS app will be deployed across the STP and the range of services offered by the app will be expanded as it is developed by the NHS.

- We will also offer more personalised therapeutic options to patients thanks to advances in precision medicine. This will facilitate a more fundamental shift towards more ‘person-centred’ care, with a wider move to “shared responsibility for health” over the next five years.

- The NHS Personalised Care Model is to be rolled out nationally and social prescribing, using link workers in PCNs, will help us to develop tailored plans for individuals and connect them to local groups and support services as needed. Accelerating the rollout of PHBs will also give people greater choice and control of their care planning and delivery and end-of-life care will be personalised also.
9.5 Governance

Please see section 6.2 for an overview of our governance structure. This will be applied to each key element within this section.

9.6 Resourcing

Please see section 13 for the detail on funding and resource issues and proposed, projected spend.

10 Key element 4 - Digitally-enabled primary and outpatient care will go mainstream across the NHS

10.1 Current Situation

As highlighted earlier each of the Black Country and West Birmingham CCGs has a primary care digital programme in place. There is, of course an amount of variation due to historic development of differing primary care strategies and each of the areas agreeing and developing different digital priorities. Whilst there is now general cohesion in programmes across the STP aligned by GP systems of choice, the patient choice agenda, the GP Five Year Forward View and the Long-Term Plan there has not been a single strategic vision on digitisation for primary care.

There is now agreement across the four CCGs to harness the opportunity afforded by the STP primary care and digital strategies to converge previously disparate programmes into a cohesive, interoperable portfolio of work to support the STP and the delivery of the NHS Long-Term Plan.

The STP is developing a Digital Strategy, working in line with the NHS National timeline for a response to the LTP in autumn 2019. The STP Digital Strategy will be included in the STP 5-year Plan at this time.

Our organisations are adopting digital solutions to become more efficient and effective in both care delivery and organisational business. For example, Sandwell and West Birmingham CCG is rolling out Microsoft Office 365 to give its workforce greater flexible to work in a more agile way. Eventually this will be rolled out to all areas across the CCG so that healthcare professionals can benefit from these new approaches to care delivery as well. We are also looking to implement and support the following:

- **On-Line Consultation** - consulting with patients using technology including email, skype, text and telephone. The STP is working towards or expanding on their online consultation facilities and whilst we recognise that this work has initially developed at place level, the STP has now developed a Digital Workstream which will work to deliver a consistent set of on-line consultation functions across the STP accessed via the NHS App, share best practice and aspire to align any future procurements of solutions. The STP is working to ensure all Practices have a solution implemented by April 2020 and twin tracking this technical work with proactive on-site marketing and engagement for GP practices and patients in order to maximise the uptake and opportunity.
- **NHS App** - NHS App will continue to be a national platform providing people with a ‘front door’ into a range of online health and care services. The STP is committed to promoting and ensuring digitally enabled services are interoperable with the NHS App. It is already proving to be an important platform in enabling the public to interact with the NHS digitally, giving fast and reliable access to symptom checking, NHS 111, practice appointment booking, renewal of prescriptions and viewing of GP medical records. The NHS App will further evolve through seamless integration with the smartest and most effective applications, tools and services on the market. The STP will
  
  o 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)
  o 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)
  o Ensure all relevant staff are briefed on the NHS App rollout and requirements for supporting patients
  o Review 111 Online provision to ensure appropriate for potential increased usage/activity from exposure within the NHS App

- **Extended Access NHS 111 Direct Booking**

  This function is already available across the majority of the STP, with plans and place to ensure full coverage by September 2019

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

- We are also upgrading Provider Patient Administration System/Electronic Patient Record system (PACs/EPR).
10.2 Role of Primary Care

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

By reviewing the local and national priorities and aligning delivery across primary care we can harness the opportunities available at scale to support improved clinical outcomes. For example, having virtual MDT consultations with both primary and secondary care health professionals so that care can be jointly planned for the patient.

Digital is a key enabler for improvements defined within the STP clinical strategy which are, in turn, aligned to the NHS Triple Aim. The digital workstream will realise the opportunity to align organisational priorities for digital with the overarching objectives of the STP and for primary care as detailed within both the clinical and primary care strategies.

10.3 Workforce

Our approach to delivering a digitally fit workforce will be based on the delivery of themes to support the workforce and empower patients so that the demands upon staff are reduced.

The foundation of this vision is based upon access to the appropriate information at the right time to improve knowledge and therefore increase independence and resilience through self-care. These themes are:

- **Empowerment** - using technology patients and citizens access and contribute to their health and care records.

- **Infrastructure** - a resilient infrastructure across the Black Country and West Birmingham health and social care economy that enables access to required information to support decisions from anywhere supporting place-based working.

- **Integration** - with the enabling economy wide infrastructure, standards and principles being a fundamental requirement for the interlinking of systems. Standards adopted nationally with the appropriate information governance framework and agreements eliminate organisational and regional boundaries to wider digital interoperability.

- **Intelligence** - development of robust business intelligence across the Black Country and West Birmingham to support decision making and identification of best practice models leading to improved patient care.
As part of the digital and workforce strategies, we will support programmes of work which equip the workforce of today and tomorrow with the skills they need to operate within a new landscape.

We are also investing heavily in developing our primary care workforce. This is through development of new roles, funding and STP wide training and development as described in earlier sections.

10.4 Service Delivery

We have an extensive programme of digitisation planned across the next 5 years. Our main programmes are:

- Electronic Document Management.
- Electronic Referrals.
- Telehealth.
- Electronic Prescription Services release 2.
- Integrated Shared Care Record.
- Clinical System Support, Data Sharing, Wi-Fi will be available in all practices.
- Outreach/Mobile Working - this will allow staff to work across the local area in patients' homes and in other clinical settings such as care homes.
- Local Electronic Service Directory - we will compile a local service directory to include primary, secondary, community and voluntary sectors. This will ensure the correct pathway is followed for individuals with a shared approach; reducing the likelihood of inappropriate referrals to secondary care.

The above will be underpinned by effective change management which facilitates maintaining momentum through any changes.

In parallel to the implementation of the above programmes we will:

- Continue to work towards system interoperability (the ability to exchange information between health and social care systems). This will provide a single consolidated view of the patient in the context in which the patient is being viewed, supporting operational excellence within of new models of care.
- Utilise the latest and appropriate technologies to engage all parties within the system including clinicians, staff, patients and partners.
- Facilitate cross organisation collaboration driving efficiency and productivity to close the finance and efficiency gap.
- Utilise technology to extend the reach of health and social care to bridge the care and quality gap.
- Implement and promote the use of digital tools and applications in support of health and wellbeing.
- Build on existing achievements and the required coherence between technology and health and care services by adopting ubiquitous access to clinical information assuring availability in the right place, at the right time to support clinical decisions.
• Be paper free at the point of care by 2020.
• Adopt new standards as appropriate. This will be particularly relevant as an STP wide interoperability capability is developed with a focus on cyber security and GDPR.
• Continue gaining maximum value from the outsourced CCG IT and GPIT service level agreements and continued alignment of the IT strategy and IT service to the organisational strategic objectives.

Success can sometimes be difficult to measure or attribute to one or two changes. However, we know we will have succeeded when clinical computer systems are interoperable and facilitate communication and information sharing between services and organisations and, when creative and innovative digital solutions are available which support and empower people to manage their own health.

10.5 Governance

Phase 1 of the STP digital programme will be to develop an STP digital enabling strategy. This will describe how the STP’s clinical strategy will be supported by digital enablers such as shared records and patient empowerment via access to information. The strategy will also be informed by the NHS Long-Term Plan, STP workforce, PCN establishment, Digital Maturity A and the Local Digital Roadmap (LDR) 10 Universal Capabilities & Ambitions. This will be developed by December 2019 (see Appendix 7 for version 1 of the LDR).

The second phase will be an STP digital enabling programme which will align defined milestones such as funding availability, other STP programme delivery dependencies and importantly the existing commitments of partner organisations. To allow for strategic foresight but temper that with the pace of technological developments, the plan will span the next 3 years. Year 4 will be a refresh of the delivery programme and a review against STP/ICS clinical priorities.

Please see section 6.2 for an overview of our governance structure. This will be applied to each key element within this section.

10.6 Resourcing

Stakeholders from across the Black Country and Wet Birmingham are already members of the STP digital programme Board. This is attended by commissioner and provider digital leads and will include social care and STP clinical guidance.

Current resource for primary care IT is ring-fenced through allocated funding to CCGs from NHS England. These budgets are fully committed to existing obligations such as GP clinical systems provision and support. Additional funding opportunities are provided through the ETTF and Health Service Led Investment (HSLI) which are co-ordinated across the Black Country and West Birmingham.

Sections 3.6 and 12 go into further detail on funding and resource issues and proposed, projected spend.
11 Key element 5 - Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere

11.1 Current Situation

The STP is making excellent progress in delivering new care models which can be evidenced by the outcomes seen from our vanguard sites. We have established; the Dudley MCP, Modality and MERIT, alongside the Wolverhampton Integrated Alliance, Sandwell and West Birmingham Healthy Lives Partnership and Walsall Together to support our integration aspirations. There remains however further progress required to realise the full benefits of these new care models.

11.2 Role of Primary Care

The STP is well progressed in the delivery of ‘place-based’ integrated models of care, however the operating model, contractual model and phasing of implementation varies across each of the boroughs.

Local place-based models of care including Integrated Care Alliances (ICA) and Integrated Care Organisations (ICO) are being developed and implemented across the STP in support of the clinical strategy. These ICAs are emerging vehicles for bringing together health and care services for defined populations. They aim to; deliver improved access to local services for their whole population, greater continuity of care for those with ongoing conditions and more coordinated care for those with the most complex needs. This work is a key deliverable for the system in transitioning to an ICS.

Each ‘place’ has its own path to an ICA/ICO, but each ‘path’ is drawn from the same central principle (as defined earlier). This will bring health, social care and voluntary sector organisations together, to achieve improved health and wellbeing. This will deliver local models of care that are tailored to their populations, but which also benefit from working alongside each other as part of the wider system described below.
Integrated Care in the Black Country and West Birmingham

**Integrated Care Alliance Wolverhampton**

**What is the vision?**
The development of a health and care alliance across Wolverhampton with a focus on a place-based model.

**Who's involved?**
City of Wolverhampton Council, Black Country Partnership Foundation Trust, Wolverhampton CCG, The Royal Wolverhampton NHS Trust and local GP practices. Also, Healthwatch and Local Medical Committee representatives.

**How will it work?**
The system-wide alliance will be clinically led and will focus on:
- Shifting resource out of hospital to support those patients at home and in their communities.
- Health promotion and disease prevention.
- It will use financial systems to incentivise changes in care and ensure sustainability.

**Population size**
Approx. 250,000 people.

**Key contacts**
Andrea Smith andrea.smith21@nhs.net

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**Dudley Multispecialty Community Provider (MCP)**

**What is the vision?**
To integrate primary and community care within a single organisation and to improve access, continuity and coordination of care.

**Who's involved?**
Dudley CCG and Dudley Metropolitan Borough Council are leading the procurement of Dudley MCP in dialogue with partnerships of four local NHS Trusts and local GPs.

**How will it work?**
The model is based on the model of “community where possible, hospital where necessary” by creating a network of GP-led health and care teams. Network will focus on co-ordination of care across the system.

**Population size**
Approx. 316,000 people.

**Key contacts**
Neil Ruddin neel.ruddin@dudleyhosp.nhs.net  
Stephanie Cartwright stephanie.cartwright@dudleyhosp.nhs.net

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**Sandwell and West Birmingham Healthy Lives Partnership**

**What is the vision?**
Providing greater integration between all providers (including primary, community, mental health and independent providers) to shift care closer to home, improve patient experience to provide seamless and timely services and take lessons learned from the vanguard.

**Who will be involved?**
Sandwell and West Birmingham CCG, Sandwell and West Birmingham Hospital Trust, Birmingham Community Trust, BSIMHT, BCFPT, Sandwell Council, Birmingham City Council, emerging new Primary Care Networks and early conversations with third sector to allow progressive integration over time.

**How will it work?**
Focus on keeping local people well and tackling underlying causes of ill health, inequality and vulnerability.

**Population size**
Approx. 372,000

**Key contacts**
Claire Parker claire.parker2@nhs.net  
Sharon Liggins shiggins@nhs.net  
Jenna Phillips jenna.phillips@nhs.net  
Paul Tulley paul.tulley@walsall.nhs.uk
To support the implementation of our place-based models of care, the following initiatives are being implemented in 2019/20:

**Primary care networks of local GP practices and community teams**

PCNs will underpin the provision of integrated care across the STP. In 2019/20, service and pathway integration will reach beyond primary care to include other health and care services. This will include district nursing, pharmacy, social workers, community psychiatric nursing, social prescribing, housing and a range of other roles to support patients’ care in their own communities. This has been implemented in parts of the STP footprint already and will be expanded to all areas, recognising the differences in approach that may be required.

Community services are based on geographical footprints to mirror PCNs for approximately 50% of the population. We expect this to be at 100% by March 2020.

**GP Five Year Forward View**

It has been three years since the implementation of the STP Primary Care GPFV commenced. It remains a priority to continue to deliver all GPFV projects in line with existing implementation plans as in-line with this strategy.

The strategy will cover a 5-year period to 2024. 2019/20 will therefore be a transition year.

**Quality and Outcomes Framework (QOF)**

NHS England and Improvement have sanctioned significant changes to the GP Quality and Outcomes Framework (QOF). This will include a new Quality Improvement (QI) element which is being developed jointly by the Royal College of General Practitioners (GPs), National Institute for Health and Care Excellence (NICE) and the Health Foundation.

CCGs within the STP have already begun to move away from using QOF indicators and towards locally defined measures. An example of this is the Dudley Quality Outcomes for Health (DQOFH) which is a key part of the proposed Integrated Care Provider contract for them.

Similar local outcome frameworks are being developed across the STP and therefore we will continue to work within the requirements of the national framework until our local frameworks are sufficiently developed. In preparation for transition to a local framework we will work closely with regulators to advise on the risks relating to accurate data collection and national performance consequences (such as CCG Improvement and Assessment Framework) when moving from QOF.

**Guaranteed NHS support to people living in care homes**

We are developing plans to meet the NHS Long-Term Plan’s goal of upgrading NHS support to all care home residents by 2023/24. This will ensure we create stronger links between PCNs and their local care homes, with all care homes supported by a consistent team of healthcare professionals, including named general practice support.
Possible legislative change
The STP supports the ambition for legislation changes to deliver new care models. This is not likely to impact in 2019/20 but appropriate consideration will be given if proposals are published in-year.

11.3 Workforce

There are two key priorities for the STP in relation to workforce; Local Workforce Action Board (LWAB) and the Organisational Development/Human Resources (OD/HR) workstream.

A common aim of both workstreams is to address the workforce challenges faced by primary care, and our organisations by working across organisational boundaries. We will not resolve the challenges we face (including the potential reduction in GP workforce across the Black Country and West Birmingham) without an STP approach.

The LWAB and STP continue to work closely with the Clinical Leadership Group to consider proposals on current workforce and future requirements.

The LWAB brings together health and care organisations and key stakeholders across a broad range of workforce issues and will develop solutions and agree a work programme to support the wider STP workforce agenda. These will include areas such as; strategic HR issues, recruitment including overseas recruitment, staff retention and absence as well as education and training. The LWAB has five programmes which have objectives within each of these to drive forward the workforce agenda. These are:

- Workforce capacity, innovation and change.
- Recruitment and retention.
- Working stronger together.
- Staff Well-being and engagement.
- Leadership and education.

The HR and OD workstream will contribute to improving wider system working in relation to HR/OD support to the process and management of STP resourcing ensuring fair and transparent systems are in place.

As highlighted through this document we will develop a 10-year workforce strategy for the STP (2019/20). This will incorporate requirements for acute, community, mental health and primary care. It will reflect the requirements of new care models across the STP, such as the PCNs supported by additional investment in community and primary care services as described in the STP’s medium term financial plans. The plan will also describe the STP’s approach to:

- Recruitment of new workforce, both medical and non-medical.
- Training and education.
- Retention of current staff.
- International recruitment.
- Enhancing productivity.
- Leadership and talent management.
11.4 Service Delivery

The service pathways are currently in development across the STP. At this time, we predict that they will sit at the provider level or ICA, which is below the ICS. Whilst there are differences in design and pace of development with each local ICP, there are also many common themes which we will be collaborating on increasingly as four CCGs. These themes include:

- Health and care services being brought together as a means of responding to the needs of a growing frail elderly population displaying multiple co-morbidities.
- Creating a more resilient primary care system and placing the patient registered with general practice at the centre of the care model.
- A population health approach to managing demand.
- A move away from activity-based contract models to our Integrated Care Partnerships/Providers being responsible for the delivery of a set of health and wellbeing outcomes.

Each CCG has begun work on developing an outcomes framework to look at improvement in patient health over time. We are committed to working together to align these frameworks, which predominantly focus on the health management of our local populations, with a view to agreeing an overall common outcomes framework for the ICS.

11.5 Governance

During 2018/19 we have established governance and reporting process for all STP work streams and programmes. We will continue to refine and improve processes focusing on delivering positive changes for the benefit of the patient.

Governance of the STP will be further strengthened in 2019/20 to incorporate the membership of PCNs and the development of appropriate risk management frameworks to manage financial risk across the STP.

During 2019/20 the STP will support member bodies through periods of organisational change. Over the next year we will be preparing for the merger of Black Country Partnership FT and Dudley & Walsall Mental Health Trust, the establishment of a joint management team across the four STP CCG’s from April 2020 and the establishment of Dudley MCP.

Please see section 6.2 for an overview of our governance structure. This will be applied to each key element within this section.

11.6 Resourcing

Please see section 13 for the detail on funding and resource issues and proposed, projected spend.
12 Measurement

12.1 Baseline and Measuring Change

The STP primary care strategy is built on the foundation of ensuring all transformational change is developed based on empirical evidence and professional business design methods. This is to ensure that:

- Financial and human resource allocations are targeted in the right areas where transformation is required i.e. achievement of the vision and outcomes outlined in this strategy.
- A robust approach and methodology is followed so there is a defined structure to follow, for example development of the case for change, Project Initiation Documentation (PID) and risks and issue logs.
- A baseline exists upon which to measure the impact of the transformation.
- Progress can be monitored and reported robustly.
- Adoption of new care models, such as PCNs can be developed and rolled out to a methodology which facilitates delivery of the aims and objectives.

Across the STP we are implementing a large programme of change within primary care to meet the growing system challenges and to support delivery of key outcomes within the GPFV and the Long-Term Plan. However, to ensure that all changes proposed and progressed supports the population we use the following approaches and methods:

- Robust data collection and analysis from a range of sources e.g. National Workforce Reporting Tool (NWRT), HEE, local CCGs and NHSE sources to set ambitions and target areas for development and/or change.
- Good application of change and programme, PMO approaches so there is a structured approach to delivery.
- STP-wide stock taking of current activity and position to ensure there is a documented baseline from which to manage progress e.g. on the development of online consultation, on the implementation of the 10 High Impact Actions.
- Staff engagement and co-design approach using a variety of methods such as events, workshops and surveys.
- Public and patient engagement.
- Researching, sharing and utilising best practice both locally and nationally.
- Piloting schemes and evaluating impact before wider rollout.
- Ensuring that all stakeholders involved in change schemes are clear on success measures, metrics and outcomes from the outset.
- Ensuring the right governance is in place to monitor work undertaken and provide assurance that the changes are resulting in improvements.
We ensure that we apply established design techniques to our change processes such as logic modelling when we are designing schemes.

We also recognise the importance of sharing and publishing the changes we have made. We use a variety of methods to evidence the impacts of change we have realised across our programmes. These include:

- Case Studies (see section 5.4 for example).
- Speaking, presenting at local and national events and conferences.
- Our intra and internet sites.
- Videos / social media – e.g. [https://www.youtube.com/watch?v=wavltz1nr-4&feature=youtu.be](https://www.youtube.com/watch?v=wavltz1nr-4&feature=youtu.be)
- Metrics dashboards – see accountability section.
- Newsletters (see below example).

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**First 5 Network**

This has been a successful workforce scheme that supports newly qualified GPs into general practice. We found that many newly qualified GPs felt isolated and have benefited from joining a network. They provide the chance to explore the range of career opportunities and foster an environment for peer support.

**Dr Nisha Raithatha**

Signed up to join a network for newly qualified GPs after moving from London to Birmingham. Speaking about her experience of the First 5 programme, she said:

“First 5 has been absolutely fantastic.”

“If it wasn’t for First 5, I think it would have taken me much longer to settle into the area professionally and socially.”

**Dr Nisha Raithatha**, GPR55 Participant: First 5 Network and Portfolio Careers Scheme

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**General Practice Nurses Network**

We have successfully bid to receive funding to support general practice nursing. We will be gathering insight from the general practice nursing and health care assistant workforce to inform priorities for future schemes. We have already engaged with more than 50 nurses through four events across the footprint and received 100 responses to a survey distributed to staff.

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**Next steps**

- Welcome new GPs and practice staff
- Promote workforce schemes
- Continue to work with healthcare professionals to shape schemes
- Opportunities to influence practices to get on board.

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

This will bring together information from a number of different sources designed to measure the impact across all the key elements of the STP. An example of how we look to layer data is shown below. This helps us to understand for example how wider determinants of health influence acute hospital admissions.

Data Alignment across STP Level

### 12.2 Monitoring the Workforce Plan

This strategy details our approach to workforce, the types of initiative we are introducing and the proposed benefits for our population. This also includes our overarching approach to programme delivery governance and accountability.

The STP is committed to investing both financial resources and Programme, PMO delivery resources into delivering the workforce plans and our soon to be created workforce strategy. As a minimum we would expect to achieve the workforce ambitions submitted to NHSE on an annual basis (see Paragraph 4.5 for the ambition for 19/20).

The primary goal of our workforce plans is to help make the STP a great place to work where primary care becomes a first class and first choice career pathway.

We recognise though the importance of having robust and varied ways of measuring and evaluating the impact of our investments. We will manage this in the following way:

- Obtain, extract and analyse regular workforce reporting data from verified sources including HEE, NHS Digital (National Workforce Reporting System), NHSE (via the ‘Future NHS collaboration platform), higher education institutes
and local sources via CCG contracting teams (for retirements, starters and leavers).

- Using the above information, we will compare our ambitions using a Metric Dashboard which includes a robust narrative of the progress of the plans/schemes against each aspect of the workforce. This will then be presented as a standing item at each STP PCPB for challenge and governance purposes. In addition, progress against workforce ambitions are reported as part of the monthly STP programme highlight reports as well as via assurance returns to NHSE on a regional basis (see Appendix 8 for full details of workforce metrics dashboard).

- For each new scheme/project the STP will ensure specific metrics/evaluation methods are included in the design phase and routinely monitored throughout implementation. This will be jointly developed by stakeholders to support the strengthening of cross organisation working.

- The STP will continually review its ambitions and trajectories on a regular basis ensuring that work is undertaken to analyse and predict future demand. Techniques such as the HEE GP supply tool forecasting model and business design methodologies will be used to analyse demand in primary care to support emerging PCNs workforce development plans.

The below diagram visualises our approach to how we structure our data for analysis and sharing:

![Workforce Plan Monitoring – Data Sources](image-url)
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:

<table>
<thead>
<tr>
<th>Local (STP Level)</th>
<th>Regional Level (Midlands and East)</th>
<th>National Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Programme Level Reporting to Primary Care Leads <em>(transitioning to Primary Care Programme Board)</em></td>
<td>Monthly Programme Level Highlight Reports to the GPFV Transformation Board</td>
<td>NHSD SDCS GPFV Monitoring Survey – Quarterly Return</td>
</tr>
<tr>
<td>Monthly Primary Care Workstream Reports to Black Country &amp; West Birmingham STP Delivery Board</td>
<td>Monthly Workforce Highlight Reports to the GPFV Transformation Board</td>
<td>STP Assurance Return on NHSE Assurance Statements (sent by NHSE Region)</td>
</tr>
<tr>
<td>Monthly Project Level Highlight Reports to Project Task and Finish Groups and fed into Programme Plan Highlights</td>
<td>General Practice Nursing Monthly highlight report</td>
<td></td>
</tr>
<tr>
<td>STP Assurance Return on NHSE Assurance Statements – to STP PMO</td>
<td>STP Assurance Return on NHSE Assurance Statements (sent by STP PMO)</td>
<td></td>
</tr>
</tbody>
</table>

**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.


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.
A metrics dashboard is under development to monitor and report progress against the assurance statements and ambitions. It is envisaged that this will go live across the STP by the end of 2019. This will be updated and reported via the governance processes on a regular basis, to the above Boards, committees and groups. This is to ensure there is visibility and give partners an opportunity to ensure any corrective action can be taken on if adverse variations to targets are seen.

As part of our ongoing monitoring of all the programmes of work we are delivering across the STP, we will ensure that any learning and outputs from these are considered. The above approaches and mechanisms we have detailed gives us a good opportunity to ensure that we embrace and mature a strong change culture and that we learn from outputs from programmes contained within the GPFV and Long-Term Plan.

12.5 Patient Participation

Across the STP there are extensive arrangements in place to engage patients and the public in the way that services are developed, delivered and evaluated. Each partner has mechanisms to involve our population in the way that services are commissioned and provided, and primary care is no different in this regard. Most of our practices have Patient Participation Groups (PPG) and we have great examples of the impact that these groups can have, not only on the way that GP practices operate but their role in empowering local people and communities more widely.

Based on feedback from the 2017/18 GP practice survey, we know that:

In Dudley, patients overall experience of their GP practice was very good. Local people are aware of online services that are offered at their GP practice, but many have not used them. Mental health and long-term conditions are recognised and supported well.

In Sandwell and West Birmingham, most patients rate their overall experience as good. Almost half surveyed were not aware of the online services offered at their practice and therefore did not use them. Most patients get a choice in date or time when booking a GP appointment.

In Walsall, the overall experience of GP practices is very good with most patients finding it easy to get through to their GP practice on the phone. Most patients were aware of online services, but a high proportion said they had not used these in the last 12 months. Their confidence and trust in staff providing services when their GP practice is closed was high.

Wolverhampton, most patients describe their overall experience of their GP practice as very good. There is a general awareness of online services locally, but most patients have not used them. There are also high levels of satisfaction with receptionists in practices and patients find it easy to use their GP practice website to look for information or access services. Satisfaction with appointment types was also high.

We also use digital solution to capture, on an ongoing basis, patient’s view of the services we provide and the care they received. An example of this is shown below:
Patient Experience Measure

The information captured in this told us that across all our localities patients’ perceptions of care received at their last GP appointment offered room for improvement, with them feeling like they are not treated with the right level of care or concern and that they are not given enough time.

Mechanisms like this are routinely employed and reviewed by individual organisations and within the STP structure so that we understand how we are performing and to help identify any areas for improvement. These are then brought into the planning and programme structure mentioned earlier.

It is also reasonable to say that whilst opinions expressed in the latest survey are consistent across the STP and positive in terms of how we benchmark with national results, there is some variation across results from practice to practice.

It is this variation that we want to tackle, so that people across the Black Country and West Birmingham recognise the level of service they can expect, regardless of the practice they visit.

We have used the knowledge from this national survey, ongoing place-based involvement work by local CCGs and specific engagement events on this strategy development to ensure that this strategy responds to the views of local populations.
The STP recognises the needs and expectations of the public are changing. We are living longer but we often require different, more complex care as a result. New treatment options are emerging, and we rightly expect better care closer to home. Our primary care services are there for people, often as the first port of call and when at its best, general practice plays a valuable role of coordinating care for those most frail and vulnerable.

Good access to general practice is something which all patients and the public want. For those living with long-term conditions they strive for not only good access but for continuity of care and want to feel able to influence their own care planning.

We know that having a sustainable primary care service and using new models of care such are networks, is very important for our population registering with a GP of choice. We know that our patients have a strong and emotive reaction to any suggested reduction in the local provision of primary care services.

Our population also recognises the challenges faced by primary care such as the issues with recruitment, many GPs reaching retirement age and increasing complexity of an aging patient population. From conversations we have had with our patients and service users we know they are open to exploring other options such as online access and being cared for by new types of workforce such as practice based pharmacists, paramedics in practice and social prescribers to address some of these challenges.

There is wide recognition and ambition across the STP to create a future where our residents have more choice and control over their own health. Care planning, which places the individual and what matters to them at the centre, is something that our residents support. It is also an area where our population have positive ideas on the role that they can play in supporting their own health.

Local people still need more information on the way in which primary care services are developing. They want to understand the new roles being introduced and understand the different ways that services can be accessed through, for example the new network structures.

As this strategy is mobilised and more plans for implementation are developed there is commitment across the STP to engage with patients and the public. We have structured this at the following levels:

- People – we will increase the choice and control that people have. Increasing opportunities for people to influence their own care, to set personalised goals, participate in shared decision making and for individuals to be seen as equal partners in their care planning.

- Practice – we will encourage each practice to have a Patient Participation Group and offer support to those practices who don’t have one or for those groups who need some support to be the best they can be. This will offer all patients, registered with a practice in our STP, a chance to have a voice about how the care is provided in their practice.

- Place – each CCG has a forum for PPG leaders to come together at a PCN or Place level. Theses forums are a great way to hear about health developments, share ideas and influence commissioning decisions. Each CCG has PCCC with patient / public representatives (including Healthwatch) and these meetings are
held in public. These are key to us being open about the way in which decisions are made in relation to planning and buying (commissioning) primary care services.

- Partners – at an STP partnership level we will offer collective clarity about the direction of travel for primary care, we will ensure that there is consistency in the opportunities for people to be involved in decisions about that strategic direction and we will support this through the introduction of ‘Black Country Voices’. A new citizen’s panel for the STP which will be in place by April 2020 and will provide a mechanism for gathering insight and feedback on health and care issues. It will help the STP to reach an unrepresented demographic from across the four localities including those who are seldom heard and will complement existing engagement methods used across the footprint.

The STP has also committed to communicate in a way that is:

- Open and transparent – our communication will be as open as we can be, ensuring that when the information cannot be given or is unavailable, the reasons are explained.

- Consistent – There are no contradictions in the messages given to different stakeholder groups or individuals. The priority to those messages and the degree of detail may differ, but they should never conflict.

- Two-way – There are opportunities for open and honest feedback and people have the chance to contribute their ideas and opinions about issues and decisions.

- Clear – communication should be jargon free, to the point, easy to understand and not open to interpretation.

- Planned – communications are planned and timely rather than ad-hoc and are regularly reviewed to ensure effectiveness.

- Accessible – our communications are available in a range of formats to meet the needs of the target audience.

- High quality – our communications are high quality in relation to structure, content and presentation at all times.

We will also ensure that there will be no service changes without adequate involvement and we will promote the ways in which local people can have their say.
12.6 Public Engagement on this Strategy

To help us identify what matters most to local people, we held four public engagement events across the STP footprint. The events encouraged people to have their say on primary care services and captured views and experiences based on a series of topical areas covering access, the development of new roles within primary care, the use of online services and the emergence of digital solutions.

The events led by primary care leads in each of the CCGs, highlighted the challenges faced by primary care, the opportunities of partnership working and how CCGs were working together to develop a system-wide Primary Care Strategy for how it will improve the care for people living in the Black Country and West Birmingham over the next five years.

A graphic recorder was commissioned to create a visual representation of the conversations that took place at each event. The visuals will be used to evidence the progress and direction of conversations in each of our four localities and will support CCGs to understand what matters most to local people – an example is included below:-

\[ \text{STP Public Engagement Event Feedback Example- Walsall – 20/5/2019} \]

Across the four events, 118 local people attended. Attendees were predominately white, of retirement age and who were experiencing several long-term conditions. Some localities did get representation from BME communities including a representative from the Refugee and Migrant Centre, which covers Birmingham, Walsall and Wolverhampton and a representative from a mental health support group.
Generally, feedback we received from local people who attended the events was consistent across our four localities. Overall patients would be happy to see a variety of health professionals in primary care for minor ailments, provided they had the training required and were able to make easy onward referrals to their GP or other services. Patients with multiple long-term conditions were more hesitant to see alternative health professionals as they thought it was important that the health professional understood their history and they valued consistent, face-to-face care.

When discussing the digital agenda, most people felt they needed further education to understand the solutions being investigated and what this would mean in practice. They also felt that if results were made available electronically they may need support to understand them. Concerns were raised regarding data security and the level of information being made between groups, with a focus on voluntary sector organisations.

Representatives on behalf of refugee and migrant populations/mental health sector highlighted the difficulties that would arise for patients if they were required to attend alternative practices and see health professionals that they were not familiar with. (See Appendix 9 for narrative and visual representation of the conversations that took place at each engagement event).

12.7 Future involvement

Going forward we will continue to run events with our local population to present the work that we are doing and to get input from public and patients on upcoming projects to ensure that it meets their needs. The outputs of events will be collated and taken to the STP Partnership Board for consideration.

12.8 The Role of the Primary Care Commissioning Committee

The PCCC oversees the commissioning of primary care and has established the Primary Care Operational Group to review and monitor contractual performance, quality and safety of primary medical care services.

12.9 Primary Care Network Analytics

One of the key benefits of PCNs will be their ability to apply the benefits of wider system integration to the specific local needs of the populations they serve. A key foundation to enable this to be as effective as possible is accurate, timely and easily accessible population information. As such the STP is committed to supporting the development of the data and BI functions that will enable this for the networks.

In order that PCNs can make the right decisions based on the data available, Business Intelligence will need to focus on the following areas:

• Infrastructure (the technology that will support the data gathering).

• Analytics (the way in which the data is used to create information for networks and their clinical directors to utilise).

• Intelligence led Intervention (how the information is then used to inform service changes). An overview of our vision for PCN Analytics is included below:-
Primary Care Networks Analytics

Infrastructure

Across the STP there are already systems in place throughout primary care where information is collected, stored and analysed. However, these systems and processes are not consistent across the emerging networks. Furthermore, different areas within the STP are currently at different stages in terms of data links, PCN wide information governance and analytical capability.

The STP knows that to move to a PCN business intelligence system that can support population health management, it will need a large pool of data and processing facilities with the capability of pulling data together. This data will need to be made anonymous when it is being analysed and location specific at practice and MDT levels. Linked data should include primary, secondary, community and mental health data as a minimum but the strategy will also include the ambition to link social care data to this data. When available the STP will use the national PCN dashboard to help understand the performance of its networks.

There are a number of options that the STP will consider in creating this data system, with the ultimate decision making and design to be co-produced with clinical directors and their networks. These options may include:

- Procurement of new sets of systems.
- Utilising existing capability such as commissioning support units (who provide business intelligence support)
- Using a combined approach with different parts of the system responsible for the different pieces data we are looking at.
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 or 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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### Draft 5-year Primary Care Financial Plan (Dudley CCG)

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### 2018/19 - 2023/24 STP Primary Care Strategy

#### Draft 5-year Primary Care Financial Plan (Sandwell & West B'ham CCG)

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<td>-</td>
<td>35,601</td>
<td>36,552</td>
<td>951</td>
</tr>
<tr>
<td>2019/20 Plan £000</td>
<td>24,618</td>
<td>1,916</td>
<td>6,524</td>
<td>2,817</td>
<td>-</td>
<td>67</td>
<td>1,058</td>
<td>4,228</td>
<td>741</td>
<td>-</td>
<td>-</td>
<td>41,145</td>
<td>41,145</td>
<td>-</td>
</tr>
<tr>
<td>2020/21 Plan £000</td>
<td>25,829</td>
<td>2,010</td>
<td>6,801</td>
<td>2,956</td>
<td>-</td>
<td>70</td>
<td>1,102</td>
<td>4,407</td>
<td>772</td>
<td>-</td>
<td>-</td>
<td>43,172</td>
<td>43,172</td>
<td>-</td>
</tr>
<tr>
<td>2021/22 Plan £000</td>
<td>27,100</td>
<td>2,109</td>
<td>7,099</td>
<td>3,101</td>
<td>-</td>
<td>73</td>
<td>1,151</td>
<td>4,601</td>
<td>806</td>
<td>-</td>
<td>-</td>
<td>45,066</td>
<td>45,066</td>
<td>-</td>
</tr>
<tr>
<td>2022/23 Plan £000</td>
<td>28,493</td>
<td>2,218</td>
<td>7,435</td>
<td>3,260</td>
<td>-</td>
<td>77</td>
<td>1,205</td>
<td>4,818</td>
<td>844</td>
<td>-</td>
<td>-</td>
<td>47,199</td>
<td>47,199</td>
<td>-</td>
</tr>
<tr>
<td>2023/24 Plan £000</td>
<td>30,062</td>
<td>2,340</td>
<td>7,818</td>
<td>3,440</td>
<td>-</td>
<td>81</td>
<td>1,267</td>
<td>5,067</td>
<td>887</td>
<td>-</td>
<td>-</td>
<td>49,631</td>
<td>49,631</td>
<td>-</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>STP</th>
<th>2019/20 Plan £000</th>
<th>2020/21 Plan £000</th>
<th>2021/22 Plan £000</th>
<th>2022/23 Plan £000</th>
<th>2023/24 Plan £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Transformation Support/PCN Development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Dudley CCG</td>
<td>482</td>
<td>487</td>
<td>492</td>
<td>497</td>
<td>501</td>
</tr>
<tr>
<td>NHS Sandwell and West Birmingham CCG</td>
<td>864</td>
<td>872</td>
<td>881</td>
<td>890</td>
<td>899</td>
</tr>
<tr>
<td>NHS Walsall CCG</td>
<td>431</td>
<td>436</td>
<td>440</td>
<td>445</td>
<td>449</td>
</tr>
<tr>
<td>NHS Wolverhampton CCG</td>
<td>441</td>
<td>509</td>
<td>556</td>
<td>599</td>
<td>639</td>
</tr>
<tr>
<td>Total</td>
<td>2,218</td>
<td>2,304</td>
<td>2,369</td>
<td>2,430</td>
<td>2,488</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>STP</th>
<th>2019/20 Plan £000</th>
<th>2020/21 Plan £000</th>
<th>2021/22 Plan £000</th>
<th>2022/23 Plan £000</th>
<th>2023/24 Plan £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP IT Costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Dudley CCG</td>
<td>1,516</td>
<td>1,289</td>
<td>1,313</td>
<td>1,337</td>
<td>1,361</td>
</tr>
<tr>
<td>NHS Sandwell and West Birmingham CCG</td>
<td>1,876</td>
<td>1,992</td>
<td>2,115</td>
<td>2,246</td>
<td>2,385</td>
</tr>
<tr>
<td>NHS Walsall CCG</td>
<td>1,054</td>
<td>1,059</td>
<td>1,059</td>
<td>1,059</td>
<td>1,059</td>
</tr>
<tr>
<td>NHS Wolverhampton CCG</td>
<td>788</td>
<td>817</td>
<td>849</td>
<td>881</td>
<td>914</td>
</tr>
<tr>
<td>Total</td>
<td>5,234</td>
<td>5,157</td>
<td>5,336</td>
<td>5,523</td>
<td>5,719</td>
</tr>
</tbody>
</table>

13.3 STP Financial Position

The STP is continuing to work up plans and quantify the total financial impact of the new models of care to 2023/24 to include:

- Inflationary pressures in future years.
- Additional workforce requirements.
- Capital and revenue consequences of the local primary care estates strategies.
- Other enables, such as digital solutions.
Workforce

Using the HEE modelling techniques, the STP requires 790 FTE GPs by March 2023 to meet predicted demand. Comparing this to the baseline FTE as at 1\textsuperscript{st} April 2019 and adjusting this baseline for predicted recruitment and retention rates and predicted retirements the STP will need 47 additional FTE GPs by March 2023. This is an additional £5.2m recurrent cost based on an estimate of £110k per FTE.

Modelling is being undertaken to forecast the capacity required to meet the case for change to the end of 2023/24 for all key staff groups, such as:

- GPs.
- General practice nurses.
- Physician associates.
- Pharmacists.
- Administrative staff including social prescribers.
- Direct patient care (e.g. HCA, nursing associate and phlebotomist).

Estates

Local primary care estates strategies have been prepared for each CCG and work is being undertaken to understand the planned and proposed developments and improvements to quantify the capital and revenue implications.

The revenue impact has been calculated using a guide measure, which is based on a review of current expenditure levels for each practice and identifying the point at which appropriate quality and capacity indicators were achieved. For example, this would equate to an additional £2m p.a. for Walsall CCG and £2.4-3m for Sandwell and West Birmingham CCG.

Further work is being undertaken to quantify the capital and revenue consequences of the local primary care estates strategy.

Digital

Current resource for primary care IT is ring-fenced and these budgets are fully committed to existing obligations such as GP clinical systems provision and support. Additional funding opportunities are provided through the ETTF and HSLI which are co-ordinated across the Black Country and West Birmingham.

Work is ongoing to quantify the impact of digital requirements as an enabler to the new models of care.

Funding Increased Expenditure

It is highly likely that the revenue cost of the new models of care will be over-and-above the level of allocation for the period to 2023/24 and therefore the STP is also considering other funding sources and the release of savings by re-providing care out of hospital, for instance.
13.4 Associated Risks

The STP is in the process of modelling the additional staffing requirements and the capital and revenue impact of estates plans and other enablers (e.g. digital and any other support/oversight).

It is likely that the STP will need to identify a way of funding the cost impact of the investments into the new models of care and this remains a significant risk.

14 Useful Data Sources

The table below includes data sources that may be useful in completing the plan. [This section may be removed or amended in the final version of the plan].

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>from PHE can be useful source of demographics info and mapping solutions.</td>
<td></td>
</tr>
<tr>
<td>Weighted populations and allocations</td>
<td><a href="https://www.england.nhs.uk/allocations/">https://www.england.nhs.uk/allocations/</a></td>
</tr>
<tr>
<td>Workforce data</td>
<td><a href="https://www.nwrs.nhs.uk/">https://www.nwrs.nhs.uk/</a></td>
</tr>
<tr>
<td>GP Patients survey</td>
<td><a href="http://www.gp-patient.co.uk/">http://www.gp-patient.co.uk/</a></td>
</tr>
</tbody>
</table>
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
## DUDLEY CLINICAL COMMISSIONING GROUP
### PRIMARY CARE COMMISSIONING COMMITTEE

**Date of Meeting:** 26th July 2019  
**Report:** Quality & Safety Report  
**Agenda Item No:** 11.0

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Quality and Safety Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To provide on-going assurance to the Primary Care Commissioning Committee (PCCC) regarding quality and safety in accordance with the CCG’s statutory duties</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr J Young, Head of Quality Assurance</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mrs C Brunt, Chief Nurse</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr Ruth Edwards, Clinical Lead, Quality &amp; Safety</td>
</tr>
</tbody>
</table>

### KEY POINTS:
- CQC visit completed to Links Medical Practice
- Summary of the general practice flu plan questionnaire – actions agreed at PCOG
- Childhood immunisations waiting list data has now been provided
- A review of preventing future deaths reports relevant to primary care has been carried out at PCOG

### RECOMMENDATION:
The Primary Care Commissioning Committee is asked to:
- **Note** this report for assurance

### FINANCIAL IMPLICATIONS:
None to report

### WHAT ENGAGEMENT HAS TAKEN PLACE:
n/a

### ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:
No conflicts of interest were declared in advance

### ACTION REQUIRED:
- ✔ Assurance
Primary Care Analysis Report – PCCC Summary

Care Quality Commission (CQC)

- A follow-up visit to The Greens was completed by members of the CCG on the 14/06/19. A visit to Steppingstones has been arranged for July.
- A CQC visit was completed to the Links Medical Practice on the 13/06/19. There is a CQC visit scheduled to Quarry Bank on the 27/06/19.
- Three further practices are currently in the process of completing a new registration application
- The Annual Regulatory Reviews (ARRs) will commence in Dudley from 01/07/2019 with 12 practices identified for the ARR during July to September 2019.

Serious Incidents (SIs)

- No serious incidents to report

Service Developments

- Datix - seven practices are currently using Datix for internal incident reporting; a total of nine practices are using the system for internal incident reporting and/or reporting patient safety concerns; a further 14 practices have registered to use the system but have yet to report anything on Datix.

Other

Special Allocation Scheme (SAS)

- There are currently 13 patients on the SAS following a further 6 being identified at panel review

Preventing future deaths

- “Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths”.
- The Q&S team has recently introduced a process to review these reports to identify opportunities for learning and gaining assurance from local providers.
- There are a number of reports published which identify actions for primary care to prevent future deaths. Examples were discussed at PCOG and agreed to bring these to the meeting on a regular basis.

Infection Prevention & Control (IPC)

Immunisations

- 36 responses have been received to the general practice flu plan questionnaire. A summary of the results have been discussed at PCOG and an action plan agreed.
- The Dudley Immunisation & Flu Planning Group are due to meet on the 26/06/19.
- Childhood imms waiting list data has recently been shared with the CCG. Initial discussion at PCOG suggests this requires further review.

Audits

- Two audits have been completed from the 2019/20 schedule
## Care Quality Commission (CQC) Ratings

This section shows the results for the latest CQC inspections, the scores are calculated as follows; 1. Inadequate, 2. Requires Improvement, 3. Good, 4. Outstanding.

<table>
<thead>
<tr>
<th>GP Practice</th>
<th>Visit Date</th>
<th>Sum of CQC</th>
<th>Overall Rating</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well Led</th>
</tr>
</thead>
<tbody>
<tr>
<td>LINKS MEDICAL PRACTICE</td>
<td>Jun 2019</td>
<td>Awaiting Results</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>THE GREENS HEALTH CENTRE</td>
<td>Mar 2019</td>
<td>12</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>STEPPINGSTONES MEDICAL PRACTICE</td>
<td>Feb 2019</td>
<td>14</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>AW SURGERIES</td>
<td>Jan 2019</td>
<td>14</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>KELLYCOTE HOUSE</td>
<td>Jan 2019</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>BATH STREET MEDICAL CENTRE</td>
<td>Dec 2018</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>CROSELEY MEDICAL CENTRE</td>
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<td>14</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>CASTLE MEADOWS SURGERY</td>
<td>Feb 2018</td>
<td>13</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>OUDLEYWOOD SURGERY</td>
<td>Jul 2017</td>
<td>14</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
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</tbody>
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**DUDLEY CLINICAL COMMISSIONING GROUP**  
**PRIMARY CARE COMMISSIONING COMMITTEE**

**Date of Committee:** 26 July 2019  
**Report:** Finance Report  
**Agenda item No:** 12.0

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Primary Care Commissioning Finance Report</th>
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</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>The report provides an overview of the financial position in respect of budgets reported to Committee</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr P Cowley, Senior Finance Manager</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr T Horsburgh, Clinical Executive for Primary Care</td>
</tr>
</tbody>
</table>

**KEY POINTS:**
- The budget reported to Committee totals £47,764m
- There have been no changes to the budget reported to Committee in this financial year.
- At this early point in the financial year a small underspend of £7,000 is reported against delegated budgets, due to a 0.16wte vacancy within the nurse mentoring team.
- An overspend of £17,000 relating to increased ECG activity within primary care is reported against Core CCG budgets.
- The initial financial plan presented to Committee noted a cost pressure of £158,000. A separate report is presented to Committee in respect of actions taken to balance the financial plan, and budget changes to implement this have taken effect at month 3.

**RECOMMENDATION:** Committee is requested to note the reported financial position for assurance.

**FINANCIAL IMPLICATIONS:** Budget reported to Committee: £47,764,000

**WHAT ENGAGEMENT HAS TAKEN PLACE:** Not applicable

**ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** No conflicts of interest were identified in advance.

**ACTION REQUIRED:** ✓ Assurance
Finance Report (July 2019)

This report submitted to Dudley CCG Primary Care Commissioning Committee provides a breakdown of financial performance for Co-commissioned Primary Care for the period to June (month 3) 2019/20.

Contents

Financial Overview p2
Financial Detail p3
Budget Allocations

Budgets reported to the committee have an annual value of £47,754,000, including both the delegated co-commissioning allocation and core CCG budgets.

There have as yet been no changes to the budget reported to Committee this financial year.

Financial Position

At this early stage in the financial year, there are no significant variances against the delegated primary care budget to budget and the reported forecast overspend of £10,000 is due to an increase in Electrocardiograms performed in Primary Care.

Allocation Breakdown

Core CCG Primary Care £4,797k
Delegated Primary Care £42,967k
Financial Detail – Delegated Primary Care

Summary

The Financial Plan submitted to Committee in April included a cost pressure of £158,000 against delegated primary care budgets, funding for which had yet to be identified.

A separate report to this Committee details a range of changes to budgets, reflecting more up to date information, and measures taken to ensure financial balance, and these changes have taken effect as at month 3.

A small underspend of £7,000 is therefore reported to Committee, reflecting a 0.16 WTE vacancy within the nurse mentoring team, with other budgets reporting a break-even position at this early stage in the financial year.

<table>
<thead>
<tr>
<th>Area</th>
<th>Budget (WTE)</th>
<th>Annual Budget (£'000)</th>
<th>Forecast Variance (£'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Contract</td>
<td></td>
<td>28,355</td>
<td>-</td>
</tr>
<tr>
<td>QOF and Enhanced Services</td>
<td></td>
<td>8,111</td>
<td>-</td>
</tr>
<tr>
<td>Premises Costs</td>
<td></td>
<td>4,707</td>
<td>(1)</td>
</tr>
<tr>
<td>Dispensing/Prescribing Drs</td>
<td>0.80</td>
<td>1,691</td>
<td>(6)</td>
</tr>
<tr>
<td>Other GP Services</td>
<td></td>
<td>104</td>
<td>-</td>
</tr>
<tr>
<td>Contingency Reserve</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.80</td>
<td>42,967</td>
<td>(7)</td>
</tr>
</tbody>
</table>
Summary

Core CCG budgets reported to Committee are currently forecast to overspend by £17,000, due to a small overspend against the Local Enhanced Services budget.

This overspend is caused by a significant increase in activity under the LIS for the provision of Electrocardiograms (ECGs) in Primary Care. While only two months data has been received, this increase does reflect a decrease in ECG activity in acute settings and could form part of a wider trend. Further investigation will therefore be undertaken in this area.

A separate report to Committee seeks approval for the continuation of the practice engagement scheme. The funding for this scheme is not included in these reported budgets, but the source of funding for the costs is reflected within this report, and the separate financial plan update report.

The adjustment required to fund the engagement scheme will be made in month 4, should the scheme be approved.
### TITLE OF REPORT:
Financial Planning Update

### PURPOSE OF REPORT:
To update Committee on steps taken to achieve a balanced financial plan in 2019/20, and progress towards the construction of a long-term financial model.

### AUTHOR OF REPORT:
Mr P Cowley, Senior Finance Manager

### MANAGEMENT LEAD:
Mr M Hartland, Chief Operating and Finance Officer

### CLINICAL LEAD:
Dr T Horsburgh, Clinical Lead Primary Care Co Commissioning

### KEY POINTS:
- The financial plan presented to Committee in April noted a cost pressure of £158,000 within budgets, and noted requirements to construct a plan to achieve financial balance in 2019/20 and model future implications of the GP contract changes.
- Revisions to the plan have reduced the unidentified cost pressure within delegated budgets to £88,000.
- A further potential pressure of £230,000 has been identified within core budgets reported to committee, in respect of the continuation of the practice engagement scheme.
- Non recurrent funding to meet these costs pressures has been identified from the balance of 18/19 DQOFH underachievement and slippage in core CCG programmes, as a result of which the 2019/20 financial plan is now in balance.
- One potential QIPP savings scheme has been identified and is currently being worked up.
- A long-term financial model has been constructed, with CCG allocations and the cost of PCN financial entitlements up to 2023/24 quantified.
- Further clarification of core GMS costs within the GP contract settlement are required before the model can be fully populated and presented to Committee. It is currently unclear whether notified funding will be sufficient to meet increases in core GMS contract costs.

### RECOMMENDATION:
Committee is requested to note for assurance:
- That a balanced financial plan is now in place for 2019/20
- Progress made to date in the construction of the long-term Primary Care financial plan.

### FINANCIAL IMPLICATIONS:
As above.
<table>
<thead>
<tr>
<th>WHAT ENGAGEMENT HAS TAKEN PLACE:</th>
<th>None</th>
</tr>
</thead>
</table>
| ACTION REQUIRED:                 | Decision  
|                                  | Approval  
|                                  | Assurance  ✓ |
1. INTRODUCTION

1.1. The Financial Plan paper presented to Committee in April, which set out budgets for the financial year 2019/20, noted a cost pressure in the current financial year of £158,000 in respect of the delegated primary care budget, and the possibility that the Primary Care Network (PCN) contract could continue to cause recurrent financial pressures. The report noted that a plan to achieve financial balance in 2019/20 would be presented to Committee in June, and a long term financial plan developed to assess the level of challenge to the budget in future financial years.

1.2. This report presents a fully funded plan for 2019/20 and updates Committee on progress in respect of the long-term financial plan.

2. 2019/20 REVISED FINANCIAL PLAN

2.1. Delegated Primary Care

2.2. As outlined above, the 2019/20 financial plan presented to committee in April included an unfunded cost pressure of £158,000 within the delegated primary care budget. Since this report, further revisions have been made to budgets in respect of:

- Updated GP contract payments information, specifically in respect of practice list sizes and premises reimbursements.

2.3. These revisions, which are summarised in table 1 (below), have the effect of reducing the cost pressure within the delegated budget by £70,000. The key items contributing to these changes are:

- Quarter 1 list size changes, which have increased contract payments by £57,000 over the course of the year and are funded from the contingency reserve as noted in the financial plan.
- Increases to premises reimbursements, which have risen by £55,000 mostly due to uplifts in costs of the LIFT buildings.
- Updated assumptions in respect of PCN costs, due to DES signup levels and the clarification from NHS England that the additional role reimbursements are full-year levels and should be reduced pro-rata to reflect the fact that the DES is only in place from July.

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost Pressure</th>
<th>Contingency Reserve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Startpoint</td>
<td>-158</td>
<td>215</td>
</tr>
<tr>
<td>Q1 List Size Changes</td>
<td>-57</td>
<td></td>
</tr>
<tr>
<td>Premises Reimbursement Changes</td>
<td>-55</td>
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</tr>
<tr>
<td>New CQC Formula</td>
<td>-3</td>
<td></td>
</tr>
<tr>
<td>Reflect DPO Offer Signup</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Network DES Amendments</td>
<td>111</td>
<td></td>
</tr>
<tr>
<td>Revised Position</td>
<td>-88</td>
<td>158</td>
</tr>
</tbody>
</table>

2.4. These revisions have the effect of reducing the contingency reserve to £158,000, in line with the plan to fund list sizes increases from this reserve, and also leave a recurrent residual cost pressure on the delegated primary care budget of £88,000.
2.5. Core CCG Primary Care

2.6. In addition to the cost pressure within the Delegated Primary Care budget, Core CCG budgets will face an additional cost pressure should the Practice Engagement Scheme be retained by Committee.

2.7. The Engagement Scheme had been expected to end due to the creation of PCNs and the transfer of the prescribing incentive scheme into the DQOFH framework, and the Financial Planning was carried out on this basis. However, a continued requirement for this scheme during 2019/20 has now been identified and a separate report will be presented to Committee recommending continuation of the scheme at a cost of £230,000.

2.8. In combination, should Committee approve the continuation of the Practice Engagement Scheme, the total in-year cost pressure within primary care will increase to £318,000. Sources of funding to mitigate this cost pressure are outlined below.

3. 2019/20 MITIGATIONS

3.1. Following the update of the financial plan and identification of cost pressures, a review of Primary Care expenditure has been undertaken to identify a) any ‘quick win’ QIPP schemes which could be brought forward to provide savings in 2019/20, and; b) any balance sheet flexibilities which could be released to fund the gap non-recurrently while more detailed QIPP schemes and longer-term plans are worked up. The outcome of this review is outlined below.

3.2. QIPP Review

3.3. In respect of QIPP, opportunities within 2019/20 are limited by the fact that the allocation reduction in respect of the national GP indemnity scheme was not notified to the CCG until after 2019/20 contracts for most discretionary services had already been signed.

3.4. A review of the remaining items of discretionary expenditure has identified just one concrete opportunity, to reduce the cost of interpreting services through re-procurement, which has the potential to save £10,000 in 2019/20 and a further £10-20,000 in 2020/21. This area is already under consideration by the Commissioning Manager for Primary Care, and a future report will be presented to Committee in its respect, but at this early stage no saving is assumed from this re-procurement.

3.5. Balance Sheet Review

3.6. The balance sheet review of items from year-end 2018/19, which normally takes place at month 6, has been brought forward to identify whether any flexibility exists to fund the cost pressure non-recurrently, avoiding the need to cut either commissioned services or GP support within this financial year.

3.7. While most of the items on the balance sheet still lack sufficient certainty to release a balance back into income and expenditure accounts, achievement payments in respect of the Dudley Quality Outcomes for Health (DQOFH) scheme were made in May, and the balance in respect of this area can be brought forward to provide funding.

3.8. In respect of this scheme, provision was made at the end of the financial year to fund payment in respect of 100% achievement by all practices. Final achievement levels of practices averaged only 94.2%, and this under-achievement releases a total of £375,000.

3.9. While uncertainty in respect of other balance sheet items precludes these from being released at this point, the review has identified a low likelihood that the remaining items will present a net cost. It is therefore possible to release from the balance sheet back into income and expenditure accounts the funding that is required to absorb the cost pressure of £318,000.
3.10. Summary

3.11. Based upon the outcome of these reviews, in respect of 2019/20 budgets:

- The cost pressure of £318,000 will be funded through the release of balance sheet flexibilities relating to 2018/19 DQOFH underperformance
- Development of a QIPP scheme for interpreting services will continue, but no specific target will be identified at this stage.

4. LONG TERM FINANCIAL MODEL UPDATE

4.1. As Committee is aware, the 2019 Contract negotiations between NHS England and the BMA resulted in a new GMS contract framework, introducing Primary Care Networks and fixing the level of investment into core contract funding for the next five years.

4.2. A long term financial model has been constructed for the period of the contract framework, and information on allocation changes and cost increases as a result of the PCN contract, which are clearly set out in the agreement, fed into this model. These are set out in table 2.

| Table 2 – Changes to CCG allocations and PCN entitlements |
|----------------------------------|-----|-----|-----|-----|-----|
| Allocation (£'000)               | 19/20 | 20/21 | 21/22 | 22/23 | 23/24 |
| 42,967                           | 44,566 | 46,309 | 48,285 | 50,564 |
| Increase (£'000)                 | 0 | 1,599 | 1,743 | 1,976 | 2,279 |
| Increase (%)                     | 4% | 3.9% | 4.3% | 4.7% |

<table>
<thead>
<tr>
<th>Cost Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCN Contract Entitlement Area</td>
</tr>
<tr>
<td>Clinical Director full year effect</td>
</tr>
<tr>
<td>Increase in PCN Role Reimbursement</td>
</tr>
<tr>
<td>Extended Access DES full year effect</td>
</tr>
<tr>
<td>Total Increase</td>
</tr>
<tr>
<td>Remaining balance</td>
</tr>
</tbody>
</table>

4.3. As table 2 shows, CCG allocations increase significantly over the next 4 years up to 2023/24, with the majority this funding committed to increasing Primary Care Network entitlements.

4.4. The framework agreement is however far less clear on changes to practice payments under the core GMS contract, with only the increase in overall national funding included within the document. Clarification of the detailed changes to core GMS payments has therefore been sought from NHS England, but it is currently unclear whether the remaining balance of allocation growth will be sufficient to fund these changes and other inflationary pressures.

4.5. It is expected that sufficient clarification will be received from NHS England to allow the plan to be brought to Committee in August. However, in light of the uncertainty surrounding this issue, should this not be possible regular updates will be provided Committee through the monthly finance report.

5. RECOMMENDATIONS:
Committee is requested to note for assurance:

- the steps that have been taken to balance the budget in 2019/20
- progress in the construction of the long-term Primary Care financial plan.

Philip Cowley
Senior Finance Manager
July 2019
## DUDLEY CLINICAL COMMISSIONING GROUP
### PRIMARY CARE COMMISSIONING COMMITTEE

**Date of Committee:** 26 July 2019  
**Report:** Update Report from the Primary Care Development Group and GPFV Workforce sub-group – GPFV work programme

**Agenda Item:** 14.0

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Update Report from the Primary Care Development Group and GPFV Workforce sub-group – GPFV work programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To update the Committee following the Primary Care Development Group (PCDG) and GPFV Workforce sub-group meetings held on 8th May and 11th July 2019</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mrs J Taylor, Primary Care Commissioning Manager</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mrs C Brunt, Chief Nurse</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr T Horsburgh, Clinical Executive for Primary Care</td>
</tr>
</tbody>
</table>

**KEY POINTS:**

- The PCDG and GPFV Workforce sub-groups have been established to oversee the implementation of the Dudley CCG GP Forward View (GPFV) Plan
- A high level project plan has been developed for both groups to monitor the delivery of all key work streams outlined within the GPFV plan and a progress update report is received at each meeting
- The group received an update from the primary care development group (PCDG) to include the following work streams:
  - Black Country STP GPFV Programme
  - IT update
  - Extended access
  - Productive General Practice Quick Start
  - Coaching Offer from NHS England for GP’s and Practice Managers
  - DPMA Training and Buddy Schemes
  - Ten High Impact Actions
  - On-line and group consultation
  - Primary Care Networks (PCNs) in Dudley
  - GP Resilience Fund 2017/18 & 2018/19
  - Practice Manager Development Fund: Additional Funding for LMC’s
- The group received an update from the GPFV Workforce sub-group to include the following work streams:
  - Primary Care Workforce Analysis
  - GP Retention including Intensive Support Site Update
  - Early Career Peer Network Programme
  - GPN Fast Track Programme
  - STP GPN Retention Plan
  - Update from Training Hub
  - Portfolio Career Applications
  - General Training Update
## RECOMMENDATION:

The Committee is asked to:
- Note the update from the Primary Care Development Group and GPFV Workforce sub-group for assurance
- Note that the sub-groups will ensure that all transformation and improving access funds which have been directly allocated by NHSE to the CCG are used in accordance with the Statutory Financial Instructions (SFIs), and comply with all relevant guidance and legislation in relation to managing conflicts of interest and procurement

## FINANCIAL IMPLICATIONS:

- All finances will be contained within the allocation for GPFV

## WHAT ENGAGEMENT HAS TAKEN PLACE:

- Localities in development of Extended Access Scheme 2018/19
- Dudley Practice Managers Alliance (DPMA)
- Dudley LMC
- GP Collaborative practices
- Clinical Executive
- Dudley Practice Managers Alliance

## ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:

No conflicts of interest identified in advance

## ACTION REQUIRED:

Decision
Approval
Assurance ✓
1.0 INTRODUCTION

This report provides an update from the Primary Care Development Group (PCSG) and GPFV Workforce sub-group following a meeting held on 8th May 2019.

2.0 BACKGROUND

2.1 Originally the Primary Care Strategy Group (PCSG) which had been formally established and approved as a sub-group reporting to the Committee in May 2017, to oversee and assure Committee that plans outlined within the GPFV plan are on track for successful delivery;

2.2 In November 2018 the Primary Care team were asked to review their work programmes resulting in a re-structure of the GPFV delivery programme to assume direct reporting arrangements and assurance responsibilities to Committee from the PCDG and GPFV Workforce sub-groups respectively;

2.3 The respective groups have been providing an update report to Committee on a regular basis for assurance.

3.0 PROJECT PLAN FOR DELIVERY OF GPFV

3.1 A high level project plan has been developed for the PCDG and GPFV Workforce sub-group to monitor the delivery of all key work streams outlined within the GPFV plan;

3.2 Project updates and presented and reviewed by both groups (Appendix 1) on a regular basis and no significant risks relating to delivery of the GPFV plan have been identified which require escalation to Committee.

4.0 UPDATE FROM PRIMARY CARE DEVELOPMENT GROUP

4.1 Black Country STP GPFV Programme

4.1.1 The STP appointed a Programme Director and Programme Manager continue to oversee the successful delivery of the GPFV work programme across the STP footprint and provide assurance to NHSE on a regular basis;

4.1.2 All allocations for GPFV from NHSE are now being made on an STP footprint and a GPFV STP Programme Board has been set up to determine how allocated funds will be distributed;

4.1.3 The BC STP is developing a Primary Care Strategy in line with the Long Term Planning guidance, for which a draft will be presented to Committee under a separate item but needs to be submitted to NHSE by the end of June 2019. Several engagement events have been
schedules across the STP with the Dudley event taking place on 23rd May. Sarah Southall – BC STP GPFV Programme Director is leading on this with support from the Commissioning Support unit.

4.2 IT Update

4.2.1 HSCN upgrade discussion were underway with Tera ferma around proposals and suggested solutions;

4.2.2 Several project initiation documents (PID) had been submitted to NHSE to obtain additional IT funding, with confirmation of approval being awaited;

4.2.3 Following a scoping exercise with Primary Care, the CCG will be undertaking an IT refresh to include new laptops/desktops. A role out plan has been produced to support this and in development equipment will have all standard software applications;

4.2.4 Further work is being undertaken to refresh the Network to enhance the current firewalls and improve download speeds.

4.3.1 Extended Access

4.3.1 The CCG have completed as contract review with the 5 lead practices and have been undertaken a capacity review before issuing changes to the contract for 2019/10, which have included:

- The ability to be able for NHS 111 to directly book into extended access appointments
- A target on utilisation of 85%
- NHS Digital mandating the GPFV data to be submitted by the 15th of the following month
- Appointment data to be directly extracted by NHS digital

4.3.2 The updated specification which were approved by Committee in March have been distributed to Member practices and contracts form 2019/20 are in place with the 5 lead practices;

4.3.3 Reporting arrangements to NHS Digital will now be required on a quarterly basis rather than monthly from April 1st 2019;

4.3.4 Due to the changes under the new Primary Care Network (PCN) arrangements the CCG will be exploring options with the 6 PCN’s regarding delivery of the Extended Hours (PCN DES) and Extended Access Local Improvement Scheme (LIS).

4.4 DPMA Training Plan

4.4.1 In line with the strategic direction outlined within the NHS Long Term Plan the arrangements for delivery of the DPMA training budget plan had now changed. The DPMA would still remain responsible for identifying the future training requirements of their practice staff but the Training Hub would be responsible for co-ordinating and organising the training plan in line with the strategic direction;
4.4.2 In addition the Training Hub will be responsible for evaluating, reporting and communicating training available to practice staff, DPMA and the CCG on a regular basis which will include a formal report to committee on a 6 monthly basis.

4.5 GP/Nurse Education

4.5.1 The rolling GP/Nurse education programme continues to be provided on a 6 weekly basis which previously has predominately been organised in house by the GP Lead for Education – Dr Rebecca Willets;

4.5.2 In line with the strategic direction the CCG has been working closely with the Training Hub to provide on-going support for delivery of this programme in particular to organise speakers and provide support for the events from the pharmaceutical industry.

4.6 Ten High Impact Actions

4.8.1 Delivery of two of the High Impact actions formed part of the practice engagement scheme for 2018/19. All practices have submitted supporting information regarding the impact and a report will be presented to the group and then subsequently to Committee in the future.

4.8.2 It is a recommendation that this report should be shared with the DPMA and PCN to share good practice.

4.7 Online and Group Consultation

4.7.1 The CCG commenced roll out of the on-line consultation solution (Sense.ley – Ask NHS) but due to potential conflicts with the National NHS app then this was paused until clarification could be gained on the preferred digital solution for patients;

4.7.2 Following further guidance the National NHS app would not have the functionality required to provide an on-line consultation solution then the CCG have re-commenced roll out of the Ask NHS app;

4.7.3 The CCG have being working with other CCG’s across the country with the same on-line consultation solution to fully release the benefits to the public and GP practices so this can be utilised as a mechanism of promotion;

4.7.4 Governance arrangements regarding the on-line consultation solution will be presented to Committee in July;

4.7.5 There are four practices who continue to be actively involved in delivery of group consultations sessions which have been most successful in the ‘at risk’ or newly diagnosed diabetes populations.

4.8 Non-Medical Prescribing

4.8.1 Four candidates expressed an interest in the offer of support for non-medical prescribing courses who were all instructed to source a suitable course. The consultant Pharmacists has not yet received any further feedback from these candidates however it was noted that there is currently a long waiting list to access these courses (January 2020) which may be the reason for the delay;
4.8.2 The group sort confirmation around the process of obtaining funding through the STP allocation for non-medical prescribing in the future.

4.9 **AMSPAR and Healthcare Assistant (HCA) Apprenticeships**

4.9.1 The CCG invested in a number of AMSPAR and HCA apprenticeships from the 2018/19 budget. Of the 20 GP practices who expressed an interest:

- 12 staff signed up for the AMSPAR Level 2 Admin diploma
- 20 staff for the AMSPAR Level 3 Admin Diploma
- 2 staff for the HCA Apprenticeship Level 2
- 2 staff for the HCA Apprenticeship Level 3
- 35 staff for the Medical Terminology Level 3

4.10 **Care Navigation / Active Signposting**

4.10.1 The CCG continue to support both active sign post and Community Information Champion over the next six months. The CCG will be working with the STP to secure additional funding through the STP allocation to provide on-going support in this area.

4.11 **Estates**

4.11.1 The CCG has commissioned a consultancy firm to undertake a review of Primary care and PCN estate requirements.

5.0 **UPDATE FROM GPFV WORKFORCE SUB-GROUP**

5.1 **PCN Development including new roles**

5.1.1 The CCG locality meeting agendas have been cleared for the past two months to allow discussions around PCN development;

5.1.2 The Clinical Directors posts have all been appointed and Committee approved registrations from the 6 PCN’s in May;

5.1.3 The key tasks for the PCN’s is to agree how they will operate in the future so that this can be reflected in Network Agreement which needs to be submitted by the end of June;

5.1.4 The PCN’s will be receiving proposals from Integrated Plus and the Pharmacy team regarding how the new roles (pharmacist and social prescribing) could be integrated into existing services.

5.2 **GP Retention including Intensive Support Site Update**

5.2.1 The STP GP Clinical lead regularly communicates to practices to promote these schemes and proposals will be submitted to the STP Programme Board to secure funding in 2019/20 for the continuation of these schemes.
5.3 Early Career Peer Network Programme

5.3.1 The programme has been developed to run consecutively with the current GP Education programme every six weeks (April to November 2019) to create a support network for new GP’s into practice and will be fully funded non-recurrently as a pilot;

5.3.2 There are 11 candidates signed up and actively taking part in the programme. The first three sessions received excellent engagement and feedback from participants. The first 5’s GP Lead for the BC STP will be invited to a future meeting to introduce her role;

5.3.3 Following completion of the programme a full evaluation will be undertaken which will be presented to Committee in the future.

5.4 GPN Fast Track Programme

5.4.1 The CCG has worked closely with the BC STP and the BC Training Hub to develop a fast track GPN skills programme to run April – June 2019;

5.4.2 The programme is not designed to replace the fundamentals of GP course (12 month programme) but to create a fast track opportunity which will enable new qualified nurses or nurses wishing to transition into a GPN role to obtain the core skills required in a 3 month programme;

5.4.3 Candidates have completed the core modules for Immunisations, smears and ear syringing and are now undertaking the long-term conditions elements of the programme;

5.4.4 Once completed the programme will be fully evaluated with a view to secure recurrent funding through the STP allocation for GPFV.

5.5 STP GPN Retention Plan

5.5.1 A BC STP group has been formed to explore and develop plans for GPN retention. A first draft has been produced and a series of co-design events have taken place to inform the development. Once the plan has been finalised and an associated action plan in place this would be presented to Committee for consideration;

5.5.2 An allocation for GPN retention has been identified within the BC STP GPFV funding secured for GP retention.

5.6.1 BC STP GPN Strategy

5.6.1 A final draft strategy for GPN Strategy and associated documents has been finalised, this includes a competency framework from HCA to ANP level and is indented as a framework to support GPNs along the lifespan of their career;

5.6.2 Engagement with the DPMA and LMC will be sort prior to it being presented to Committee for ratification in July.
Update from Training Hub

5.6.1 The training hub has received no further update from Health Education England (HEE) with regard to future commissioning arrangements for the BC STP Training Hub;

5.6.2 The group requested the Training Hub provide a training session on appropriate documentation within the patient record, specifically with the move to patients having access to their medical record.

6.0 RECOMMENDATION

The Committee is asked to:
- Note the updates from the Primary Care Development Group and GPFV Workforce sub-group for assurance
- Note that both sub-groups will ensure that all transformation and improving access funds which have been directly allocated by NHSE to the CCG are used in accordance with the Statutory Financial Instructions (SFIs), and comply with all relevant guidance and legislation in relation to managing conflicts of interest and procurement
**DUDLEY CLINICAL COMMISSIONING GROUP**  
**PRIMARY CARE COMMISSIONING COMMITTEE**

**Date of Meeting:** 26 July 2019  
**Report:** Primary Care Network (PCN) Registration  
**Agenda Item:** 15.0

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Primary Care Network (PCN) Update</th>
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<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To update and provide assurance to the Committee regarding PCNs</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr D King, Head of Membership Development and Primary Care</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mrs C Brunt, Chief Nurse</td>
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<tr>
<td>CLINICAL LEAD:</td>
<td>Dr T Horsburgh, Clinical Executive for Primary Care</td>
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**KEY POINTS:**

- The Committee approved the registration of 6 PCNs at its meeting in May 2019

**Update**

- Network Agreements are in place and were agreed between all practices in each PCN by 30th June 2019 (as required by the DES specification).
- Since the last Committee Central Clinic has confirmed that they will not be participating in the PCN DES.
- The CCG now has 2 practices that have confirmed that they will not be participating in the PCN DES.
- NHS England have confirmed the contractual arrangements for those practices that haven’t signed up the PCN DES – the CCG will commission PCN DES services on behalf of practice population of both practices using an NHS Standard Contract with the local PCN.
- The CCG will be establishing a PCN/CCG Review Group between the PCN Clinical Directors, CCG GP Board Members and Primary Care Team ensure that the DES requirement are delivered
- Locality meetings will no longer take place. This is set out in more detail in the GP engagement scheme paper for Committee.
- The PCNs have received their payments for participating in the DES
- The Primary Care team will be supporting each PCN produce a workforce plan
- The Communications and Engagement team, Primary Care Team and Non-Executive lead for patient engagement will be meeting the
PCN lead for patient engagement to discuss how patients will be represented and involved in PCNs

<table>
<thead>
<tr>
<th>RECOMMENDATION:</th>
<th>The Primary Care Commissioning Committee is asked to:</th>
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<tbody>
<tr>
<td></td>
<td>o Note this update for assurance that the PCN DES requirements post registration have been met</td>
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<table>
<thead>
<tr>
<th>FINANCIAL IMPLICATIONS:</th>
<th>The PCN registration results in DES payments to each practice within the PCN, and the PCN itself</th>
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<tbody>
<tr>
<td></td>
<td>Those payments have been enacted following the approval of the PCN registrations by Primary Care Commissioning Committee in May 2019</td>
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<td>Total payments made under the scheme will reach a maximum in 2019/20 of £1.868m</td>
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<thead>
<tr>
<th>WHAT ENGAGEMENT HAS TAKEN PLACE:</th>
<th>Senior Management Team</th>
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<tbody>
<tr>
<td></td>
<td>Clinical Executive Team</td>
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<td></td>
<td>Clinical Forum</td>
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<td></td>
<td>PCN Clinical Directors</td>
</tr>
<tr>
<td></td>
<td>Primary Care Operational Group</td>
</tr>
</tbody>
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| ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE: | None |
1. BACKGROUND

The Committee approved the registration of 6 PCNs for Dudley at its meeting in May 2019 and received assurance that the all patients in Dudley would be provided with services commissioned under the DES.

2. PCN NETWORK AGREEMENTS

Following registration, each PCN must have the following in place by 30th June

- A PCN Network Agreement
- Data Sharing Agreement (DSAs) and, if appropriate, data processor agreements.

Each PCN has confirmed to the CCG that PCN Network Agreements and DSAs are in place – copies have been shared with the CCG.

3. CONTRACTUAL ARRANGEMENTS FOR THOSE PRACTICES NOT PARTICIPATING IN THE PCN DES

Meadowbrook Road Surgery in Halesowen did not sign up to the PCN DES. They have confirmed, in writing, that they wish for the CCG to contract the PCN DES for their patients to the Halesowen PCN.

Central Clinic informed the CCG in writing that they would not be signing up to the PCN DES post registration.

NHS England has confirmed the contractual arrangements for the CCG in this circumstance – that the CCG uses an NHS standard contract for a Local Improvement Scheme (LIS). The Primary Care team will be working with the Contracts team to ensure that the LIS is in place by the end of July 2019.

The CCG will also need to put in place a Memorandum of Understanding (MOU) with Meadowbrook Road and Central Clinic that sets out how they will be expected to work with the both the PCN and the CCG in discharging this arrangement, including how they ensure that their patients are made aware of the extended access arrangements.

The primary care team are fully sighted on the reasons behind the decision of each practice. There has been a significant amount of engagement with each practice, undertaken by the GP engagement lead, primary care team and PCN Clinical Directors over the last month.

4. PCN/CCG REVIEW GROUP

The Senior Management Team (SMT) and Clinical Executive Team (CET) have agreed with the PCN Clinical Directors that there will be a new group established to review the DES arrangements. A meeting will be held bi-monthly and also provide a forum in which the GP Board members are able to meet with, and discuss, the wider commissioning engagement between the CCG and the PCNs.

This arrangement will come into effect from July 2019. The Committee paper setting out changes to the GP engagement scheme in 2019/20 provides background and context. These changes will be presented back to the membership meeting in August by the CCG GP Board Members and GP Clinical Executive Lead for Primary Care.

5. PAYMENTS

The basis of payments to be made to each PCN is set out in the contract framework agreement and other published guidance, with payments to PCNs made up of two elements:

- Automatic entitlements for Clinical Director funding, extended access requirements and core PCN support funding
• Role reimbursements in respect of costs incurred in the employment/contracting of additional clinical pharmacists and social prescribers.

The table below provides a breakdown of these payments per PCN, and shows a maximum payment to practices in respect of these entitlements of £1.32m, with automatic PCN entitlements totalling £996,000. The payment figures in respect of role reimbursements are set at the maximum level of £324,000, but the actual level incurred will depend upon the timing of recruitment into these roles.

<table>
<thead>
<tr>
<th>Payment Type</th>
<th>Payment Basis</th>
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<th>HWN</th>
<th>KFD</th>
<th>SGC</th>
<th>SWL</th>
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</thead>
<tbody>
<tr>
<td>Clinical Director contribution</td>
<td>£0.514 per <strong>registered</strong> patient to cover July 2019 to March 2020</td>
<td>26</td>
<td>29</td>
<td>24</td>
<td>22</td>
<td>29</td>
<td>34</td>
<td>165</td>
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<tr>
<td>Extended Hours Access</td>
<td>£1.099 per <strong>registered</strong> patient to cover period July 2019 to March 2020 - Note: This amount is pro-rata from the £1.45 full year amount</td>
<td>55</td>
<td>62</td>
<td>51</td>
<td>48</td>
<td>61</td>
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<tr>
<td>Core PCN funding</td>
<td>£1.50 per <strong>registered</strong> patient per year (equating to £0.125 per patient per month)</td>
<td>76</td>
<td>85</td>
<td>70</td>
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<td>84</td>
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<tr>
<td>Additional Roles - Social Prescriber</td>
<td>100% Reimbursement, up to a maximum of £25,585</td>
<td>26</td>
<td>26</td>
<td>26</td>
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<td>Additional Roles - Clinical Pharmacist</td>
<td>70% Reimbursement, up to a maximum of £28,358</td>
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<td>228</td>
<td>262</td>
<td>1,320</td>
</tr>
</tbody>
</table>

In addition to these PCN payments, each practice which has signed up to the Network DES will receive a payment of £1.761 per weighted patient. This DES payment totals £548,000, bringing total payments in respect of the DES and PCN entitlements to £1.868m.

Payments in respect of the scheme will begin in July, with payments in respect of DES signup and Core PCN funding being backdated to 1st April.

6. **PATIENT ENGAGEMENT**

Dr Gillian Love, PCN Clinical Director for Halesowen presented to the Patient Opportunity Panel (POPs) in June to discuss the opportunities for patient involvement in PCNs.

A further meeting has been organised with Helen Moseley, Lay Member for Patient and Public Involvement and members of the Primary Care team, Engagement Team and Dr Love to discuss progressing patient involvement at a PCN level.

7. **RECOMMENDATION**

The Primary Care Commissioning Committee is asked to:

• Note this update for assurance that the PCN DES requirements post registration have been met
TITLE OF REPORT: Report on governance arrangements for Ask NHS Online solution

PURPOSE OF REPORT: To update the Committee on the governance process for the Ask NHS Online solution within Dudley CCG

AUTHOR OF REPORT: Mrs J Taylor, Primary Care Commissioning Manager, Mrs S Crawford Thomas – Project Manager.

MANAGEMENT LEAD: Mrs C Brunt, Chief Nurse

CLINICAL LEAD: Dr J Darby, Clinical Executive for Acute and Community

KEY POINTS:
The Ask NHS Online solution has been commissioned and piloted within Dudley CCG from April 2019. A clinical governance process has been developed for the symptom checker part of app within the CCG to provide governance and oversight of any Serious Incidents (SI’s) or clinical issues for patients who utilise the symptom checker within the online solution.

- Ask NHS is managed by Sense.ly UK and links into its clinical governance system.
- Ask NHS has national approval and on list of nationally approved apps.
- Ask NHS has been presented to Clinical Executive Meeting
- Dr Darby is a member of the quarterly Sense.ly UK clinical governance meetings.
- The Ask NHS solution is being piloted in 3 practices.
- A clinical governance process has been developed and running in draft format since the 1st practice went live with pilot.
- The CCG Head of Quality Assurance has reviewed Sense.ly’s and CCG’s governance arrangements.
- Monthly clinical reference calls are held to discuss any Serious Incidents (SI’s) or clinical issues with Dr Darby and pilot practices.
- No Serious Incidents or clinical issues have been reported since pilots commenced.
- Plan to onboard and roll out Ask NHS Solution into all GP practices by March 2020 once governance signed off within CCG.
- Equality Impact Assessment completed and reviewed by Clinical Governance and Quality team.

RECOMMENDATION: The Committee is asked to:
<table>
<thead>
<tr>
<th><strong>FINANCIAL IMPLICATIONS:</strong></th>
<th>The cost of the scheme is funded from the STP allocation for Online Consultations.</th>
</tr>
</thead>
</table>
| **WHAT ENGAGEMENT HAS TAKEN PLACE:** | • Pilot practices and identified testing practices within CCG  
• Dudley Practice Managers Alliance (DPMA)  
• Practice patients via pilot practices |
| **ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** | No conflicts of interest identified in advance |
| **ACTION REQUIRED:** | Decision  
**Approval** ✔  
Assurance |
1.0  INTRODUCTION

This report provides information to the Primary Care Commissioning on the clinical governance arrangements that have been developed within Dudley CCG for the Ask NHS Online solution.

2.0  BACKGROUND

2.1 The Ask NHS online solution was commissioned by the CCG in December 2018. The contract is until June 2020.

2.2 The app is an approved national application and the symptom checker utilises the Odessey system that is used within NHS 111.

2.3 The application has been presented to the Clinical Executive Committee and agreement made to continue roll out once governance has been approved.

3.  Ask NHS Online solution

3.1 The CCG recommenced engagement with GP practices to identify interested parties for testing of application.

3.2 The 3 pilot practices are utilising the solution and have promoted it to their patient population. There will be another promotion of Ask NHS in the pilot practices and more widely once governance has been approved.

3.3 The CCG has developed governance arrangements for the Ask NHS solution and ensured it is linked to Sense.ly UK governance systems to report any Serious Incidents or clinical issues.

3.4 There are monthly Clinical Reference calls in place which are led by Dr Darby. Any issues would also be reported to PCOG and Sense.ly UK quarterly meetings.

3.5 The CCG have been working with other CCG’s across the country with the same on-line consultation solution to understand their governance processes and benefits for their patients so far.

3.6 The CCG has developed a roll out plan for solution and aims to have it within all practices by March 2020.

4.0  RECOMMENDATION

The Committee is asked to:

- Note the governance arrangements for Ask NHS Online solution and approve.
- Note Equality Impact Assessment for the Ask NHS Online solution
Appendix 1

Clinical Governance arrangements for Ask NHS Online Consultation

1. Introduction

Dudley CCG has contracted with Sense.ly UK (supplier) to deliver an Online solution within General Practices across the CCG area. The Online solution roll out is in 2 phases, pilot and full roll out over a number of months across the CCG until the end of March 2020.

The Ask NHS app is a nationally approved application that is on a national list of suppliers to the NHS. It is established is the format proposed at Dudley CCG, within Lewisham CCG and Buckingham CCG.

The Online solution is in the format of a downloadable application onto a smart device that allows a patient registered at a Dudley practice to access a number of functions that provide recommendations and support. The Online solution will also be accessible via GP Practice websites.

The Ask NHS solution in Dudley is currently available to people aged 18 and over. There will be a version released in next few months that will be available to people aged over 16 years. The Odyssey algorithm is nationally approved for people aged over 16 years.

2. Functionality of the Ask NHS Online solution

The app has 4 main functions within its current offer.

It will offer a Long Terms Conditions management solution from August 2019.

3. Four Main Functions

3.1 Symptom Checker

This allows a patient with a clinical presenting symptom to access triage protocol (based on Odyssey algorithm) that will triage them to a recommendation around the next steps for clinical management of their issue.

The Odyssey algorithm is an established medical algorithm that has been extensively researched and unpins the NHS 111 algorithm. Clinicians are familiar with its use, outcomes and recommendations.

3.1.2 Symptom checker outcomes

There are 3 outcomes associated with when a patient completes the symptom checker;

1) Emergency - 999

2) Appointment scheduled – GP priority appointment categories 1-4 (depending on clinical outcome)

3) Self-Care – A patient is directed to NHS choices for self-care advice.
3.2 Admin Triage

Allows a patient to email GP practice to request advice e.g. Fit note.

3.3 Self-Care

Patient is directed to NHS Choices for self-care management.

3.4 Service Finder

Patients are directed to the national service directory via NHS Choices.

4. Additional Functions

The application will also have an additional function. Long Term Conditions (LTC) management for GP Practices will be available from August 2019 to support GP practices in the management of Asthma and general Hypertension. It is anticipated further LTC conditions will be managed through this platform over the next 2 years.

5. Responsibilities and management of Serious Incidents/Clinical Issues.

5.1 Responsibilities

Only patients who are registered with a GP practice in Dudley will be able to register with the application as it matches the patient registration details within the app to the GP Spine. Responsibility and vicarious liability for the patient remains with the GP practice if patients use the Ask NHS app. This position has been confirmed by Dr Darby in July 2019 after discussion with the Medical Dental and Defence Union of Scotland.

Patients must agree and tick a disclaimer within the app that ensures they are responsible for their own actions if they chose not to follow the recommendation given by the symptom checker or any of the Ask NHS recommendations.

5.2 Management of Serious Incidents or Clinical Issues

Sense.ly UK remains responsible for the application and its content and advice it gives to patients.

If there is a Serious Incident that would require action, the GP practice will contact the CCG or Sense.ly UK either via the identified CCG email (monitored daily Mon- Friday) or Sense.ly email. The Clinical Executive for Acute and Community and Head of Quality Assurance in the CCG would be informed. They would ensure that the Primary Care Commissioning Manager was aware of any issue.

A review of any incident would follow CCG and Sense.ly UK procedures that are in place and findings would be reported to Online Project meeting, PCOG, GP Practice and Sense.ly UK quarterly meetings.

The Head of Quality Assurance has reviewed Sense.ly UK procedures and no concerns have been raised.

The Ask NHS app has been in place in 2 other CCG’s for a number of months and no Serious Incidents or clinical issues have been reported.

The app has been presented to PPG groups and practice staff at the pilot sites and practices who are interested in testing the application. PPG’s have engaged well and positive feedback has been given.

7. CCG Clinical Governance Structure for Online Solution.

The Ask NHS Online solution governance has been discussed and agreed at the Online project meeting within the CCG. The named CCG Clinical lead for governance is Dr Jonathan Darby.

The following process is in place for management of any Serious Incident or clinical issue that may occur as a result of using the Ask NHS Online solution.
Clinical issues and scenarios will also be brought to CCG PCOG meetings for discussion and clinical learning on a monthly basis.

8. **Supplier Clinical Governance process.**

The supplier has confirmed that there will be a quarterly clinical governance meeting in place which Dr Jonathan Darby will link into.

The CCG Clinical lead will report any relevant additional actions and feedback via monthly Clinical reference call, PCOG, CCG Online monthly project group or via Primary Care Commissioning lead or CCG Head of Quality Assurance.

9. **Ratification for Ask NHS Online solution**

The Ask NHS Online solution has been approved for pilot and roll out across Dudley CCG via the CCG IT Strategy Group and Clinical Executive committee.

The Clinical governance arrangements for Ask NHS require approval at July PCCC meeting.
Appendix A

Definition of SI /Clinical Issue for Ask NHS – Odyssey system

The points below may typically arise with use of Symptom checker aspect of application

- Any event which has led to unintended and / or unnecessary harm to a patient.
- Wrong advice or endpoint reached
- Missing question sets
- Inappropriate question sets
- Integration problems with Adastra, EMIS, TPP, etc.
- Odyssey not launching properly
- Incorrect upgrading / downgrading of symptoms
- A security breach or the potential for a security breach
- Information governance issues
# EQUALITY ANALYSIS FORM

**INITIAL ASSESSMENT**

*Ask NHS Online*

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

All patients of GP practices within Dudley CCG area will be able to access the Ask NHS Online solution. The GP practice staff are responsible for promoting its use alongside the CCG and will be fully aware of its impact and benefits.

### Is a full Equality Analysis required for this project?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Proceed to the full Equality Analysis form (Next Page)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Explain why further analysis is not required</td>
</tr>
</tbody>
</table>

**Reason why further analysis is not required**

If a full assessment is required please ensure that the final version is approved by Neill Bucktin, Director of Commissioning – See Section 9.
**EQUALITY ANALYSIS FORM (FULL)**

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

### 1. Evidence Used

*What evidence have you identified and considered in determining the impact of this decision e.g. census demographics, service activity data, consultation responses*

There are 4 categories within the Equality Impact Assessment that need to be noted.

- Accessibility of the Online application to people who do not use English as their first language.
- People who have a Learning Disability who may not be able to access the Online solution as it is not in Speakeasy format.
- In addition, there could be a general impact on age and gender that is applicable in Dudley that needs to be noted.

The Ask NHS Online solution is currently only available in English language. The patient population of Dudley CCG consists of a number of different ethnic groups where English is not the first language. As of 2017/18 there were 1,591 people on the Learning Disability register within GP practices (Dudley CCG data) which indicates the need to ensure this population are able to fully utilise the application themselves or supported via an advocate.

### 2. Impact of decision

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

There has been evidence provided within the GP Five Year Forward View (2016) to support the use of digital solutions within primary care. These national guidelines have been supported by a local digital Dudley roadmap around its use within primary care.

The development of access to digital services within general practice should provide more opportunity to patients to access relevant health information and services 24 hours a day, 7 days a week via a nationally recognised application – Ask NHS.

#### 2.1 Age

*Describe age-related impact and evidence. This can include safeguarding, consent and welfare issues.*

The Ask NHS App is available to the general public aged 18 and above. A restriction for younger citizens clearly represents direct discrimination under the Equality Act 2010. However, direct age discrimination is permitted “provided that the organisation or employer can show that there is a good reason for the discrimination”\(^1\).

This is known as objective justification. In this case, the discrimination is objectively justified in the following way:

At present, the Medical Defence Union asks its members to notify where such services are provided to under 16s so there is clearly an element of increased clinical risk. Additionally, there is a need to consider issues of under 16s being more vulnerable than adults, particularly when it comes to the use of online services and presenting issues when it comes to validating capacity and consent. Whilst the age limit for use of informational services is set at 13 by data protection law, making decisions about healthcare at this young age requires assessment of capacity by the clinician which is not possible through the Ask NHS App

## 2.2 Disability

Describe disability-related impact and evidence. This can include attitudinal, physical, communication and social barriers as well as mental health/learning disabilities, cognitive impairments.

Like the majority of available Apps, Ask NHS is available to the all the general public where they are able to access and use devices that support Apps. This assessment recognises that the App may be of limited use for citizens with some sensory impairments such as visual impairments or hearing impairments. There is, however, the option to have the App provide audio or text or both simultaneously – such that this might support an individual with impairments to some extent.

This is perceived to be a justified discrimination in the sense that the App is merely an additional route to access existing services and that patients with disabilities are able to access the same services through alternative routes such as directly with their GP, using NHS 111 or accessing NHS Direct.

Sensely UK has developed an Easy Read privacy notice to support patients with learning difficulties and is currently developing a function whereby the App can be used by a carer or other nominated third party.

## 2.3 Gender reassignment (including transgender)

Describe any impact and evidence in relation to transgender people. This can include issues such as privacy of data and harassment.

When registering with Ask NHS, the user is required to enter their gender among other identifying fields. During development, the issue was raised around both the binary approach to gender – such that non-binary or transgender app users are not provided with an opportunity to enter their identity. This functionality clearly discriminates against these users and so this was explored.

This is not regarded as a justifiable discrimination as there is no real reason why individuals who identify as non-binary or transgender should not be able to use Ask NHS. This issue lies with the spine matching service provided by the NHS infrastructure. The App is only able to validate users and link them to certain services where a match exists for them on the NHS Spine. Summarily, whilst this is not a justifiable discrimination, it is not one over which Sensely UK has any control.

## 2.4 Marriage and civil partnership

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

Use of Ask NHS is not impacted by the marital status of the App user.

## 2.5 Pregnancy and maternity

Describe any impact and evidence in relation to marriage and civil partnership. This can include working arrangements, part time working and caring responsibilities.
Use of Ask NHS is not impacted by pregnancy or maternity status.

### 2.6 Race

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

Ask NHS has the technical capacity to be available in multiple languages and so, the technology can be accessible to UK citizens for whom English is a second language or non-English speakers.

The commissioning customer normally determines and would consider its population segmentation and the accessibility needs of this cohort. At present, Dudley have not currently commissioned any language conversation.

Additionally, Ask NHS is an additional route to access existing services and that patients with language needs are able to access the same services through alternative routes such as directly with their GP, using NHS 111 or accessing NHS Direct – where translation services can be made available.

### 2.7 Religion or belief

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

Use of the Ask NHS will not impact a person’s religion or beliefs.
2.8 Sex
Describe any impact and evidence in relation to men and women. This could include access to services and employment.
Use of Ask NHS is not impacted by sex.

2.9 Sexual orientation
Describe any impact and evidence in relation to heterosexual people as well as lesbian, gay and bisexual people. This could include access to services and employment, attitudinal and social barriers.
Use of Ask NHS is not impacted by sexual orientation.

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

2.11 Other disadvantaged groups
Describe any impact and evidence in relation to groups experiencing disadvantage and barriers to access and outcomes. This can include socio-economic status, resident status (migrants, asylum seekers), homeless people, looked after children, single parent households, victims of domestic abuse, victims of drug/alcohol abuse. This list is not finite. This supports the CCG in meeting its legal duties to identify and reduce health inequalities.
No additional groups will be disadvantaged from using the Ask NHS app.

3. Human Rights
The principles are Fairness, Respect, Equality, Dignity and Autonomy.

<table>
<thead>
<tr>
<th>Will the proposal impact on human rights?</th>
<th>Yes</th>
<th>No</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are any actions required to ensure patients’ or staff human rights are protected?</td>
<td>Yes</td>
<td>No</td>
<td>X</td>
</tr>
</tbody>
</table>

If so what actions are needed? Please explain below.
4. How will you measure how the proposal impacts health inequalities? The CCG has a legal duty to identify and reduce health inequalities. 

E.g. patients with a learning disability were accessing cancer screening in substantially smaller numbers than other patients. By revising the pathway, the CCG is able to show increased take up from this group, this a positive impact on this health inequality.

The Ask NHS supplier, Sensley UK have detailed within the information above how they will mitigate any impacts that the app may have on patients/users.

Uptake and use of the Ask NHS app will be provided to the CCG and GP practices that are using it on a monthly basis in the format of a detailed data report.

5. Engagement/consultation

What engagement is planned or has already been done to support this project?

<table>
<thead>
<tr>
<th>Engagement activity</th>
<th>With who? E.g. protected characteristic/group/community</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dudley CCG Comms and Engagement lead has worked with pilot practices to develop comms tools for dissemination in GP practices. The lead will continue to engage and support practices with engagement and communications are required during roll out of app across CCG area.</td>
<td>All Communications and publications given to practices are available to all patients but not in easy read or different languages at this point.</td>
<td>March 2019 onwards</td>
</tr>
</tbody>
</table>

Please summarise below the key finding / feedback from your engagement activity and how this will shape the policy/service decisions e.g. patient told us, so we will… (If a supporting document is available, please provide it or a link to the document)

GP Practices have been involved in engaging patients within their practices and response to publicity is good. The CCG plans to do wider publicity to the public once pilot sites have been established and roll out commences.

6. Mitigations and changes

If you have identified mitigations or changes, summarise them below. E.g. restricting prescribing over the counter medication. It was identified that some patient groups require high volumes of regular prescribing of paracetamol, this needs to remain under medical supervision for patient safety, therefore an exception is provided for this group which has resolved the issue.

No further changes are planned at this stage of pilot and roll out of Ask NHS app.
7. Is further work required to complete this EA?

*Please state below what work is required and to what section e.g. additional consultation or engagement is required to fully understand the impact on a particular protected group (e.g. disability)*

No further work is required at this point.

<table>
<thead>
<tr>
<th>Work needed</th>
<th>Sections</th>
<th>When</th>
<th>Date completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. Further engagement with disabled service users to identify key concerns around using the service.</td>
<td>2 - Disability</td>
<td>June - July 2017</td>
<td>Sep-17</td>
</tr>
</tbody>
</table>

8. Development of the Equality Analysis

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

| e.g. Version .01 | The impact on wheelchair users identified additional blue badge spaces are required on site to improve access for this group. | 26-Sep-17 |

9. Final sign off

*Completed EA forms must be signed off by the Director of Commissioning. They will be reviewed as part of the decision-making process. Completed forms should be sent to: neill.bucktin@nhs.net so that the CCG can maintain an up to date log of all EAs.*

| Version Approved: | | |
# Black Country and West Birmingham Sustainability and Transformation Partnership (STP) Primary Care Programme Board Update

**AGENDA ITEM:** 17.0

## TITLE OF REPORT:
Black Country and West Birmingham Sustainability and Transformation Partnership (STP) Primary Care Programme Board Update

## PURPOSE OF REPORT:
To update the Committee on the 1st meeting of the STP Primary Care Programme Board

## AUTHOR OF REPORT:
Mr D King, Head of Membership Development and Primary Care

## MANAGEMENT LEAD:
Mrs C Brunt, Chief Nurse

## CLINICAL LEAD:
Dr T Horsburgh, Clinical Executive for Primary Care

## KEY POINTS:
- From 1st April 2019 the allocations from NHS England in respect of the Long Term Plan (LTP) for Primary Care Development have been made to the STP.
- NHS England and the STP have agreed a Memorandum of Understanding (MOU) that required the STP to establish an STP Primary Care Programme Board to co-ordinate and manage the allocations and activities set out in the MOU.
- The STP Primary Care Programme Board has been established by the 4 CCGs in The Black Country and West Birmingham STP and met for the first time on 21st June 2019.
- The Programme Board is accountable to the Boards of the CCGs in The Black Country and West Birmingham STP.
- The management and clinical leads for primary care from each of the 4 CCGs sit on the STP Primary Care Programme Board.
- All 4 CCGs have agreed that the notes from each meeting would be shared with their respective Primary Care Commissioning Committee’s along with an update report.
- The MOU, ToR and notes from the meeting on 21st June 2019 are attached.

## RECOMMENDATION:
The Primary Care Commissioning Committee is asked to:
- Note that the STP Primary Care Programme Board has been established.
- Note that Mr D King and Dr T Horsburgh will become members of the STP Primary Care Programme Board.
| **Note that the Committee will receive the notes and summary report from each STP Primary Care Programme Board meeting.** |
| **Receive the Terms of Reference and MOU between the STP and NHS England for assurance** |
| **FINANCIAL IMPLICATIONS:** |
| The STP received confirmation of its allocation on 28\(^{th}\) June 2019 – an allocation of £2,272k |
| NHS England have scheduled meetings with STPs in July to identify development and investment plans – to be co-ordinated through the STP Primary Care Programme Board |
| **WHAT ENGAGEMENT HAS TAKEN PLACE:** |
| STP Primary Care leads |
| **ANY CONFLICTS OF INTEREST IDENTIFIED IN ADVANCE:** |
| None |
Black Country and West Birmingham Sustainability and Transformation Partnership (STP)

Primary Care Programme Board Actions and Decision Notes from 21/6/2019

<table>
<thead>
<tr>
<th>Attendees</th>
<th>Paul Maubach (Chair), Nick Harding, Matt Hartland, Sarah Southall, Dan King, Donna MacArthur, Lisa Maxfield, Jo Reynolds, Leon Mallet, Paul Aldridge (Actions), Carol Marston, Mike Hastings, Sally Roberts, Simon Butler, Ian Sykes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apologies</td>
<td>Raj Kalia, Anand Rische, Joanne Weller, Salma Reehana, Della Burgess</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Action/Decision</th>
<th>Action Owner</th>
</tr>
</thead>
</table>
| Terms of Reference | Following discussions the Board requested a number of amendments to the draft TOR that was presented:-  
• Para 2.1 – TOR will need to go to CCG Governing Bodies for approval  
• Para 3.1 (f) – Ensure wording is more explicit that the finances are specifically for NHSE supplied GPFV Funding and STP allocations of funding for Primary Care (General Practice) Training Needs only (and not for Primary Care Funding that flows via CCGs)  
• Para 3.1 (e) – Amend Estates section to reflect that updates will be provided as there are already existing Governance Arrangements  
• Para 5.1 – Amend to state that there will be 5 Clinical Representatives from each Place plus a member of LMC (unless one of the 5 Clinicians represents). CCGs to nominate representatives  
• Para 5.1 – Agreed to include a Lay Member – Lay Members to nominate  
• Para 5.1 – Agreed that there needs to membership from the Clinical Leadership Group represented  
• Para 5.5 – Agreed that the Lay Member be nominated as the Deputy Chair  
• It was also agreed that a HEE representative be nominated and the TOR be adjusted to reflect their requirements (so there is one STP Primary Care Board that incorporates the Training Hub Board). It was also agreed that this representative needs to sit on the LWAB | Paul Aldridge to co-ordinate, amend and circulate revised draft to group for final comment |
- Para 6.1 – Agreed that the meetings would be bi-monthly, not arranged on Mondays or Fridays and meetings to have the ability to function using video and telephone conferencing facilities.

### National/Regional Update

Sarah Southall gave an update to the group from the Regional Transformation Board – there were no questions.

Nick Harding suggested that once PCNs have completed their staffing data collection that this be shared with the Group as a more up to date source of workforce information.

### Investment Proposals

Sarah Southall presented investment proposals for a range of schemes to seek Board agreement for utilisation of a range of GPFV and other NHSE funding.

- Four Pillars Scheme – proposal was agreed
- Portfolio Careers – discussions were held on this proposal including whether to adopt a set of principles around the funding utilisation e.g. ensuring all CCGs receive an equal share. It was agreed that the principles should be more aligned to demand/PCN development requirements and not equal CCG split. The proposal was agreed but the Board requested the following actions:-
  1. Share GPRISS Evaluation and Outcomes
  2. Profiling of PCN developments requirements developed – then track resource to profiling over time
  3. Range of Portfolio Careers offered to be reported to next Board along with a dashboard of cases
  4. Nick Harding highlighted some gaps in specialisms that Clinical Directors could prioritise – Neurology, Breast Clinics, Oncology and Cardiology. High risk of Flu for this winter was also highlighted

- First 5 Network – proposal was agreed and Nick Harding acknowledged the success of the scheme to date and thanked the team. The following actions were requested from Board following discussions:-
  1. Board wanted to try and influence a push for permanent/salaried GPs rather than Locums. Board wanted a report detailing the current split between locums, salaried, partner GPs
  2. A proposal to be produced on how GPs currently practicing as locums could be converted into salaried GPs and could we

**Paul Aldridge**

**Primary Care Leads**

**Paul Aldridge**

**All (when considering PCN Portfolio Career applications)**

**Paul Aldridge**

**Dr Raj Kalia**
| **Resilience Funding Process Proposal** | Paul Aldridge presented a draft proposal on a process to allocate the GPFV Resilience funding. Following discussions Board asked for a revision of the process to involved each PCCC to co-ordinate – Dan King produced a draft form of word. Revised process to be produced and circulated | Paul Aldridge |
| **Digital and Estates Update** | Mike Hastings gave the Board a brief overview of both pieces of work. The Board requested the following Actions  
1. A framework for a report that analyses the quality of current IT performance in Primary Care and whether there is a potential for a single GP IT provider across the STP  
2. A report around GP Online Consultation, requirements and current status across the STP | Mike Hastings |
| **Training Hub Update** | Della’s apologies were noted and Lisa Maxfield gave an update on the Training Hub position. Board requested the following actions:-  
1. HEE to produce and present a report a written update on Training Hubs for the next meeting which should also include updates from each Training Hub in the STP  
2. Agreed that this work needs to link with the development of a Training Academy | |
| **Risk Log and Highlight Report** | Both presented and no questions/comments | |
| **AOB** | Jo Reynolds presented a proposal for utilising of some of the GPFV Admin/Clerical Funding to support Practice Manager development across the STP. This proposal was not agreed as there wasn’t Director consensus.  
PCN Accelerator Bids – it was suggested that a process be agreed for applications across the STP – detail to come to the next meeting. | |
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FOREWORD

Our ambitions is 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. This strategy describes the beginnings 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, the public, all our frontline staff and our partner organisations in the drive to achieve better health, care and value.

Our local NHS is a success story, and despite significant pressure and constrained resources local people have access to comprehensive and universal healthcare - free at the point of need. This is testament to our hardworking, committed staff that come to work every day and provide the very best care they can. We 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 service. Public support for what we do is unwavering, which speaks for itself (Kings Fund research September 2017).

Added to this, through our innovation and creativity we have successfully made progress against many of the challenges to our health and healthcare, evidenced by steady falls in mortality from heart disease and stroke and increasing life expectancy. We have some of the very best work going on in the NHS currently in terms of leadership, clinical pathway redesign, quality of care in both community and hospital settings.

We have some incredible clinicians driving leading edge change in practice and behaviours in each of the Black Country and West Birmingham boroughs. By taking these remarkable care innovations and ensuring all clinicians provide the associated services in the same way, it is clear we would achieve great outcomes for the people we serve in the combined geography.

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, growing prevalence of obesity accompanied by low physical activity and many households living in fuel poverty to name but a few. 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.

Through this strategy, commissioners, with health and care providers will combine to deliver healthier lives, better care and best value provision of services consistent with the ambition set out in the Birmingham and Black Country Sustainability and Transformation Plan 2016-21. Our clinical and professional leaders commit to a continuous drive to deliver services of the highest quality and value, a more important and appropriate way of planning and managing resources than an isolated focus upon living within budget. Collaboration and cooperation will drive the improvements to outcomes for local residents.

This clinical strategy sets out a framework for the development of health and care services across the Black Country and West Birmingham for the next few years. It does not give prescriptive details of exactly what developments are required – it is designed to take the priorities our clinical leaders have identified and present an evidence-based, high level perspective of why change is needed and provide indicators of the direction that change needs to take. This clinical strategy will provide a unifying direction to the range of service reviews currently underway so that the Sustainability and Transformation Partnership footprint can progress to a coherent, comprehensive and sustainable high-quality service.

20181123 Black Country Clinical Strategy Exec Summary And Strategic Direction V14.2
It is cast as a living breathing document that will continually evolve and adapt as new evidence, policy and paradigms emerge.

Prof. Nick Harding OBE  
Clinical Leadership Group Chair

Mrs Sally Roberts  
STP Chief Nurse

Dr Helen Hibbs  
Senior Responsible Officer

Black Country and West Birmingham Sustainability and Transformation Partnership
EXECUTIVE SUMMARY

1 This strategy sets out what our clinical leaders consider matters most to improve care and outcomes for the people of the Black Country and West Birmingham (BCWB). Our work builds on the strong partnerships already in place, recognising the significance of ‘local place’ as determined by our four place-based arrangements across the Black Country but also embracing the strength in delivering integrated strategic approaches to clinical care. Taking account of the operating context, this strategy combines the public health indicators that point to the wider determinants challenges locally and the ambitions set out in the Sustainability and Transformation Plan 2016-21 (STP Plan) to identify a ‘long-list’ of priority areas for clinical transformation or standardisation.

2 This strategy acknowledges the considerable work undertaken to identify 12 clinical priority areas. It dedicates a chapter to each priority area, providing a high-level case for change founded upon the evidence base obtainable in the timeframe for production. The case for change combines the earlier work undertaken by the Sustainability and Transformation Partnership (STP) with additional evidence sourced through desktop research, collating Right Care intelligence and seeking the views of professional experts and appointed leads. We have aligned our evidence against the triple aim to maintain the focus upon citizen and system benefits to be realised.

3 The strategy is clear that planning of care starts at the individual and those that care for them; building care at a locality level in the first instance. Care provided at larger scale will be because better clinical outcomes or financial prudence make this a more appropriate option. Whilst the strategy focuses on clinical service provision, an underpinning principle is that good healthcare starts with prevention, self-care and healthy lives.

4 Engaging with those who use services and those who care for service users is a central part of this strategy. Clinical services will be designed to ensure a positive user experience while driving high quality clinical outcomes. Co-designing change in partnership with those who use the service is vital to this key aim.

5 The strategy recognises the need to address national priorities, namely delivering 7-day services, integrating mental health and physical health in service provision, promoting mental well-being and driving earlier cancer diagnosis. Underpinning delivery of the strategy requires some fundamental enablers for the STP:
   - Workforce
   - Digitisation
   - Shared records
   - Capital and estate
   - Communications and engagement; and
   - Strategic joint commissioning arrangements.

6 The strategy aims to drive forward a reduction in variation across the system, shared approaches to reviewing clinical practice, agreeing clinical standards and protocols and effective clinical engagement is fundamental to the success of the strategy.

7 The case for change for each priority area does not prescribe the specific actions needed to address the performance issues, unwarranted variation or realise the opportunities to improve health, care and/or value. Whilst the initial priorities for action are established, future work involves those tasked with leading the transformation in each area adopted by the STP applying the clinical principles agreed to change options decision making processes to produce the corresponding action plan for delivery.
8 At a macro level this clinical strategy sets out the case for:

- Planning and delivery of primary care services around individuals and their communities;
- Developing networked provision of acute services, at the appropriate population level;
- Providing high value, proportionate, effective and sustainable healthcare; and
- Establishing consistent best practice across the STP and effecting transformational change supported by investment in e-health and technological advances, taking local people with us.

9 At a meso-level, this initial strategy provides the information upon which the Clinical Leadership Group (CLG) can determine which resources should be collectively mobilised, and which actions will deliver the greatest contribution to improving health, care and value. The content can inform the phasing of the transformation work, providing for focus on the areas where immediate attention and action is required. Clinical leaders need to determine together what must be done first and make this recommendation to the STP, so they can endorse the priorities and mandate concerted system-wide action and delivery.

Bringing health, social care and voluntary sector organisations together, to achieve improved health and wellbeing.
1.0 PURPOSE

1.1 This strategy outlines the approach to defining the clinical priorities that will materially improve the health and well-being of Black Country and West Birmingham population on a sustainable basis. It establishes the operating context, primary drivers for change, principles and governance informing the development of our strategy. It seeks to secure the necessary buy-in from our STP partners to make the changes happen.

1.2 Building on the considerable work already undertaken, this strategy takes each of the clinical priorities already identified and provides a case for change. It takes account of national policy, our STP plan, current performance, RightCare analysis, and opportunities to achieve better health, better care and better value. It sets out a proposed framework for prioritisation based upon the agreed clinical principles, the strength of the case for change and a systematic clinical transformation process. The development of this strategy will culminate in the CLG recommending the initial strategic clinical priorities to the STP Board, which in turn will inform the service change portfolio through which the strategy will be delivered.

1.3 Whilst this strategy establishes the initial clinical priorities for action, further work is needed to identify the system level at which services might be provided in the future and what needs to be changed and how. Recognising that pathways of care cut across the system levels of provision, aligning the operation of the whole system and the most appropriate forms of networking/collaboration for each clinical specialty/pathway will need to be prime considerations in subsequent clinical design activities that will enable clear change definition and implementation.

1.4 Our clinical strategy is a ‘living, breathing’ strategy that will develop and re-shape as emerging evidence and other intelligence impacts upon its content, such as the first iteration of this will be available in August 2018. It will define our STP transformation programme and in turn, those services and/or care pathways with the greatest benefits to be realised through collaborative commissioning via our Joint Commissioning Committees (JCCs). Importantly, it acts as a summary of evidence and priorities at a point in time, a working document to be used as the basis of building, strengthening and integrating our clinical leadership in pursuit of what matters most to our STP from a clinical perspective and in the name of patient safety and high-quality care.

1.5 We are clear that this will continue to evolve as the wider STP journey to ICS unfolds. We will revise it with comments from those who use our services, those who care for people who use our services, and clinicians and other health and care staff who deliver care engage with us on this journey.

2.0 OUR COMMITMENT

2.1 The STP plan aims to materially improve the health, wellbeing and prosperity of the BCWB population, delivering better health, better care and sustainability (NHSE triple aim). Our clinical and other professional health and care leaders support this ambition, recognising the benefits to be realised from achieving deeper collaboration through integrated networks of care. With a holistic whole population management focus, the strategy aims to shift the BCWB NHS from a treatment to a preventative and well-being service and through providing standardised, streamlined and more efficient 7-day services.

2.2 Building on our existing strengths, accelerating learning from innovation and taking advantage of technology advances, our clinical and service leaders understand the need to agree a strategy for clinical services across the STP to drive concerted action (where it makes sense to do this) to create a sustainable health and care system with improved outcomes and a better experience.

2.3 Clinical leadership and involvement, with managerial support, is critical to the development of the clinical strategy and subsequent co-design and implementation activities to ensure the strategy will provide clinical sustainability and improve population healthcare outcomes. Our CLG, comprising health and care clinical and other professional leaders and representatives from provider and commissioner organisations across
the geography, is the driving force behind this strategy. It seeks to set out those clinical services considered the highest priorities for transformation between 2018 and 2021. Identifying clinical priorities has been informed by:

- Professional views of clinicians and caregiving professionals (see 2.4 below)
- Our drive to develop services closer to the service user and recognise the importance of our place-based vision, and the strategic changes required to deliver this improvement.
- Findings from specifically commissioned work across STP forums
- NHS England (NHSE)
- NHS England – as commissioners of Dental Services, Community Pharmacy, General Ophthalmic Services, Immunisation Services, Screening Programmes, Child Health Information Services, Sexual Assault Referral Centres, Health Services in the Justice System, Armed Forces and Veterans’ Health.
- Best practice publications
- Patient and Service User perspectives

2.4 We have used the views of our clinicians (doctors, nurses and other healthcare professionals), those who work in supporting roles and those who work in other elements of caring roles to help inform our view of place-based care. As we consult with our service users and those who care for them, this view will continue to evolve. These views will drive the strategic change necessary to deliver high quality care close to home where at all possible.

2.5 We will share learning to ensure each element builds on the success of others.

2.6 The CLG has agreed to oversee strategy development to inform the determination of the STP work programme, delivery and performance monitoring by the Partnership Board as well as the priority areas for collaborative commissioning by the Black Country and Western Birmingham JCCs. Going forward, clinical leadership and input to strategy delivery will be sourced via the BCWB CLG.

3.0 OPERATING CONTEXT

3.1 The BCWB STP has been asked to develop a ‘clinical strategy’ to shape system transformation in terms of the triple aim, and to ensure that clinical leadership is fundamental to that transformation. It is important that BCWB identifies those areas where there appears to be the greatest opportunity for improvement in health outcomes, quality of care and/or service sustainability, and to set a strategy that seeks to address them.

3.2 We understand that these opportunities are likely to result in changes to the way we configure ourselves, our organisations and our services. We embrace this opportunity; our clinical strategy is a key driver for the development of the Black Country and West Birmingham ICS.

3.3 We will want to use this plan to have an informed discussion with clinicians and those who use the service on how many beds we need in acute hospitals and how many beds we need in community locations. This will change over time as place-based care becomes more embedded in the way we deliver healthcare. An additional driver for this will be the reduction in length of stay in acute hospitals. Where patients can be supported and cared for closer to home, this will be encouraged.

3.4 Integral to both strategy development and delivery is taking account of what matters most to our service users in delivering high quality care. Residents across the BCWB footprint tell us they want:

- Services when I need them most
• To have a say in my care
• To tell my story once
• To be able to help myself to manage my health
• To know where to go when I need help or advice.

3.5 At the heart of the BCWB STP plan is a focus upon standardising service delivery and outcomes, reducing variation through place-based models of care provided closer to home and through extended collaboration between GP practices, hospitals and other providers of healthcare services (e.g. oral health professionals, community pharmacy, eye health) founded upon the principles of whole population integrated care provision.

3.6 We will make systematic learning a key part of our strategy. By updating the clinical cases for change regularly and publishing these we will share learning and best practice.

3.7 Given the forecast increase demand outstripping increases in funding, meeting the triple aim challenge will require joint action with Local Authority partners on the wider determinants of health, growing self-care and strengthening community resilience. This is consistent with the latest policy directive that challenges our system to establish itself as an integrated care system, requiring a shift from NHS versus social care to NHS and social care together, operating in alignment to address Public Health issues that include deprivation and wider determinants of health such as housing, education, children’s services.

3.8 Consistent with the Five Year Forward View, the clinical strategy must support delivery of the other national priorities:
• 7-day services – right care, right time, right quality
• Integrated mental health and physical health
• The promotion of good mental health and prevention of poor mental health
• Driving up early cancer diagnosis as well as treatment times.

Key STP enablers are:
• **Workforce**: a reshaped workforce, working across professional boundaries, with proven competencies to ensure safety and quality of care and working in a way that shifts treatment to prevention, reactive to proactive care and to steady state rather than crisis care

• **Digital enablement**: for services and service users, using technology to help those responsible for care (including patients) to access available intelligence to provide the right care

• **Shared records**: legally compliant, timely sharing of relevant information with all providers and agencies involved in a person’s care for the purpose of facilitating and delivering appropriate services across different care settings

• **Capital and Estate**: ensuring the estates infrastructure required for service delivery and supporting functions is configured, financed and utilised in the most efficient way.

• **Business intelligence**: to provide the context, both now and in the future, including:
  - Current service use (demand)
  - Unmet need (waiting lists)
  - Patient flows
  - Predicted demographic growth
  - Workforce numbers
- Performance data
- Risk profiling
- Financial data based on activity, workforce, estates and other fixed costs
- Population projections
- Future health needs

- Communications and engagement: involving and taking local people with us. This is detailed further on in this strategy.

- Strategic joint commissioning arrangements across the Black Country, to include a joined up planning and delivery approach between statutory commissioners of all healthcare and social care services (i.e. CCGs, NHS England and Local Authorities).

We have articulated the drivers for integrated care

3.9 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.

- In primary care networks 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.
- Working with CCGs, local authority and other system wide agencies, we will seek to make joint decisions based on shared intelligence and joint resources. Artificial system barriers will be overcome to allow patient centred care to be the focus of our system wide approach.
4.0 **Place Based Care**

4.1 Our local place is a fundamental foundation to delivering an integrated care system across the Black Country and West Birmingham. Being able to define and articulate delivery and provision of care at local place is critical to us delivering the right care across a larger setting.

4.2 Local place-based models of care are being developed and implemented for each of the STP boroughs. They aim to deliver improved access to local services for the 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 consistent with developing our STP as an integrated care system founded on accountable care organisations providing great services for the long term.

4.3 We do not view our model of place based care as four areas with four separate plans; but rather as a single model with local variation addressing unique needs in each locality. Each plan is drawn from the central principle of delivering improved access to local services for the whole population, greater continuity of care for those with ongoing conditions and more coordinated care for those with the most complex needs.

Bringing health, social care and voluntary sector organisations together, to achieve improved health and wellbeing.

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**Black Country Clinical Strategy place based care model initiatives**
4.4 In each area several initiatives are underway to deliver this single vision of place based care.

**Dudley**: Dudley is developing a place-based model of care centred around the commissioning and procurement of an Integrated Care Organisation – the Multi-Specialty Community Provider (MCP).

The MCP will hold a contract for up to 15 years duration and manage a whole population budget of c £235m (50% of the CCG’s commissioning portfolio) covering a range of out of hospital services including:

- Community physical health services for adults and children#
- Primary medical services
- Primary care prescribing
- Urgent care centre and primary care out of hours services
- All NHS commissioned learning disability services
- All NHS commissioned mental health services
- NHS Continuing Healthcare and Intermediate Care
- Council commissioned public health services
- Some outpatient specialties
- Voluntary and community sector services

The contract will be outcomes based with 20% of the contract value linked to delivery of a set of evidence-based outcomes.

**Sandwell and West Birmingham**

Sandwell & West Birmingham local initiative is Healthy Lives Partnership. The aim of the Partnership is to support individuals and their carers to live independently and to take responsibility of their own care through the personalisation of health and care wherever possible. Health and care partners will deliver placed based integrated care models through a decentralised approach. It brings together health and social care commissioning with a move to a strategic commissioning process focusing on outcomes and experience and long term agreements.

The approach will be characterised by:

- A focus on the first 1,000 days of life (to reduce adverse childhood experience and improve equity & life chances).
- A focus on later life (including integrated care for the frail elderly and end of life care).
- To achieve outcomes in key areas that are in the upper quartile for comparable inner city/urban areas in England.
- The development of shared health and care records and information systems
- The development of enabling approaches to workforce recruitment, training and development
- A focus on diversity & equality to reflect the community served.

**Walsall**: Walsall Together is an ambitious programme to transform the health and social care people receive in Walsall. The programme brings together all the local NHS organisations, NHS Walsall CCG, Walsall Healthcare Trust, Dudley and
Walsall Mental Health Partnership Trust and Walsall Council; as well as the voice of Walsall residents and key representatives from the voluntary sector.

Health and care partners in are working together to develop a new model of care: supporting prevention, self-care and community resilience and creating integrated teams, with the GP at the centre, to support people with long term conditions and help people receive care closer to home.

This includes:

- Early intervention and prevention to support people and communities to live independently and to have active, prosperous and healthy lives.
- Putting people at the heart of what we are doing so that care is more co-ordinated across care settings and over time, particularly for people with long-term chronic and medically complex conditions who may find it difficult to ‘navigate’ fragmented health care systems.
- A single point of access for care co-ordination and navigation for all health, care and prevention services.
- Accessible, high quality care with local hospital teams working as part of a network of specialist care.

**Wolverhampton**

The Wolverhampton Integrated Care Alliance (ICA) is the drive for place based care in Wolverhampton and focuses on Wolverhampton working as a system rather than independent processes. The strategy is clinically led, managerially supported and patient centred. There are shared governance system across the parties which provides system leadership and who are mutually accountable for delivery.

A key feature of the ICA is an integrated data system where all parties can access data to support the patient’s pathway. This reduces delay, encourages cooperation and supports integrated working.

The ICA will shift resources from hospital to out of hospital services so that more people are supported proactively in their home and communities. It will focus on health, developing our approach to health promotion and disease prevention to support the wellbeing of our communities alongside the care that we already provide.

The ICA must be financially sustainable, making the best use of the resources that we have collectively. This will mean amending the current funding flows as they do not always incentivise best practice.

The ICA has a number of key aims that are guiding its programme:

- To modernise and support ALL primary care to improve care quality and financial sustainability
- To redesign our local NHS system by removing barriers that act against integrated care, to support strategic commissioning
- To redistribute risk in a better a way across the system
- Improve population health outcomes in partnership with the commissioner’s mental health services, social care services, public health and the voluntary sector
- To improve co-ordination of services and move care out of hospital where appropriate- Integrated user focussed care delivery
- Facilitate networked solutions for hospital services where there is opportunity to improve care quality and financial sustainability
5.0 PRIMARY CARE NETWORKS

5.1 We will support and drive the continued development of Primary Care Networks (PCN). CCGs are enabling GP practices to form primary care networks (PCNs) with approximate individual population of 30,000-50,000, allowing practices to:

- Provide proactive, personalised care aimed at prevention and well-being
- Share community nursing, mental health, and clinical pharmacy teams
- Expand diagnostic facilities and other services
- Pool responsibility for urgent care and extended access
- Work more closely with community pharmacists and other community services (e.g. primary care dental services and General Ophthalmic Services) to make full use of the contribution they make
- Take full advantage of the use of technology in care provision
- Make a key contribution to system-wide leadership
- Optimise the use of estate.

5.2 Primary Care Networks will support the delivery of the General Practice Forward View. Its key elements of investment, workforce, workload, practice infrastructure and care redesign will be supported through this strategy and its workstreams.

5.3 PCNs are based around a GP registered list of approximately 30,000 – 50,000 patients, encompassing general practice and other partners in community health care (e.g. community pharmacy, primary care dental services and General Ophthalmic Services) and social care. These networks offer care on a scale which is small enough for patients to get the continuous and personalised care they value, but large enough – in their partnership with others in the local health and care system – to be resilient. For example, in Wolverhampton, there are 11 networks over 3 localities.

5.4 PCNs represent the building blocks of place-based models of care provision and are the key to preserving the integrity of NHS service provision going forward and as such are a given in terms of establishing clinical priorities.

5.5 PCNs will be a true multidisciplinary approach to care. These will include nursing, pharmacist, social workers, community psychiatric nurse and a range of other roles to support patients care in their own communities. We will innovate with role development to test new and improved models of care.

5.6 The development of PCNs in Black Country and West Birmingham will vary with maturity and opportunity. Some site will act as pioneer and pace setters for others. We are committed to sharing learning and encouraging all primary care providers to be integrated within a Primary Care Network.

5.7 For our service users, patients and carers, PCNs will bring:

- Access to a wider range of professionals than may have been available in individual practices.
- Improved/shorter waiting times that are focused around the access needs of those using services.
- Improved access to a wider range of services and support through use of the resources and partners within the PCN.
- Using the wider access to professionals and services, provide a focus on increasing access to care locally (place based care) and avoiding admission avoidance and hospital attendance where possible.

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6.0 Service Configuration & System Levels of Provision

6.1 With a greater emphasis in the Black Country Clinical Strategy on place based care (services closer to home and support for vulnerable services); this strategy recognises that the configuration of services in 2018 is unlikely to remain in their current form and is not where we want to be. Development of a model that meets the clinical strategy ambition is the drive to create a range of service that meet the clinical and holistic needs of residents in the Black Country and West Birmingham.

6.2 However, it is important to understand the existing hospital trust clinical configuration as the basis for our starting position.

6.3 Mental Health Services for BCWB are led from two NHS Trusts. Black Country Partnership NHS Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust. They provide a range of services, both on the hospital sites and within the community for adult and children with a range of mental health needs.

6.4 There are four acute Trusts, working from nine sites, providing acute and community services within the BCWB STP footprint: The Dudley Group NHS Foundation Trust (DGFT), The Royal Wolverhampton NHS Trust (RWT), Walsall Healthcare NHS Trust (Walsall) and Sandwell and West Birmingham Hospitals NHS Trust (SWBH). This provision includes:

- Elective and emergency paediatrics on four sites
- Maternity services on four sites
- A and E services on five sites
- Adult unselected medical take on five sites
- Elective medical and surgical specialties on seven sites
- Some national screening programmes (Bowel Cancer, Breast Cancer, Abdominal Aortic Aneurysm,
- Secondary Care Dental, Oral Surgery and Orthodontic Services.

6.5 Some acute services are already networked across BCWB. Vascular services are currently networked across the STP and provided at DGFT and some Interventional Radiology are provided across four Trusts, with other networked services in formation e.g. Black Country Pathology Service. In addition, various specialist and tertiary acute services are provided by specialist centres outside and within the STP footprint.

6.6 In the BCWB, levels of care can be defined as:

- **Primary Care Networks** – services that can be provided closer to patients’ homes at locality level, i.e. sub areas within a Borough/City with populations of between 30,000 and 50,000;
- **CCG/LA** – services that are best provided and/or coordinated at the level of existing Clinical Commissioning Group/Local Authority footprints, enabling an overarching and integrating place-based view to be taken;
- **ICP** – Integrated care partnerships (ICPs) are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.
- **ICS** – Integrated care systems (ICSs) have evolved from STPs and take the lead in planning and commissioning care for their populations and providing system leadership. They bring together NHS providers and commissioners and local authorities to work in partnership in improving health and care in their area.

6.7 In writing this strategy, we recognise that the Black Country and West Birmingham areas do not sit in isolation. In other areas of the West Midlands, similar strategies are being developed. Over the course of the life of this strategy, and beyond, the STP and ICS leadership will recognise and understand the work
being done by others. We will recognise their impact on our work, and our impact on theirs. We will work with system partners to avoid conflict and confusion.

6.8 We will work with partner organisations such as West Midlands Ambulance Service and recognise the role they play in working across systems as well as within our own.

7.0 REDUCING UNWARRANTED VARIATION

7.1 There is growing and clear evidence that unwarranted variation causes both waste in the system and risk to patients. Programmes such as The Getting It Right First Time (GIRFT) initiative is helping to improve the quality of care within the NHS by reducing unwarranted variations, bringing efficiencies and improving outcomes.

7.2 It is recognised that there will always be variation in clinical care and this is at the heart of place-based systems. Some variation is based on clinical need and appropriate decision-making; on adoption of innovation and of new technology (early adopters). However, unwarranted variation is not acceptable and can often lead to poorer outcomes.

7.3 We understand that the healthcare needs of our population will be different across localities. In driving out unwarranted variation we will actively drive in clinically appropriate and necessary variation to meet local needs. In taking this proactive approach, we expect to see a reduction in unnecessary variation.

7.4 The key driver for this strategy is to provide the highest quality care to local residents. This plan sets out a clear commitment from all partners to improving quality and outcomes by tackling unwarranted variation.

7.5 The initial programme will look at identifying this variation using nationally recognised data. Sharing information to benchmark firstly within the STP, and then Regionally and Nationally will help identify the priority areas for action.

7.6 Clinicians across the STP will be encouraged to support teams and colleagues who are shown to be outliers through a supportive peer network and service development. A range of national tools (e.g. through GIRFT) will aid improvement.

7.7 The Model Hospital is a digital information service provided by NHS Improvement to support the NHS to identify and realise productivity opportunities. The Model Hospital supports trusts to identify and tackle unwarranted variation. These data are currently available to providers on an individual basis. Providers are encouraged to share these within the STP to allow a common basis for planning and discussion.

7.8 Data from the RightCare programme will underpin these analyses and inform evidence based actions.

7.9 We are committed to tackling variation and improve quality through both the national GIRFT programme and also through locally led initiatives such as standards based peer review and quality system reviews.

7.10 Working through PCNs we drive out unwarranted variation by taking an optimisation management approach to either high risk or complex conditions. Working with clinicians we will describe optimal pathways and standards of care.

7.11 Using optimisation tools and algorithms, we will describe the challenges clinicians face in identifying diagnosis and care plans. This will allow solutions to be mapped to the reality our clinicians face on a daily basis.

7.12 Using simple and clear visual indicators, we will describe prompts and trigger points to good outcomes and the key issues to consider. Written by clinicians for their own use, it will be an easy aid to high quality outcomes for their patients.
7.13 Recent work by PHE in the South West discusses the diagnosis and treatment gap in cardiovascular disease. We will use national evidence mapped to local provision where this is available.

7.14 As an example, in Sandwell & West Birmingham, since the introduction of the Primary Care Commissioning Framework in 2015/16, the number of patients with diabetes receiving eight care processes has increased from 23% to 65%; representing better care through proactive case finding and less unwarranted variation between GP practices.

8.0 PRIMARY DRIVERS

8.1 Public health England (PHE) ‘fingertips’ indicators

8.1.1 Only about 10% of a population’s health and wellbeing is linked to access to healthcare, meaning that attempts to reduce demands on the health service simply by investing in more health services will make very little difference to the demand for healthcare. BCWB public health colleagues have undertaken an analysis of these profiles as they provide a rich source of intelligence to inform our clinical plans to improve health and wellbeing and reduce inequalities.

8.1.2 Across the BCWB there are a number of key drivers that have a huge contribution towards the development of future illness and corresponding demands on health services. These wider determinants of health – education, employment, wealth, housing, nutrition, family life, transport, social isolation etc cannot be addressed by any single organisation. However, without a collective and effective response to them, demand for public services will always outstrip supply. Conversely, improvements in wider determinants can lead to health gains, a healthier workforce and a lower burden of illness.

8.1.3 These factors are found at every stage of the life course and the accompanying charts from Public Health England’s Fingertips tool in Appendix 1 show how the Black Country local authorities compare to those in other areas for those measures in which local rates are notably poor. Many factors interact with one another, meaning that failure to improve one leads inevitably to another in the next generation.

8.1.4 The BCWB has some of the highest infant mortality rates in the country, and whilst smoking rates in pregnancy remain high, 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 rates. In turn this leads to poorer employment opportunities, less earning potential, greater likelihood of teenage pregnancy, unemployment or providing unpaid care.

8.1.5 The urban environment poses considerable challenges for both children and adults, and in the Black Country 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 relatively easily available. In turn this increases the risk of diabetes and other weight-related conditions prematurely.

8.1.6 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. Mortality from conditions considered preventable is relatively high in the Black Country.

8.1.7 The Black Country STP Plan recognises the important role the NHS can bring to help challenge and overcome some of these drivers of poor health and the reality that the sustainability of local services hinges on how effectively these wider determinants will be addressed in coming years. More effort on upstream interventions is fundamental if we are to realise our ambition for the people we serve.

8.2 Black Country and West Birmingham STP Plan 2016-2021

8.2.1 The BCWB STP Plan was developed in 2016/17 to mitigate the health and well-being, care and quality, and finance and efficiency gaps. The CLG has undertaken an initial review of RightCare evidence, determining that there are a number of services that might benefit from a strategic clinical review and has initiated focussed working groups for Respiratory, Hypertension and Frailty care.
8.2.2 Bolstering primary care is of fundamental importance from both a policy and patient need perspective. PCNs represent the cornerstone of the BCWB ICS being able to provide safe, sustainable services in the future amidst a potentially bleak workforce picture without immediate and continuous action.

8.2.3 The Acute Sustainability Review will consider acute capacity and capability now and, in the future, which should facilitate planning for future services provision. Its findings are due to be reported in August 2018, and the impact upon our strategic clinical direction considered.

8.2.4 Recruitment and retention challenges are not isolated to primary care and extend to mental health and secondary care. This is exacerbated by the drive to 7-day services, meaning that workforce sustainability poses a serious challenge to our ability to provide sustainable services throughout the provider network.

8.2.5 There is growing evidence of the links between physical and mental health. Physical health problems significantly increase the risk of poor mental health, and vice versa. Evidence tells us that 30 per cent of all people with a long-term physical health condition also have a mental health problem, most commonly depression/anxiety. Delivering the parity of esteem agenda is a key contributor to delivering the triple aim.

8.3 Improved outcomes

8.3.1 Each of the programmes will address the expected improvements and health gains against the NHS England Triple aim. The triple aim is part of the NHS Five Year Forward View. This sets out areas where action must be taken to ensure that people in England receive high quality care. The have been summarised under the three headings: Better Health; Better Care; Better Value.

8.3.2 Setting each programme out in this way allows transparency of outcomes and us to be clear of why we are making any change.

8.4 Personal Health

8.4.1 We will support patients taking control of their own health plans where possible. Empowering patients to live a healthy life is vital to this plan.

8.4.2 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.

8.4.3 We will promote improved outcomes both through clinical intervention but also through health and lifestyle improvements. We recognise (see appendix 2) 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.

8.4.4 We are clear this is a long journey and will not be achieved in a short time frame. We will not shy away from this challenge. We will support those who live in Black Country and West Birmingham in working with us on this journey.

8.5 Use of Technology

8.5.1 Increasing use of available technology will drive our plans and approach.

8.5.2 We will use technology such as video communication and patient centred apps’ on smart-phone and tablet devices to avoid patients making unnecessary journeys.

8.5.3 Advice on best care and alternative care options will be available to those using services and those who care for them without the need to attend a physical location.

8.5.4 Technology will put those needing to access care in greater control of booking and managing appointments. This will empower people using our services to best meet their personal needs. This will drive a true partnership between patient and clinician in jointly working towards improved healthcare and outcomes.

8.5.5 Technology will drive public health promotion and healthier life styles to support service users in their plans to lead healthier lives.
8.5.6 Additionally; we will ensure clinicians have access to latest clinical guidance and advice through the use of innovative platforms.

8.5.7 Through the use of technology we will reduce unwarranted variation through offering clinicians a more robust approach to high quality decision making.

9.0 ENGAGEMENT

9.1 Our communications and engagement strategy outlines our approach to engaging and communicating effectively with service us, public, partners, staff and stakeholders across the Black Country. The plan outlines how we will work with local stakeholders to improve the health and care of people of the Black Country and west of Birmingham.

9.2 We recognise what people and communities want from their local health and care services and what they could do for themselves, by reorienting and reshaping health and other services to support them. This shift from a clinically and managerially led process to a coproduced approach to health and care is at the heart of our plans around communication and engagement.

9.3 We are 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.

9.4 We will actively provide the following channels for communication, sharing, learning and strategic advice:
- Communications Concordat
- Local communications and engagement networks
- Communication and engagement leads on each transformation work-stream
- Communications and engagement lead to attend/report into the Operational Group
- Communications and engagement lead to attend/advise Sponsoring Group.

9.5 The five community empowerment dimensions are helpful in thinking about how we work with people. Empowerment is not just about the people and communities, it is also about organisational structures and processes being empowering. When developing new ways of working we will take an empowering approach to engagement.
• By ‘confident’, we mean, working in a way which increases people’s skills, knowledge and confidence – and instils a belief that they can make a difference.

• By ‘inclusive’, we mean working in a way which recognises that discrimination exists, promotes equality of opportunity and good relations between groups and challenges inequality and exclusion.

• By ‘organised’, we mean working in a way which brings people together around common issues and concerns in organisations and groups that are open, democratic and accountable.

• By ‘cooperative’, we mean working a way which builds positive relationships across groups, identifies common messages, develops and maintains links to national bodies and promotes partnership working.

• By ‘influential’, we mean working in a way which encourages and equips communities to take part and influence decisions, services and activities.

9.6 The success of our STP relies on our relationship with our patients, people who use our services, our staff and clinicians. We will take an engaging and co-production approach to our STP by getting patients, people who use our services, our staff and clinicians to lead change. Taking decisions together, we will ensure that collective action can make a positive difference to the health and care of people across the Black Country and West Birmingham.

9.7 Each clinical case for change will have its own individual engagement plans that are underpinned by this central engagement strategy.

10.0 PRIORITISATION BASED UPON CLINICAL PRINCIPLES

10.1 In August 2017, the CLG agreed the key principles to apply in the determination of clinical priorities, set out in Developing Clinical Principles to inform the work of the BCWB STP provided by The Strategy Unit (part of the CSU):

• Population needs
• Opportunities to address unwarranted variation in care and outcomes
• Workforce sustainability challenges
• Clinical evidence relating to service consolidation outcome benefits
• Patient choice and access
• Clinical co-dependencies
• NHSE specialised commissioning plans
• NHSE commissioned services planning.
• Estates considerations.

10.2 A clinical transformation prioritisation tool is in development based upon the agreed clinical principles. This will allow us to identify those priorities identified in each of the service area chapters to follow that are considered by clinical leaders to be the most important to work on first. The tool will help in the ranking of problems or issues identified as priorities using weighted criteria. The tool, and its accompanying prioritisation process, will be useful in explaining how initial priorities were decided.

10.3 In the context of the proposed clinical transformation process, an additional set of key characteristics apply to the identification of a service/pathway/specialty as a priority:
• National ‘must do’
• Patient safety and service quality concerns
• Fragile services
• Workforce constraints
• Financial constraints
• Changes needed to achieve 7 day working requirements
• Benchmarking.

10.4 Understanding fragile services represent a strong opportunity for the STP to focus attention on resilience and greater stability. In the context of wider system transformation, this will lead to a stronger and resilient clinical care model.

10.5 A programme is underway to identify fragile and vulnerable services across the STP. Understanding how we support them and how we ensure a consistent model of care can be provided is key.

10.6 We have begun this looking at Acute Trusts. In this way, Walsall Healthcare Trust have shared both a model and their data. In this open and transparent sharing, it is expected under the umbrella of the STP that other organisations will share these data too and support each other.
11.0 OVERARCHING CASE FOR CHANGE

11.1 The clinical strategy is based upon:

- the need to determine specific service development/translation/rationalisation activities to deliver better outcomes, better care and better value, considering the five Joint Strategic Needs Assessments covering the STP population (see Appendix 1)
- the imperative to embed PCNs as the bedrock of BCWB NHS provision, with the capacity and capability to deliver
- delivering care in a way that attends to physical and mental health issues in equal measure and simultaneously
- the need to provide high quality acute services across 7 days
- ensuring our ability to provide a sustainable clinical workforce
- developing a care model for an Integrated Care System (ICS) across the STP
- an ambition for services to be recognised by regulators (e.g. CQC, NHS Improvement) as delivering continued improvements in healthcare and of services being recognised for these improvements through achieving CQC ratings of Good or Outstanding.

11.2 Most Acute Trusts across the Black Country have shown improvements against their original CQC ratings, with some organisations achieving an ‘Outstanding’ rating for either service level or CQC Key Question. The current key service rated inadequate by CQC are Urgent and Emergency Care at DGFT, with Maternity Services in Walsall now moving from inadequate to a recent inspection outcome of requires improvement.

11.3 Both Mental Health Trusts had improved their overall CQC ratings. One Trust had achieved outstanding ratings for some of its service. Although both will be inspected imminently again.

11.4 As workstreams develop, clinical leaders will want to review the regulators ratings for all providers of health and social care to ensure the case for change fully addresses concerns and improvements.

11.5 We recognise that despite improvements, some individual services are not yet delivering the quality of care and outcomes we want to see for those living in the Black Country and West Birmingham. We will be open in each case where we believe services are falling short and demonstrate how changes will seek to improve this. We will hold leaders to account for delivering these improvements to services.

11.6 Using national and local data benchmarked to provide context; we will describe the workforce constraints of each service and recognise how these will be addressed or supported by change. We anticipate there will be a need to develop networked clinical solutions involving a more unified workforce across the STP serving more than one organisation.

11.7 We recognise that attracting the very best staff to work alongside our existing high calibre clinicians, we will need to have innovative models of care that will drive better outcomes. There are some pathways where workforce needs are becoming an increasing challenge. This strategy will seek to recognise and address these.

11.8 In almost all NHS services, delivering a balanced budget is increasingly difficult. Where it makes financial sense, we will seek to implement change that will release resources to support other clinical developments.

12.0 DEFINING CLINICAL PRIORITY AREAS

12.1 The starting point for CLG’s strategy development lies in the NHSE Five Year Forward View and the 2018/9 Planning Guidance that set out national ambitions for transformation in six vital clinical priorities:

- **Cancer**: Advance delivery of the National Cancer Strategy to promote better prevention and earlier diagnosis and deliver innovative and timely treatments to improve survival, quality of life and patient experience by 2020/21
- **Mental Health**: Implementing the Mental Health Forward View (July 2016), Stepping Forward to 2020/21, providing equal status for mental and physical health
• **Primary Care**: Stabilise general practice today and support the transformation of primary care and for tomorrow, by delivering General Practice Forward View and Next Steps on the NHS Five Year Forward View

• **Urgent & Emergency Care**: Redesign and strengthen the urgent and emergency care system to ensure that patients receive the right care in the right place, first time

• **Transforming Care for People with Learning Disabilities**: To transform the treatment, care and support available to people of all ages with a learning disability, autism or both so that they can lead longer, happier, healthier lives in homes not hospitals.

• **Maternity**: Continue to make maternity services in England safer and more personal through the implementation of the *Better Births*

12.2 Further to this, the CLG reviewed a large amount of data, the timeliest data being the elective and non-elective spend by specialty area (2017 data) in the Table 1 below.

**Table 1: RightCare Better Value Opportunities – Elective/Non-Elective Spend**

<table>
<thead>
<tr>
<th>Sum of Significant Opportunity to best/lowest 5. (£’000)</th>
<th>Elective</th>
<th>Non-elective</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Row Labels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circulation</td>
<td>£2,134</td>
<td>£6,901</td>
<td>£9,035</td>
</tr>
<tr>
<td>Respiratory</td>
<td>£101</td>
<td>£7,686</td>
<td>£7,787</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>£1,029</td>
<td>£5,120</td>
<td>£6,149</td>
</tr>
<tr>
<td>MSK</td>
<td>£4,610</td>
<td>£644</td>
<td>£5,254</td>
</tr>
<tr>
<td>Neurological</td>
<td>£0</td>
<td>£4,097</td>
<td>£4,097</td>
</tr>
<tr>
<td>Cancer</td>
<td>£1,345</td>
<td>£2,299</td>
<td>£3,644</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>£513</td>
<td>£3,105</td>
<td>£3,618</td>
</tr>
<tr>
<td>Endocrine</td>
<td>£121</td>
<td>£1,173</td>
<td>£1,294</td>
</tr>
<tr>
<td>Trauma &amp; Injury</td>
<td>£99</td>
<td>£823</td>
<td>£922</td>
</tr>
<tr>
<td>Grand Total</td>
<td>£9,952</td>
<td>£31,848</td>
<td>£41,800</td>
</tr>
</tbody>
</table>

This resulted in the CLG prioritising the following areas in addition to the national programme areas in section 12.1 above:

- Cardiovascular
- Respiratory
- Musculoskeletal
- Frailty – this addresses the non-elective opportunities in
  - genitourinary which is mainly UTIs in 65+
  - neurology which is mainly admissions for syncope and collapse, disorientation and tendency to fall
  - trauma & injury which is mainly injuries due to fall in 65+

12.3 Added to this, priorities identified in other STP forums and within the documents listed below all contributed to informing CLG’s initial ‘long-list’ of clinical priorities (as set out in Table 2 below):

- Right Care Perspectives for the Black Country STP Clinical Service Review Process (Strategy Unit);
- Developing Clinical Principles to inform the work of the BCWB STP (Strategy Unit);
- Determining the Black Country Collaborative Commissioning Portfolio (Black Country Joint Commissioning Committee, BCJCC);
- Programme Briefs for existing collaborative transformation work (BC JCC);
- Proposals for addressing opportunities in relation to hypertension, respiratory care, MSK and frailty (Right Care).
- NHS England Direct Commissioning Operational Planning.
## Table 2: Black Country and West Birmingham Clinical Priorities – April 2018

<table>
<thead>
<tr>
<th>Proposed Priority Area</th>
<th>Scope includes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Primary Care Networks – sustainability of General Practice and the integration of care at the ‘locality’ level (30-50k population) working towards the involvement other providers of primary care (dental, pharmacy and optometry).</td>
</tr>
<tr>
<td><strong>Cancer</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td>RTT, Urology, Upper GI, Haematology, screening, radiotherapy, services requiring 1m+ population</td>
</tr>
<tr>
<td><strong>Mental Health</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Access for children and young people, IAPT, crisis care, dementia, suicide prevention, integrating mental/physical health</td>
</tr>
<tr>
<td><strong>Learning Disability Services</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Transforming Care programme, including shift towards greater community provision</td>
</tr>
<tr>
<td><strong>Maternity &amp; Neonates</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Better Births, infant mortality, maternity capacity (incl. consultant-led vs MLU, antenatal and newborn screening and maternal and neonatal immunisation programmes).</td>
</tr>
<tr>
<td><strong>Children and Young People</strong></td>
<td>It is our ambition that the Black Country is a place where children and young people thrive: that all children in the Black Country get a good start in life and are healthy; that all families are supported to be independent, responsible and successful; where the most vulnerable children are protected; and where our children are supported to become function and productive members of our communities We want to move the Marmot curve for our CYP population. Services work towards this ambition including specialist 24/7 care, TCP, CAMHS, Community services, prevention (e.g. oral health, screening and immunisations, Healthy Child Programme safeguarding etc.</td>
</tr>
<tr>
<td><strong>Urgent &amp; Emergency Care</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td>Reducing attendance/admission, UTC specification, emergency general surgery, trauma/ITU provision, emergency/elective split</td>
</tr>
<tr>
<td><strong>Cardiovascular Disease</strong></td>
<td>Prevention</td>
</tr>
<tr>
<td><strong>Clinical Support Services</strong></td>
<td>Pathology, interventional radiology</td>
</tr>
<tr>
<td><strong>Musculoskeletal Conditions</strong></td>
<td>Standardising elective orthopaedics</td>
</tr>
<tr>
<td><strong>Respiratory Disease</strong></td>
<td>Smoking cessation, COPD pathway</td>
</tr>
<tr>
<td><strong>Frailty</strong></td>
<td>UTIs, falls, dementia</td>
</tr>
</tbody>
</table>

Note: *NHSE Five Year Forward View priorities*
13.0 CLINICAL CASE FOR CHANGE

13.1 This document includes the summary for each current clinical case for change.

13.2 It shows the ‘plan on a page’ approach to support oversight by the CLG and STP Board. It allows, at a strategic level, key drivers to be seen and progress to be maintained.

13.3 For detailed commentary on the work on each please refer to the accompanying document ‘Black Country Clinical Strategy, Clinical Case for Change’ which should be read in conjunction with this document.

13.4 The Clinical Case for change has the level of detail that allows the workstream leads to monitor, report and take action to maintain progress. Each clinical workstream has identified leads who will be tasked with leading progress on behalf of the STP. We expect the approach to be bespoke recognising the individual challenges; but to be guided by the principles and approach in this strategy.

13.5 Each Clinical Case for Change will develop its own approach to resolving challenges. We will not impose a single one-size solution.

13.6 Appendix 1 carries the list of the 12 initial priority areas.

13.7 We chose these areas because they represent the key areas that will most impact on the health and wellbeing of our population. Including:

- Primary care is the cornerstone of almost all NHS care. Improving our primary care provision is key to an effective healthcare and wellbeing strategy.

- Cancer has a number of diagnostic pathways and processes in common with many other conditions. It is well recognised that improving pathways for cancer patients will have a clear benefit for many other non-cancerous conditions.

- Mental health problems are one of the main causes of the overall disease burden. It is estimated nationally that 1:6 people of working age have symptoms of a common mental health problem. The rates of common mental health problems are higher (18.4%) in the West Midlands than in many other areas of the country. Making mental health one of our top priorities is vital to the health and wellbeing of our population.

- Among the most vulnerable in our society are those people living with learning disabilities. We want to work quickly to ensure our services protect them and meet their individual needs where possible. We are proud of how much we have already achieved here.

- Heart and circulatory diseases cause more than a quarter (25.4 per cent) of all deaths in England. PHE indicators (see appendix 2) show we have a high proportion of obese adults and in some areas a high density of fast food outlets. These alone indicate this is a key health priority. Over 150,000 people are likely to be living with cardiovascular disease in the Black Country and West Birmingham area.

- Our population has a higher than average incidence of respiratory disease compared to the rest of the country (e.g. Sandwell 1.255).

Our priorities will have the greatest impact on our population health.
14.0 SUPPORTING STRATEGIES AND ENABLERS

14.1 Whilst our clinical strategy sets out our priorities it also serves to inform other important strategies across the integrated care system for the Black Country. We fully recognise the opportunities and challenges associated with system change and will need to work alongside the development of a capital estates programme to better utilise and develop good estate for care delivery. We also recognise the developing technologies agenda and will endeavour to make good use of modern technologies across clinical programmes, embracing all that this infrastructure has to offer in the name of information sharing, enablement and empowerment.

14.2 Effective people engagement is critical in supporting any change, and consideration needs to be given to how we support this approach on a wider footing, building on excellent work already in place across the Black Country and better understanding the concept of ‘self-management’. This will provide a platform on which to encourage and motivate people to change lifestyles, ingrain responsibility for, and control of, their health and well-being, and move from being a dependent recipient of medical care to a more selective and independent consumer of health and care, utilising their own resources first where possible.

14.3 A sound financial plan for system delivery will need to underpin everything that we do and ensures that the appropriate policies, procedures and support is in place to influence and achieve the clinical priorities identified. The underlying principles of financial governance will be supported through the delivery of the clinical programmes, ensuring financial viability of services and sustainability for clinical delivery across the integrated system.

14.4 Quality assurance of system level change and delivery is critical to success to ensure lessons are learned where required, good practice is shared and embraced, and any statutory requirement is evidenced.

15.0 CLINICAL TRANSFORMATION APPROACH (CTA)

15.1 The STP service redesign and system transformation approach, whilst rooted in the STP plan has been largely emergent to date, with regulatory requirements arising out of national priorities acting as significant stimulus. Going forward, the CLG proposes a more systematic approach to identifying and addressing clinical priorities is proposed using the five key stages identified in Table 3 below: identification, planning, design, delivery and review.

15.2 Applying this approach will ensure consistency and transparency and serve to evidence progress and achievements for local and national reporting and celebration.

15.3 A programme management process, tools and governance will be developed to support this approach, appropriately interfacing with the STP performance management framework.

15.4 Focus on delivery at pace and a commitment to tackle the often difficult issues will be an important part of this process. Partner in the STP with be committed to finding solutions that work in the best interests of those using the services. These are the guiding principles required on our journey to an Integrated Care System.

15.5 The programme management will recognise work in other STPs and ICSs where this will have an impact on local plans. We will work with partners in other areas in a spirit of mutual cooperation.

15.6 We will not wait for the Care Quality Commission or other regulators to tell us where services are not delivering the standards we expect to see. We will proactively evaluate the quality of care and act swiftly where improvements are needed.
### Table 3: BCWB Clinical Transformation Approach

| Identification | Programme area presented to Clinical Leadership Group. Identify reasons to prioritise, applying agreed clinical principles:  
- National must do  
- Patient safety and service quality concerns  
- Fragile services  
- Workforce constraints  
- Financial constraints  
- Changes needed to achieve 7 day working requirements  
- Benchmarking |
| Planning | Identify clinical lead, executive lead, provider lead and commissioner lead.  
Organise clinical transformation group meetings.  
Describe and understand the population in need.  
Describe current pathways and profile of resources currently invested.  
Benchmarking review to inform opportunities for change.  
Review clinical evidence, best practice and care pathways from prevention to end of life.  
Engage of public and service users.  
Develop ambition, objectives and desired outcomes.  
Present to Clinical Leadership Group. |
| Design | Workshop with stakeholders across all pathway to design optimal pathway – right care at right time for people.  
Develop person-centred models for delivery. Consider opportunities for prevention, early detection, self-care and patient activation.  
Consider requirements of workforce, digital enablement, capital and estates and communication and engagement.  
Identify opportunities for innovative commissioning/contracting to support delivery.  
Focus on creating sustainable clinical system where waste/ unwarranted variation is minimised.  
Prioritise and schedule planned actions.  
Define outputs and outcomes and trajectories. |
| Delivery | Shared approach to change management and service redesign. Build capacity across system.  
Ensure contracts are structured to incentivise desired outcomes. |
| Review | Formative evaluation - Monitor outputs and outcomes against designed trajectories. Continuous review and improvement.  
Summative evaluation – At end of project, review and record lessons learnt. Share with stakeholders. |
16.0 SUMMARY STATUS ANALYSIS BY PRIORITY AREA

16.1 A summary analysis of the priority areas for which the case for change has been set out in chapters 9-20 above has been undertaken to identify where:

- A national strategy/mandate for action exists
- The service area has been identified as a priority in the 2016-21 STP Plan
- Where service redesign/transformation is being undertaken primarily at an STP level or by each individual CCG
- STP governance arrangements, including lead appointments and organisation for service review and implementation
- Clinical transformation ‘stage’; and
- Initial priorities.

16.2 The analysis highlights:

- 6 out of the 12 priority areas have national strategies, are identified as STP plan priorities and have STP Executive leads (Cancer, Learning Disabilities, Maternity & Neonates, Mental Health, Pathology & Urgent & Emergency Care); however, STP Clinical Leads only exist for Cancer, Maternity & Neonates and Pathology.
- The clinical leadership group looked at progress already made in each area and ‘state of readiness’. They concluded that Primary Care, Cancer, Mental Health, Learning Disabilities and Maternity were the areas that were able to be progressed to the design and delivery phases.
- 4 of the 12 priority areas that neither have a specific national strategy nor identified as a STP priority are considered by the CLG to be key priorities, namely Children & Young People, Cardiovascular services, Frailty and Respiratory services
- Whilst collaborative arrangements are in place, and operating, there are pockets of activity where CCGs come together but redesign is largely taking place within each individual CCG e.g. musculoskeletal services
- The majority of areas for service review/transformation are in the planning stage; however, Learning Disabilities, Interventional Radiology, Maternity & Neonates and Pathology are all in delivery or review; all with strong Regulator interest given performance and sustainability drivers
- All specialty/service areas have one or more identified initial priorities.

17.0 LEARNING

17.1 Through the Learning Disabilities clinical work stream, it is clear that establishing a PMO function, a leadership group and a board structure, progress is rapid, and success follows.

17.2 Strong clinical and managerial leadership are key to delivering programmes at scale and at pace.

17.3 Using the output from the ‘So what, what next?’ project in Learning Disabilities; the project has been able to capture ‘Top tips for decision makers, professionals and supporters’. These will form the basis of wider learning for all specialities.
<table>
<thead>
<tr>
<th>Top tips for decision makers, professionals and supporters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Start early</strong></td>
</tr>
<tr>
<td><strong>Remember my history</strong></td>
</tr>
<tr>
<td><strong>Work with all the people in my life</strong></td>
</tr>
<tr>
<td><strong>Focus on the positives</strong></td>
</tr>
<tr>
<td><strong>Find out about my dreams</strong></td>
</tr>
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<td><strong>Stretch further than person-centred</strong></td>
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<td><strong>Don’t let the risks take over</strong></td>
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<td><strong>Understand what I might offer my community</strong></td>
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<td><strong>Help me meet new people and make new connections</strong></td>
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<td><strong>Plan for my good days and bad days</strong></td>
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<td><strong>Recognise and celebrate all achievements</strong></td>
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<td><strong>Hold my dreams through good times and bad</strong></td>
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18.0 CONCLUDING REMARKS AND NEXT STEPS

18.1 The Black Country clinical strategy identifies an initial series of clinical priorities for our integrated system. It provides the information upon which the CLG can determine which of the priority areas are most important, and for which resources should be collectively mobilised to decide which actions will deliver the greatest contribution to improving health, care and value. The content can inform the phasing of the transformation work, providing for focus on the areas where immediate attention and action is required. Clinical leaders need to determine together what must be done first and make this recommendation to the STP so they can endorse the priorities and mandate concerted system-wide action and delivery. The development of these priorities going forward will be an iterative process shaped by our ongoing review of services across the Black Country, by our workforce review and by our engagement strategy.

18.2 We will ensure we continue to listen to the views of our citizens, staff and wider stakeholders to help inform the bold decisions needed for the future of healthcare across the Black Country. Our strategy is built from the principal of local services wherever possible delivered through our GP networks and our local place-based models which are working in close partnership with our colleagues in social care. This clinical strategy describes the priorities that exist at a wider Black Country system level whilst recognising and complimenting the delivery of integrated services at local place.

18.3 We will expect clinical leaders to show how they have engaged (or how they plan to do so) with those who use the services in bringing forward their plans. We expect that engagement to be an ongoing process.

18.4 In Primary Care, we will work to build capacity, developing primary care networks and promoting a multi skilled workforce for care delivery. Community services need to demonstrate ingenuity in delivering a significant proportion of community-based care across the places in the BCWB. In addition to primary care networks comprising of GP providers, we will also explore ways in which other providers of primary care services (General Ophthalmic Services, oral health providers and community pharmacy) can work collaboratively to offer a joined up approach for the local population.

18.5 Secondary care clinical teams who provide complex and high-tech services often get improved outcomes for their patients when they work in networks. Opportunities must therefore exist to maximise the benefits of these arrangements through delivery of the clinical strategy. In health, we cannot achieve what is needed alone, this is where our partnership arrangements must come to the fore, whole pathways of care demand multi agency and voluntary sector working, shaped by the needs of our local population.

18.6 The changes required are complex and will require consideration of workforce resources, evidential outcomes, inter relationships across organisations and financial review for effective delivery. It will require complex and compelling discussions between clinicians, people of the Black Country and wider stakeholders to effect change and improve outcomes, all built on a set of principles which underpin this clinical strategy:

- To adopt the least invasive, disruptive process at first step, an example being the choice of lifestyle interventions before drugs and surgical procedures, supporting people to be in control of and responsible for their own illness;
- Avoid unwanted variation in standards of care or activity;
- Ensure sustainable services for our future generations.

18.7 The BCWB Integrated Care System (ICS) will manage delivery of the priorities through a series of clinically led work programmes, reporting progress through a well-developed programme management office (PMO). The PMO will work closely with clinical programme system leaders to ensure delivery of the key priorities of the integrated care system. Each work stream will operate with an appropriately nominated clinical lead, working alongside senior commissioning and provider representation.
18.8 We will know if we are achieving against our priorities through delivery of a range of metrics and evidence developed for each clinical programme, reported through a robust governance arrangement, reporting through to the ‘Health Partnership Board’ and subsequently to the wider partnership board and receiving scrutiny and support via the Clinical Leadership Group of the Black Country.

18.9 The Black Country ICS is committed to supporting clinical leadership and firmly supports the statement: ‘Clinical Leadership is at the core of delivering a patient led NHS. In order to improve local services, it is critical that the clinicians who deliver these services are instrumental in their transformation’, Sir Bruce Keogh, NHSE Medical Director (2007-2017).

18.10 We will be bold in our drive for improved clinical quality and better outcomes. We will support those living in Black Country and West Birmingham to improve their health and wellbeing; and empower them to have an improved access to care through placed based care initiatives.

18.11 Firmly based upon this premise, this clinical strategy provides a sound basis from which we can truly collaborate to both ensure best practice care is delivered as standard across our patch and continue our journey of transformation across the Black Country to enable our services to become the best they can be and to ensure sustainability for the future.
APPENDIX 1 CLINICAL CASE FOR CHANGE SUMMARY

CASE FOR CHANGE: PRIMARY CARE

QUALITY OF CARE STATEMENT

We want patients to have access to resilient accessible primary care.

TRIPLE AIM OPPORTUNITIES

Better Health: Involving GPs in commissioning discussions and decision making enables new approaches to prevention and management of ill health for our population.

Better Care: Networks supporting local populations will allow the provision of personal care. Move from disease management alone, towards prevention, wellbeing and self-care, optimising patient outcomes.

Better Value: Rebalancing the investment between primary and secondary care providers makes sense as optimising the use of out of hospital services averts the current waste.

INITIAL PRIORITIES

• Develop a collective STP Programme of Work that fulfils the requirements of GPFV
• Introduce a dedicated resource to enable implementation of the programme
• Interface with NHS England and Health Education England to ensure all national guidance & funding are accessed on behalf of the STP and deployed across the footprint
• Continued engagement with member practices, clinical leaders & LMCs in delivering GPFV & integration
• Continue to implement the STP Workforce Strategy recruiting and retaining a workforce that contributes to achieving a sustainable primary care
• Conclude delivery of the programme of work across the STP in 2020.

PROGRESS

• We are focused on delivering the 10 High Impact Actions, which are agreed.
• These are Active Signposting; Develop the Team; Support Self-Care; New Consultation Types; Reduce DNAs; Social Prescribing; Partnership Working; Productive Workflows; Personal Productivity; Develop QI Expertise
• Transformation Funding is targeted at this work. Significant investment is being made.
• The headline achievements are shown in the clinical case for change

STP GOVERNANCE

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CASE FOR CHANGE: CANCER

QUALITY OF CARE STATEMENT
We want services for patients to be in the top quartile for prevention, early diagnosis and treatment.

TRIPLE AIM OPPORTUNITIES
**Better Health:** Taking concerted action to address some of the environment, societal and lifestyle issues that drive poor health outcomes.
**Better Care:** Our key opportunities are to targeted interventions to improve the uptake of cancer screening; Implement the national faster [28 day] diagnosis pathways; Deliver Living With and Beyond Cancer.
**Better Value:** Taking actions to increase screening uptake and earlier diagnosis should not only save lives but reduce costs for unplanned cancer care.

INITIAL PRIORITIES
- Achieving the 62-day waiting time standard.
- Implementing early diagnosis by 2020.
- Improving patient experience, including through implementation of the national Recovery Package.
- Review options for stronger collaboration on cancer services between Walsall’s cancer unit and the Wolverhampton cancer centre.

PROGRESS
- First tranche of national funding agreed
- Priority pathways established for review
- Deep dive focus on cancer performance across STP with particular reference to RWT
- Agreement to undertake stratification follow up across STP
- Ongoing engagement with West Midlands Cancer Alliance

STP GOVERNANCE

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CASE FOR CHANGE:  MENTAL HEALTH

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QUALITY OF CARE STATEMENT

We want our patients to have access to universal and specialist mental health and mental wellbeing initiatives that improve the quality of life chances and opportunities.

TRIPLE AIM OPPORTUNITIES

Better Health: Improved access to universal and specialist mental health and mental wellbeing initiatives, with increased focus upon prevention and early intervention at key moments in life, reducing levels of complexity and chronicity including physical health and improving the quality of life chances and opportunities.

Better Care: Improved access to integrated health and social care initiatives including focus on primary care mental wellbeing and the wider determinants of mental ill health in individuals, families and communities

Better Value: Transformed outcomes, experience and reduced demand on mental and physical health secondary and tertiary services. Releasing savings through reductions in inappropriate out of area placements.

INITIAL PRIORITIES

- Confirm agreement regarding the suite of services where there is a financial case to commission ‘as one’ and have involved the two mental health providers in this process. This synergy will enable optimal implementation of the Mental Health Delivery Plan and realise the benefits that reflect the views and ‘ask’ from service users and their families/carers.
- The STP ‘Mental Health Plan on a Page’ for 2018/19 and 2019/20 submitted to NHSE details the work to be done (see MH Plan on a Page V1 STP for submission).
- The strategic commissioning platform as outlined in 9.6.3 will be in place by 01/04/19.

PROGRESS

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20181123 Black Country Clinical Strategy Exec Summary And Strategic Direction V14.2
QUALITY OF CARE STATEMENT
We want people with learning disabilities and/or autism seen as citizens with rights, who should expect to lead active lives in the community.

TRIPLE AIM OPPORTUNITIES
Better Health: The TCP programme will result in people with learning disabilities and/or autism seen as citizens with rights, who should expect to lead active lives in the community.
Better Care: The TCP programme will improve the quality of life for people with a learning disability and/or autism. The right specialist community services will be in place to allow service users to benefit from maintaining links with their local support network and family.
Better Value: The reduced reliance on bed-based care, reduced A&E attendances, less inpatient admissions and fewer delayed discharges of care will release costs; expensive out of area placements can be reduced.

INITIAL PRIORITIES
• The initial priority is to ensure the ED services across the Black Country fulfil the requirements set out in the Planning Guidance 2018/19. This will ensure effective services that meet national delivery requirements are available to all residents of the Black Country. Given the national challenges to ED delivery, we do not underestimate how difficult this may be.
• To do this we will work together across each ED team, sharing best practice. We will maximise the use of ‘out of hospital’ interventions to ensure patients who do not need to have an attendance at ED are offered alternative routes to care.

PROGRESS
• Tier 4 admission rate demonstrating improvement
• 18/19 TCP Funding plans now agreed
• Community model agreed
• Improving trajectory for inpatient bed based reduction

STP GOVERNANCE

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<td>Dr Jas Lidher</td>
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<td>Sally Roberts/Yvonne Higgins/Wendy Ewins/Emma Hall/Susan Brady /Scott Humphries/Dr Jas Lidher</td>
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**QUALITY OF CARE STATEMENT**

We will provide a maternity care pathway that involves women, and those close to them, in the right choices for them to give birth in a safe and caring environment.

**TRIPLE AIM OPPORTUNITIES**

**Better Health:** Have reduced rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20%, and are on track to make a 50% reduction by 2025; Are investigating and learning from incidents and are sharing this learning through their Local Maternity Systems and with others; Are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Health Safety Collaborative.

**Better Care:** All pregnant women have a personalised care plan; All women are able to make choices about their maternity care during pregnancy, birth and postnatally; Most women receive continuity of the person caring for them during pregnancy, birth and postnatally

**Better Value:** Delivery of ambition within financial envelope

**INITIAL PRIORITIES**

- Delivery of ‘A Healthy Pre-Conceptual and Pregnancy Strategy for the Black Country and West Birmingham’
- Timely escalation in the event of reduced foetal movement, remaining alert to the need for this at every contact
- All women will have access to a maternity record through an effective IT system
- Staffing baseline and profile of future workforce requirements will have been established against pathways.
- Specialist Perinatal Mental Health Community Service will be in place across Black Country during 2018.
- Low Risk women will receive care provided by midwives in continuity-of-care – 20% for each Trust.
- Low risk women will be provided with a Personalised plan of care that the woman agrees with and has been formed with her.

**PROGRESS**

- Delivery of a healthy pregnancy strategy for Black Country by 2019 on track
- Plans to achieve 20% trajectory for continuity of carer at booking by March 2020 on track
- Sharing incident learning in place across Black Country
- Saving babies lives care bundle supported across Black Country and on track for full implementation by March 2019
- Fully engaged in the Maternity and Neonatal Health Safety Collaborative
- Personalised care plans being developed for larger cohort of women
- Successful MVP in place across Black Country with Whose shoe’s engagement events recognised

**STP GOVERNANCE**

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Dawn Lewis/Siobhan Heathfield/Caroline Brunt
Rachel Carter/Neil Shah/Paula Gardiner/Claire Parker
Nicola Wenlock/Mr Ghazal/Karen Dunderdale/Sarah Shingler
Tracy Palmer/Tracey Vanner/Ann-Marie Cannaby/Sally Roberts
CASE FOR CHANGE:   CHILDREN AND YOUNG PEOPLE

Children & Young People  Identification  Planning  Design  Delivery  Review

QUALITY OF CARE STATEMENT
Children and Young People in Black Country and West Birmingham are our future; and so we will ensure they are in good physical and mental health, enabling them to become independent and productive members of our society.

TRIPLE AIM OPPORTUNITIES
Better Health: To ensure that children and young people in the Black Country are in good physical and mental health, enabling them to become independent and productive members of our society.
Better Care: Children and young people shall receive their care as close to home and social network environment as possible.
Better Value: RightCare data suggest an opportunity to invest in higher value interventions (prevention and proactive care) and disinvest in lower value interventions (reactive care in an emergency).

INITIAL PRIORITIES
- Invest more (or at least the same) in children. Reinvest savings in areas where there is unmet need (e.g. mental health, adverse childhood experiences)
- Identify examples of good practice in the BCWB and elsewhere nationally that we will explore around the potential for roll out across the STP footprint: e.g. increasing physical activity in children; Connecting Care for Children; The ‘Big 6’; Non-urgent referrals via paediatric triage; Urgent advice and guidance; GP practices – the primary care quality mark for children and young people; GP Education; Pathways for self-harm
- Safeguarding. Expanding scope within Child Sexual Exploitation and the SCRs across Black Country and PREVENT/WRAP models

PROGRESS
- Agreed as priority by Clinical Leadership Group
- Primary Care Clinical Working Group established

STP GOVERNANCE

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<td>Linda Cropper</td>
<td>Kharma Boothe, Sarah Farmer</td>
<td>Nicky Warrilow/Sarah Shingler</td>
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CASE FOR CHANGE: URGENT & EMERGENCY CARE

QUALITY OF CARE STATEMENT
To sustainably meet the urgent and emergency care needs of local people through the development and delivery of a comprehensive and integrated care service.

TRIPLE AIM OPPORTUNITIES

Better Health: Address the environment, societal and lifestyle issues that drive poor health outcomes, in addition to providing information and support for individuals to self-care and act quickly in response to changing health will reduce demand for UEC.

Better Care: Allow the specialist skills of the ED workforce to increasingly focus on people with more serious or life-threatening emergency needs by increasing access to primary care.

Better Value: Stem the growth in the number of people using UEC, reduce fragmentation of the system and inconsistent service provision.

INITIAL PRIORITIES
- To fulfil the requirements set out in the Planning Guidance 2018/19.
- Development of primary care to offer 7 day access and multidisciplinary care through Primary Care Networks
- Place based integration with local authorities to further reduce delayed transfers of care
- ??

PROGRESS
- The STP has supported a system wide co-ordination through monthly calls co-ordinated by the STP lead.
- This has already led to the submission of a system wide proposal for committing the addition £500k funding provided to the STP.
- An STP discussion with WMAS is scheduled for the second week in October in preparation for winter.
- An ongoing process of STP engagement in the renegotiation of the ambulance service contract for the area and the continued development of the Integrated Urgent and Emergency Care system.

STP GOVERNANCE

| Clinical Chair | Dudley | Geraint Griffiths |
| Executive Lead | Andy Williams | SWB |
| Management Lead | Rachel Ellis | Walsall | Andy Rust |
| PM Support | Wolverhampton | Dee Harris |

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**PROGRESS**

- The programme working group has been finalised. Both clinical and commissioning input has been taken from each CCG and this will aid in the implementation of any pathways formed.
- Terms of reference for the working group has been agreed and signed.
- Initial data gathering exercise being undertaken. This includes hypertension figures, comparison to right care opportunities and potential for improvement to be identified.
- The involvement of public health and pharmacy networks achieved.
- Scoping any voluntary sector involvement especially in achieving identification of patients with raised BP in the community.

**STP GOVERNANCE**

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CASE FOR CHANGE: CLINICAL SUPPORT SERVICES: INTERVENTIONAL RADIOLOGY (IR)

QUALITY OF CARE STATEMENT

Our patients will have access to an Interventional Radiology Service within Black Country and West Birmingham that will deliver high quality clinical outcomes.

TRIPLE AIM OPPORTUNITIES

**Better Health:** Angiography helps maintain people’s health by identifying areas of concern before they present symptoms. Catheter placement for renal dialysis patients enables dialysis in the community and supports patients to maintain a (near) normal life in their own home.

**Better Care:** Improved patient outcomes through accessing the procedure more quickly, preventing the condition from worsening and through recovery starting sooner, and reduced costs.

**Better Value:** Less delay in patients receiving this diagnostic has resulted in reducing hospital length of stay and contributed to the retention of skilled clinical staff within the Black Country.

INITIAL PRIORITIES

- Appraisal of the vascular and other non-vascular procedures model of service provision to determine whether this can be provided 24/7 sustainably by DGFT, RWT and SWBH.

PROGRESS

- A six-month pilot to provide seven-day fast-track percutaneous nephrostomy and/or stenting for acute/progressive renal failure/sepsis.
- This model extended to vascular and other non-vascular procedures on 1st December 2017 with provision operating 24/7 as a 3-month pilot.
- Since the start of the 3-month pilot, there has been an increase in cases referred in to the service.
- Agreed that the 24/7 IR service provision would become the standard operating model.

STP GOVERNANCE

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Cn – Consultant, N – Nurse, Cm -Commissioner
CASE FOR CHANGE:  CLINICAL SUPPORT SERVICES: PATHOLOGY

Clinical Support Pathology

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QUALITY OF CARE STATEMENT
A Black Country Pathology Service that delivers prompt diagnostic and clinical intelligence in a cost effective and efficient organisations.

TRIPLE AIM OPPORTUNITIES

Better Health: Supports the drive to earlier identification and intervention and the proactive monitoring of disease and progression, thereby contributing to patients making changes to their lifestyles.

Better Care: Improve the quality of the current service through sharing of resources and allow standardisation of the service across all sites, eliminating existing variations across services.

Better Value: Provide economies of scale and deliver annualised savings of £6.7 million spread across pay, non-pay and reduced overhead costs that exceeds the £5.1 million target set by NHSI.

INITIAL PRIORITIES

• To proceed with the establishment of the BCPS to enable the Target Operating Model (TOM) to be in place by February 2020.

STP GOVERNANCE

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### Case for Change: Musculoskeletal Conditions

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#### 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.

#### STP Governance

<table>
<thead>
<tr>
<th>Clinical Chair</th>
<th>Dudley</th>
<th>Mark Curran</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Lead</td>
<td>SWB</td>
<td>Jess Glenn /Natasha Dupree</td>
</tr>
<tr>
<td>Management Lead</td>
<td>Helen Black</td>
<td>Walsall</td>
</tr>
<tr>
<td>PM Support</td>
<td>Wolverhampton</td>
<td>Claire Barrett</td>
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CASE FOR CHANGE: RESPIRATORY DISEASE

Respiratory

<table>
<thead>
<tr>
<th>Identification</th>
<th>Planning</th>
<th>Design</th>
<th>Delivery</th>
<th>Review</th>
</tr>
</thead>
</table>

QUALITY OF CARE STATEMENT
We will reduce premature mortality rate for respiratory disease to below the England average. Patients living in the community will be able to access Consultant outreach.

TRIPLE AIM OPPORTUNITIES

**Better Health:** 8268 more people with COPD detected (16/17 data). 60 lives saved (12-14 data)

**Better Care:** 6650 more smokers with COPD offered support, 457 more people with COPD receive an annual review, 744 more people with COPD receive a flu vaccination, Best Practice Tariff introduced.

**Better Value:** 21,836 less bed days (2016/17 data), £7,686k less non-elective spend (2017 data), £3,737k less primary care prescribing spend (2016/17)

INITIAL PRIORITIES

- Quality assured diagnostic spirometry services meeting new ARTP criteria.
- Breathlessness management including PR uptake
- Optimising End of life care as pathways
- Harmonising formularies
- Disease prevention services including smoking cessation.

PROGRESS

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STP GOVERNANCE

<table>
<thead>
<tr>
<th>Clinical Chair</th>
<th>Dudley</th>
<th>Phil Brammer, Joanne Hamilton, Mark Hopkin, Andrew Hindle</th>
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<tr>
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<td>SWB</td>
<td>Arvind Rajasekaran, Manish Latthe, Elaine Cook, Kelly Redden-Rowley, Mohammed Khalil</td>
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<td>Shaheed Nadeem, Carsten Lesshafft, Nicola Humphrey, Catherine Easthorpe</td>
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<td>PM Support</td>
<td>Wolverhampton</td>
<td>Stanley Ejiofor, John Burrell, Tracey Slater, Claire Morrissey</td>
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**Frailty**

<table>
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<th>Planning</th>
<th>Design</th>
<th>Delivery</th>
<th>Review</th>
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</thead>
</table>

**QUALITY OF CARE STATEMENT**

We will put patients at the heart of their own care through better coordinated care that meets their needs when they are both at home and in hospital. We will reduce avoidable emergency admissions.

**TRIPLE AIM OPPORTUNITIES**

**Better Health:** Ensuring improved prevention and better prevention, effective acute care and management and recognition of frailty, managing better our most poorly frail patients, especially at the end of life.

**Better Care:** There are six contributing conditions to frailty: falls, mobility, polypharmacy, delirium/dementia, incontinence and end of life. There are opportunities to improve outcomes in all these areas.

**Better Value:** The average cost of per patient for older people in the ‘fit’ category is £975 per year; for older people in the ‘severe’ category £4,189 per year. Therefore, investing in improving or maintaining fitness would be better value than reacting to late presentation and resulting hospital care.

**INITIAL PRIORITIES**

- Engage with all stakeholder to develop a STP integrated frailty strategy
- Review current use of frailty measurement tools and coding across STP, recommendations for consistent use.
- Understand current activity around supporting older people to stay fit and develop additional innovative approaches including healthy ageing communication plan.
- Review current good practice to support moderately and severely frail people and make recommendations for systematic roll out across STP.
- Focus on pathways for the key conditions that contribute to frailty: falls, mobility, polypharmacy, delirium/dementia, incontinence and end of life.

**PROGRESS**

- Initial scoping meeting completed
- Agree a set of five work streams to underpin the frailty work at ICS
- Sharing of good practice across the patch
- Agreement of care home initiative as ICS priority
- Frailty Logic Model developed.
- Link to WM End of Life Group

**STP GOVERNANCE**

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Location</th>
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<tr>
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<td></td>
<td>Jess Glenn, Dr Anna Lock, Sharon Liggins</td>
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<td>Louise Jones, Dr Simon Harlin, Katie Welbourne</td>
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<td>Sally Roberts, Claire Morrissey, Dr Stuart Hutchinson, Dr Elizabeth King, Dr Gill Pickavance, Ankush Mittal</td>
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APPENDIX 2  PUBLIC HEALTH ENGLAND’S FINGERTIPS INDICATORS FOR HEALTH AND WELLBEING

Life expectancy at birth (female) by local authority in England, 2014 - 2016, years

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<tr>
<th>Authority</th>
<th>Sandwell</th>
<th>Dudley</th>
<th>Walsall</th>
<th>Wolverhampton</th>
<th>ENGLAND</th>
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Healthy life expectancy at birth (female) by local authority in England, 2014 - 2016, years

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<th>Wolverhampton</th>
<th>ENGLAND</th>
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Life expectancy at birth (male) by local authority in England, 2014 - 2016, years

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Healthy life expectancy at birth (male) by local authority in England, 2014 - 2016, years

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Infant mortality per 1000 live births by local authority in England, 2014 - 2016

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Smoking status at time of delivery by local authority in England, 2016 - 2017

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Breastfeeding initiation 2016 - 2017 by local authority in England (percentage)

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School readiness: Good level of development at age 5 by local authority in England, 2016 - 2017 (percentage)

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School readiness: Year 1 pupils achieving the expected level in the phonics screening check by local authority in England, 2016 - 2017 (percentage)

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Obese children percent in Year 6 by local authority in England, 2016 - 2017 (percentage)

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GCSE achieved A*-C including English & Maths by local authority in England, 2015 - 2016 (percentage)

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<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
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<tbody>
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<td>50.2</td>
<td>52.1</td>
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GCSE achieved 5A*-C including English & Maths with free school meal status by local authority in England, 2014 - 2015 (percentage)
### Pupil absence by local authority in England, 2016 (percentage)

<table>
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<th>Local Authority</th>
<th>Sandwell</th>
<th>Dudley</th>
<th>Walsall</th>
<th>Wolverhampton</th>
<th>ENGLAND</th>
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### 16-17 year olds not in education, employment or training by local authority in England, 2016 (percentage)

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<th>Wolverhampton</th>
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### Under 18 conceptions by local authority in England, 2016 (per 1000)

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<th>Wolverhampton</th>
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### Children in low income families (under 16s) by local authority in England, 2015 (percentage)

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<th>Wolverhampton</th>
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<tr>
<td>Unpaid carers by local authority in England, 2011 (percentage)</td>
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<table>
<thead>
<tr>
<th>Young people providing 20+ hours/week of unpaid care (aged 16-24) by local authority in England, 2011 (percentage)</th>
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<thead>
<tr>
<th>Young people providing unpaid care (aged 16-24) by local authority in England, 2011 (percentage)</th>
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<table>
<thead>
<tr>
<th>Income deprivation by local authority in England, 2015 (percentage)</th>
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Density of fast food outlets, 2014, crude rate per 100,000 by local authority in England

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
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<td>808.0</td>
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Excess weight in adults 2016 - 2017 by local authority in England (percentage)

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<th>2018</th>
<th>2019</th>
<th>2020</th>
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Violent crime: Rate of hospital admissions for violence by local authority in England, 2014/15 - 16/17 (age standardised per 100,000)

<table>
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<td>79.0</td>
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<td>ENGLAND</td>
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</table>

Hospital stays for alcohol-related harm by local authority in England, 2016 - 2017 (per 100,000)

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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Income deprived older people (60+) by local authority in England, 2015 (percentage)

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Injuries due to falls in people aged 65 and over by local authority in England, 2016 - 2017 (age standardised per 100,000)

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<td></td>
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Hip fractures in people aged 65 and over by local authority in England, 2016 - 2017 (per 100,000)

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Fuel poverty by local authority in England, 2015 (percentage)

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Under 75 mortality rate from respiratory disease by local authority in England, 2014 - 2016 (age standardised per 100,000)

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<th>Mortality Rate</th>
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<td>Dudley</td>
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Mortality rate from causes considered preventable by local authority in England, 2014 - 2016 (age standardised per 100,000)

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<th>Mortality Rate</th>
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<td>Sandwell</td>
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<td>Walsall</td>
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**APPENDIX 3 LIST OF CONTRIBUTORS TO THE INITIAL VERSION**

Black Country and West Birmingham Clinical Strategy - List of Contributors to the initial version.

We are also grateful to the many members of clinical and managerial teams, too numerous to mention, who have given input and thought to each clinical section.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tbody>
<tr>
<td>Dr Simon Butler</td>
<td>GP, Primary Care Lead – SWB CCG</td>
<td>Primary Care</td>
</tr>
<tr>
<td>Dr Simon Grummett</td>
<td>Consultant and Honorary Senior Lecturer in Medical Oncology Royal Wolverhampton NHS Trust &amp; University of Birmingham, BCWB Cancer Lead Clinician</td>
<td>Cancer</td>
</tr>
<tr>
<td>Joanne Gutteridge</td>
<td>Dudley CCG</td>
<td>Primary Care</td>
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<tr>
<td>Donna Macarthur</td>
<td>Director of Primary Care – Walsall CCG</td>
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<tr>
<td>Lisa Maxfield</td>
<td>Deputy Chief Officer (Primary and Community Transformation) – SWB CCG</td>
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</tr>
<tr>
<td>Sarah Southall</td>
<td>Head of Primary Care – Wolverhampton CCG</td>
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<tr>
<td>Mr Paul Tulley</td>
<td>Director of Commissioning – Walsall CCG, BCWB Cancer Commissioning Lead</td>
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<tr>
<td>Steve Marshall</td>
<td>Director of Strategy &amp; Transformation - Wolverhampton City CCG, STP Lead for Mental Health</td>
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<tr>
<td>Rita Gupta</td>
<td>Programme Manager - Transforming Care Programme</td>
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<tr>
<td>Dr Helen Hibbs</td>
<td>Accountable Officer – Wolverhampton CCG, Chair – Black Country TCP Board</td>
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<tr>
<td>Rita Symons</td>
<td>Programme Consultant - Transforming Care, WMDCO - NHSE</td>
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<td>Kulbinder Thandi</td>
<td>Senior Commissioning Manager – SWB CCG</td>
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<tr>
<td>Julie Warner</td>
<td>Business and Contract Performance Manager – SWB CCG</td>
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<tr>
<td>Kate Wilkins</td>
<td>Programme Support Officer - Black Country Transforming Care Partnership</td>
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<tr>
<td>Grace Hodgetts</td>
<td>Project Manager – Maternity Services Transformation Programme</td>
<td>Maternity &amp; Neonates</td>
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<tr>
<td>Dr Louise Stewart</td>
<td>Head of Maternity Clinical Network West Midlands Clinical Networks &amp; Clinical Senate</td>
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<td>Dr Cathy Higgins</td>
<td>Divisional Medical Director/ Consultant Paediatrician - Royal Wolverhampton NHS Trust</td>
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<tr>
<td>Dr Tim Horsburgh</td>
<td>GP, Clinical Lead for Children &amp; Young People – Dudley CCG</td>
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<tr>
<td>Lucy Heath</td>
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<td>Children &amp; Young People</td>
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<tr>
<td>Dr Mohit Mandiratta</td>
<td>GP – Dudley CCG</td>
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<tr>
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<tr>
<td>Mary Passant</td>
<td>Partnerships Manager – Partnerships in Paediatrics</td>
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<tr>
<td>Dr Doug Simkiss</td>
<td>Deputy Medical Director and Consultant Community Paediatrician, Birmingham Community Healthcare NHS Trust</td>
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<td>Rachel Ellis</td>
<td>Chief Officer for Transformation – SWB CCG</td>
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<td>Diane Wake</td>
<td>Chief Executive, Dudley Group of Hospitals NHS Trust</td>
<td>Urgent &amp; Emergency Care</td>
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<td>Andy Williams</td>
<td>Accountable Officer SWB CCG</td>
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<td>Lucy Heath</td>
<td>NHS RightCare Delivery Partner</td>
<td>Cardiovascular Disease Services</td>
</tr>
<tr>
<td>Dr. Salma Reehana</td>
<td>Chair- Wolverhampton CCG; Training Programme Director- Walsall GP VTS Principal GP- Health and Beyond</td>
<td>Cardiovascular Disease Services</td>
</tr>
<tr>
<td>Lisa Peaty</td>
<td>Deputy Director - Strategy &amp; Business Development - Dudley Group of Hospitals NHS Foundation Trust</td>
<td>Interventional Radiology</td>
</tr>
<tr>
<td>Graham Danks</td>
<td>Black Country Pathology Service Operational Manager</td>
<td>Pathology</td>
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<tr>
<td>Karen Morrey</td>
<td>Supporting Black Country Pathology Service – Royal Wolverhampton NHS Trust</td>
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<tr>
<td>Mike Sharon</td>
<td>Director of Strategic Planning &amp; Performance – Royal Wolverhampton NHS Trust</td>
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<tr>
<td>Clare Barratt</td>
<td>Solutions and Development Manager – Planned Care, Wolverhampton CCG</td>
<td>Musculoskeletal Services</td>
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<tr>
<td>Mark Curran</td>
<td>Senior Commissioning Manager – Dudley CCG</td>
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<td>Jess Glenn</td>
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<td>Dr Helen Ward</td>
<td>Consultant Respiratory Physician, Royal Wolverhampton NHS Trust</td>
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<tr>
<td>Helen Jarvie</td>
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<td>Lucy Heath</td>
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<tr>
<td>Louise Jones</td>
<td>Senior Commissioning Manager; Walsall CCG</td>
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<tr>
<td>Claire Morrissey</td>
<td>Solutions &amp; Development Manager – Long Term Conditions, Frail Elderly, Wolverhampton CCG</td>
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<tr>
<td>Dr David Pitches</td>
<td>Head of Service for Healthcare Public Health and Consultant in Public Health Medicine Dudley Metropolitan Borough Council</td>
<td>Public Health &amp; Wider Determinants</td>
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<tr>
<td>Charlotte Gee</td>
<td>Communications Manager</td>
<td>User Engagement</td>
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<tr>
<td>Jayne Salter-Scott</td>
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<tr>
<td>Jo-anne Alner</td>
<td>Locality Director (Herefordshire &amp; Worcestershire and Black Country STPs), Executive Lead for Mental Health - NHSE (West Midlands)</td>
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<tr>
<td>David Frith</td>
<td>Managing Consultant – The Strategy Unit</td>
<td>All</td>
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<tr>
<td>Prof Nick Harding OBE</td>
<td>Chair – SWB CCG, Chair – Black Country &amp; West Birmingham Clinical Leadership Group, NHSE Senior Medical Advisor to Primary Care ICS</td>
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<tr>
<td>Angela Poulton</td>
<td>Programme Director – Black Country Joint Commissioning Committee</td>
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<tr>
<td>Sally Roberts</td>
<td>Chief Nurse – Wolverhampton CCG and Black Country STP Board Nurse – Deputy Chair Black Country &amp; West Birmingham Clinical Leadership Group, SRO Black Country and West Birmingham LMS</td>
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<tr>
<td>Sarah Shingler</td>
<td>Chief Nurse, Walsall CCG</td>
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<td>Richard Yeabsley</td>
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The Black Country and West Birmingham STP

CCG Primary Care Programme Board

TERMS OF REFERENCE

1. Purpose

1.1. The Primary Care Programme Board ("the Programme Board") has been established by the 4 CCGs in The Black Country and West Birmingham STP to provide a forum for co-operation and collaboration across the footprint. Its core purpose is to provide a structure through which CCGs can support one another to successfully deliver their local primary care strategy.

1.2. The CCGs in The Black Country and West Birmingham STP have agreed that the Programme Board will co-ordinate a small number of workstreams on behalf of all CCGs. These areas have been selected on the basis that working together is likely to be more effective in delivering local plans than each CCG working alone.

2. Status and authority

2.1. As the purpose of the Programme Board is principally to co-ordinate activities, it does not have the authority to take decisions about resources that will bind an individual CCG.

2.2. In order to ensure the Programme Board is effective, each CCG will need to ensure that its representatives on the Programme Board have sufficient delegated authority/seniority to enable the Programme Board to function effectively in discharging its duties within these Terms of Reference.

3. Responsibilities

3.1. The Programme Board will:

   (a) promote and champion primary care within the The Black Country and West Birmingham STP system, as well as regionally and nationally;

   (b) provide mutual support to the CCGs to implement the agreed primary care strategy and each CCGs' local implementation plan;

   (c) oversee a small number of shared workstreams (initially identified as workforce, estates, digital and organisational development/leadership);

   (d) agree STP wide work programmes, bids or returns on behalf of the CCGs (e.g. estates/capital submissions) and where relevant/necessary secure formal sign off from each CCG;
(e) on behalf of the CCGs, liaise directly with the regional and national teams of NHSE on matters that are STP wide, including:

- Primary care estate;
- Implementation of the GP Forward View; and
- developing initiatives that will benefit primary care, the CCGs and the wider system (e.g. the current finance 'experiment');

(f) take an overview of the financial position for primary care in The Black Country and West Birmingham STP, including tracking investment against the agreed financial plan;

(g) where relevant, develop bids for additional funds for investment in primary care across The Black Country and West Birmingham STP, and where required ensure sign off/ratification by each CCG;

(h) develop a proposed approach to the oversight, deployment and administration of any pooled STP funds, for ratification for CCG Boards

(i) provide a forum for co-ordinating the development of localities/neighbourhoods and for practices to influence the strategic direction;

(j) provide a forum for other system partners to liaise with on matters that affect primary care (e.g. development of strategic plans);

(k) provide a forum for sharing innovation and best practice.

4. **Accountability**

4.1. The Programme Board is accountable to the Boards of the CCGs in The Black Country and West Birmingham STP.

4.2. It is anticipated that members of the Programme Board will ensure that their respective Boards or equivalent are regularly briefed on discussions and decisions taken at the Programme Board.

4.3. Update reports will be provided to the STP Partnership Board and the CCG Joint Committee, for information only, as and when required.

4.4. The Programme Board may establish sub groups where it is agreed that the five CCGs should work together on a single programme. These sub groups will be accountable to the Programme Board. In the first instance, it is envisaged that there will be four groups established, covering Digital, Estates, Workforce and OD/Leadership:

4.5. The minutes of the Programme Board will be sent to the participants within 10 working days of each meeting.

5. **Membership and Quorum**
5.1. The membership of the Programme Board will include the following:

- Clinical Chairs of each of the CCGs (or their nominated clinical lead/deputy)
- Nominated Accountable Officer for GPFV
- Representative from the Clinical Leadership Group
- The Director/Senior Manager for Primary Care of each of the CCGs
- The STP Finance Lead or nominated representative
- Project Director/Programme Lead

* The Black Country LMCs are represented within existing governance arrangements in each locality.

5.2. It anticipated that each CCG will decide who is best placed to participate in the Programme Board on a meeting by meeting basis; it is not expected that the Chair, Accountable Officer and Primary Care Lead will all attend all meetings. However, representatives must be of sufficient seniority to enable the Programme Board to function effectively.

5.3. The Programme Board may invite additional members that it considers necessary to achieve its objectives. The intention is to retain a degree of flexibility in membership, ensuring that established and emerging clinical leaders have the opportunity to participate.

5.4. The Programme Board will be quorate if two thirds of its members are present, subject to the members present being able to represent the views and decisions of the members who are not present at any meeting.

5.5. The Programme Board will be chaired by the nominated Accountable Officer for GPFV or their appointed deputy.

5.6. Where the Chair is absent, the Deputy Chair shall take on the role of the Chair.

6. **Conduct of Business**

6.1. Meetings will be held bi-monthly.

6.2. The agenda will be developed in discussion with the members of the Programme Board and its work programme. Circulation of the meeting agenda and papers via email will take place approximately one week before the meeting is scheduled to take place. If members wish to add an item to the agenda they need to notify the Chair or Project Director accordingly.

6.3. At the discretion of the Chair a decision may be made on any urgent matter within these Terms of Reference through the written approval of every member. Such a decision shall be as valid as any taken at a quorate meeting but shall be reported for information to, and shall be recorded in the minutes of, the next meeting.
7. Decision Making and Voting

7.1. The Programme Board will aim to achieve consensus for all decisions of the Participants.

8. Conflicts of Interests

8.1. All conflicts of interest must be declared and managed appropriately.

9. Confidentiality

9.1. Members of the Programme Board are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Programme Board. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair. Such items should not be disclosed until such time as it has been agreed that this information can be released.

10. Support

10.1. Support to the Programme Board will be provided by the Primary Care Director/Lead.

10.2. The programme structure and supporting work groups will be developed and agreed as part of the Programme Board work plan.

11. Review

11.1. These terms of reference will be formally reviewed annually.

19/3/2019
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<th>Abbreviation</th>
<th>Meaning</th>
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<td>#NOF</td>
<td>Fractured Neck of Femur</td>
</tr>
<tr>
<td>£K</td>
<td>£1,000 equivalent</td>
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<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<td>ACO</td>
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<tr>
<td>ALOS</td>
<td>Average Length of Stay (in hospital)</td>
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<td>Area Medicines Management Committee</td>
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<tr>
<td>AMR</td>
<td>Antimicrobial resistance</td>
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<tr>
<td>Anti-D</td>
<td>An antibody occurring in pregnancy</td>
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<tr>
<td>Anti-TNF</td>
<td>Drugs used in the treatment of rheumatoid arthritis and Crohn’s disease</td>
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<td>AQP</td>
<td>Any Qualified Provider</td>
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<tr>
<td>ARIF</td>
<td>Aggressive Research Intelligence Facility</td>
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<td>ASAP</td>
<td>As soon as possible</td>
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<td>BACs</td>
<td>Bank Automated Credit</td>
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<td>Board Assurance Framework</td>
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<td>British Society of Colposcopy and Cervical Pathology</td>
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<tr>
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<td>Citizens Advise Bureau</td>
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<td>Clinical Negligence Scheme for Trusts</td>
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<tr>
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