Appendix 2

Birmingham and Solihull
Integrated Care System
Caring about healthier lives

Enabling Primary Care

A strategy for enabling primary care across BSOL ICB

Working Draft: Version 4.0

JULY 2023

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01

The context

What the direction of travel is

- Introduction to BSOL
- National policy drivers for change
- Local context and transformation

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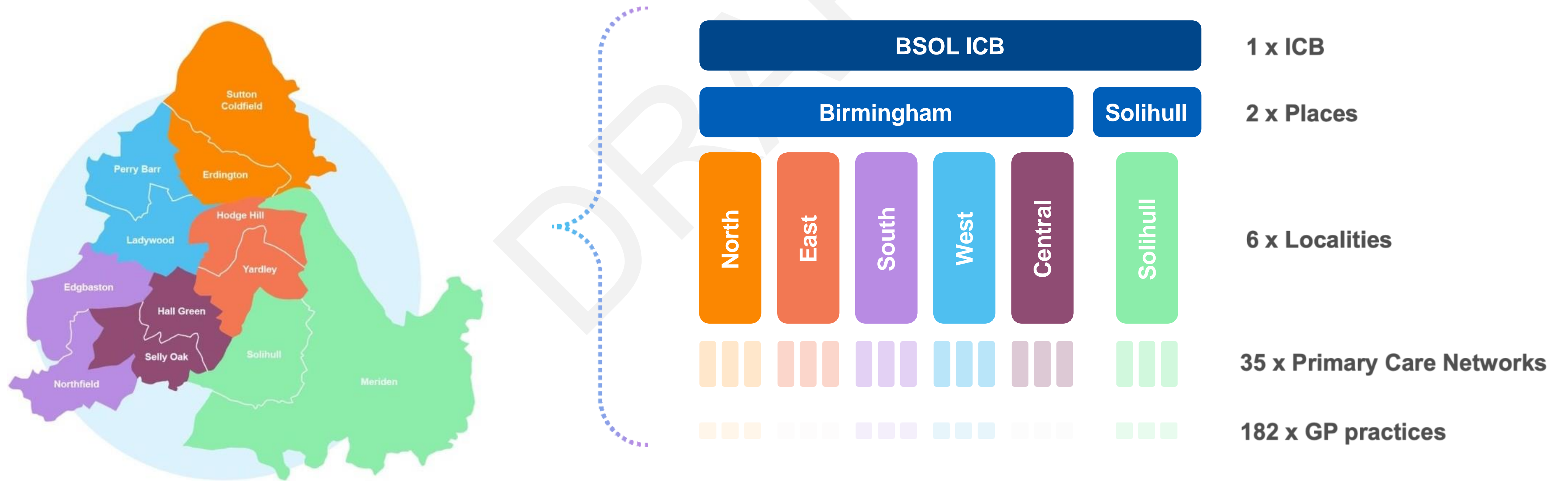
Introduction to BSOL

What our primary care landscape looks like at a glance

BSOL ICS is one of the largest and most diverse geographies in the country, with a population that experiences high rates of health inequalities, disparities in deprivation, and different opportunities to access health and care services. Pertinent trends include changing demographics and an ageing population, workforce recruitment and retention issues, and high post-pandemic waiting lists have all added extra pressure into the system.

Despite this, our vision for the future is for Birmingham and Solihull to be a healthier place to live and work, driving equity in life chances and health outcomes for everyone. The primary care sector has a critical role in realising this vision – it is the anchor that will enable at-scale working across localities and neighbourhoods as the footprints for driving more effective integration between community, hospital, social care and voluntary partners to deliver better outcomes for our citizens.



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National policy drivers for change

How national policy is driving increased integration, subsidiarity and transformation within primary care

Within the last year, there have been major policy drivers to catalyse change within primary care. The *Fuller Stocktake Report* establishes a new vision for primary care within the NHS, and the *Hewitt Review* supports these recommendations with a focus on system-wide enablement.

FULLER STOCKTAKE REPORT

- The *Fuller Stocktake Report* sets out a new vision for the role of primary care in ICSs as an integral voice in collaboration and integration, with general practice as the bedrock of the NHS and 'the heart of communities'
- One of Dr. Fuller's key recommendations is the development of integrated neighbourhood teams. This will prove critical in providing support to local population health outcomes, promoting the principle of subsidiarity in local decision-making, and driving greater personalisation in the care services offered
- Acknowledging the changes required to make this happen, however, a key priority underpinning this and other recommendations is the need for primary care to become more sustainable, ensuring both its stability and its longevity as a sector
    - This includes **tackling access** to primary care as well as urgent care, which is having a direct impact on general practice's ability to keep up with demand and **offer continuity of care** to patients

HEWITT REVIEW

- The *Hewitt Review* builds on the *Fuller Stocktake Report* and emphasises the importance of collaboration, organisational redesign and cultural evolution within ICSs, with a focus on joint problem-solving
- For primary care, the review also makes clear that models of care will need to shift further 'upstream', with an **increased focus on prevention**; this must also bring the associated resource and investment required to facilitate that shift in a sustainable way

> **"There are real signs of growing discontent with primary care – both from the public who use it and the professionals who work in it."**

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National policy drivers for change

How national recovery plans rely on joined-up strategies and delivery across care settings

Relatedly, the national recovery plans for both primary care access and urgent and emergency care (UEC) services have driven the way we have structured our *Operating Framework*. NHS England and supporting policy has emphasised the importance of joined-up delivery plans across ICSs to drive recovery and resilience across the system, so the transformations planned in secondary care must interface seamlessly with our strategy for enabling primary care locally.

PRIMARY CARE RECOVERY PLAN

- The *Delivery plan for recovering access to primary care* also builds on the *Fuller Stocktake Report*, and references system-wide responses to integrated urgent care and neighbourhood teams
- The plan is centred on two key ambitions for access – tackling the 08:00 rush to ensure patients can receive same-day support and guidance from their local practice, and enabling patients to know how their needs will be met when they contact their practice
- To do this, it focuses on four areas to alleviate pressure and drive greater access – **building capacity**, **reducing bureaucracy**, **empowering patients** and **modernising GP access**
- Delivery in these areas includes improving the information, functionality and interoperability of technologies available; expanding the role of community pharmacy; and driving capacity increases through enabling workforce and estates initiatives to better support primary care

UEC RECOVERY PLAN

- Beyond increasing capacity and improving discharge in hospital settings, the *Delivery plan for recovering urgent and emergency care* includes a **core focus on expanding care outside of hospitals**
- This specifically references the importance of the development and improved integration of community services, access to primary care, and more joined-up working and collaboration across settings; these care models will also be underpinned by investment and acceleration of enabling technologies

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Local context and transformation

How local policy is driving increased integration, subsidiarity and transformation within primary care

Central to the ICS's agenda is the development of partnerships that support innovation and accelerate change. The main vehicle for delivering this transformation is the development of BSOL's integrator programmes, covering mental health, acute and community services. These will enable scalable planning, delivery and management whilst ensuring direction-setting remains local.

VISION AND OPERATING FRAMEWORK

- BSOL ICS has committed to wider system integration and more joined-up service provision for the public, regardless of where or how our citizens choose to engage with our care services
- To do this, the ICS is using 'integrators' as the vehicles to develop greater integration between different parts of the system in order to:
  - make it easier for patients to **access** the care they need when they need it
  - create the space for our staff to care, and the time for our clinicians to provide the **continuity of care** that is so important to our patients
  - enable a greater future focus on **prevention**
- These three components of access, continuity of care and prevention are critical to becoming a more productive system, enhancing capacity and improving culture in order to deliver better outcomes for our citizens
- This is being driven in practice through three integrator programmes across acute, mental health and community service settings
- Each of these three integrator programmes interacts with primary care in a different way, but **general practice is the common denominator** across them all. This aligns directly with the implementation of Dr. Fuller's recommendations and the piloting of INTs, which will be vital to each integrator programme working well

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02

The case for change

Where we are now, and why we need to transform

- Current situation
- Sector and community engagement
- What we heard

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Current situation

What the reality of primary care looks like in BSOL right now

Primary care is currently facing cultural, structural and financial challenges that are making day-to-day life in the sector unsustainable. It has historically low patient satisfaction rates in the latest GP Patient Survey; there is financial instability bred from short-term approaches to resourcing; and the data and estates needed for basic service provision are not consistently fit for purpose. Despite this, general practice is building on foundations of huge success in recent months and years, including stepping up vaccination sites and urgent care hubs, with incredible teams improving service delivery and supporting patients in the face of increasingly challenging circumstances.

Access and patient satisfaction

Increasing levels of demand, greater levels of need and longer waiting lists have all meant that more people are asking to see their GP more often, which is reflected in patient satisfaction rates. The public's unhappiness with access is even more of an issue in deprived areas, which have 17% more demand than those areas with lower rates of multiple deprivation.

Finances

With increasing financial pressures on everyone in the country, GP practices and their staff are no different, with a £6m deficit in primary care funding locally. Practices are having to work harder and for longer to meet contractual targets; many funding streams are inflexible to local needs; and contract changes this year do not include additional investment to counteract the damaging impact of inflation.

Digital, data and technology

GP practices have been at the forefront of the NHS's digital developments, including ePR, e-prescriptions and online booking. However, there is more to be done to support different practices and partners to speak to each other digitally, and to share and use accurate data across organisations. Practices must embrace greater online access and consultation routes for a more digitally-informed public.

Estates

GP practices' estates are extremely variable across BSOL, ranging from modern building to premises unchanged for half a century. New ways of working and connectivity requirements mean the current estates portfolio does not have the capacity to manage increasing demand in the community and the transfers from hospital care. New estates fill up quickly, and yet there is void space that isn't fit for purpose consuming funding that could be used elsewhere.

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Sector and community engagement

How this strategy has been informed by the primary care sector and the communities it serves

SECTOR ENGAGEMENT

- Over the last nine months, we've held multiple primary care engagement and clinical leadership events to listen to what's important for over 200 primary care clinicians and practice staff
    - This has included input from elected members, ICP leaders, and BSOL's Health & Wellbeing Board and Health Overview and Scrutiny Committees to ensure engagement and collective alignment across the system
- These roadshows drove engagement have provided the inputs, structure and challenge needed to develop a robust roadmap for transformation, and have helped clarify where our biggest focus areas should be as a sector

COMMUNITY LISTENING EVENTS

- In addition to the sector engagement events, we have also been working closely with multi-agency community engagement leads from both Birmingham and Solihull to promote greater dialogue with seldom-heard communities and understand how best we support their needs
    - These events have included a wide range of representation, from ICS Board members to local citizens who represent their communities and voluntary organisations
- This has helped us shape a community engagement framework, which will ensure we can listen, engage and respond to the needs of our communities more effectively as a sector and as a system

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What we heard

From our extensive engagement, there have been six thematic issues that represent the range of views we heard

We've engaged with over 200 GPs and PCN Clinical Directors as part of a series of engagement and listening events across BSOL since November 2022, including clinical leaders from every PCN and almost every GP practice, as well as community representatives across Birmingham and Solihull as places. We have since distilled these conversations into a handful of key themes.

ENGAGEMENT EVENTS

THEMATIC NEEDS

Meeting demand

Demand on BAU activity in primary care is rising. Despite access rates rising with it, practice and PCN teams are left stretched, making future improvement and development unsustainable.

Embedding into the ICS

There is a sense that the sector often feels 'done unto' by the ICS instead of an equal partner, rooted in legacy commissioning arrangements that blurred contracting and development.

Leading change

Primary care leadership has very little surplus capacity nor developmental support. This means leading change locally and collaborating considerately with ICS partners becomes challenging.

Integrating care

The drive for integration out of fragmentation on a locality footprint is well-received, and must connect sensitively into existing work for a system-wide approach that is greater than the sum of its parts.

Allocating resource

Working alongside the GMS contract, a 'boom and bust' approach to resource feeds short-term development; allocations need to be planned and predictable to support sustainable development.

Supporting delivery

The way that central support functions were originally developed has meant that they aren't fit for purpose to support the sector and enable transformation at scale.

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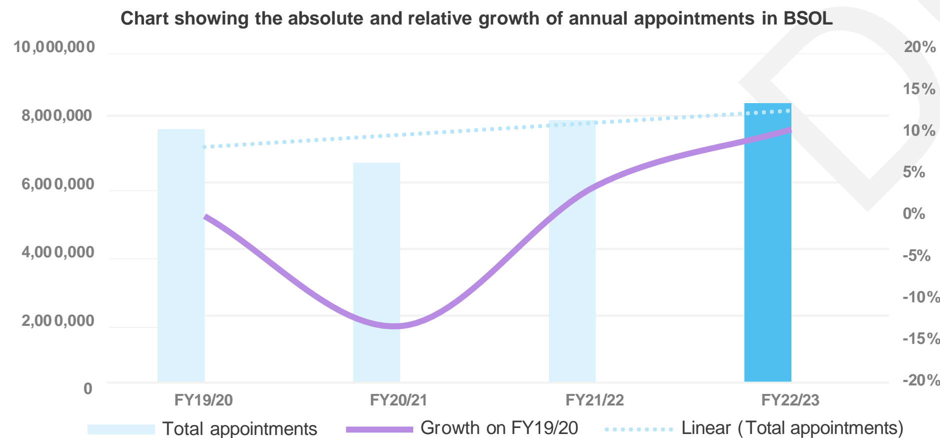
Meeting demand and integrating care

A fragmented sector experiencing unprecedented need must integrate to continue improving access and meeting demand

MEETING DEMAND

- GP practices are seeing **more patients per month** than ever before, and **more of them on the same day**
- Practices delivered **10% growth in appointments** compared to FY19/20 rates, with weighted GP access rates also growing by 16%
- BSOL delivered almost **100k more monthly appointments** in FY22/23 when compared to rolling averages from 2019 to 2022
- Monthly **same-day appointments have increased by 10%**, and BSOL offers 7% more same-day appointments than the national average
- Despite this, public satisfaction surveys show continued dissatisfaction – BSOL recorded the lowest GP Patient Survey score in England with **just 63% patient satisfaction** against a regional average of 79%

Chart showing the absolute and relative growth of annual appointments in BSOL



INTEGRATING CARE

- The sector also experiences **fragmentation and siloed care**, which has built up over time; we have one NHS but many different organisations that work separately within it
- We are building better relationships between these organisations based on patient care rather than contracts, **building a relational discourse** as opposed to a transactional one with patients and system partners
- Wider **societal issues** like the cost of living and loneliness all mean that the NHS needs to work closer with social care and community organisations to address physical and mental health impacts
- Practices have told us that **greater integration is the antidote** when carried out in a considered way, enabling more joined up care across pathways and providers – together we can do so much more

Word cloud showing collective emphasis on the greatest determinants of primary care success

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Embedding and allocating resource

General practice wants to be embedded into the system as an equal partner that can influence strategic investment decisions

EMBEDDING INTO THE ICS

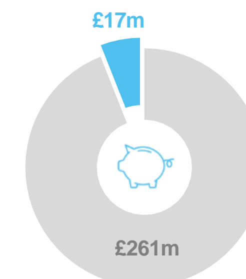
- There is a **lack of structure across the sector** which means it hasn't had a meaningful 'home' in the ICS, and has therefore **struggled to influence and impact** the system
- In order to contribute meaningfully to system development, the sector needs to be **treated as an equal partner** in relation to strategic planning, resource allocation, workforce and digital enablement
- Instead, there should be a **unified voice for primary care** that interfaces with the system and is aligned behind a single vision and strategy
- This need is being addressed by the GP Partnership Board (GPPB), which is the vehicle that enables the sector to interface into the system
- **Localities will also be able to draw influence** from an embedded structure within the ICS, as well as PCNs and providers influencing the system through their locality representatives on the GPPB

Diagram showing the current structure of the GPPB's interfaces with the ICS

ALLOCATING RESOURCE

- **Historical under-investment** in the core contract for primary care needs to be remedied, with funding that should follow the required shift in patient activity further 'upstream', as set out in national policy
- Of the primary care resource available each year**, 94% is fixed on GMS contract and core services**, leaving little flexibility in non-core resource to promote innovation or service development at scale
- The sector has **historically disagreed on how best to use what little flexible resource exists**, with competition leading to small allocations
- The **stop-start nature of incremental resource** undermines the sector's ability to plan and deliver, making investment decisions difficult
- Instead, where there is flexibility on how to use resource, it must be allocated in a way that **has the GP community's sign-off**, and aligns with the ICS's strategic investment decisions

Chart showing how much primary care resource is potentially available for transformation



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Leading change and supporting delivery

Primary care leaders need capacity, opportunities to build capability and a coherent central support offer to deliver effectively

LEADING CHANGE

- General practice has often been **left out** of cross-sector planning and decision-making at the system level
- GPs and PCN Clinical Directors **have limited time** to be involved at ICS level, and **have variable experience** to do so effectively
- To do this, the primary care sector recognises it must become 'match fit' in to offer meaningful input and lead change
- There must be a **robust programme of capability development** and associated investment into clinical leadership to ensure change is led through, and owned by, general practice
- Place and locality leads are now **driving transformation from the bottom-up** across primary care, with the GPPB providing strategic direction and support across the ICS

SUPPORTING DELIVERY

- Central support for GP practices has been **relatively disorganised** to date, with inconsistent offerings and applications
- Instead, **the sector needs its support infrastructure to be 'match fit'** in order to deliver against its vision, providing the essential capabilities and capacity required for transformation
- The foundation of this delivery support is the GP Provider Support Unit (PSU), which should **bring together the sector's existing expertise and capacity**
- This support must **fit alongside other delivery structures** that already exist, reinforcing the current support mechanisms offered by the ICB and driving development more sustainably across GP providers

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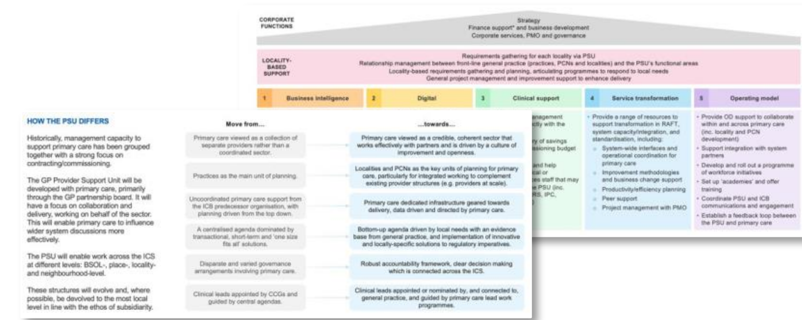
Illustration of the sector's governance, leadership and organisational development plans

Illustration of the GP PSU's future purpose, vision and functions



03

The road ahead

What we'll do together

- Access and service transformation
- Common operating model
- Winter planning and resource allocation
- Integration
- Central support for delivery
- System enablers

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Service transformation

To transform successfully, the system needs to move away from piecemeal approaches and towards a set of clear, cohesive goals

MOVING FROM

In light of the challenges faced by sector colleagues every day, we must move away from **disjointed interventions for alleviating demand**; from uncoordinated and **siloed winter planning**; and from **piecemeal approaches to funding and support** for general practice.

MOVING TO

To navigate the road ahead, we will **evolve the sector's access programme**; we will ensure primary care is **at the table for winter planning**; and we will **promote integration** and collaboration at every level in the ICS through the development of locality hubs, Integrated Neighbourhood Teams (INTs) and more.

Primary care providers will have…

- Sector identity and cohesion
- Sector alignment and collaboration, supported by the GP PSU
- Locality development with focused support and development for key enablers (i.e. workforce, digital and estates delivery plans)
- Bottom-up clinical leadership, resourcing frontline clinicians to network with local practices as the foundation for quality improvement (QI) and transformation
- System-wide transformation activities, driving clarity of focus on a few key priorities and doing them well (e.g. improved access programme)
- Clear infrastructure, governance and processes for partner engagement and whole-system prioritisation

The ICB will have…

- Coherent commissioning strategies that address inequalities and aligning with BSOL's *Operating Framework*
- Strong contract and performance management, with the same degree of quality and assurance oversight as for other providers
- Streamlined enhanced services and alignment of System Development Fund monies (all incentives) with access and integration initiatives across general practice and other settings
- Sponsorship and a refreshed support infrastructure for GPs, including leadership and transformation development resource
- Interfaces with the West Midlands for POD delegation activities

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Responding to the national recovery plan

The sector's single biggest goal is access – and if it improves, then so will continuity of care, prevention and transformation

ACCESS

- Both the sector and the system's **single biggest focus is improving access** to primary care services and meeting demand across the system
- We will address this through a **new transformation programme, Right Access First Time (RAFT)**, which will be the sector's vehicle for change, including the general practice requirements of the national recovery plan
- Improving access **does more than just increase access to care** – by improving access, we are also ensuring clinicians have time to:
  - provide greater **continuity of care** for patients who need it
  - **support prevention** and teach self-management
  - **lead transformation** and integration in line with wider system strategies

QUALITY ASSURANCE AND OVERSIGHT

- Primary care colleagues are committed to **improving quality in general practice** and will commit to developing a new approach to supporting QI
- We will use supportive data to understand the **three key quality domains** for service delivery – clinical effectiveness, patient experience, and patient safety/safeguarding
- We will also commit to **developing a QI framework** to ensure that the three domains of quality are understood and supported through clinical governance structures and external sources, like CQC
- This will ensure **a uniform and fair approach** is taken to managing practice quality across BSOL, and will assist in ensuring strong and **sustainable primary care services that are equipped for the future**

+16% Average GP appointment access rates have increased by 3% since last year, and are **16% higher than they were in 2019**.

+100k There have been almost **100k more appointments every month** than there were from 2019 to 2022.

63% Despite this, demand continues to outstrip supply and average GP **patient experience is 63% positive**, which is the lowest in the country; the Midlands average was 79% by contrast.

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Developing a common operating model

The RAFT programme will be the new approach for the sector to improve access, increase capacity and lead transformation

We are now refreshing our general practice access work into a large-scale improvement programme called Right Access First Time (RAFT), which is summarised in the depiction below. This will help practices manage workload more sustainably, improve patient care and deliver against the requirements of the GMS contract. Its outcomes will include more access, more capacity, and more change leadership – and specific success metrics of this programme will be agreed by the GPPB and ICB executives in Q3 FY23/24.

AIMS

The aims of the RAFT programme are to improve access and to manage workload, to the extent that:

By **Apr-24**, every patient in BSOL will be offered an **assessment of need**, or be **signposted** to an appropriate service, at first contact.

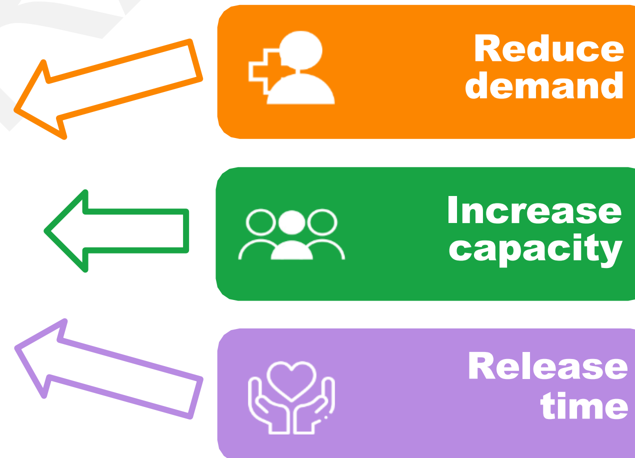
By **Apr-25**, every patient in BSOL will have **consistent access** to the right care from the right person at the right time and in the right place, irrespective of geography, demography, clinical need or registered practice.

MODEL

A holistic approach to optimise the appropriate use of clinicians' time, and an end to the 08:00 rush and 'one size fits all' approaches.

IMPROVEMENT

Wide-ranging actions within and around general practice to drive sustainable improvements.



SUPPORT

Locally-led change projects, with support, advice and coordination from central enabling functions like the GP PSU.

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Resource allocation

To drive this impact through RAFT, both the sector and the system must take a different approach to resource allocation together

LONG-TERM FUNDING APPROACH

- Building on GMS, general practice and the ICB must jointly **move away from the ‘stop/start’ funding approach** that it often ends up relying on; when the ICB has moved away from this approach, the sector has demonstrated benefit and impact
- We will hardwire our commitment for **primary care to be a constructive partner for winter planning** at the outset – this will drive an integrated, whole-system approach to preparations, with additional funding distributed for those cross-sector programmes that will have the biggest impact on system access

FINANCIAL PLANNING

- BSOL will move to **create and enable greater financial flexibility** for general practice’s use of existing funding streams for primary care, and ensure all potential resources are accessed and utilised to enable the sector to support the BSOL *Joint Forward Plan* and *10 Year Strategy*
- This will include the **use of enhanced service funding** such as the Universal Patient Offer and Primary Care Commissioning Framework to ensure resource is focussed on the enablement of primary care to support communities and respond to system transformation priorities, including the *Fuller Stocktake*
- We will **bring together existing central funding** for primary care wherever practicable (e.g. SDF, HEE monies), simplify the Universal Offer, and **lobby for a more equitable distribution of system resource** into general practice
- This will drive a **renewed focus on tackling inequalities** as a result of deprivation – BSOL has some of the country’s most deprived areas, which adds further pressure to the sector and requires adequate resource to mitigate against unwarranted variation

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Example of the impact of consistent funding approaches

When describing the need for consistency approaches to funding and reducing non-recurrent, hand-to-mouth approaches, the Washwood Heath Locality Hub in the East locality exemplifies how more strategic funding can drive impact.

Compared to other locality hubs, the East has:

- ✓ delivered disproportionate activity compared to other localities
- ✓ driven the highest rates of cross-PCN and cross-practice referrals
- ✓ supported the best weighted GP access rates in BSOL
- ✓ offered access to same-day appointments at over twice the rate of those localities asked to stand up hubs on a non-recurrent basis

The hub team has attributed this to a more strategic funding approach that has allowed for greater collaboration, improved integration and consistency of delivery across the locality.

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Integration

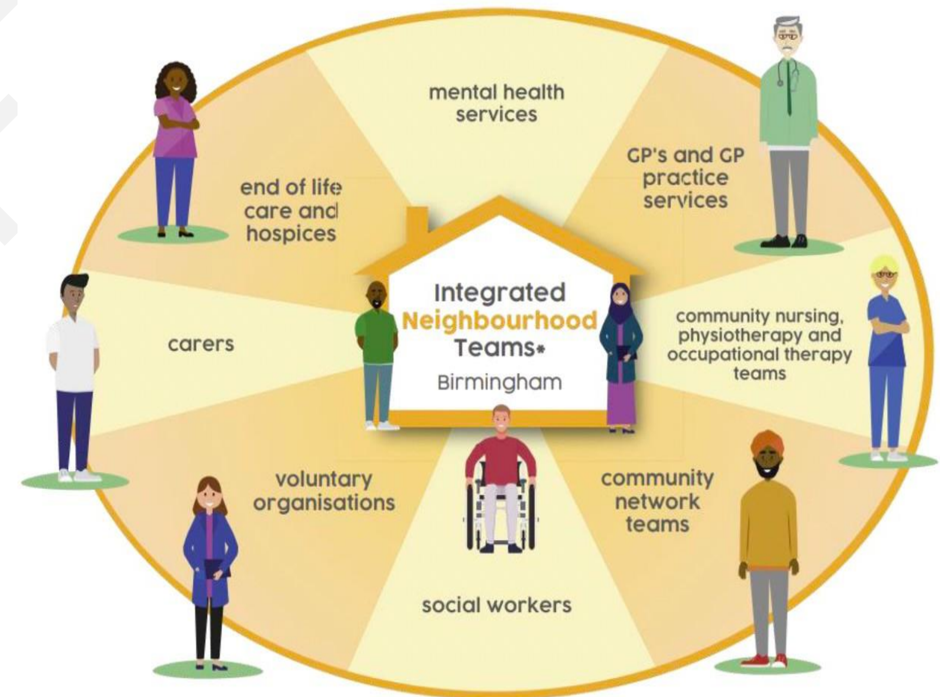
Cross-sector integration is essential to shifting the dial on access, and to enable system transformation in intermediate care and UEC

INTEGRATION AT EVERY LEVEL

- Access is an issue that collectively affects intermediate, urgent and emergency care settings as well as GP practices – and with each part of the system struggling, the **solution necessitates greater integration** across locality and PCN footprints to generate value that is **greater than the sum of its parts**
- We will use **localities as the currency for change**; they will be our wayfinders to drive aligned investment and deliver effective integration across system providers, with **locality hubs as the physical and virtual anchors for integration** at scale
    - This approach is already showing green shoots, with some localities joining up practice and PCN strategies into a coherent, collective locality voice that is driving change and maximising its economies of scale
- We will also **reinforce our commitment to INT development** as part of the Community Integrator Programme which includes GP leadership, driving collaborative service delivery across the acute and mental health Integrator programmes
- As we develop localities and collaborate across primary care, there is also a need to ensure we develop support structures; an engagement model that practices connect with; and a governance approach that **enables and protects inter-PCN working**

STRATEGIC ALIGNMENT

- While improving access and meeting demand is the biggest focus for primary care, **access cannot be an issue for primary care to tackle alone**
- We must therefore **connect into broader system agendas** and strategies, and in this way we're reliant on collaboration with community, secondary care and VCFSE partners



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Central support for delivery

We will support primary care by offering dedicated resource to support providers, and giving leadership and organisational development

GP PROVIDER SUPPORT UNIT REFRESH

We are refreshing the functions and the form of the GP PSU so that it is fit for purpose to respond to the sector's needs, and has the corporate stability and capability required to underpin transformation activity.

The GP PSU's future functions and form are being refreshed so that it is better equipped to respond to sector needs, enables work at place, locality and practice level, and is clearly delineated from central contracting and commissioning functions.

The PSU will complement the delivery capability that primary care providers have. It will be the central delivery vehicle for providing the support required to transform services and ways of working through the RAFT programme, supporting the sector as it transforms whilst building trust and confidence throughout.

LEADERSHIP DEVELOPMENT

We are setting up a robust leadership development programme for primary care, providing support, advice and coaching to build capability and confidence across general practice.

To influence and impact the system in a meaningful way, our primary care leaders need a robust programme that offers upskilling opportunities and developmental support. This will connect our primary care leaders at every level of the system, from the GPPB, to PCN CDs and locality leads, to recently-appointed Fuller clinicians.

This support includes developing a Training Hub that meets the needs of all PCNs, as well as a locality-based understanding of training requirements to inform a sustainable development programme. These activities are being delivered as part of the RAFT programme, in line with the national GP recovery plan.

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Central support for delivery

The GP Provider Support Unit will complement existing capability and drive transformation through the RAFT programme

FUTURE FUNCTIONAL DESIGN

- The GP PSU's functions have been refreshed so that it aligns more closely to meet sector needs, enables work across the ICS at different levels, and can advocate for general practice appropriately with the ICB's commissioning and contracting function
- We have worked closely with the GPPB, the PSU Steering Group and representative GPs, practice managers and operational leads to reimagine what the PSU's purpose is, and what we're trying to achieve through it
- This has allowed us to agree its key functions and also identify what is out of scope for the PSU; together these will enable delivery of the RAFT programme alongside other strategic imperatives for primary care

FUTURE FORM APPRAISAL

- Relatedly, we have carried out an independent options appraisal to assess where best the PSU should sit in order to add value in the most effective way for primary care and the wider system
- With close consultation from primary care colleagues and ICB executive leadership, we developed a series of assessment criteria and options for the future form, with an independent body developing a recommendation for our consideration and seeking input from relevant cross-sector organisations
- This will introduce a managed transition period for the PSU as it evolves its functions and form, supporting teams to prepare and clarify what it might mean for them

As a primary care sector, we want to…

…drive stability: creating a stable, sustainable and resilient general practice that helps primary care function well as a sector to deliver better access, service quality and experiences.

…create capacity: building the time and thinking space needed to support transformation and service improvement initiatives, with dedicated support to deliver system priorities.

…build clear leadership: developing clear leadership and engagement models for both the sector and its partners to engage with general practice, reducing the degree of fragmentation of the sector's voice and connecting front-line GPs to Board representation.

…influence priorities: working with system partners as equals to influence and impact service improvements, including the development of a clear and concise set of priorities to inform system transformation planning and delivery.

…develop trust: reinforcing the trust and confidence within the sector to have more effective and efficient conversations.

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System enablers

We are also giving clear statements of intent for the workforce, digital and estates changes required to enable wholesale transformation

WORKFORCE

We are developing our workforce by retaining the staff we train, reducing our reliance on agency staff, and redistributing system capability into primary care.

Local workforce analysis identifies BSOL's primary care multi-disciplinary team (MDT) profile as an outlier, with a 6% reduction in nurses compared to 11% growth nationally.

We'll continue to work in partnership with the BSOL Training Hub to implement our strategy. This includes an interface education and training providers to ensure a proactive approach for the pipeline of new entrants.

More work is needed to make the sector more attractive by addressing work-life balance and parity with other NHS career paths.

DIGITAL AND DATA

We are accelerating digital enablement by maximising the use of our IT infrastructure and accelerating the adoption and optimisation of new technologies.

Digital, data and technology enablement is integral for general practice and the wider system to realise its vision. A shared patient record, interoperability and system-level data analysis capabilities are essential to planning and delivering service in a coherent way.

We'll continue to plan and set out a programme for digital improvement and innovation, including AI and other products. This will help lay coherent plans for data sharing to improve its understanding of root causes and its service planning to meet the needs of patients and the system.

ESTATES

We are optimising our estates at the locality level by reconciling localities' clinical needs against our estates portfolio, exploring opportunities with civic partners.

BSOL's current estates footprint is inhibiting growth and collaborating across primary care.

To rectify this, there needs to be greater weighting of capital investment to primary care estates, informed by a detailed review of physical space within systems to build a one public estate approach.

The *Estates Strategy and Condition Analysis* was set out 18 months ago, resulting in funding applications from NHSE to support system-wide, locality-level estates planning that considers deprivation and demographies.

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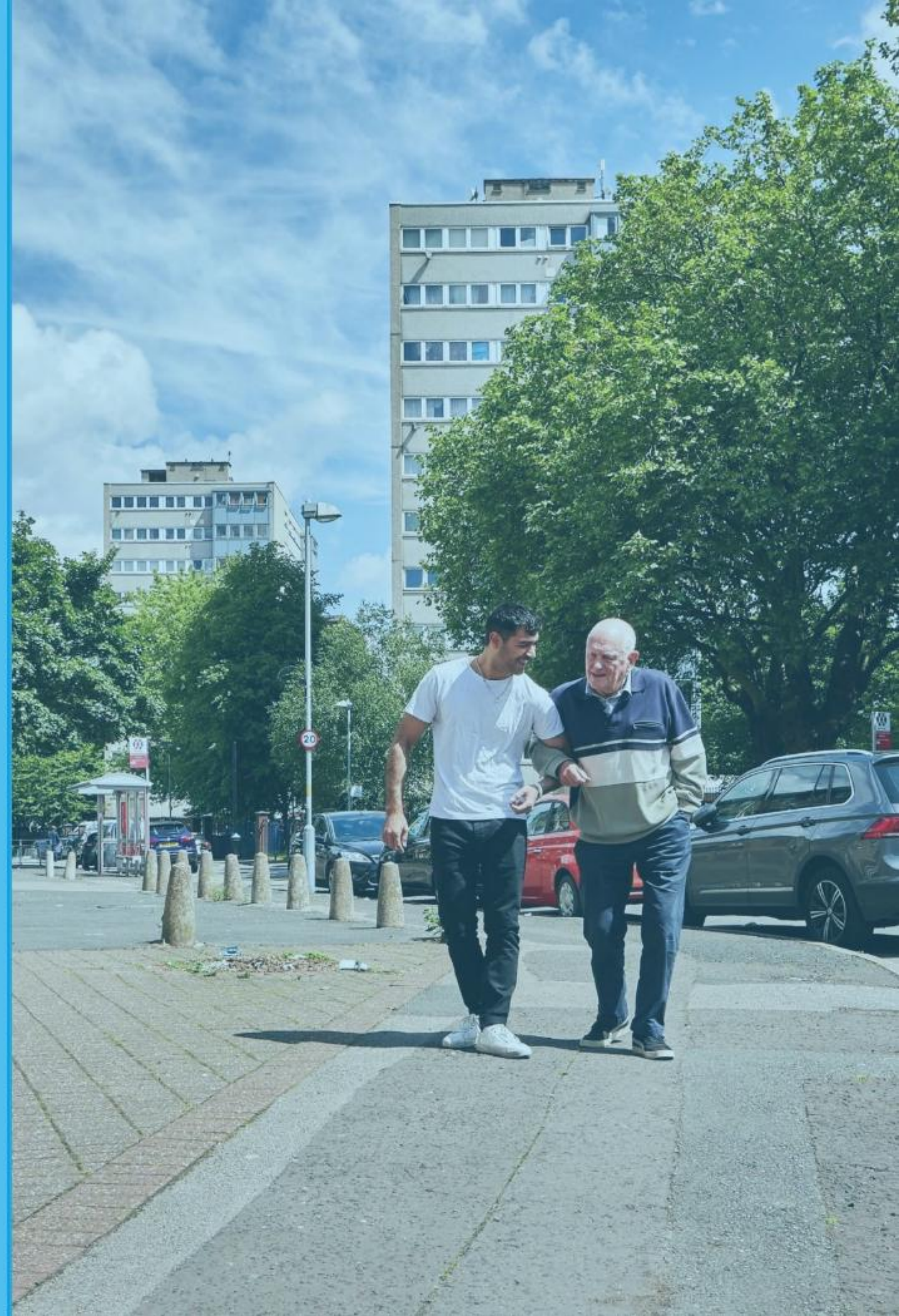
04

The journey

How we'll deliver this together

- Transformation programme development
- Workforce delivery plan
- Digital and data delivery plan
- Estates delivery plan
- Success metrics

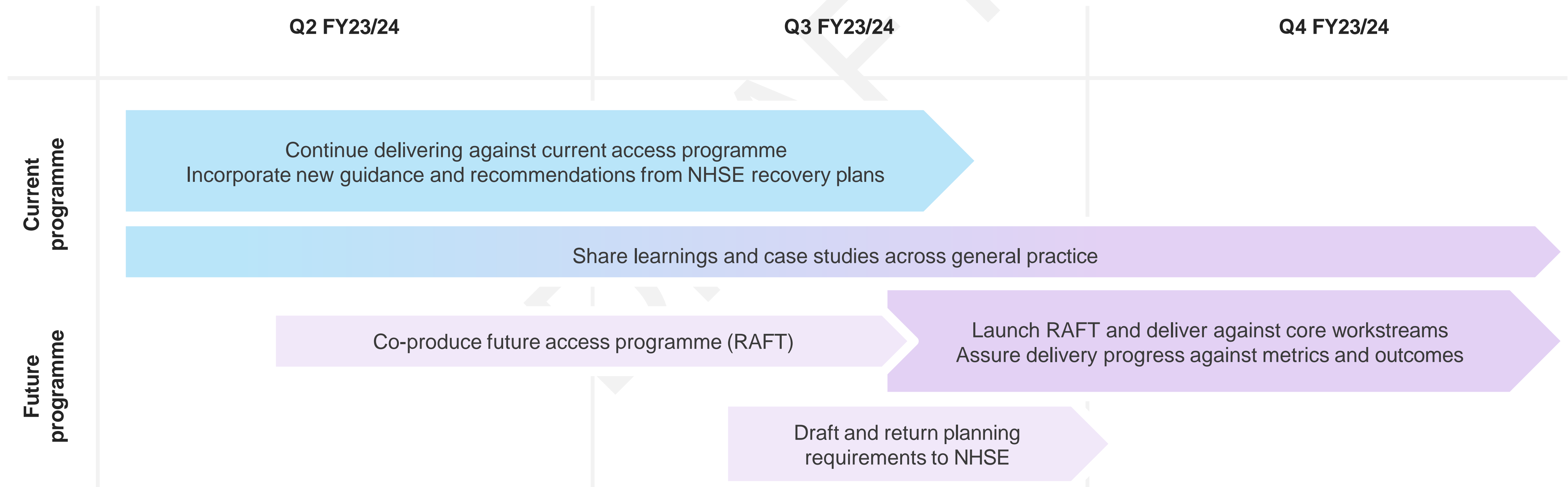


WORKING DRAFT

Transformation programme development

Our current access programme will continue while the RAFT transformation programme is co-produced before it launches in Oct-23

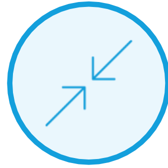
Our existing access programme will continue through Q2 FY23/24 in order to maintain momentum across our core initiatives, and to provide continuity of support to primary care colleagues. This will precede a transition from our current access programme into the future transformation programme, RAFT, which will continue to be co-produced directly with general practice before we launch it in Oct-23.

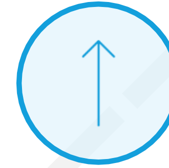


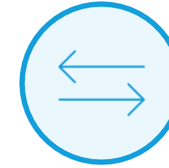
WORKING DRAFT

Delivery focus for the current access plan

The current programme's activities will continue to reduce demand, improve capacity and tackle variation while co-creating RAFT







AIMS

REDUCE DEMAND

Reducing demand in primary care by streamlining activity across the system.

IMPROVE CAPACITY

Improving system capacity by using alternative flow routes and better forecasting.

TACKLE VARIATION

Tackling variation by understanding root causes with better data and support.

ACTIVITIES

Reduce demand

- Improving access to diagnostics
- Refining integrated advice and guidance processes with secondary care
- Improving community responses to assist patients who need a quick response (e.g. wound care and SPA)
- Doing comprehensive audits to understand why patients contact general practice
- Increasing the use of social prescribing
- Signposting patients to access support for social issues from appropriate services

Improve capacity

- Enhancing escalation processes to trigger system interventions when demand and capacity forecasts indicate mismatches
- Working more closely with cross-sector providers to ensure activity isn't 'dumped' inappropriately into primary care services
- Using enhanced access and integrated locality hubs to boost capacity
- Implementing Community Pharmacist Consultation Services (CPCS) to provide additional capacity through pharmacies
- Improving online repeat prescriptions

Tackle variation

- Maximising the use of data to understand variation and the root causes driving it
- Improving the quality of primary care data to support the design and monitoring of change
- Building robust, sector-owned interventions to tackle variation informed by business intelligence and management information
- Providing peer support to address variation in working practices and processes
- Establishing new locality-based QI teams
- Supporting business change to improve telephony and the use of digital solutions

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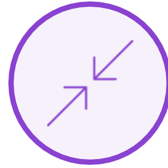
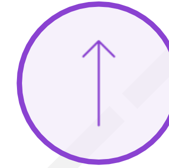
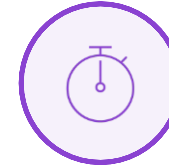
WORKING DRAFT

Delivery focus for transformation

The future programme's activities will catalyse our approach to access by reducing demand, increasing capacity and releasing time







AIMS

REDUCE DEMAND

Reducing and redirecting demand through work across the ICB with patients and the public.

INCREASE CAPACITY

Increasing capacity in all staff roles through training, recruitment and retention initiatives.

RELEASE TIME

Freeing up appointments through streamlining access and follow-up processes in practices.

ACTIVITIES

Reduce demand

- Decompress general practice
- Enable greater continuity of care and support prevention activities
- Enhance single-point-of-access
- Streamline information requests and cut bureaucracy
- Optimise UEC pathways
- Standardise communications
- Empower patients with long-term conditions
- Optimise self-care and self-referrals

Increase capacity

- Retain and recruit GPs and practice nurses
- Increase numbers of ARRS staff
- Optimise use of ARRS roles in primary care
- Develop community pharmacy and online prescription improvement plans
- Develop management capabilities
- Develop premises and estates
- Build transformation and change management capacity through the GP PSU

Release time

- Embrace digital communications and automated workflows, modernising GP access and business change
- Develop advanced signposting
- Streamline appointment systems
- Design for continuity
- Support frequent attenders
- Incentivise efficient follow-ups
- Enable proactive long-term condition care

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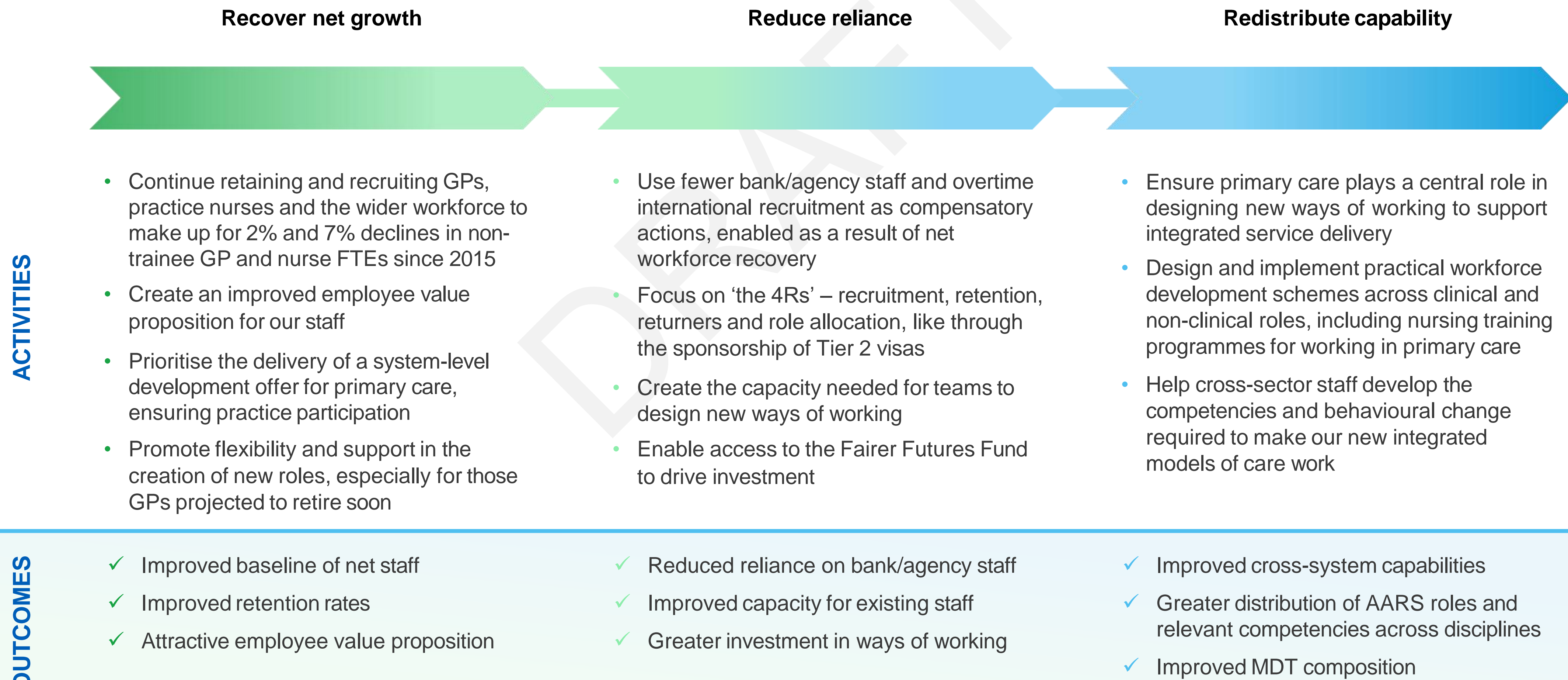
WORKING DRAFT

Workforce delivery plan

How the workforce strategy will be delivered to enable primary care

Workforce capacity remains a huge pressure on primary care. We will ensure a continued focus on recruiting and retaining GPs and the wider primary care workforce, alongside optimising current capacity with a long-term, system-wide workforce strategy that includes primary care. This builds on our Primary Care Workforce Strategy, and is underpinned by a number of practical workforce development schemes across a range of clinical and non-clinical roles.



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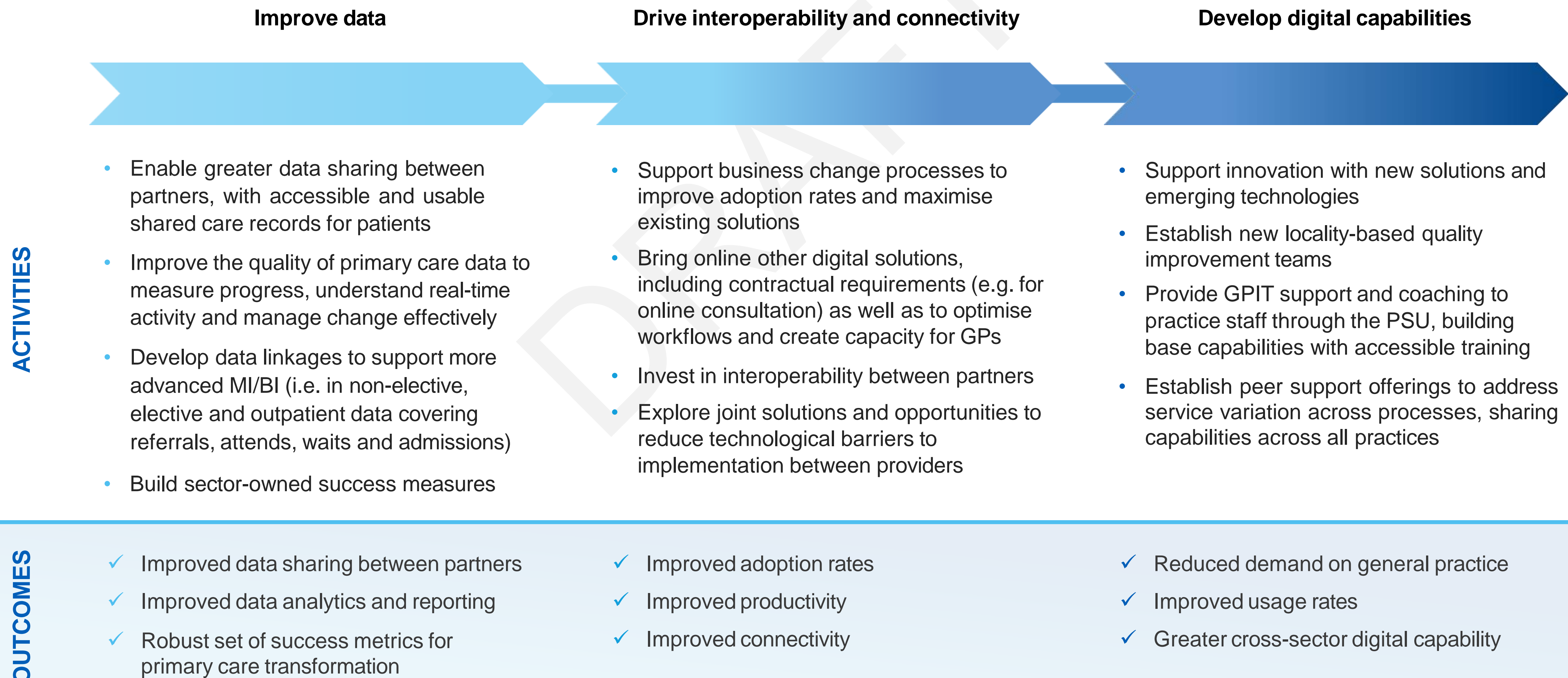
WORKING DRAFT

Digital and data delivery plan

How digital acceleration will be delivered to enable primary care

There is room for us to use technology to transform more effectively and more quickly. Our approach to accelerating digital, data and technology centres on maximising existing assets, and then investing in new enabling technologies. There is also a need to develop digital capability across the sector, supporting adoption and usage rates to drive efficiencies through integration – these needs will be informed by locality models of care as they continue to develop.



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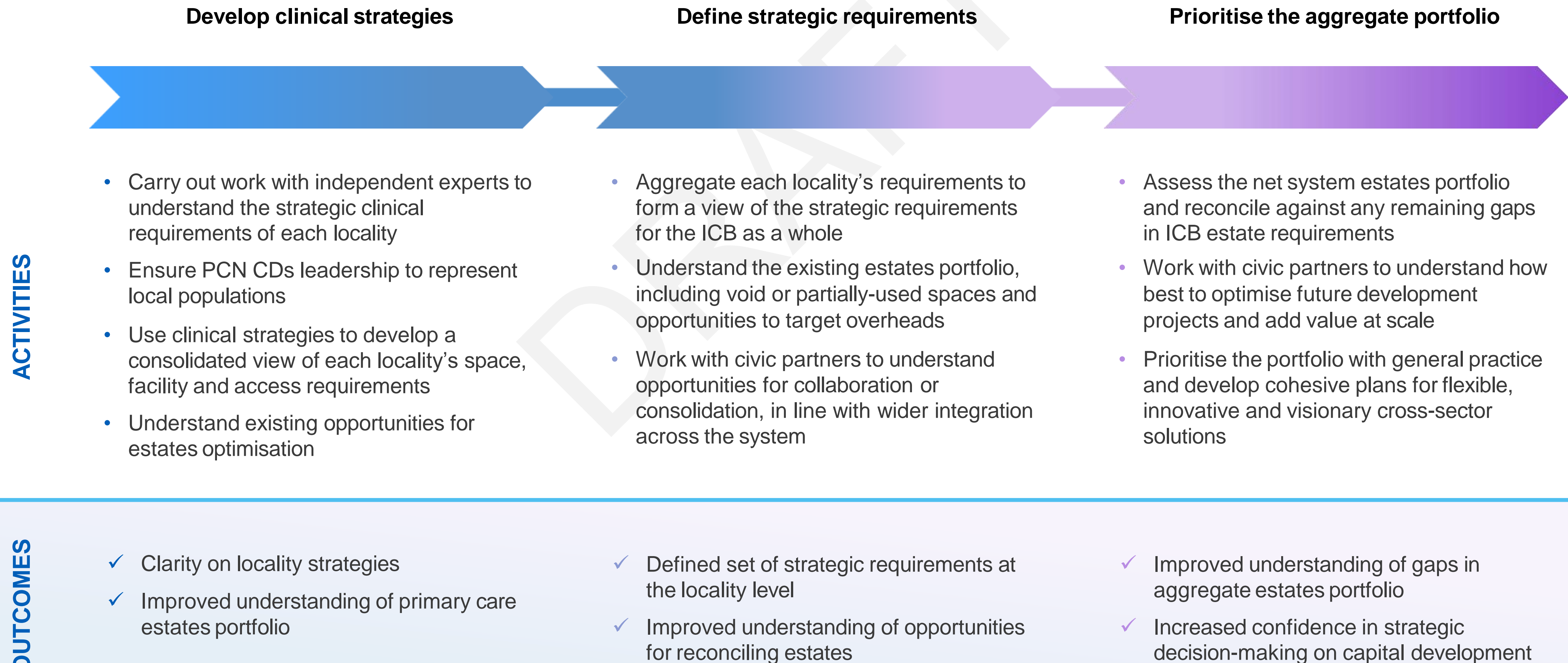
WORKING DRAFT

Estates delivery plan

How the estates strategy will be delivered to enable primary care

Our estates strategy will be informed by each locality's clinical strategy for general practice. And to underpin this strategy, we must acknowledge the shift required to move away from new hospital buildings and refocus investment into community and primary care settings to manage demand there. This work will give us a clear view of sector requirements across the system, which can then be reconciled against wider ICS development portfolio and capital allocations.



WORKING DRAFT

Defining transformation success metrics

We have identified a set of key performance indicators to measure primary care's success in delivering this strategy

We must be able to measure the outputs of our strategy, assess its impact and evaluate its outcomes on our primary care sector and citizens. To date, we have measured a series of key performance indicators (KPIs) as interim metrics. Going forwards, however, we will define a new set of meaningful outcome measures that allow us to evaluate this strategy's success. This will be reinforced by our efforts in generating more granular data across care settings.

CURRENT KPIs

Lead indicators:

- Rates of DNAs per weighted 1,000 list population
- Rates of same-day access
- Number of two-week appointments
- Number of face-to-face appointments
- Rates of CPCS activity
- Rates of social prescribing
- Number of online repeat prescriptions served
- Reported patient experience, concerns and complaints (with a dataset comprising >1m responses)

Impact KPIs:

- Rates of NHS111 activity (in-hours)
- Rates of ED walk-ins (in-hours)
- Rates of activity compared to pre-COVID levels
- Relative distribution of activity across all practices/PCNs

Primary KPI:

- Number of GP appointments per 1,000 list population

Secondary KPIs:

- Number of GP FTEs per weighted 10,000 list population
- Number of DC FTEs per weighted 10,000 list population
- Number of nursing FTEs per weighted 10,000 list population

FUTURE MEASURES

Our future outcome measures will be defined as part of the RAFT programme's development during Q2 FY23/24.

These will go beyond simply measuring access metrics, but rather explore the impact of transformation on patients' care outcomes; on patient and staff experience; on our estates portfolio; on our resource efficiency and productivity, and related measures.

WORKING DRAFT

Impact and outcomes

What the impact of realising our collective ambitions will be for the sector, system partners, and our citizens

WHAT WE HEARD

- We have a growing population which is more complex than ever before, but we have the same amount of funding
- We don't have the time nor the support to focus on thinking about or leading transformation in a sustainable way
- We don't feel like an equal partner within the ICS and its decisions
- That growth includes many people who need language interpretation, which makes it even harder to do a proper consultation in 10mins
- We can't plan services in a consistent or collaborative way
- We have more financial pressures, with contractual uncertainty and stop/start funding
- Self-help and self-management isn't the starting point for our patients – they come to us instead
- We have to spend more time on admin, often with manual workarounds for inefficient processes
- We struggle to recruit and retain so must rely on locums, which often increases the workload for partners
- We feel growing public and political discontent, including negative media portrayals that undermine morale
- We don't have enough space to serve a growing population, let alone to transform services
- We can't see patients' records, access their notes, or share data

WHAT WE WILL DO

- We will improve access through our current programme by reducing demand, building capacity and tackling variation
- We will co-design and launch RAFT as the sector's transformation programme
- We will set up a robust development programme to support primary care leaders and build skills
- We will commit to using localities and neighbourhoods as the footprints for integration at scale across partners
- We will upgrade the central support provided to general practice by refreshing the GP PSU
- We will reinforce existing governance and appoint GP representatives at each level of our operating model
- We will deliver workforce interventions to retain and recruit staff more effectively, like sponsoring Tier 2 visas
- We will work with system partners to prioritise estate needs and optimise void capacity and spend for new space
- We will invest in digital improvement and innovation, accelerating DDaT strategy roll-out
- We will enable more data sharing and develop advanced analytics and BI for primary care
- We will contribute to system-level investment discussions and support cross-sector winter planning at the outset
- We will develop more flexible and equitable funding models and make use of enhanced service funding

WHAT IT WILL FEEL LIKE

- We have less demand on a consistent basis
- We have more time to work on prevention and provide continuity of care for our patients
- We can devote time to co-designing new ways of working and leading transformation
- We have better working relationships with cross-sector partners
- We are able to offer better services using localities which we couldn't do at the practice- or PCN-level
- We understand local population health trends
- We can plan targeted interventions and service improvements
- We have to do less administrative work
- We can share information between partners effectively, and can see and read patient records and notes
- We can use technology-enabled processes
- We have a more steady pipeline of staff who have more development and learning opportunities
- We have the physical space we need to transform our services
- We have primary care representation at every layer of governance so can trust our voice is being heard in the ICS
- We can contribute meaningfully to ICS investment decisions
- We can use discretionary funding in a way that makes sense locally
- We have more sensible funding allocations and winter isn't a surprise

WHAT OUTCOMES WE WILL DRIVE

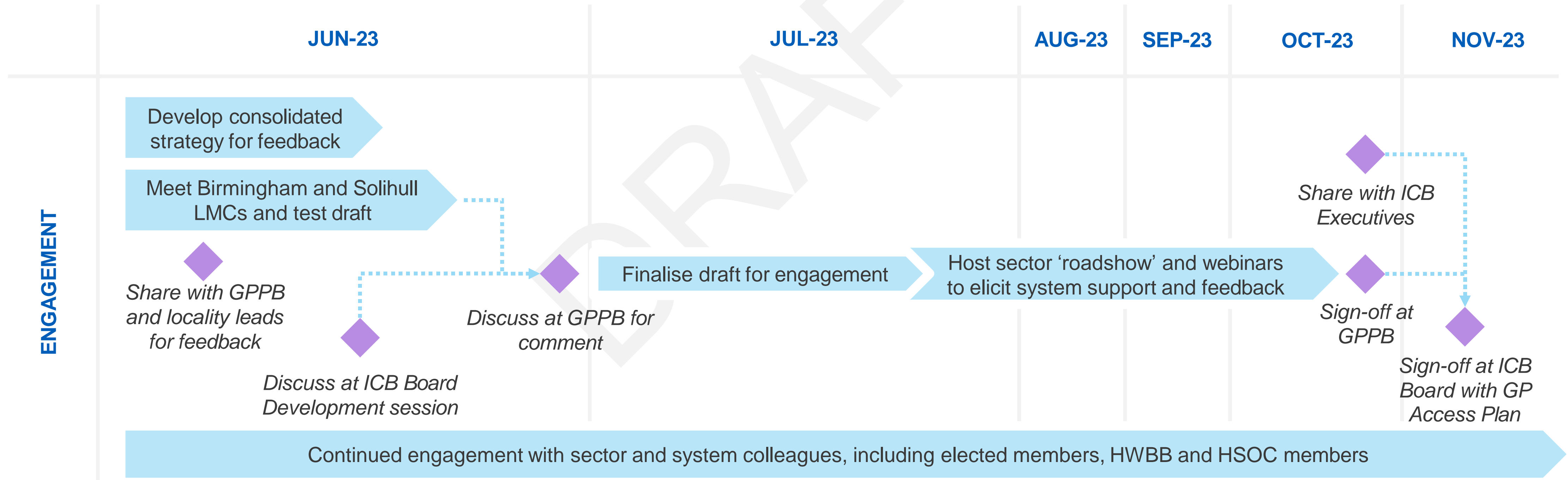
- Improved access and increased capacity to support continuity of care and prevention
- Reduced variation in outcomes and inequalities for our local populations
- Improved leadership capabilities embedded within the sector
- Localities have the identity and cohesion to support service integration at scale
- Increased influence in, and impact on, the ICS and its decision-making
- Reduced bureaucracy between the sector and its system partners
- Stable clinical leadership structures in locality and neighbourhood footprints
- Improved staff morale, experience and engagement across the sector
- A fair approach to improving premises and strategic planning that makes best use of system resource at scale
- Improved patient satisfaction and experience with primary care services
- High-quality datasets that inform service planning and collaborative investment decisions
- Shared care records that work and support integrated working meaningfully
- Financial resource is aligned and GPs are engaged to collectively plan and drive transformation activities

WORKING DRAFT

Next steps

This strategy continues to be refined, tested and iterated with primary care and relevant system colleagues as it develops

After significant engagement to date, the sector's strategy is now reaching the final stages of its development. Further system and sector engagement is required to ensure the strategy is clear, is relevant and is reflective of the sector's ambitions and the system's commitments to transformation the way primary care works. The next steps to signing this work off are set out below, although this is subject to change while some sections are finalised and further detail is built into the delivery plans.



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Thank you.