NHS
Black Country
Integrated Care Board

# Future Primary Care in the Black Country

## 5 Year Outline Transformation Strategy

# Foreword

**Primary Care is an integral part of the NHS delivering 95% of overall activity.** As we navigate the complexities of healthcare in the Black Country, the Integrated Care Board (ICB) and the Black Country Primary Care Collaborative (BCPCC), have made a commitment to co-designing a roadmap towards a more sustainable future for Primary Care. The *Future Primary Care in the Black Country* five year outline transformation strategy has been developed in partnership with our communities and partners. It lays out the vision, strategic priorities, and future way of delivering primary care to better meet the needs of those receiving or delivering health and social care.

**This outline transformation strategy is not merely a document, but a shared ambition and commitment towards doing the best for our local people and those working in primary care.** This requires us to act on what we have heard people say and be ambitious in transforming primary care in the Black Country. At the core, lies the principle of co-designing solutions moving forwards, and underpinning this work to date is the views of local people and the voices of our primary care workforce and partners.

We have heard:

- Booking appointments is a challenge, with a lack of options and guidance
- People want more time for their range of needs to be addressed and access to specialist support
- Likewise, those working in primary care teams want more time to support patients with complex needs
- Community Pharmacists want to support more people who would benefit from their services

This strategy has been developed for discussion so that we can build on the conversations to date and use local views to inform any future transformation to the way that primary care works in the Black Country.

**Currently our System is under pressure** - within Primary Care demand continues to increase despite more appointments being provided. Our services are catering to the varied needs of 1.26 million local people, who may be living with complex needs or multiple long-term conditions and in areas of deprivation. This requires a more integrated approach to better address the interface between primary and secondary care and support an emphasis on the need for quality driven services which are more productive and cost-effective. We currently spend £368 million (c.12% of ICB budget) on primary care, which includes general practice, pharmacy, optometry and dentistry services, and primary care prescribing. This further highlights the importance of transformation and increased funding as we know from national research there is £14 return on every £1 invested in Primary Care*.

**Looking ahead, our vision is ambitious but achievable.** It is a vision for healthcare that starts with communities, enabling equity of access and promoting integration within neighbourhoods, and across health and care providers. It is a vision of scaling what works well within the Black Country, leveraging digital innovation, and reducing unwarranted variation to enhance the quality of care delivered. In addition, our future way of providing primary care has been informed by the national direction to deliver care closer to home and to shift towards preventative and proactive care, with primary care playing a central role in preventing illnesses and managing chronic conditions. Reports such as the 'Fuller Stock take' on Primary Care, Primary Care Access and Recovery Plan (PCARP), The King's Fund 'Making care closer to home a reality' and the Long Term Workforce Plan, echo similar points, with the Fuller Stock take highlighting the need for multi-disciplinary support through integrated neighbourhood teams.

**Fulfilling this outline strategy requires action and commitment from all stakeholders across the System**, from clinicians working in Primary Care to community leaders who know local people best. The Black Country Primary Care Collaborative will have a key responsibility for taking the initiatives forward, and co-designing them at Place with patients and the public as well as with Primary Care Networks and Place Based Teams. Although, continued involvement and support from our System partners will be essential for success.

**Lastly, in transforming Primary Care we want to foster a culture of learning, listening, and improving.** This is integral to further develop the future way we deliver primary care. This strategy balances the immediate pressures and need for long-term sustainability, and is guided by principles that keep us grounded in improving the health and wellbeing of the people we serve. Your feedback is needed to make sure we get it right and take steps forward towards creating a more sustainable, healthier and resilient Black Country.

***Thank you to everyone who has, and will continue to contribute to this outline strategy, its further development and implementation.***


**Figure 1:** Examples of National policy documents that have informed the strategy

*NHS Confederation (2023) Creating better health value. Available at: https://www.nhsconfed.org/system/files/2023-08/Creating-better-health-value.pdf

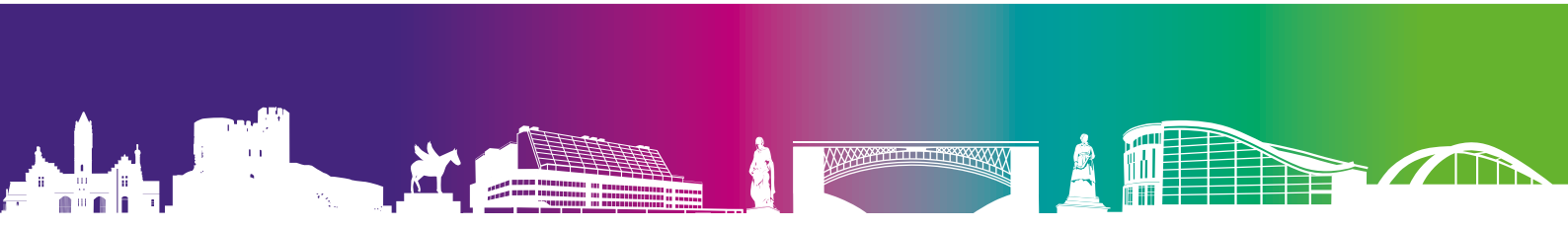
# Contents

# Glossary and definitions

| Terms | Definition |
|---|---|
| Additional Roles Reimbursement Scheme (ARRS) | A summary term, referring to a range of centrally funded roles which allow PCNs to establish multidisciplinary teams and provide more integrated health and social care services. These roles include, but are not limited to, Clinical Pharmacists, Social Prescribers, Physician Associates, and Care Coordinators. |
| Black Country Integrated Care Board (ICB) | A statutory NHS organisation that is responsible for managing the NHS budget for the Black Country and arrange for the provision of health services locally. |
| Black Country Integrated Care System (ICS) | Known as 'Healthier Futures', this is a partnership of multiple health and care organisations within the Black Country. It includes NHS Trusts, councils and organisations within the voluntary, community and social care sector. The purpose of the ICS is to deliver better, more integrated care for its population. |
| Black Country Joint Forward Plan | A plan that sets out the challenges, vision and strategic priorities of NHS Black Country ICB, up to 2028. |
| Black Country Primary Care Collaborative (BCPCC) | An organisation of Primary Care professionals in the Black Country established to promote the interests, wellbeing and sustainability of Primary Care services, with a single voice for Primary Care in decision making forums at all levels. |
| Clinical Design and Reference Group (CDRG) | A group of individuals working within Primary Care across all four Places (including but not limited to GPs, Community Pharmacists, Practice Management and a Public representative) brought together to provide input, insights, and feedback during the design of the Black Country's Future Operating Model for Primary Care in Phase 1 of the programme. |
| Core20PLUS5 | An NHS England approach to inform action to reduce healthcare inequalities at national and system level. |
| Digital First Primary Care (DFPC) | An initiative offering patients the opportunity to receive advice or treatment via remote or digital channels, as part of NHS Black Country ICB's Joint Forward Plan. |
| Dudley Quality and Outcomes Framework (DQOF) | Framework developed by Dudley Integrated Health and Care NHS Trust to formalise standards; measure, assess and recognise performance and clinical outcomes from clinicians. |
| Future Operating Model (FOM) | A strategic blueprint outlining how Primary Care providers and partners will operate to collectively achieve the Primary Care vision and goals. |
| Financial Recovery Plan | System-wide financial efficiency programme to identify areas of improvement with associated potential savings that address the System's financial deficit. |
| Local Care Hubs | A key focus moving forwards will be to determine what these hubs look like, their services offerings, and how they operate for the Black Country. The aim is to develop local plans on how practices and PCNs may deliver improved same-day access and planned care (for patients with long term conditions). |
| Multidisciplinary Team (MDT) | A group of health and care staff, from different organisations and professions (e.g. GPs, nurses, pharmacists, social workers), making decisions collaboratively on the management of service users. |
| One Health and Care | The name of our local NHS shared care record in the Black Country. |
| Population Health Management (PHM) | An approach aimed at improving physical and mental health outcomes of people within defined local, regional or national populations, while reducing health inequalities. It includes action to reduce the occurrence of ill health, deliver appropriate health and care services, and address wider determinants of health, and requires working with communities and partner agencies. |
| Primary Care Network (PCN) | A collaboration between multiple GP practices, serving ~30,000 - 50,000 patients. Within NHS Black Country ICS, there are 27 PCNs, including 172 General Practices. |
| Voluntary, Community, Faith and Social Enterprise (VCFSE) | An incorporated voluntary, community, faith or social enterprise organisation which serves communities solely within England and is either a charity, community interest company, community benefit society or unregulated body. |

# Executive Summary

# 01



# 1.1 Overview of Primary Care

## Primary Care is an essential and invaluable part of the NHS

**95%** of NHS activity is delivered in Primary Care*

**12%** of ICB budget flowed into Primary Care FY23/24

**£368m** spent on Primary Care in the Black Country FY23/24

**95%** return on every £1 invested in Primary Care*

## Within Black Country, there are currently…

**27** Primary Care Networks

**172** GP practices

**270** Community Pharmacies

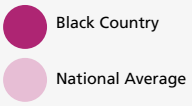
**135** Dental Practices

**166** Opticians

## Providing care and support for…

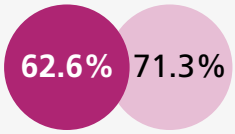
**1.26 million** residents

## Black Country Primary Care is facing challenging times…

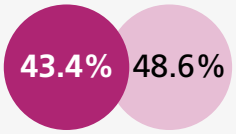




No. of GPs per 10,000 registered patients**




Patients who had a positive experience with their GP**




Patients who were satisfied with their appointment waiting times**

## …from the mounting pressures on Primary Care in the Integrated Care System, such as:

During 2011 - 2022, the Black Country population has grown by‡ **7.1%**

**71.6%** of the population is obese, versus a national average of 64%**

Proportion of patients with a long-term health condition** - **57.7%**

## Still, we have continued to improve access to care for our patients…

**6%** increase in the number of appointments delivered in 2023

## …and been recognised for the impacts we have made.

**HSJ Partnership Award**
*Developing a workforce dashboard and planning tool*

**Primary Care Impact Award**
*Assisting asylum seekers and care home patients (PCN in Wolverhampton)*

**PCPA Excellence in GP Pharmacy Awards**
*Establishing a specialist pharmacist respiratory clinic (Clinic in Dudley)*

*NHS Confederation Empowered, connected and respected: a vision for general practice at scale and primary care networks (2023). **Fingertips (GP Profiles for Patients, National General Practice Profiles).
† Percentage as a reflection of total ICB commissioned services and includes spend on both Prescribing (9%) and Primary Care Services (9%) (Black Country ICB Annual Report 2022-23). ‡ ONS Population Projections (High International Migration).

# 1.2 Executive Summary

## Context

### Case for Change

We serve a diverse population in the Black Country of communities facing significant inequalities, with changing health needs. Our workforce continuously strives to meet these needs to the best of their abilities, but this is against a backdrop of challenges including demand for Primary Care services exceeding capacity.

**Black Country statistics (comparison to national average*)**

**Healthy life expectancy at birth** (in years)

| Male | Female |
|---|---|
| 60.9 | 60.2 |
| 63.1* | 63.1* |

**General Practice List size growth** (2019 - 2023)

| |
|---|
| 8.1% |
| 4.5%* |

**Plateauing GP workforce growth** (Qualified GPs, 2019-2023)

| |
|---|
| 1.6% |
| -1.25* |

This document outlines what we seek to achieve over the next five years to better support our people - both patients and staff alike in the delivery of Primary Care. Whilst this outline strategy focuses on General Practice and Community Pharmacy, it provides an overarching view of the intended direction for primary care, how care is best organised, and describes the range of digital assets and support functions needed to build local ownership of the transformation. It serves as a frame of reference all future improvement.

**Our outline transformation strategy is...**

**The culmination of us listening over the past six months**

Our outline strategy has been involvement-led at every stage meaning each initiative can be traced back to what we heard from our staff, our patients and our System partners.

**Aligned with the national direction and ambition to provide care closer to home**

- Fuller Stock take report (Fuller, 2022)
- Delivery plan for recovering access to Primary Care' (NHSE, 2023)
- King's Fund 'Making care closer to home a reality' (Baird et al., 2024)
- NHS Confederation 'Creating better health value' (NHS confed 2023)
- NHS Long Term Plan (NHSE, 2019)
- NHS People Plan (NHSE, 2020)
- NHS Long Term Workforce Plan (NHSE, 2023)
- A Plan for Digital Health and Social Care (DHSC, 2022)
- 2024/25 priorities and operational planning guidance (NHSE 2024)

**Deliberately ambitious**

Our outline strategy has been involvement-led at every stage meaning each initiative can be traced back to what we heard from our staff, our patients and our System partners.

## Future Primary Care in the Black Country

### Vision

We have clear aspirations, and our vision statement defines what good will look like in the Black Country with the support of our System partners and communities. We have also identified key goals for the Future Primary Care programme and strategic priorities that are in line with the Black Country Joint Forward Plan, and with the needs of our population.

**Our vision for the Black Country is equitable access to high-quality health and care for all**, building resilient communities with improved health outcomes. Our mission is to empower people, carers, staff and volunteers, with the know-how, ability and tools to access care that meets their unique needs, closer to home.

By creating a supportive and innovative environment that encourages mutual respect and collaboration among health and care providers across the System, we aim to reduce health inequalities, and make sure everyone gets the right care they need.

### Design Principles

Co-developed with the Clinical Design Reference Group (CDRG), a group of professionals serving patients in the Black Country, design principles have underpinned the formation of initiatives aligned with how we will organise ourselves in the future to deliver our strategy. Moving forward, these principles will continue to inform our decision-making process and act as a guide that the model remains suitable for its intended purpose:

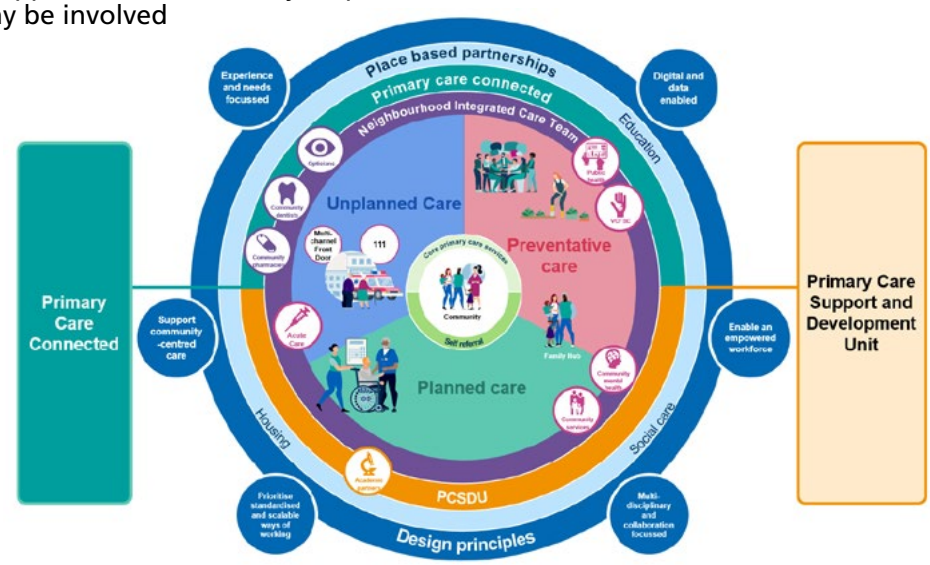
- ❖ Experience and needs focused
- ❖ Support community-centred care
- ❖ Prioritise standardised and scalable ways of working
- ❖ Digital and Data enabled
- ❖ Enable an empowered workforce
- ❖ Multi-disciplinary and collaboration focused

# 1.2 Executive Summary

## Delivery of Care model

A key part of the transformation of Primary Care is the Delivery of Care model which is the culmination of extensive involvement activities and work of the CDRG. It conceptualises our future thinking on:

- **how** support and services may be organised
- **where** support and services may be provided
- **who** may be involved




The model is centred around the importance of the community in maintaining healthy individuals. Surrounding this, there are three broad groupings of activity: Unplanned, Planned and Preventative Care. Each segment represents a different way of access, delivering activity, measurements, data, workforce and skills and has associated initiatives to help make the strategy a reality. Consensus through involvement is that these core components should be delivered at neighbourhood level, supported by a Neighbourhood Integrated Care Team.

| 1. Unplanned Care | 2. Planned Care | 3. Preventative Care |
|---|---|---|
| ✓ Scale-up a standardised access blueprint | ✓ Establish neighbourhood-level Integrated Care Teams | ✓ Establish a Black Country Population Health Management (PHM) framework |
| ✓ Explore options for Local Care Hubs | ✓ Use PHM approaches to collaborate with specialist services and community teams | ✓ Co-design and launch targeted health promotion initiatives with Public Health and VCFSE |
| ✓ Support patient navigation through 'active signposting protocol | ✓ Optimise local enhanced services in Community Pharmacy | |

The model is further **supported by Primary Care Connected** (depicted to the left in the visual above) - a consolidation of the currently available digital tools available to staff and/or patients that can enhance the delivery of care when optimised and embedded within appropriate workflows. Also, establishment of the **Primary Care Support and Development Unit** (depicted to the right in the visual above) or 'PCSDU' - a delivery vehicle to provide capacity alongside a range of transformational change functions to help drive and shape the transformation until it becomes 'business as usual' over time. Importantly the PCSDU also means that we build local support and capability to assist our Primary Care workforce in delivering the strategic change (for full visual, see section 4.6), and create the infrastructure for the BCPCC to drive the transformation.

## Next steps

This outline transformation strategy reflects a point in time and the intended direction. In Horizon 1, we will work with clinicians, professionals and Place partners to further co-design how high-level model will translate in Places and Neighbourhoods to establish potential service changes subject to public consultation. Building on our initial involvement meetings (for full detail, see section 2.2), we will encourage local people to exchange ideas in a two-way process so that informed feedback can further shape initiatives to meet needs.

Moving forward, efforts are required to work through the funding, resources, contracting mechanisms, incentives for the future, and ongoing involvement as we incorporate feedback and develop the finer details of the initiatives.

# Introduction

# 02

# 2.1 Introduction to the Outline Strategy

**Primary Care plays a central role in our communities, offering care, support, and guidance to people at all stages of life.** As the Black Country Integrated Care Board (ICB), we have a responsibility to the 1.26 million people in the Black Country, in making sure they have access to safe, timely and effective Primary Care services.

We recognise that Primary Care also supports with preventing illness, promoting health and the overall wellbeing of our people. As the second most deprived ICS in the country, our community faces significant health inequalities with an increased prevalence of the major disease areas that drive demand (e.g. diabetes, mental ill health). We also have a younger, growing population that is highly diverse (30% from ethnic minority background vs national average of 14%), that will continue to require tailored, appropriate care.

As we look ahead to the future, there is a need to transform the way we deliver Primary Care services efficiently and sustainably. In the Black Country, Primary Care includes General Practice, Community Pharmacy, Dental, and Optometry services, which are often the first point of contact with the healthcare system. Community assets including the voluntary, charity, faith and social enterprise organisations (VCFSE), are increasingly becoming a recognised part of the primary care provider landscape.

For the purpose of this initial outline strategy, we will focus on General Practice and Community Pharmacy initiatives in more detail. The equivalent for Dentistry and Optometry will be integrated in later phases of our transformation.

This strategy is a key output of the first phase of the transformation and sets out the five year journey of the **Future Primary Care (FPC) in the Black Country** programme (see Figure 2), developed in partnership with the Black Country Primary Care Collaborative (BCPCC) and with the involvement of system health and care partners and local people.

Collectively, we are aligned that to achieve meaningful transformation in Primary Care there must be direction of travel set out supported by initiatives that are locally-driven, community-led and System-supported.

Our objective is to create the environment for transformation by working alongside the four Places in the Black Country, encouraging Primary Care services across the System to work collectively and collaboratively towards and overarching vision that primarily focuses on delivery care differently.

**Black Country ICB vision:** Our vision is to lead health and care collaboration in the Black Country to enable all our communities to live longer, healthier and happier lives.

Despite increasing pressures, General Practice in the Black Country has continued to provide more appointments than before, and our Pharmacies are providing a growing, wider range of services. We have a history of being extremely adaptable and innovative in Primary Care, most notably demonstrated in recent years through the extraordinary efforts in rolling out the NHS COVID-19 Vaccination Programme. However, we are now at a critical juncture as demand continues to increase and our expanded workforce is doing all they can but are significantly stretched. To meet the needs of our local people and improve the experiences of everyone involved in delivering and receiving care, there needs to be demonstrable change.

Nationally, there is an ambition to provide care closer to home. The NHS Long-Term Plan (2019), Fuller Stock take report (Fuller, 2022), 'Delivery plan for recovering access to Primary Care' (NHS England, 2023) and the King's Fund report 'Making care closer to home a reality' (Baird et al., 2024), outline the critical changes required in leadership, culture and integration, highlighting the need for a greater focus on primary and community health and care services. The FPC programme outline strategy is aligned with the national direction and has a clear vision of what good Primary Care looks like in the Black Country over the next five years.

Beyond the challenges, this document highlights what we need to do differently to deliver the vision and goals of the programme, guided by the strategic priorities and design principles. It also includes supporting initiatives for the future operating model and key next steps for Horizon 1.

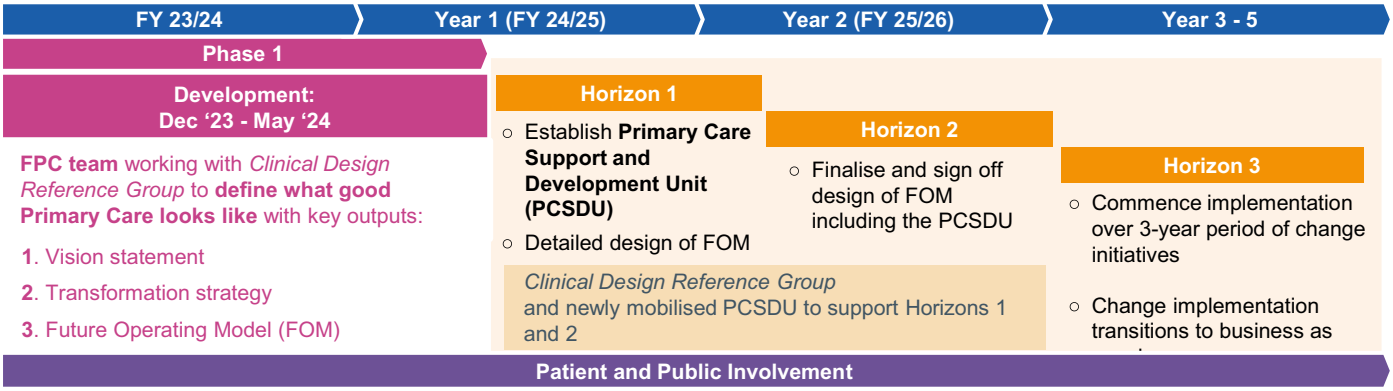



**Figure 2:** Future Primary Care five year transformation journey

# 2.2 Approach to Development

**Our approach to developing this outline strategy to transform Primary Care in the Black Country has been driven by involvement, with a strong emphasis on involving people who experience and deliver primary care at every step.** This included establishing a Young Professionals group and Clinical Design Reference Group (CDRG) (see Exhibit 1), to co-design the emerging Future Operating Model (FOM), capturing the insights and expertise of clinical and non-clinical healthcare professionals from all four Places.

**We have successfully had over 800 stakeholder interactions and engaged with over 115 practices, with high attendance and active participation from colleagues in both face-to-face and virtual meetings and workshops.** The voices of local people have also shaped and guided our work, and we are committed to broadening their involvement as we implement the strategy.

**Throughout these interactions, we have learned valuable lessons.** We gained a greater understanding of the challenges faced by individuals and communities, as well as the remarkable efforts being made to provide quality care. This in turn has allowed us to develop a vision that truly reflects the needs and aspirations of the people we serve.

**The most pressing issue to address is the demand on services**, other themes include the importance of respectful leadership, developing a highly skilled workforce that meets the needs of the population, interoperability and digital enablement, patient-centred care, cross organisational integration, and mutual understanding of roles, responsibilities, and working contexts.

**In addition to involvement, we have looked at the evidence base, drawing from national and international best practices.** The evidence has been instrumental in informing the workshops and discussions held during the co-design process. By incorporating our research and proven approaches, we have been able to shape a vision and Future Operating Model that is grounded in experience and expertise.

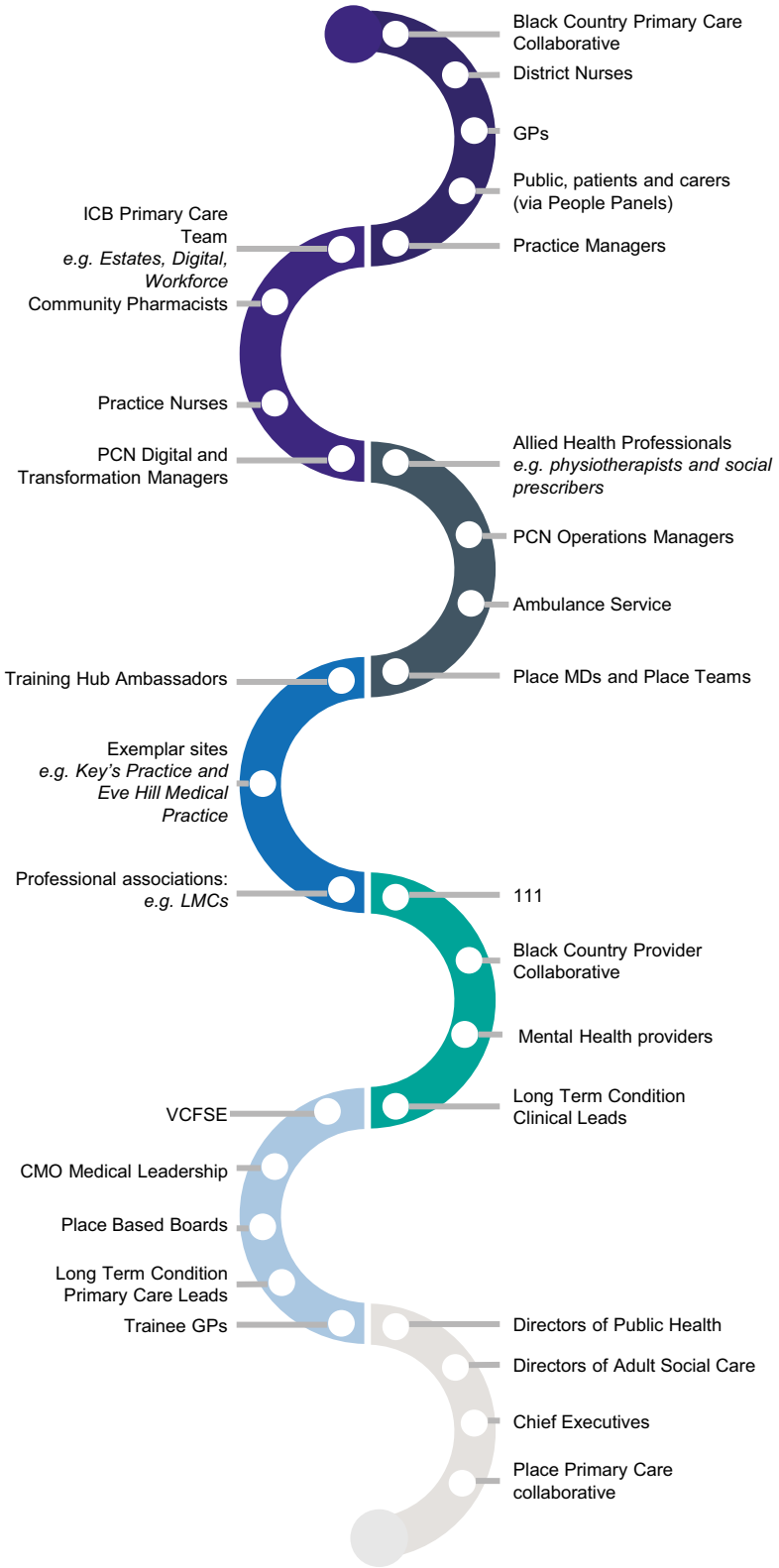



**Figure 3:** List of primary care stakeholders interacted with throughout Phase 1

**Exhibit 1: Overview of Young Professionals group and CDRG member representation**

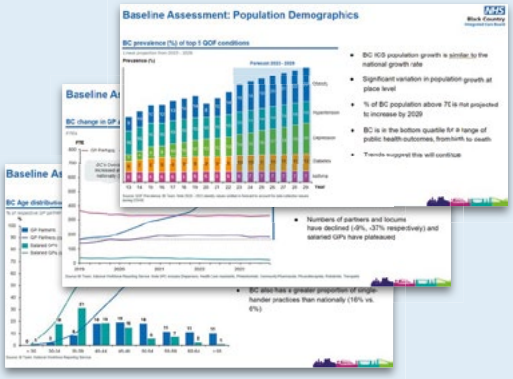
| | |
|---|---|
| **Young Professionals:** | Social Prescribing<br>Community Pharmacy<br>First Contact Physio<br>First 5 GP<br>Physicians Associate |
| **CDRG:** | GP from each Place<br>First 5 GP<br>Mid-career GP<br>Public representative<br>ICB Digital<br>Practice Nurse<br>Allied Health Professionals<br>Community Pharmacy<br>Local Medical Committee (LMC)<br>Practice/PCN Management |

# 2.2 Approach to Development

Collaboration has been core to this outline strategy. To make sure the needs of the community and people who work in primary care were reflected in all parts of the development, we approached involvement in three stages: listening, co-design and testing. We also critically engaged with stakeholders across the System that interact with primary care to make sure their perspectives were heard and incorporated into the future operating model.

## During the outline strategy **Listening stage**:

**We had over 400 interactions with stakeholders across Primary Care and the System**, to understand what is working well, and identify both short-term and long-term areas for improvement. This, alongside reviewing existing strategies and data, such as the Primary Care GP survey results (2023), and collated insights from patients and the public from People Panels, Healthwatch and the involvement report* in 2023, helped us gain a deep understanding of the **current state of primary care in the Black Country.**




## During the outline strategy **Co-design stage**:

We held a General practice focussed event in each Place to validate what we heard during the Listening stage and start building what the future could look like. We continued to iteratively co-develop, canvas and validate ideas through:

**3 People Panel events**
Open discussions were had with patients and the public in Wolverhampton, Walsall and Dudley, to inform and shape any changes to primary care access, unplanned care and self-care

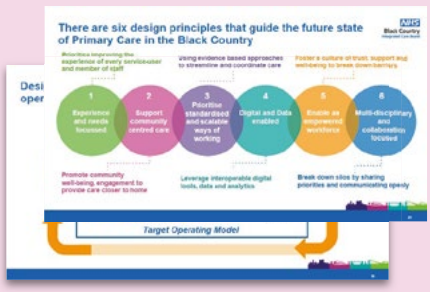
**Multi-professional working groups**
- **2 Young Professionals Focus Groups**
- **6 CDRG workshops**

Insight and intelligence from the Listening stage, People Panel events, and best practice national and international case studies, supported discussions in the working groups where the future operating model was further developed. Activities such as exploring the functions of best practice planned care, and analysing unplanned-care models at System, Place, Neighbourhood or Practice-level were held with the CDRG.

This **involvement-led approach** has allowed us to develop a future way that meets the critical needs expressed by local people and which will continue to be debated.

## During the outline strategy **Testing stage**:

We organised an event with over 60 stakeholders from across the System, including representatives from General Practice, Community Pharmacy, Secondary, Social and Community Care to discuss the feasibility of the draft Delivery of Care model and initiatives, as part of the Future Operating Model.




*The insights are based on the following involvement practices: Microgrants (Dec 2023 - Jan 2024), Community Conversations (Jan - Aug 2023), People Panels (Jan-Feb 2023).

# Case for Change

# 03

# 3.1 Case for Change Drivers

**The drivers summarised below, play a crucial role in the development of our outline transformation strategy and provide context around the need for change.** By identifying and understanding these drivers, we are better equipped to address what is within our control, and work collaboratively with System partners to ultimately improve patient outcomes and achieve a more sustainable Primary Care system.

## Policy Drivers

There are a number of national reports that influence Primary Care provision, such as NHS Long Term Plan (NHS, 2019), the Core20PLUS5 approach to reducing health inequalities, Delivery Plan for Recovering Access to Primary Care (with a focus on four areas in the plan - empowering patients, implementing Modern General Practice Access, building capacity and cutting bureaucracy) (NHS England, 2023), 2024/25 Priorities and Operational Planning guidance (NHS England, 2024), Digital Health and Social care plan (DHSC, 2022) and Black Country strategies such the Joint forward plan 2023-28 and ICS Digital Strategy. Also, more recently the King's Fund 'Making care closer to home a reality' (Baird et al., 2024).

## Patient Drivers

Feedback from People Panels and insights from the involvement report* highlights declining patient satisfaction. Patients are experiencing difficulties booking appointments such as choice in booking out-of-hours appointments, signposting to other professionals and flexibility in how to access services including face-to-face, phone and video consultation. There are also reports of variable care coordination and access challenges for marginalised groups; such those who have sensory impairments, those with autism, and those for whom English is a second language.

## Population Drivers

As the second most deprived ICS in the country, we are facing housing challenges, population growth, and significant health inequalities with an increased prevalence of the major disease areas that drive demand (e.g. diabetes, mental ill health). We have a diverse population with 30% of people from ethnic minority background vs national average of 14%, and an increased risk of digital exclusion, with more digital modes of accessing care.

## Workforce Drivers

Falling recruitment and retention, an increased burden of work and a declining number of GP partners - this alongside patient demand, challenges with processes and the level of training opportunities is affecting staff experience.

## Clinical Drivers

Ongoing challenges include an increased demand for unplanned care, impacting the capacity for complex care, a need to improve preventative care, fragmented ways of working, and a call for better integrated services.

## Financial Drivers

Nationally there is a real term reduction in funding for Primary Care, and currently our System is in deficit, with a System-wide Financial Recovery Plan in place to address existing challenges. We need to review how we organised to better manage with what we have and make a case for investment where possible.

## Digital Drivers

We are working towards Digital First Primary Care (NHS, 2019), and making sure that every patient is offered digital-first Primary Care. Digital innovation has the potential to drive positive change for both staff and the community, including supporting the workforce through improved demand management and improved interoperability between providers.

## Estates Drivers

Our Primary Care Estates Strategy has a comprehensive work programme underway, and highlights restrictions in our physical clinical capacity and challenges related to the suitability of current premises and tenure. Capacity pressures stem from population growth, the poor condition of existing premises and increasing numbers of trainee GPs and ARRS staff.

## Environmental Drivers

Nationally we are working towards delivering a net zero NHS, and aim to be world's first net zero national health service. The ambition is to reach net zero by 2045, with an 80% reduction in carbon emissions by 2036 to 2039.

*The insights are based on the following involvement practices: Microgrants (Dec 2023 - Jan 2024), Community Conversations (Jan - Aug 2023), People Panels (Jan-Feb 2023).

# 3.2 Key challenges affecting Primary Care

**Building on our understanding with further analysis and from the involvement undertaken, we have identified key challenges which highlight the increasing need for transformation, and developing a future state for Primary Care that not only meets the current needs of patients, but is resilient and sustainable for the future.**

A longstanding challenge is that of demand for Primary Care services exceeding capacity. We have increased the number of appointments provided in General Practice year on year over the last five years, through a number of ways including scaling up telephone and video consultations and increasing the number of ARRS roles working in Primary Care. This trend is unsustainable against a backdrop of an increasing list size rate, increasing complexity of patient needs, plateauing GP workforce growth, and reduced funding (in real terms). This presents a strain on all Primary Care staff, including Practice Staff and Community Pharmacy, who often deal with frustrated patients.

## 1 Demand and Capacity

- No. of appointments not able to keep up with demand - average appointments per patient per year increasing 6% in the last year to 5.52.
- List size has increased by 8.1% (2019-2023), fast outgrowing the workforce and no. of appointments that can be offered
- The ratio of clinical workforce to patients is in the bottom quartile nationally (1:7 vs 1:6)
- The % of same day appointments (as a proportion of the total appointments offered that year) are increasing
- Number of GP partners have declined (2019-2023) and salaried GP numbers have plateaued (2021-2023)
- The leaver rate of qualified GPs exceeded the rate of joiners (Sep 2023) by 1.8%

## 2 Health Inequalities

We are making progress with health inequalities in every aspect of the care we deliver across the Black Country. Healthy life expectancy at birth in the Black Country is significantly lower than the national average (60.2 years vs 63.9 years for women, and 60.9 years vs 63.1 years for men) and this trend exists across all four Places. Our indicators within Primary Care, spanning from birth to death, reveal the extent of the challenges faced by our population. Our community faces unique health challenges, with higher rates of disease prevalence than the national average. Rates of obesity are particularly raised (71.6%), surpassing the national average (63.8%). The trends in the top five long-term conditions affecting our population -obesity, hypertension, depression, diabetes, and asthma-are either worsening or plateauing. This indicates that inequalities are deeply entrenched and likely to persist unless we do something different to change the tide.

There is also notable variation in deprivation across different areas within the Black Country, with approximately 50% of the population residing in the most deprived quintile,which correlates with disease prevalence. As the population continues to grow and diversify, the complexity of care increases, further exacerbating existing inequalities. Addressing these health inequalities is crucial in supporting equitable access to high-quality primary care for all residents in the Black Country.

**Black Country has poorer outcomes than England for many social determinants of health**:**
(comparison to national average*)

| Income | Income | Income | Income | Income |
|---|---|---|---|---|
| 24% *15%** | 73% *15%** | 69% *81%** | 170 *147** | 12 *11** |
| Children (<16) live in absolute low-income families | People in paid employment | Children achieve a good level of development at 2-2.5 years | (per 100,000) Higher rates of first time entrants to youth justice system | (per 1,000) Higher rates of homelessness |

**Fingertips: Public Health Outcomes Framework (2023)

# 3.2 Key challenges affecting Primary Care

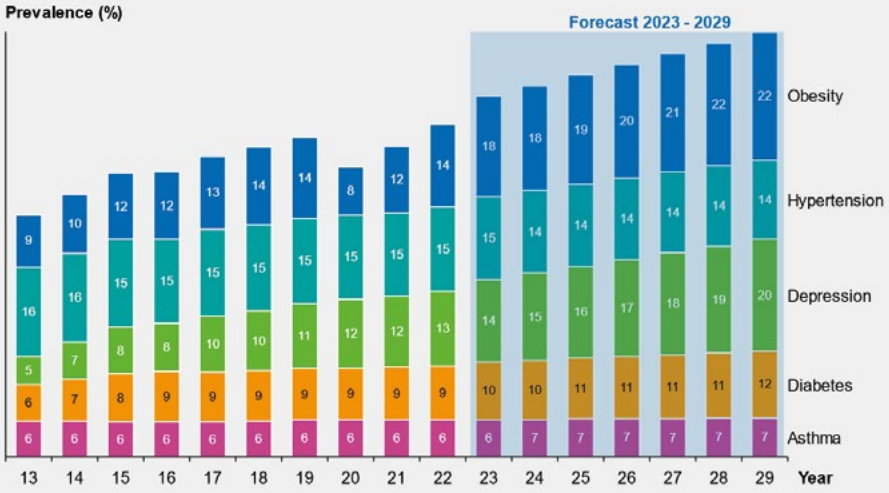
## Exhibit 2: Insights from Baseline Assessment

### Population growth, increasing prevalence of LTCs and poor health outcomes is driving demand pressures on Primary Care services

- Black Country population has grown by **7.1%** (2011-2022), and is **expected to grow**, in-line with the national average, until 2029*
- Rates of **obesity**, **depression** and **diabetes** are projected to increase in the next 5 years**
- Percentage of adults classified as **overweight or obese** is **71.6%** across Black Country, compared to national average of 63.8%***

**Black Country prevalence (%) of top 5 QOF conditions**

*Linear projection from 2023 - 2029.*

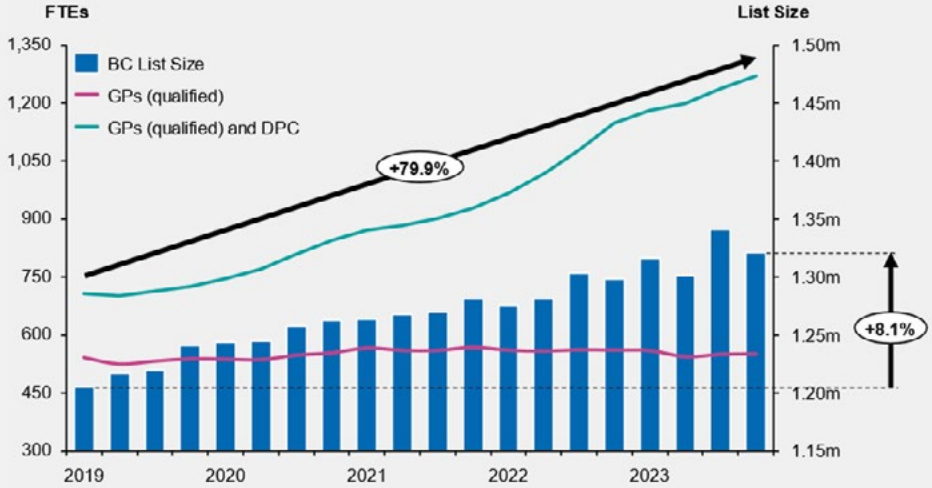



### Despite the increase in demand, more appointments have been provided in General Practice; however this is at a slower rate than the growth in GP list size

- **Black Country list size** has increased by **8.1%** over the past 5 years†
- The number of qualified GPs, on the other hand, has increased by only **1.6%**†
- Meanwhile, **general practice has continued to deliver more appointments over the last 5 years**, with an increase of **5.2%**†
- **And the number of same-day appointments** has increased from **2.40m to 2.78m**, and now make up **47.0% of all appointments**†††

**Black Country GP workforce growth vs. list size**

*FTEs, list size in millions*[1]




*Note: Direct Patient Care (DPC) includes Dispensers, Health Care Assistants, Phlebotomists, Community Pharmacists, Physiotherapists, Podiatrists, Therapists.*

- This has been supported by the **79.9% increase in Direct Patient Care (DPC) roles**, which has been driven by the additional roles reimbursement scheme (ARRS)†

*ONS (2018) Sub-national population projections for England: 2018-based, **NHS England (2023) Quality and Outcomes Framework, 2022-23, ***Fingertips: Public Health Outcomes Framework (2023), † NHS England National Workforce Reporting Service, ††† NHS England GP Appointments Data Dashboard

# 3.2 Key challenges affecting Primary Care

**We have a duty to meet the needs of our patients and our workforce, and the feedback we have received suggests that their experiences of care and work are deteriorating.** Over the last year, we have heard from People Panel forums across all four Places, about their experience of Primary Care. Most notably, people are experiencing challenges with booking appointments, and adequate signposting elsewhere when they cannot access an appointment. Patients have also expressed a need for improved access to specialist services, for example from mental health providers. Whilst addressing mental health support in Primary Care is a transformation that is currently underway, there is more we can do to improve the experience of patients, carers and their families.

**From the perspective of our staff, morale is currently low.** We have heard that the demand on services is taking a toll on their ability to provide the level of care they aspire to, and unclear roles and responsibilities presents challenges for care navigation. There is also a call for improved training opportunities for clinical and non-clinical staff, and improved digital and physical infrastructure to enable delivery of effective Primary Care services.

## 3 Patient Experience

**Inadequate specialist services access,** particularly in Mental Health.

**Poor appointment experience,** reduced continuity of care and short appointments have led to a level of distrust.

**Dissatisfaction with access to appointments,** choice of appointments, and unaware of alternatives to the GP.

There are **significant barriers for marginalised communities** including, language, disabilities and digital access.

## 4 Staff Experience

### Low morale

**32%**

of staff often or always feel burnt out because of work*

### Variable training opportunities

**53%**

of staff agreed that there are no career development opportunities*

### Low engagement

**11%**

of staff responded to the 2023 Primary Care Staff Survey*

### Roles and Responsibilities

Currently a lack of guidance and support to help staff effectively integrate into new roles

## 5 Variable infrastructure

| | |
|---|---|
| **Digital** | Uneven digital maturity across the System due to the lack of a standardised operating model |
| | Basic IT connectivity and resilience limiting day-to-day activities, and a perceived lack of guidance for everyday issues |
| **Data** | Access to patient data across providers varies and is often shared through verbal communication (e.g. in meetings) though the One Health and Care Record is being enriched |
| | Data sharing between the ICB and providers is variable, limiting the data manipulation and visualisation support the ICB can give to Providers to enhance demand management |
| **Estates** | Current physical infrastructure is of variable quality and is not always used to maximum efficiency |
| | In some areas low availability of physical space is limiting GPs ability to meet clinical demand from patients and support an increase in workforce recruitment and placements |

The challenges in Primary Care are interconnected and complex, with impacts that can reinforce the drivers, and continuously increase the pressure and strain on service delivery and sustainability. We have committed to addressing these challenges by co-designing a joint system vision and operating model that promotes integrated ways of working by reducing unwarranted variation, to shift Primary Care from surviving to thriving in our System.

*NHS Black Country ICB Staff Survey Benchmark report (2023).

# 3.2 Key challenges affecting Primary Care

## Exhibit 3: Insights from our Community

**To understand the primary care challenges faced by local people, we reviewed insights* and feedback from across all four places gathered throughout 2023.** These insights shed light on the main hurdles encountered by the public and patients in their primary care journeys. This has been categorised into five key themes reflected below which have informed the delivery of care model.

**Booking Appointments**

- **Lack of face-to-face and walk-in appointments** is considered impersonal and less effective
- Limited opportunities to **pre-book non-urgent appointments**
- **Unclear guidance** on where to go or gain other support if people can't get an appointment
- **Not enough choice in appointment type:** between telephone and face-to-face

**Appointment Experience**

- **Poor continuity of care** for patients who want to be able to see the same GP
- **Allocated time per appointment is too short** and the length of appointment does not match according to individual needs/for more complex patients

**Barriers for marginalised communities**

- **Language barrier limiting access** to services if English is not their first language, including for BSL users
- **More support is needed for disabled young people** in terms of advice and training for carers and professionals
- Older people and people with autism **struggle with NHS turning digital;** phone bookings and using the NHS app is a barrier due to digital literacy, lack of digital gadgets, mental or physical impairment and language issues

**Improved access to specialised Services**

- More **enhanced mental health support** is needed, especially for children and young people
- More **GP practices with their own specialists** are needed as it is not easy to access these services

**Ways of Working**

- **More training is required for professionals** to improve their knowledge on how to best interact and communicate with older people, people with hearing loss, and people with learning disabilities
- **Change and improvement** is needed, and GPs and practices who are doing good work should share more widely their expertise and knowledge with other practices

**Insight led statements**

Want to pre-book non-urgent appointments in advance rather than do it on the day at 8am

You need to tackle the 8am calls to get an appointment

I want a named GP to build trust and not have to repeat our story!

GPs need more than 10 mins per patient

Carers should have longer GP appointments

Sessions are needed in different languages and with cultural sensitivities

Older people cannot book appointments online or use apps to book due to eyesight

Have mental health specialists available to support patients

Several GPs in a practice with own specialists are good and takes less time to wait to see someone

Practices who do good work should share what they do with other practices

# Future Primary Care

# 04

# 4.1 Our Vision for the Future

We have clear aspirations, and **our vision statement defines what Primary Care in the Black Country stands for,** and what we aim to achieve now and in the future with the support of our System partners and communities across the Black Country.

**Our vision for the Black Country is equitable access to high-quality health and care for all**, building resilient communities with improved health outcomes. Our mission is to empower people, carers, staff and volunteers, with the know-how, ability and tools to access care that meets their unique needs, closer to home.

By creating a supportive and innovative environment that encourages mutual respect and collaboration among health and care providers across the System, we aim to reduce health inequalities, and make sure everyone gets the right care they need.

# 4.2 Future Primary Care Goals

As primary care is often the first point of contact with the healthcare system in the Black Country, ultimately, both patients and the wider System will benefit from its transformation. Achieving this vision is a five-year journey, and our goals (as noted below) provide a clear direction for what we need to accomplish collectively through the programme moving care closer to home.

### Enhance linkages

Cater to diverse needs by **improved linkages within Primary Care services** while guaranteeing a balanced approach between scalability, consistency in service delivery, and justified variations.

### Support the workforce

Foster an environment that actively **supports the growth, retention, and recruitment of clinical and non-clinical professionals** in Primary Care, contributing to the wider System aspiration of the Black Country becoming the best place to work.

### Improve premises

Identify and leverage opportunities to **enhance the quality of premises where Primary Care services are provided**, upgrading infrastructure and facilities.

### Build capability

Strengthen the capabilities of general practice services, particularly in **managing demand and optimising capacity** to meet the healthcare needs of the population effectively.

### Improve access

Introduce innovative solutions, including the integration of digital technologies, to enhance access to Primary Care services, **improving efficiency, patient satisfaction and experience**.

### Activate communities

Empower and engage local people both as individuals and as part of community networks, to be **well-informed, actively involved and responsible** for their own healthcare decision-making.

### Understand patient needs

Implement a **data-enabled** approach to better **understand patient needs to direct treatment** in a more effective, personalised manner, and to **understand system demand and capacity**, supporting dynamic ways of working.

### Support resilience

Promote activities that **build resilience in communities and professionals**, and interventions that encourage **adapting to change**.

# 4.3 Our Strategic Priorities

Listening to the voices of those who experience and deliver Primary Care was crucial in shaping this outline strategy. Through our discussions, we have heard that **delivering meaningful, visible changes - both immediate and long-term**, is important. To focus our efforts effectively, we have identified **four strategic priorities** that align with what we have heard through our interactions, the latest NHS operational planning guidance for 2024/25, the Fuller Stock take report and the Black Country Joint Forward Plan refreshed priorities.

## Black Country Joint Forward Plan Priorities 2024:

1. Improving access and quality of services
2. Care closer to home
3. Preventing ill health and tackling health inequalities
4. Giving people the best start in life
5. Best place to work
6. Fit for the future

**Strategic priorities**


### Enhance and streamline access to unplanned care

Our communities want access to the right care, by the right professional, at the right time - in the right place. However, we recognise that need is not consistently met. By **optimising access to unplanned care** within General Practice and Community Pharmacy, **prioritising the highest quality of care**, we can work to improve the experiences of service users in all pillars of Primary Care.

### Activate communities to focus on prevention and tackle health inequalities

Whilst we are making great progress, we need to be more proactive in Primary Care to **address health disparities and promote well-being**. We will **leverage data and digital tools** to **co-develop tailored initiatives with public health, local authorities, and the VCFSE sector**. By tapping into their expertise and established community networks, we can empower communities to activate more of these resources, such as learning programmes like Make Every Contact Count, to support effective health promotion and develop public health knowledge.

### Improve integrated care for patients with complex care needs

Many people in the Black Country are living with multiple health conditions (multimorbidity) and living in deprivation. This complexity increases their care needs, requiring a **more personalised approach** and continuity of care to enhance their overall health and wellbeing. Our focus is on **improving integration and collaboration** between all the partners involved in their care to better serve those who may be most in need.

### Promote skill and capability development, expand training opportunities

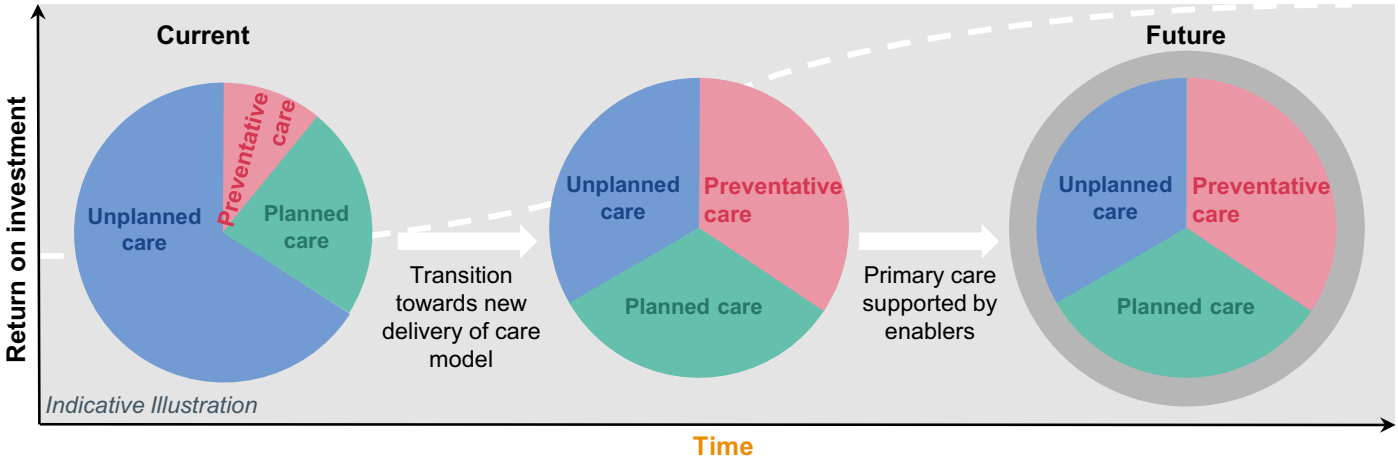
Our workforce is multi-skilled, and passionate about providing quality care. To enable our Primary Care colleagues to perform at their best and consistently enhance the experiences of people in the Black Country, we recognise the **importance of investing in leadership, digital skills, clinical and operational training**. We are fully committed to supporting colleagues to thrive in their roles and promote their professional development whilst helping staff remain resilient and maintaining their wellbeing.

# 4.4 Investing in Future Primary Care

**Latest research highlights that general practice funding per patient has fallen by approximately 7% in real terms nationally, and 10% in the Black Country.**[1] Falling investment is driving a reactive model of care where the workforce have limited capacity to focus on prevention and planned care. This is contributing to more unplanned demand (such as the latest Measles outbreak) and worsening the patient experience of receiving care. Despite this general trend, there are exemplar sites that have met Modern General Access criteria and a number of successful initiatives through social prescribing and closer working with VCFSE, and improved education around the management of diabetes that are showing great potential in supporting people to stay healthy and closer to home.

**We need to invest in prevention and a more proactive (planned) model of care that maximises every pound we spend on our healthcare system, enables us to introduce targeted activities to reduce healthcare inequalities in line with Core20PLUS5, and creates a better patient experience where people are supported to stay healthy for longer.** The NHS Confederation recommend prioritising investing in primary care for the additional 'health value' and economic impact it has, suggesting that for every £1 invested in primary care, £14 are returned.

**Despite this, only 12% of the Black Country ICB commissioning budget is currently spent in Primary Care. In contrast, 95% of NHS activity, on average, is conducted in Primary Care.** The growth received for 24/25 for Primary Medical Care Services was 3.89%. It is assumed that this growth will continue for the next five years. This will enable us to transition towards a model of care where activity can be more equally distributed, based on need, across unplanned, planned and preventative care, as depicted in the illustrative diagram below. This will allow us to more effectively support our people to stay healthy and closer to home and reduce demand for unplanned care, e.g. by reducing avoidable escalations for patients with long term conditions, and in turn improve access for those who need unplanned care, despite the proportionate shift in activity. System-level enablers such as workforce, estates, digital, data and analytics will enhance the delivery of care, for example through better recruitment and retention of staff or supporting practices with demand analytics.




Alongside this transition, Primary Care Providers also have a responsibility to contribute towards the System-wide FRP and support turning around the System deficit of £119m through the delivery of identified initiatives. The FRP primary care initiatives are in their early stages and will be further iterated on by the BCPCC who will be responsible for driving them forward alongside their other priorities (as detailed in Appendix G). These FRP initiatives, have been considered as part of the FOM development and align with the three core components of care:

| | | Financial Recovery Plan activity |
|---|---|---|
| **Unplanned Care** | 1 | Acute Respiratory Infection (ARI) Hubs |
| | 2 | Optimised Urgent Community Response (UCR) |
| **Planned Care** | 3 | Virtual Wards (VW) |
| | 4 | Medicines Optimisation (Primary Care) |
| | 5 | Continuing Healthcare Integration |
| | 6 | Proactive Case Management |
| | 7 | LTC management - enhanced services |
| **Preventative Care** | 8 | Homeshare |
| | 9 | Integrated Neighbourhood Team Maturity |

1. Pulse Today. GP funding sees 7% real-terms cut since 2019 (2024)

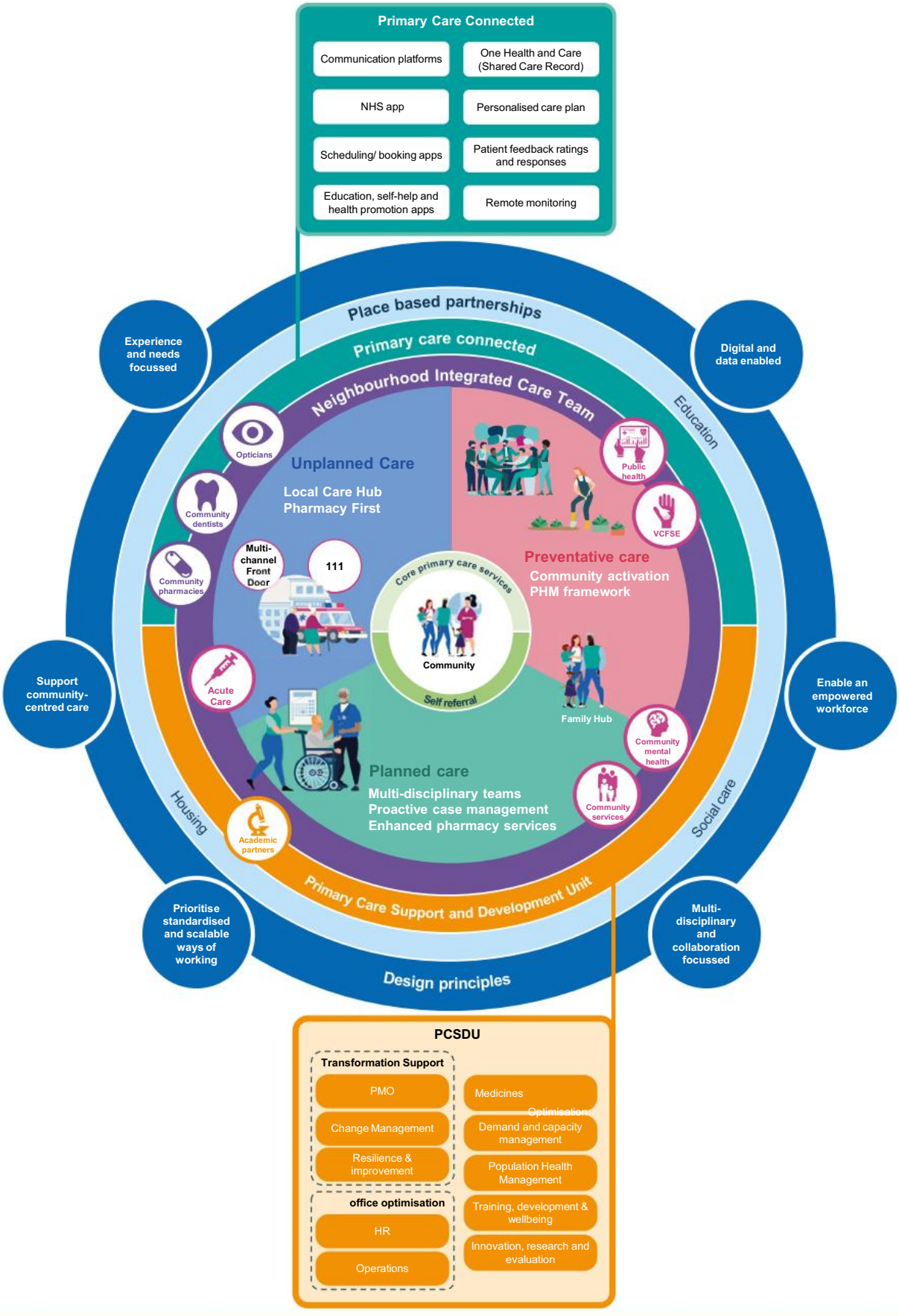
# 4.5 Design principles for the Future Operating Model

The FOM aligns capability with the strategic vision, reflecting what we will do to achieve our vision and the tools required to get there. **We created six design principles to guide the development of the FOM, serving as criteria for evaluating initiatives in alignment with the needs of the Black Country**. Moving forward, these principles will continue to inform our decision-making process, guiding us toward our goals and guaranteeing that the model remains suitable for its intended purpose throughout our transformation journey.


- Prioritise **improving the experience** of every person involved in receiving, or delivering care, whilst **aligning this with their needs**.
- Using **population health management** to understand local needs, and developing the provider landscape to facilitate a proactive, personalised, holistic approach to health and wellbeing that prevents and reduces inequalities.
- Embrace **collaboration** to actively promote physical and mental wellbeing within communities and **provide care closer to home**.
- Engage with local people to shape health and care services and adopt a flexible approach to service delivery at all levels, emphasising **targeted health promotion** to encourage local people to participate in their care and build resilience.
- Use an evidence-based approach to **streamline and coordinate core services** where appropriate, to promote **consistency, efficiency**, and **improve the quality of care** across the System, learning from best practice.
- Leverage interoperable digital tools, data and analytics at **every stage of operation** to inform decision making processes and optimise performance.
- From **integrating risk stratification** to enable targeted, tailored interventions, and measuring demand and capacity to enable good access, to using **data-led insights** and digital technologies to maximise efficiency and foster innovation across the Primary Care system.
- Building a **culture of trust and ownership**, and supporting individuals, teams, and organisations to operate at their fullest potential, recognising that the quality of care a service user receives is directly linked to the experiences of those delivering it.
- This includes **removing barriers**, providing adequate **development opportunities**, and prioritising **improving staff morale and well-being** as essential elements of optimising performance.
- Sharing priorities to deliver the right care, in the right place, at the right time. Promoting **multi-disciplinary teams** working together through open collaboration and **breaking down silos** between and across providers.

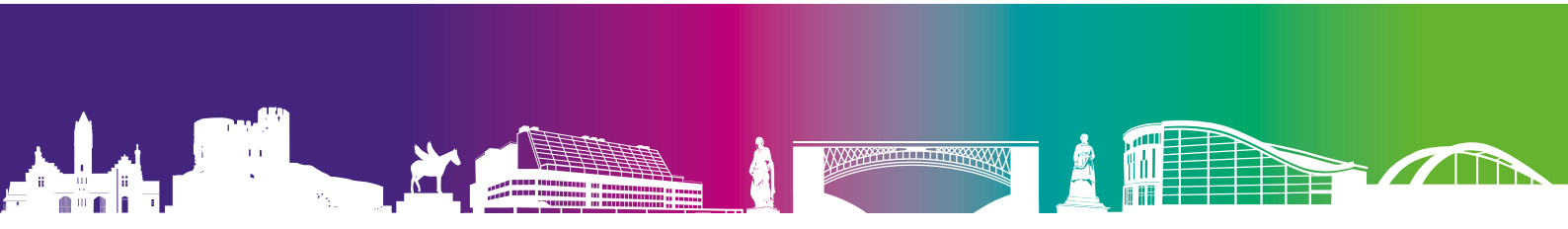
# 4.6 Delivery of Care model

As part of the transformation of Primary Care we have developed a system-focussed FOM (outline in Appendix A) that depicts at a high-level how we will organise ourselves to achieve the vision of the Future Primary Care programme. A core component of the FOM is the Delivery of Care model which conceptualises our thinking on how Primary Care support and services will be organised in the future, where they will be provided, and who will be involved. This is the culmination of extensive involvement activities and work of the CDRG.



# Strategic Initiatives

# 05



# 5.1 Delivery of Care: Unplanned Care

A key part of our vision is **equitable access to high-quality health and care for all**, and we know from our interactions that this is one of the most significant challenges we have, with demand for same-day appointments increasing and a lack of clarity on the routes to access support impacting our ability to provide timely care.

In line with our strategic priority to **enhance and streamline access to unplanned care** we want to take a multi-layered approach to supporting local communities with accessing care, from the right professional, when they need it. We are making progress with implementing Modern General Practice Access (MGPA), and to take greater steps towards our vision, there are three key initiatives we will explore to understand how they could be organised, implemented and funded to better support access to unplanned care.

| | |
|---|---|
| 1 **Scale-up a standardised access blueprint** with implementation support for all Practices | We have a number of exemplar sites that already meet the criteria for Modern General Practice Access. **Learning the commonalities amongst these practices**, will allow us to create a standardised specification to support other Practices to deliver excellent access, with best practice from within the Black Country at the core. For Practices who are yet to implement these criteria, learning from the successes of earlier adopters is likely to make the process easier and overall improve equality in access to primary care, by being needs-based as opposed to first come first served. Forging a clearer and more formal relationship between GPs and Community Pharmacies within a hub and spoke model within PCNs will be a key part of the access blueprint, helping to unify primary care and create a seamless patient experience. |
| 2 **Explore Local Care Hubs** to manage unplanned (i.e. same-day), lower complexity patient needs | Over the last five years, we have increased the proportion of Same-Day GP appointments, and last year we were able to provide 47% of appointments on the same day, yet this does not quell demand. A significant proportion of these appointments are for lower-complexity healthcare challenges which may not require a GP consultation but do need to be addressed quickly. **We want to explore the co-design of Local Care Hubs to address lower complexity unplanned care, in neighbourhoods at each Place** (neighbourhood to be further defined). The work moving forward will be to determine what these hubs look like, the services in scope and how they operate for the Black Country. The aim is to develop local plans on how practices and PCNs will potentially organise themselves to deliver improved same day access for local people. |
| 3 **Create an 'active signposting' protocol** to support staff to navigate patients towards services including Pharmacy First, Social Prescribing and others in the community, where appropriate | We will optimise the use of services offered by Public Health, Community Pharmacy and the VCFSE Sector and work to support that patients, their families and carers can access these resources more effectively with better guidance. We will develop a protocol that equips staff with the **tools to confidently navigate people** towards the **most appropriate services and professionals** in all pillars of Primary Care. |

**Case study:** Eve Hill Medical Practice (GP surgery in Dudley)

**What was the problem?**

The practice undertook a GP survey which suggested a high level of avoidable appointments:

1. Poor care navigation leading to unnecessary GP appointments where patients need care by another professional
2. Inappropriate appointment type (face to face vs telephone) being allocated to patients leading to unnecessary appointments

**What was the solution?**

1. A shift to 65% face to face and 35% telephone appointments was created to help release capacity to where it's needed
2. EMIS and AccuRx templates to guide on acceptance criteria and referral methods
3. Scripts created for administrative staff to enable them to signpost effectively
4. Dedicated continuity of care slots with regular GPs to guarantee continuity for complex cases

**What was the impact?**

1. 25% of GP appointments saved through improved care navigation e.g. direct appointment with ARRS staff
2. 23% of duplicated appointments prevented by appropriately allocating face to face appointments

*The detailed case study can be found in the Appendix B*

# 5.2 Delivery of Care: Planned Care

By streamlining and improving our response to the unplanned care needs of patients, **we can better free up capacity to deliver planned care for patients at the right time and place**, with support from a combined range of professionals. We will work to allocate more time for appointments for patients with Long Term Conditions and Complex Care needs, however this can only be achieved by working differently and more closely with our partners. Aligned with the 2024/25 priorities and operational planning guidance from NHS England, we will also work to make **better use of population health management approaches and data** to comprehensively stratify our patients into cohorts based on risk and proactively develop shared care plans based on an in-depth understanding of their complex needs.

| | | |
|---|---|---|
| 4 | **Establish Neighbourhood-level Integrated Care Teams,** collaborating and operating as a singular MDT, to provide holistic, specialist support for people with Long Term Conditions and multimorbidities, and proactive case management for patients with the most complex needs | In Walsall, a model is already in place that revolves around primary community services and their strong integrated relationships with on-site specialists. This model, along with the use of MDTs, has proven effective in managing complex diseases. Building on this success, we aim to **establish and support Neighbourhood-level Integrated Care Teams**. What constitutes as a neighbourhood will be defined in later horizons of the programme, however core to this initiative is joint working between primary and secondary care, including mental health practitioners, social prescribers, first contact physiotherapists and social workers. These teams will provide multidisciplinary wrap-around support for patients that is appropriate for the complexity of their needs, preventing fragmented working and improving continuity of care and collaboration between the professionals responsible for their care. It will also be inclusive of partners such as community services, who provide proactive care. |
| 5 | **Use PHM approaches to collaborate with specialist services and community teams** to facilitate appropriate treatment for patients along the entire continuum of care | Adopting PHM approaches allows for a holistic approach to be taken in improving outcomes for patients with Long Terms Conditions and complex needs. Primary Care providers **can support patients with receiving appropriate interventions and treatment**, that are better aligned with the impacts of social determinants of health. This may involve coordinating care across various healthcare settings, implementing targeted interventions and preventive measures, to achieve improved population health outcomes. |
| 6 | **Optimise local enhanced services in Community Pharmacy** that are focussed on providing support for Long-Term Conditions management (e.g. Diabetes, Cardiovascular disease) | Pharmacy First has been introduced to support with **freeing up capacity** in general practice. With all pharmacists gaining prescribing abilities by 2026, a **wider range of enhanced services** can be **locally commissioned** and planned for. Our involvement interactions have highlighted that community pharmacists may be well suited to provide diabetes reviews, blood pressure checks and vaccinations, but that this would need to be supported by a streamlined and accurate referral process, including regular review and feedback to maximise the benefit. |

**Case study:** Neighbourhood Integration in Leeds (Place Level)

**What was the problem?**

Siloed working leading to:
1. Too many patient referrals (attributable to poor communication between community-based care teams)
2. Duplication of efforts and work
3. Unwarranted variations in care

**What was the solution?**

1. 13 multidisciplinary neighbourhood teams were created
2. Neighbourhood MDTs were co-located into the same building
3. Adopted a case management approach
4. Shared care record used by primary and secondary care
5. Incorporated mental health workers into GP surgeries
6. Single point of referral system

**What was the impact?**

1. Earlier identification of risks and issues
2. Quicker referrals and shorter waiting times
3. Better care for patients with complex needs

*The detailed case study can be found in the Appendix C*

# 5.3 Delivery of Care: Prevention

As part of achieving a sustainable, more resilient Primary Care system we need to drive a greater shift towards **preventative care**. This is especially important considering the prevalence of risk factors that may lead to long-term conditions, such as obesity, and the entrenchment of health inequalities, stemming from high-levels of deprivation. To pre-empt the need for treatment, we will **focus on keeping people in the Black Country healthy**, and preventing further exacerbation of conditions that could lead to complex needs.

To achieve this, we will harness a **data-driven approach** to identify at-risk groups and their health needs so we can better plan to provide patient-centric and proactive care. Moreover, we will act collaboratively with System partners such as Public Health and VCFSE, to **work alongside local communities**, to support with self-management of their own health.

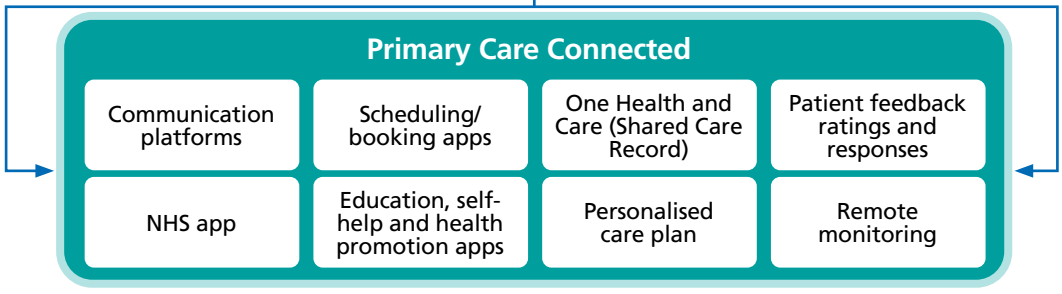
| | | |
|---|---|---|
| 7 | **Establish a Black Country PHM framework** to formalise methodologies and processes around risk stratification, data collation and analysis to gather insights on at-risk population groups and local health needs | A **formalised PHM framework**, developed alongside Public Health and VCFSE, will build on our initial analysis from Core20PLUS5, exploring a broader range of health focus areas to support insights being more aligned to the specific needs of the Black Country local population. To develop this framework, considerations will be given to: (1) **identifying population data sources**, especially regarding socioeconomic data, (2) **preferred risk-stratification methodology** (e.g. Charlson's comorbidity index, Johns Hopkins etc.), and (3) allocating responsibilities within teams, including the BI unit, **Digital Unit and Public Health**, to drive data collection and analysis. |
| 8 | **Co-design and launch targeted health promotion initiatives with Public Health and VCFSE** using community activation to help local people become more knowledgeable and committed to leading healthier lives | As part of our 'joined-up' **approach to early intervention**, we will collaborate with other community partners in Primary Care, including Public Health and VCFSE, to engage with the community and empower individuals to take more responsibility over their own health. Colleagues have shared many opportunities for improvement, such as reducing vaccination DNA rates. Our partners understand the local need and know the communities who are at higher-risk of illnesses and moreover, under served by healthcare providers. **Targeted health promotion initiatives** co-designed with our partners and the community, will support improved outcomes. |

# 5.4 Delivery of Care: Primary Care Connected

Primary Care Connected is aligned with **Black Country ICB's Digital Strategy** (2023-26) to improve accessibility of care for patients and to support the workforce to deliver efficient and appropriate care. Communication between General Practice staff and Community Pharmacists has been highlighted as a critical area of improvement, with a need to establish **digital feedback loops** and access to booking appointments online, and work is currently underway with national teams to improve on this.

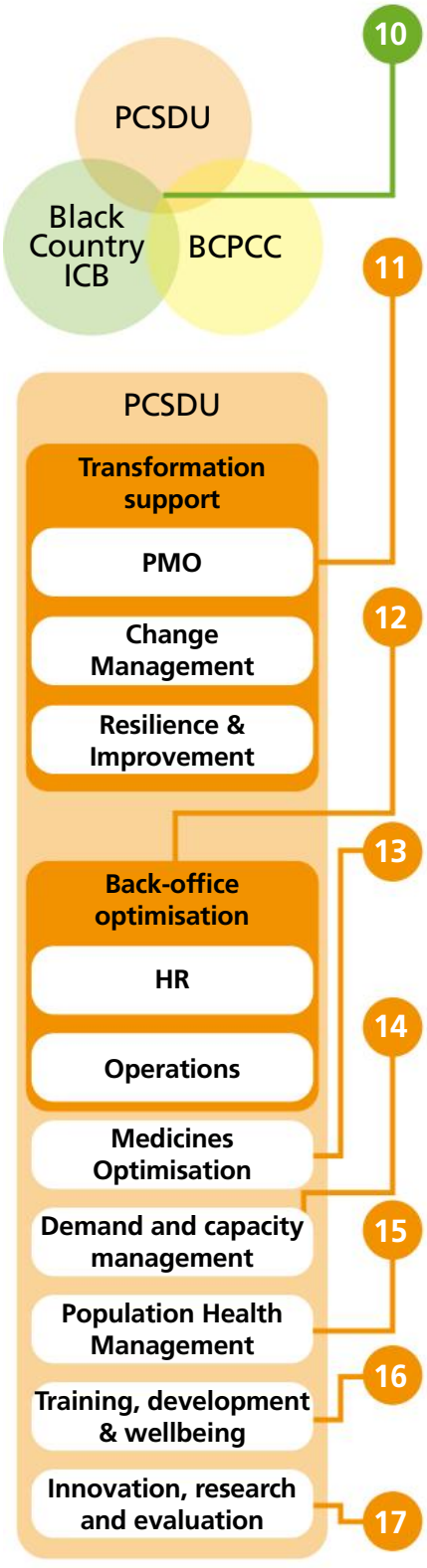
As part of Primary Care Connected, we will provide a technology toolkit to increase the knowledge of staff on the digital solutions available to improve communication and enhance care. This will deliver a range of benefits, including improved **accessibility** to Primary Care services for patients; better support for Primary Care staff in **managing demand** more efficiently; and promoting better treatment across the **continuum of care**. We will also continue to inform and support patients in using the emerging access routes through Black Country Connected, using digital to provide patients with greater choice on how to access care in a way that best suits them.

8 **Provide a 'Primary Care Connected' toolkit**, which shows the range of applications available to support the digital delivery of care and how they can be used to enhance service provision



# 5.5 Primary Care Support and Development Unit

**We will be exploring the establishment of a Primary Care Support and Development Unit (PCSDU) as the delivery vehicle that supports the BCPCC to drive strategic transformational change at System and Place** and embed new ways of working into business as usual alongside everyday operations. It will support and offer capabilities to help better foster a culture of innovation within Black Country, including creating capacity, reducing bureaucracy and providing process support. The initiatives outlined below reflect the feedback received from the workforce throughout the first phase of work about what is need to support change on the ground. The initial functions are set to be hosted by the ICB, however this could change as the unit evolves and initiatives are refined in future horizons.




10 **Develop a Black Country standard** to align incentives, improve quality and encourage ways of working that support the future state. This 'standard' will be jointly developed and build on lessons from the development of the Dudley 'Long Term Conditions Framework' and further recommendations following it's evaluation. It is proposed that the PCSDU support the adoption of the new standard by providing the training, support and required templates for providers.

11 **Establish a transformation support team** that will be responsible for delivering FPC programme activities alongside the BCPCC. It will be made up of three core capabilities that will evolve and mature alongside the programme:

- PMO team will work hand in hand with other relevant PMO teams to align priorities across Primary Care, and with the Communications & involvement team to strengthen awareness and contributions to the programme.
- Change Management team will work closely with CDRG members and other change champions across the System to collectively build buy-in and support.
- Resilience and Improvement team will provide dedicated support to practices undergoing significant challenges and in need of additional support to respond to pressures.

12 **Optimise back office functionality**, by reducing the admin burden on individual practices and create capacity by centralising admin intensive processes across HR and Operations organised by Place. We have heard repeatedly through our interactions that admin intensive processes such as pre-onboarding checks for staff and fit notes are where frustrations lie and efficiencies in the System can be realised. The specific processes that will be centralised will be further identified and prioritised in future horizons.

13 **Reshape Medicines Optimisation at Place** to reduce unwarranted variation in prescribing support and access to policy-based effective treatments - encouraging GPs, pharmacists and other healthcare professionals to prescribe the most appropriate, cost-effective, safe medicines, and enable patient choice.

14 **Enhance visibility of demand and capacity** at scale to enable practices and PCNs to make informed decisions on how best to organise themselves for patients and staff. The PCSDU team may act as an intermediary between the ICB data and analytics team, supporting them to use demand and capacity visualisation tools, and to identity and address failure demand, where possible.

15 **Develop the Black Country population health management framework** and use PHM techniques to support Primary Care providers to risk-stratify their population and identify cohorts for targeted intervention to embed a prevention focus in the way people are cared for in the Black Country.

16 **Transition the training hub into the PCSDU** to align training, education, workforce planning, well-being, recruitment and retention support, assist with change management functions and build on current efforts to provide digital upskilling opportunities, alongside the Digital First team.

17 **Establish an innovation, research and evaluation team** with the capability to design, develop and evaluate pilot programmes and studies, working in partnership with providers and academia.

# 5.6 Enablers: Workforce and Talent

Having a **vibrant, effective workforce** across all parts of Primary Care is critical to achieving our priorities. Our interactions have emphasised that our workforce within the Black Country are keen for a **structured and supportive working environment**, that better meet the changing profile and preferences of the expanded workforce. It is clear this should include **better support and supervision for ARRS staff**, and **clearer development opportunities** and structured **leadership training** programmes to keep staff engaged, promote team working and enable high quality management processes across all those providing care for patients. We also know that a lack of harmonised terms and conditions can make it challenging for practices to attract staff who seek out better pay and terms and conditions.

We understand that some staff roles may be **unclear about the skills and responsibilities of other roles** within the System, therefore they are not effectively supporting demand management and creating unnecessary workload. Additionally, through our involvement interactions we heard that although training is generally available and of high quality, particularly for clinical staff, it **does not consistently focus on enhancing working as an integrated system**. This then limits the opportunity for different staff roles to network and break down organisational silos.

The initiatives outlined below are not new concepts and some of these are already being considered in other system strategies. For example, the need for leadership training has already been outlined in the System Organisational Development (OD) strategy.

## Workforce & Talent

| | |
|---|---|
| 18 Create **greater awareness of the different roles and responsibilities** within Primary Care through provision of materials and sessions | We heard that frustrations of system working and feeling undervalued could be enhanced by a **better understanding of the skill sets, roles and responsibilities** that individuals have. This is often at the primary/secondary care interface and need for better understanding and support for ARRS roles and pharmacy referrals. In partnership with the Training Hub, we will work to provide materials and sessions, such as '**a day in the life of**', to **enhance understanding, improve ways of working** and **increase a sense of parity** amongst staff both within and beyond Primary Care. |
| 19 Provide **leadership and transformation training programmes** for staff across leadership, management, clinical and non-clinical care delivery to enhance staff capability in driving transformation initiatives | We need to develop **practical leadership programmes** that create **clear progression opportunities** for the primary care workforce. We also need to provide our current leaders with training to support their role in transformational programmes; and **encourage multidisciplinary ways of working** that align with the transition to the FOM. |
| 20 Establish a **skills matrix** to assess and understand the training and upskilling needs of staff | To appropriately upskill our workforce we need to **outline what capabilities our current workforce has**, what it is missing and what is duplicative. For example, we heard through our People Panels that our staff need to improve their understanding of how to cater for patients with autism or sensory impairments. We then need to **identify the capabilities our future workforce will need** so that we can **maximise the skills** that some of our workforce have and upskill others in a targeted and complimentary way. |
| 21 Create a **Workforce Development Plan** to understand **future demand, skill and capability requirements** | We will develop a **Workforce Development Plan (WDP)**, aligned to our EDI strategy and the NHS Long Term Workforce Plan to outline how we can equip our workforce with the skills and capabilities that will sustainably support our FOM. It will detail **how we plan to recruit, retain and develop our workforce**, and how the System can better support this. For example, through increasing the standardisation of career development opportunities or support (via the PCSDU) in pre-onboarding process to lower the admin burden on practices. |

# 5.6 Enablers: Digital, Data & Analytics and Estates

**To enable the uptake of Primary Care Connected, staff will need to feel confident and proficient with using current, and adapting to new, technologies** to understand how digital can be integrated within care pathways. This will in turn empower staff to encourage patients to use the tools available to them too, alongside the Digital Inequalities programme which is working to enhance patient proficiency and confidence. One Health and Care - our shared care record - has a significant opportunity to improve sharing of critical patient data to improve continuity of care. We also need to develop a clear strategy for how the Shared Care Record will be used uniformly within Primary Care to have the desired effect, and we recognise strategic planning, and bringing our colleagues on this journey, will be critical to realising it's full potential.

**We recognise the impact that poor estates conditions** and space availability are having on the ability to deliver care and we will use an agile approach alongside System partners to continue to address these challenges. We have also heard consistently that **poor interoperability between systems** is reducing the quality of care clinicians can deliver and is creating unnecessary low value repetitive tasks, such as scanning hospital letters, which directly reduce both the capacity and morale of staff. We recognise the need to fix the basics and, as part of this, the need to continue to work with secondary care to redesign pathways and workflows to reduce operational inefficiencies. The initiatives below are not exhaustive of the current work in motion, but outline some key steps that can be taken.

## Workforce & Talent

| | | |
|---|---|---|
| 22 | Implement **comprehensive digital upskilling programmes** for our workforce | Digital upskilling programmes, which will be developed alongside the training hub where suitable, will be aimed at **enhancing staff proficiency** and **confidence** in using **digital care delivery tools** within **Primary Care Connected** effectively. |
| 23 | **Optimise existing digital processes** and systems to enhance operational efficiencies. Through this exercise, **identify capability gaps** and define future requirements. | We know we have **untapped potential** in digital assets within our system, so we need to first work to understand what systems are **already available, review processes** and **optimise solutions** wherever possible. For example, digital technologies such as cloud telephony have been recently implemented, but workflows have not been updated to realise their full potential. Through this exercise we can identify what may not be fit for purpose, and can then **pinpoint capabilities gaps and future requirements**, alongside acting on the outcome of the Digital Maturity Assessment. |
| 24 | Establish a systematic approach to refine and increase usage of the **One Health and Care** in Primary Care | One Health and Care presents a significant opportunity for us to **improve patient handoffs** which have been frequently referenced as a burden throughout involvement, particularly between primary and secondary care. The **ICB digital team** will work with system partners to identify a **systematic approach** that will support the **realisation of these efficiencies**. |

## Data & Analytics

| | | |
|---|---|---|
| 24 | Explore establishing a **Universal Data Sharing Agreement** to support research, capacity and demand analysis and population health management | We heard through interactions at Place events that **demand and capacity data manipulation** and **visualisation tools** would support the system to **better meet patient need**. Current data sharing arrangements reduce our ability to harness the capabilities of our Business Intelligence as they spend significant time completing discrete data agreements. We need to better understand the **barriers around data sharing** and explore how we can **reduce bureaucracy** to allow the capabilities within our system to be more effectively used, whilst making sure there is appropriate security. |

## Infrastructure - Estates

| | | |
|---|---|---|
| 24 | Work with wider System partners to **utilise and maximise existing estates** | Each Place within the Black Country has different quality and quantity related Estates challenges. We will work with wider System partners, such as Local Authorities, to **improve estate availability** through **maximising existing estates**. This will be tailored to the different needs of each Place. |

# 5.6 Enablers

## Commissioning

**To deliver the future Delivery of Care model, we need to align our commissioning frameworks**. The development of a consistent Black Country local incentive framework for general practice with a focus on the three pillars of planned, unplanned and preventative care will act as a key enabler in delivering the future operating model.

The **harmonised framework** will take account of the tools, policies, processes and resources deployed by our Modern General Practice exemplar sites with a view to **developing the right mix of incentives** to drive rollout and contribute to the establishment of the standardised access model. Our framework is an integral transformation lever within this 5 year programme to elicit the required behaviours across practices and PCNs to deliver our vision of equitable access to high-quality healthcare for all. It will act as the key incentive tool to encourage the implementation of the FOM across primary care and start to address the balance of spend across the three pillars of planned, unplanned and preventative care in the future.

This work will commence in 2024/25, aiming to have a standardised incentive framework commencing April 2025.

### High level Financial overview:

For 2023/24 the total Primary Care spend was £367.6m, and 12% of the total budget. This includes £19m investment on local frameworks and enhanced services.

| Primary Care Co-Commissioning | £ | % |
|---|---|---|
| National contracts in place (GMS, QOF) | 201,032,897 | 54.7 |
| Primary Care frameworks | 19,281,372 | 5.2 |
| Other and Local Commissioned Services | 1,334,387 | 0.4 |
| Premises | 19,568,476 | 5.3 |
| POD (Community Pharmacy, Dentistry and Optometry | 126,424,027 | 34.4 |
| Total | 367,641,159 | 100% |

### Future Commissioning Framework development:

We will develop a future commissioning framework which set outs the targeted elements of unplanned, planned and preventive care and outcomes that are common across the whole Black Country System, specific to each Place or specific to each neighbourhood/PCN footprint. This will enable Primary Care providers to work with the ICB to transition this ambitious outline transformation strategy to business as usual and make sure we that we strike the right balance across the three pillars above.

| | Unplanned | Planned | Preventative |
|---|---|---|---|
| System | | | |
| Place | | | |
| Neighbourhood /PCN | | | |

## Communications & Involvement

**We understand that to successfully implement the future operating model, it requires collaboration at every level and transparent conversations**. This is why communications and involvement with the public, staff and our partners is a golden thread through all the initiatives in the strategy.

### Patients and the Public

We have a co-produced, tried and tested approach to working with people and communities. In line with our principles, we will create a **comprehensive, inclusive communications and involvement plan** to make sure the public is involved in the further development of the initiatives. We will also continue to be in spaces where we can listen and understand where improvements can be made throughout the transformation programme. Each initiative in the delivery of care model will require its own tailored communications and involvement approach.

As part of this, we will provide **clear, accessible information at every stage of the process and offer communities the education they need to access services or help themselves**. For example, efforts are already underway to explain the seven conditions that are part of Pharmacy First, and where they can access support in the Black Country. The support provided will need to be appropriate for the diverse local communities we serve.

### Primary Care Staff and Partners

In parallel to engaging with patients and the public, we will work with our Place-Based Partnerships to develop a communications and involvement plan for further perspectives to be shared by primary care staff and Partners, and especially General Practice and Community Pharmacy Staff who have not yet been reached. As detail around initiatives is formed using their insights, we will support staff and Partners to understand what the future delivery of care model means for them, the potential benefits and support them with the implementation of the initiatives.

# 5.7 You Said, We Included - listening to what our patients and public need

The purpose of this page is to outline how insights from patients and the public at People Panels and the involvement report* have guided and informed our strategic decisions. **By actively listening to the community's concerns and opinions** (more fully detailed in section 3.2, Exhibit 3), **we have gained a clear understanding of the challenges people are facing** and developed initiatives to address these head-on. In Sections 5.1-5.6 we have detailed these initiatives, and in this section, we highlight those that have been directly influenced by the needs and desires of the public and this will continue to be an ongoing conversation.

Want to prebook non-urgent appointments in advance rather than do it on the day at 8am

You need to tackle the 8am calls to get an appointment

Time spent in an appointment is short and not long enough to explain symptoms. Doctors only focus on what is urgent, not the bigger picture

I want a named GP to build trust and not have to repeat our story!

GPs need more than 10 minutes per patient

Older people cannot book appointments online or use apps to book due to eyesight

People with dementia are going to A&E if they can't get hold of their GP

Who is checking on quality for patients?

Practices who do good work should share what they do with other practices

**We have heard that patients often face frustration when trying to access appointments and may be redirected between their GP, A&E, 111 and out-of-hours services due to limited availability.**

- ✓ Our proposed initiatives such as the **'active signposting' protocol** will guide staff in directing patients to appropriate services within the community, and the **Local Care Hubs** would provide streamlined access to handle same-day, lower complexity patient needs.
- ✓ These initiatives aim to **enhance patients' experience in accessing appropriate care and appointments when they need**. The goal is to make the process easier and quicker by seeing the right healthcare professional that is best suited to address their specific needs.
- ✓ Patients will still be able to request to see their professional of choice.

**Continuity of care and having more time with healthcare professionals when a patient has more complex needs is something that we have heard is extremely important.**

- ✓ Our initiatives include **establishing Neighbourhood-level Integrated Care Teams and Multidisciplinary Teams (MDTs)**, using proactive case management and the **One Health and Care shared care record**, all of which are designed to **reduce the need for patients to repeat their story**.
- ✓ We understand that patients with complex needs are most in need of longer appointments to provide comprehensive care. Our initiative to **pilot Local Care Hubs** in neighbourhoods for patients with lower complexity needs will **reduce demand on GPs** and **create greater flexibility** in their day for longer appointments for those that need it most.

**Feedback from our People Panels and involvement meetings* highlighted the challenges faced by older people and individuals with autism or sensory impairments, in accessing primary care and their concerns about the NHS becoming more digital.**

- ✓ Issues such as digital literacy, language barriers, and mental or physical impairments hinder patient ability to book appointments and use the NHS app. Also, people report staff members are often not equipped with the skills to cater to the specific needs of these patients. **Establishing a skills matrix** to assess and understand the training and upskilling requirements of our staff will help identify any knowledge gaps they may have, allowing us to **provide appropriate upskilling to better serve these patient groups**.
- ✓ The **'Primary Care Connected' toolkit** aims to **improve digital accessibility** by raising awareness and usage of the digital tools available to support delivery of care. This builds on the work of the Black Country Connected programme that is supporting patients with the skills and confidence to use digital solutions.
- ✓ Non-digital routes to access care will remain available to the public, and an assessment will be completed to review the impact of increasing digital routes.

**The public's perception of varying quality among different practices highlights the need to improve standards and best practice sharing in primary care.**

- ✓ We aim to **develop a Black Country Standard** whereby Practices across all the four Places will agree to improve access, quality, long term condition management and reduce health inequalities. This will be supported by a local incentive framework which will encourage alignment with the standard.
- ✓ The **PCSDU**, will include **training, development, research, capacity and demand management support** - all of which will encourage the sharing of best practice and experience between Primary Care providers.

*The insights are based on the following involvement practices: Microgrants (Dec 2023 - Jan 2024), Community Conversations (Jan - Aug 2023), People Panels (Jan-Feb 2023).

# 5.8 You Said, We Included - listening to what our staff and providers need

## You Said

Primary care providers in the Black Country **frustrated with the increasing demand for their services**. While GPs find great satisfaction in providing continuity of care and managing complex medical issues, they are now often **working beyond their contracts and putting in discretionary efforts**.

*General practice cannot do it all - acute, LTC care and visits. It is an impossible situation*

Community pharmacies are feeling stretched and frustrated by the number of referrals they are receiving from GPs. Moreover, they feel the **majority of these referrals are inappropriate**, so **pharmacists must redirect the patients** back to general practice. This is primarily due to a **lack of collaboration and communication** between teams.

*Of 10 GP referrals to pharmacies, only 4 patients are passing the gateway criteria*

Primary Care providers in the Black Country are united in their belief that **everyone in Primary Care should be focused on prevention and population health management** - focusing on keeping people healthy and **addressing the root causes of health problems** to avoid unnecessary costs and long-term consequences.

*We need a stronger focus on prevention so we can reduce demand on Primary Care*

Primary Care providers feel there is **significant disparity** existing between **leadership/management** roles and the Primary Care clinical workforce. Further, Primary care clinicians often feel that their colleagues in secondary care lack understanding of their roles and responsibilities. Those in ARRS roles also feel there is a lack of understanding of how their expertise can best address patients' needs.

*The ICB should spend a day in general practice per month*

GPs feel there is a **significant administrative burden**, with a high **demand for reducing the time spent on administrative tasks** among general practice and pharmacies. This challenge is prevalent across all four Places in the Black Country. Furthermore, inefficient processes often lead to **duplication of work**, further exacerbating the burden on clinicians.

*I wish I could see 50 patients and there is no admin*

## We Included

**6 Local enhanced services in Community Pharmacy**

We will **optimise local enhanced services in Community Pharmacy** to provide **support for Long Term Conditions management**. This will help relieve demand for GPs.

**1 Access blueprint**

**2 Local care hubs**

Scaling up an access blueprint which will improve the **rate of effective referrals**, while local care hubs will facilitate **effective communication between teams**.

**7 PHM approaches**

We will develop and establish the **Black Country PHM framework** and use PHM techniques to **support Primary Care providers to risk-stratify their population** and identify cohorts for targeted interventions.

**18 Awareness of different roles and responsibilities**

We will provide materials and sessions to enhance understanding and recognition of different roles and responsibilities within Primary Care.

**12 Back office optimisation**

**23 Optimise existing digital systems and processes**

We will improve digital processes and systems, embrace innovative technologies and optimise back-office functions to **speed up and reduce duplications in administrative workload**.

# 5.9 The difference transforming Primary Care will make in five years

We have set out below the difference transforming Primary Care will make for the **public, our staff, NHS partners** and the **wider system**, and **we will also be developing clear measures of success – as part of our outcomes framework**. As we develop a harmonised primary care financial framework and progress wider work in Horizon 1, we will start the development work for success metrics. This will also be informed by the national work that the ICB is feeding into which is co-chaired by the NHSE's Medical Director for Primary Care.

## For the public

- Improved access to Primary Care
- Greater choice and options to personalise care
- Improved continuity of care for those who need it most
- Care provided in the right place, by the right person, at the right time, enabled by triage
- Greater ability to take ownership of care
- Those with complex needs are better managed and monitored
- Improved quality of life by being proactively supported within the community
- Better experience moving between points of care, only having to tell their story once
- Simplified messaging and better understanding of how to access care
- Increased trust in the System
- Better remote monitoring support to allow people to remain as independent as possible within their own homes

## For our staff

- Improved wellbeing
- Greater satisfaction and productivity through clearer career structures and progression opportunities
- Being recognised for the care we deliver and feeling valued
- Reduced bureaucracy creating opportunities to locally improve care and innovate
- Supportive estates and digital technologies to enhance working practice
- Feeling supported to take on opportunities for personal development and improvement
- More fulfilling tasks at work through fewer non-value adding tasks
- A safe and healthy environment with work flexibility
- Increased parity of esteem across workforce roles
- Equipped with skills to make the best use of resources

## For NHS partners

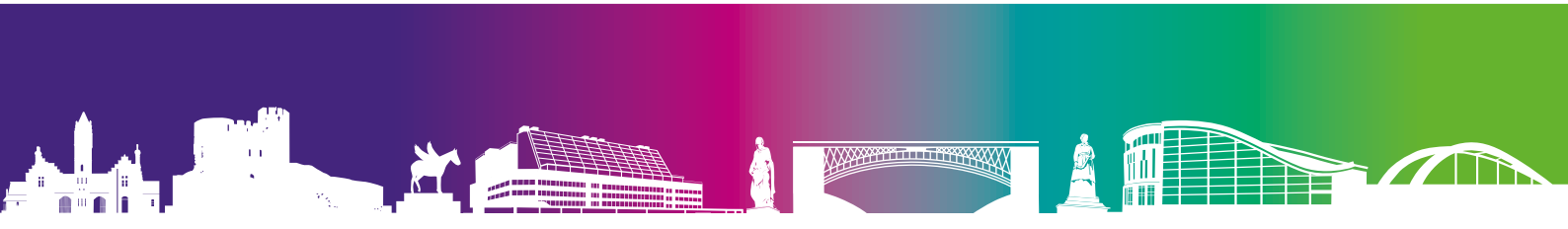
- Greater potential for redistribution of funding across the System to support care closer to home
- Financial stability
- Improved working with System partners, with a greater appreciation for different roles and improved data sharing
- Care closer to communities
- Integrated care, with greater capacity to provide sustainable resilient services
- Reduced bottlenecks in the System through improved demand management with the standardised access model
- Productive, motivated and supported workforce
- Greater access to research and innovation through the PCSDU
- A sustainable and greener NHS

## For the wider system

- Reduction in health inequalities for our population with a collaborative approach to addressing wider determinants of health alongside Public Health
- Cohesive approach to quality improvement and prevention
- Reduction in unwarranted variation of care, through more standardised ways of working
- Support for closer working between Primary Care and the voluntary, social and community sector
- Healthier people, healthier communities
- Engaged, upskilled and growing workforce, fit for the future
- Sustainable services designed to meet future need

# The Journey Ahead

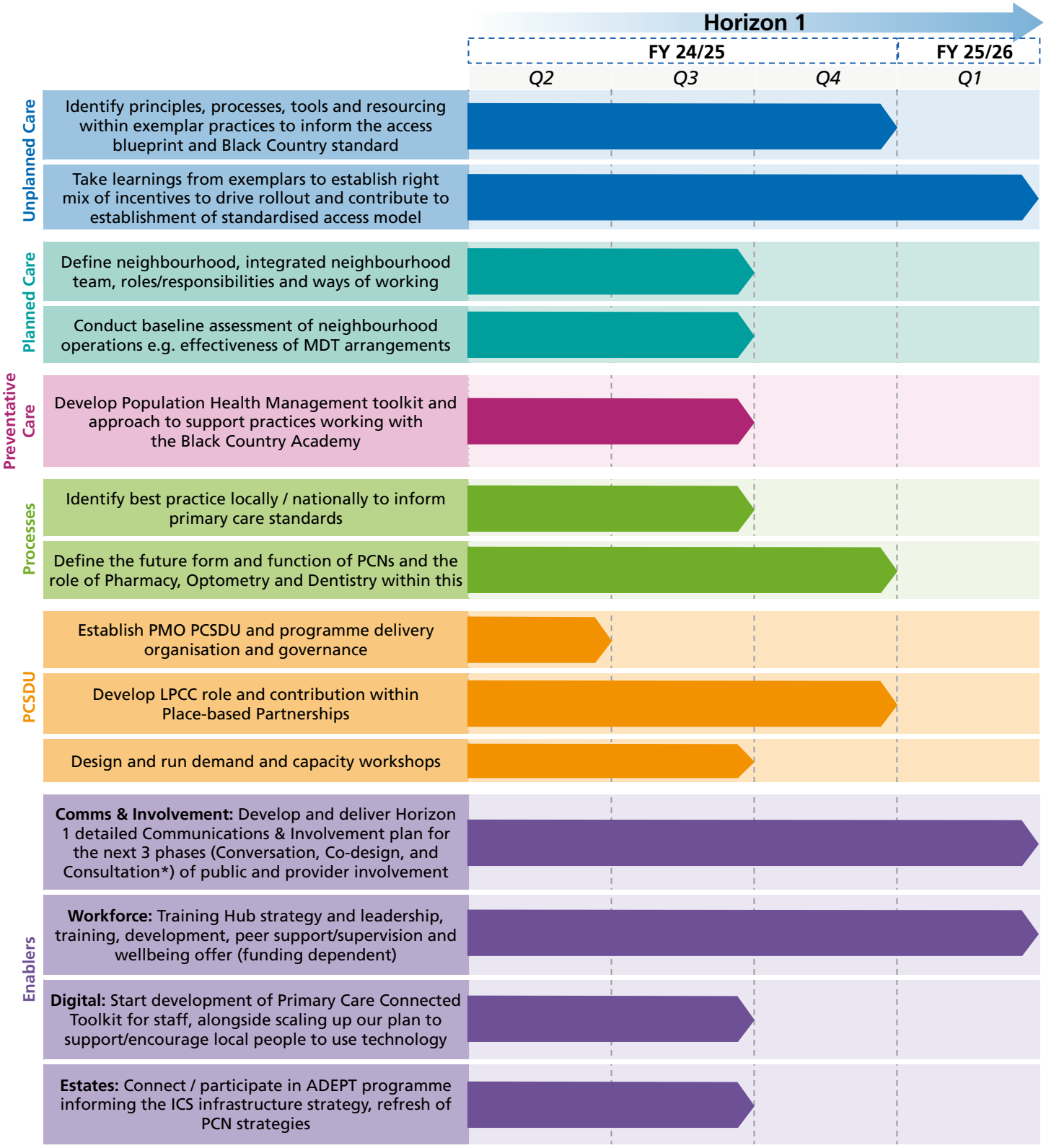
# 06



# 6.1 Our plan for the next 12 months

**We have identified a number of immediate priority activities that are critical to driving Horizon 1 of the transformation over the next 12 months**. These activities align with the various core initiatives of the future operating model and will need to be completed before further progress can be made. Taking this into account, we have also developed work-plans which highlight when core initiatives are estimated to be completed over the next 5 years (see Appendix D-F).

The start times are dependent on the approval of the pre-consultation business case that supports the continued programme management of the Future Primary Care programme and activities will occur in parallel with a detailed co-design/development phase involving consultation with the public and patients, Primary Care clinicians/ PCNs, and Place partners and stakeholders.




*Indicative timelines for the future phases are as follows: Conversation – July/Aug '24; Co-Design – Jan/Feb 25'; Consultation – to be confirmed

# 6.2 Next steps

**This outline transformation strategy is a starting point, providing a vision for what good Primary Care will look like in the Black Country in five years**, and highlighting key elements of the journey ahead as we organise ourselves differently to provide better care for our patients and support our local communities to be healthier.

As we move forward into the future horizons of the Future Primary Care programme, and towards testing and implementing this strategy, we need to work as one team with our colleagues at Place to map the finer details of how the delivery of care model will be translated in Places and Neighbourhoods. This will help determine how to best meet the needs of our populations in a way that reduces unwarranted variation and promotes sustainability. Also, over time, as we have identified we will need to consider our commissioning framework to support the delivery of how we want Primary Care services to change and our financial investment.

We have heard how important it is to act on opportunities for improvement, whether large or small, and as part of this work, we have identified a few wider change activities that will improve our ways of working and can be implemented more quickly (for some examples, see Figure 4). We will review these activities and aim to introduce them early in Horizon 1 of the programme alongside the priority activities.

## Wider change activities

| | | | |
|---|---|---|---|
| Implement **CQC compliance** support programme<br><br>***Why?*** To improve Practice readiness | Create campaigns focussed on **understanding of different roles** that exist within Primary Care<br><br>***Why?*** To increase public awareness and effective use of services | Re-establish Place-based **Protected Learning Time** annual programme<br><br>***Why?*** To improve knowledge sharing | Provide support to implement **regular structured check-ins** with staff members, within- and across- providers<br><br>***Why?*** To promote understanding and morale |

**Figure 4:** Shortlist of activities identified during interactions with stakeholders across Primary Care

We also need to understand how our transformation efforts fit into the bigger picture within the System, as ongoing programmes such as our ICB Financial Recovery Plan and Organisational Development strategy, continue to evolve.. There are critical interdependencies that will become clearer in time, and we must make sure our plans integrate well with wider System initiatives. In addition, we need to be aware of potential risks as we align with these programmes, taking proactive steps to address them and keep our strategy on track.

This outline transformation strategy reflects the input and commitment of stakeholders across our four Places and System. To make our bold ambitions a reality, we need everyone to take joint ownership of the next steps, and collaborate openly, sharing our learnings and successes along the way.

Lastly, and most importantly, we will continue to involve patients, the public and communities, with a focus on seeking the views and experiences of those from health inclusion groups and under-served communities. This includes co-developing our plans, exchanging ideas in a two-way process, so that informed feedback can be provided to further shape initiatives to meet the local people's needs.

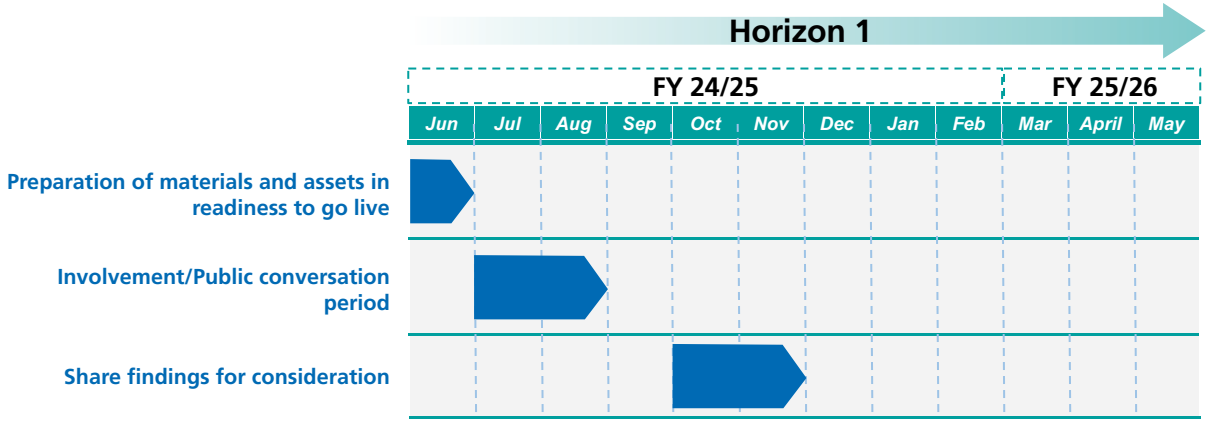



**Figure 5:** Next steps for patient involvement

Working alongside everyone, living and working in the Black Country, will support us to ultimately achieve our vision for Primary Care and provide ***equitable access to high-quality health and care for all, building resilient communities with improved health outcomes.***

# References and Appendix

# 07

# References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NHS (2024) *Local NHS team win top award.*

NHS Black Country ICB (2023) *NHS Staff Survey Benchmark report 2023.*

NHS Confederation (2023) *Creating better health value.*

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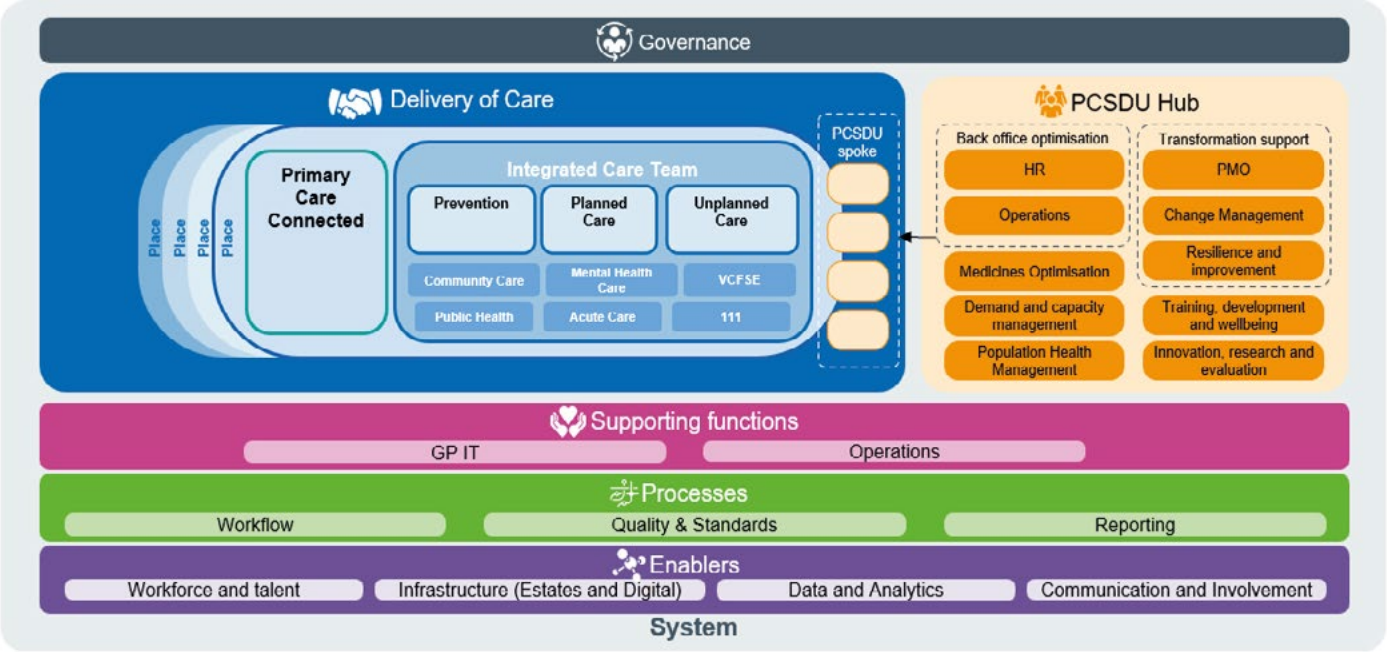
# Appendix A - Future Operating Model Overview

The proposed Future Operating Model reflects at a high-level how we will organise ourselves to achieve the vision of the Future Primary Care programme, indicating some of the functions and capabilities that are required. It includes **six interconnected layers**, with support provided by the ICB for Practices and Pharmacies at Place. Moving towards this future state, will require further involvement with colleagues, System partners, patients and the public to develop the next layer of detail, to make sure we provide support and services that meets the needs of all.




| Description of each layer | |
|---|---|
| **Governance** | Highlights where oversight and responsibility lies |
| **Delivery of Care** | Reflects what Primary Care support and services will be provided in the future, where they will be provided and who will be involved |
| **Primary Care Support & Development Unit** | Describes the functions and capabilities of integrated support for Primary Care providers |
| **Supporting Functions** | Core functions of the ICB Primary Care team including back-office business functions |
| **Processes** | Cross cutting activities that connect delivery of care with the PCSDU |
| **Enablers** | Cross cutting requirements within key areas (e.g. Workforce, Estates, Digital, Data, Communication and Involvement) to implement changes in ways of working |

# Appendix B - Case Study*: Implementing Modern General Practice at Eve Hill Medical Practice

## Background

Eve Hill Medical Practice in Dudley has approximately 8,600 patients. They have a deprivation score of 32.4, a higher age demography of mid-to-late female patients, with 75% of patients who are White British, and 11% Asian patients. They have a higher than national prevalence of hypertension, diabetes, asthma, COPD, depression, CKD and mental health.

### Challenges

Eve Hill Medical Practice were working under a total triage model where all patients were offered a GP triage appointment which the GP would try to manage over the phone at first instance if they could not be booked in for a face to face appointment. Their capacity was still not able to keep up with demand under this model, and patients were poorly navigated for their care. The practice undertook a GP survey which suggested a high level of avoidable appointments attributable to:

1. Poor care navigation leading to unnecessary GP appointments where patients need care by another professional
2. Inappropriate appointment type (face to face vs telephone) being allocated to patients leading to unnecessary appointments

### Solutions

The whole practice team looked at the data and worked together to create solutions and a new way of working.

- A shift to **65% face to face and 35% telephone appointments was created**, and patients are now able to book directly with other care providers without having to go through a GP first.
- **EMIS template** that has guidance on acceptance criteria and referral methods, including **AccuRx templates** to support this and trained all staff on usage.
- Scripts were created that admin staff could use to describe other professionals/services to make sure that **front of house staff are able to signpost effectively**.
- Staffed with an on-call doctor that manages non-patient workload and is able to **support and provide triage if all appointments are full on the day** and cannot be care navigated.
- **Continuity of care slots with regular GPs**, in order to create continuity for complex cases. A robust follow-up procedure is also in place.
- **Consultations booked with a GP are audited to make certain they are appropriate**, and consultations with other staff are also audited to assess re-attendance rate.

### Impact

- **Patients are able to request assistance via all means**, telephone, online and in person, but all requests are managed by the same procedure.
- **25% of GP appointments saved through improved care navigation:**
  - 20% are now seen by Physician Associate or Paramedic
  - 3% are now seen by first contact physiotherapist
  - 2% are now referred to pharmacy first
  - 1% are now referred to other services
- **23% of duplicated appointments prevented by appropriately allocating face to face appointments**

# Appendix C - Case Study*: Neighbourhood-level integrated care in Leeds

## Background

Leeds has a growing population with areas of high deprivation. 20% of the population is among the most deprived nationally. There is an increase in people with long-term conditions and early-onset illnesses. Leeds also has high rates of childhood obesity and 12% of households are in poverty.

### Challenges

Healthcare organisations across Leeds (e.g. local authority, Council, NHS community, mental health and acute providers as well as local universities, charity and third sector organisations) aimed to actively involve and engage staff and local people from the beginning of the process through regular engagement sessions. They encountered several challenges that impacted healthcare providers across the region:

- **Fragmented services** and lack of communication between teams.
- **Too many referrals** and confusion about which teams to pass referrals to.
- **Lack of multi-disciplinary working** and underutilization of skills and expertise.
- **Inefficient ways of working** and duplication of effort.
- **Poorer quality care** and unwarranted variations in care.
- **Disjointed services** and repetition of health history for service users.

### Solutions

- **New health and wellbeing strategy principles** were adopted with a renewed focus on joint working, needs of population, and wider determinants of health.
- Creation of **13 multidisciplinary neighbourhood teams** - each comprising of a core team, leadership representatives, additional services and admin support.
- **Co-location of neighbourhood MDTs in the same building**.
- Implementation of a **case management approach**.
- Use of shared care record (**Leeds Care Record**) across primary and secondary care.
- **Incorporation of mental health workers** into GP surgeries
- Establishment of a **single point of referral system**, led by a senior clinician in neighbourhood teams.

### Impact

- Co-location of teams has **improved professional relationships** and understanding of different disciplines
- **Better sharing of information** and earlier identification of potential risks and issues
- Joint approach benefits client groups with complex needs
- **Positive feedback from staff** and opportunities for professional development
- **Single point of referral system** led by a senior clinician for quicker triage of referrals
- Collaborative working and case discussions lead to **quicker referral process** and **shorter waiting times**

# Appendix D - Delivery of Care: high-level work-plan

**The majority of envisioned changes to Delivery of Care will come into fruition by Horizon 3**. Horizon 1 will focus on demand focussed initiatives to relieve pressures on the Unplanned Care workforce, such as scaling up a standardised triage blueprint and creating an 'active signposting protocol'. During Horizon 2, we will set up the foundations for delivering patient-care through local care hubs, community pharmacy, and the 'Primary Care Connected' toolkit. Finally, in Horizon 3, we will establish neighbourhood-level integrated care teams and collaborate with specialists and community organisations so that we are delivering appropriate patient-care.

| Delivery of Care | | | |
|---|---|---|---|
| Work Program **To be delivered by:** | Horizon 1 | Horizon 2 | Horizon 3 |
| **1. Access Blueprint** Scale-up a standardised access blueprint with implementation support for all Practices | ✓ | | |
| **2. Local Care Hubs** Establish Local Care Hubs to manage unplanned (i.e. same-day), lower complexity patient needs | | ✓ | |
| **3. Active Signposting** Create an 'active signposting' protocol to support staff to navigate patients towards services including Pharmacy First, Social Prescribing and others in the community, where appropriate | ✓ | | |
| **4. Neighbourhood-level Integrated Care Teams** Establish Neighbourhood-level Integrated Care Teams, collaborating and operating as a singular MDT, to provide holistic, specialist support for people with Long Term Conditions and multimorbidities, and proactive case management for patients with the most complex needs | | ✓ | |
| **5. PHM collaboration with specialists** Use PHM approaches to collaborate with specialist services and community teams to facilitate appropriate treatment for patients along the entire continuum of care | | | ✓ |
| **6. Local enhanced services in Community Pharmacy** Optimise local enhanced services in Community Pharmacy that are focussed on providing support for Long-Term Conditions management (e.g. Diabetes, Cardiovascular disease) | | ✓ | |
| **7. PHM framework** Establish a Black Country PHM framework to formalise methodologies and processes around risk stratification, data collation and analysis to gather insights on at-risk population groups and local health needs | ✓ | | |
| **8. Health promotion initiatives** Co-design and launch targeted health promotion initiatives with Public Health and VCFSE using community activation to help local people become more knowledgeable and committed to leading healthier lives | | | ✓ |
| **9. 'Primary Care Connected'** Provide a 'Primary Care Connected' toolkit, which shows the range of applications available to support the digital delivery of care and how they can be used to enhance service provision | | ✓ | |

# Appendix E - PCSDU & Processes: high-level work-plan

**By Horizon 2, the majority of internal functions within PCSDU and quality assurance processes will be established**. Horizon 1 will focus on setting up transformation support within the PCSDU to drive the transformation journey. By Horizon 2, the majority of change initiatives will be completed - this includes integrating the training hub and an innovation, research an evaluation team into PCSDU, developing a PHM framework, and a Black Country standard for Primary Care services. Finally, in Horizon 3, the back office team will have been optimised with tools and processes embedded to support practices to visualise their demand and capacity.

| Processes | | | |
|---|---|---|---|
| Work Program **To be delivered by:** | Horizon 1 | Horizon 2 | Horizon 3 |
| **10. Black Country Standard**<br>Develop a Black Country standard building on lessons from the development of DQOF or the 'Long Term Conditions Framework' | | ✓ | |

| PCSDU | | | |
|---|---|---|---|
| Work Program **To be delivered by:** | Horizon 1 | Horizon 2 | Horizon 3 |
| **11. Transformation support**<br>Scale-up a standardised access blueprint with implementation support for all Practices | ✓ | | |
| **2. Local Care Hubs**<br>Establish a transformation support team, focused on providing PMO, change management, resilience and improvement capabilities, and responsible for delivering FPC programme activities alongside the BCPCC | | | ✓ |
| **13. Medicines Optimisation**<br>Reshape Medicines Optimisation at Place to reduce unwarranted variation in prescribing support and access to policy-based effective treatments - encouraging GPs, pharmacists and other healthcare professionals to prescribe the most appropriate, cost-effective, safe medicines, and enable patient choice | | | ✓ |
| **14. Capacity & Demand visualisation**<br>Enhance visibility of capacity and demand at scale to enable practices to make informed decisions on how best to organise themselves for patients and staff | | ✓ | |
| **15. PHM Framework**<br>Develop the Black Country PHM framework and use population health management techniques to support Primary Care providers to risk-stratify their population and identify cohorts for targeted interventions | ✓ | | |
| **16. PCSDU training hub**<br>Transition the training hub to be hosted by the PCSDU rather than the ICB to support with workforce planning, recruitment and retention, align training and support with change management functions | ✓ | | |
| **17. Innovation, research and evaluation team**<br>Create an innovation, research and evaluation team with the capability to design, develop and evaluate pilot programmes and studies, working in partnership with providers and academia | | ✓ | |

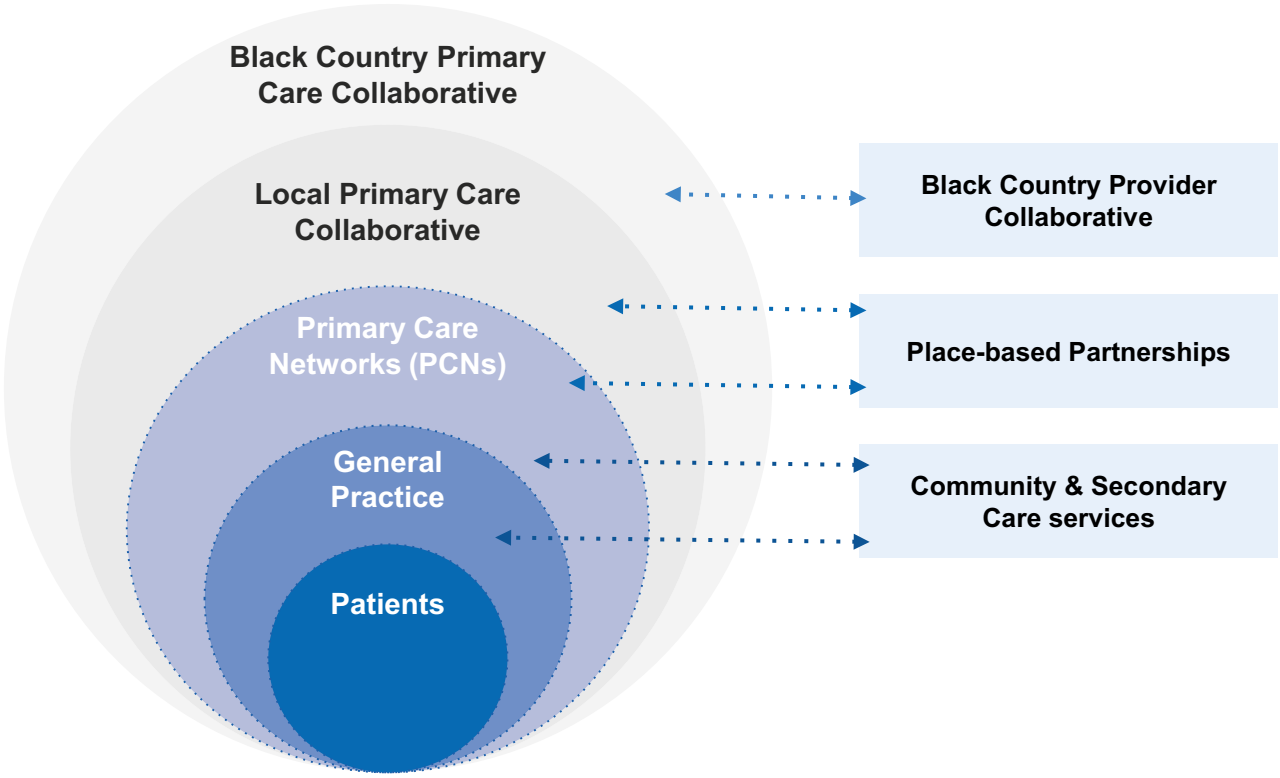
# Appendix F - Enablers: high-level work-plan

**The majority of enablers will need to be established by Horizon 1, so that other interdependent initiatives can undergo development**. In Horizon 1, we will gain insights into the skills our workforce requires to be able to adapt to and support Primary Care Transformation, and also support staff in understanding the different changes across the organisation. We will also provide clarity and instructions to providers on how to best utilise shared care records. Finally, we will establish a data-sharing agreement to minimise information-risks around PHM approaches and Demand & Capacity visualisation. Horizon 2 will focus on aligning and upskilling the workforce around the transformation. Finally, in Horizon 3, we will seek to identify and resolve inefficiencies within internal digital processes and systems, to alleviate administrative workload for practices and support staff in delivering appropriate care for patients.

| Delivery of Care | | | |
|---|---|---|---|
| Work Program **To be delivered by:** | Horizon 1 | Horizon 2 | Horizon 3 |
| **18. Awareness of different roles and responsibilities** Create greater awareness of the different roles and responsibilities within Primary Care through provision of materials and sessions e.g. 'a day in the life of', to enhance understanding and improve ways of working amongst staff | ✓ | | |
| **19. Leadership & transformation training** Provide leadership and transformation training programmes for staff across leadership, management, clinical and non-clinical care delivery to enhance staff capability in driving transformation initiatives | ✓ | | |
| **20. Skills Matrix** Establish a skills matrix to assess and understand the training and upskilling needs of staff | ✓ | | |
| **21. Workforce development plan** Develop a Workforce Development Plan to understand future demand, skill and capability requirements | ✓ | | |
| **22. Upskilling programmes** Implement comprehensive upskilling programmes alongside the training hub, aimed at bolstering staff proficiency and confidence in using digital care delivery tools effectively e.g. within Primary Care Connected | ✓ | | |
| **23. Optimise existing digital processes and systems** Optimise existing digital processes and systems to enhance operational efficiencies. Through this exercise, identify capability gaps and define future requirements | | | ✓ |
| **24. Shared Care Record** Establish a systematic approach to refine and increase usage of the Shared Care Record in Primary Care | ✓ | | |
| **25. Data-sharing agreement** Establish a Universal Data Sharing Agreement to support research, capacity and demand analysis and population health management | ✓ | | |
| **26. Maximise existing estates** Work with wider System partners, such as local authorities, to utilise and maximise existing estates | ✓ | | |

# Appendix F - Enablers: high-level work-plan

**The Black Country Primary Care Collaborative (BCPCC)** was established in July 2022 and provides representation for **all 742 primary care services and providers at System and Place** (including general practice, community pharmacy, optometry and dentistry) to drive forward change as a collective. The BPCC is comprised of representatives from the **four Local Primary Care Collaboratives (LPCCs)**, one for each of Dudley, Wolverhampton, Walsall and Sandwell. These LPCCs, in turn, are comprised primarily of **local neighbourhood PCN Clinical Directors**. This enables two-way lines of **communication, involvement, representation** and **accountability** that flow through Individual Providers, Neighbourhoods, Place and System:




## Purpose and Priorities of the BCPCC:

### 1 Representation

- A unified and collaborative voice for Primary Care providers
- Support policy and decision making within ICB and wider system
- Support workforce wellbeing

### 2 Clinical & Strategic Leadership

- Manage budgets and allocation of funding
- Coordinate strategic planning and transformation throughout System and Place
- Develop Quality processes
- Responsible for strategic input to workforce planning, and research and Innovation

### 3 Communication & Involvement

- Make certain staff and patients are kept involved and informed.
- Integrating and linking with BCPCC, LPCCs, PCNs, local committees, practices and providers

### 4 Primary Care Support

- Support delivery of Primary Care services and make sure providers benefit from new technologies and other innovations.
- Centralisation of functions and digitisation

### 5 Provision of Services

- Explore options for the future provision of services across the Black Country system benefit patients, providers and the wider system.