Primary Care Strategy 2022

Dudley Integrated Health and Care NHS Trust

Contents

Executive Summary

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Joint Medical Director

Dudley Integrated Health and Care NHS Trust is an organisation created by Primary Care to focus on improving population health, and to support the development and sustainability of Primary Care as the first point of contact and principle point of continuing care for the population.

DIHC is entirely focussed on improving Primary Care and integrated out of hospital services as a means of supporting patients and communities to stay well and healthy, support those with ill health in their communities wherever possible; and enable secondary care and specialist services to maintain access and focus for those who need them most.

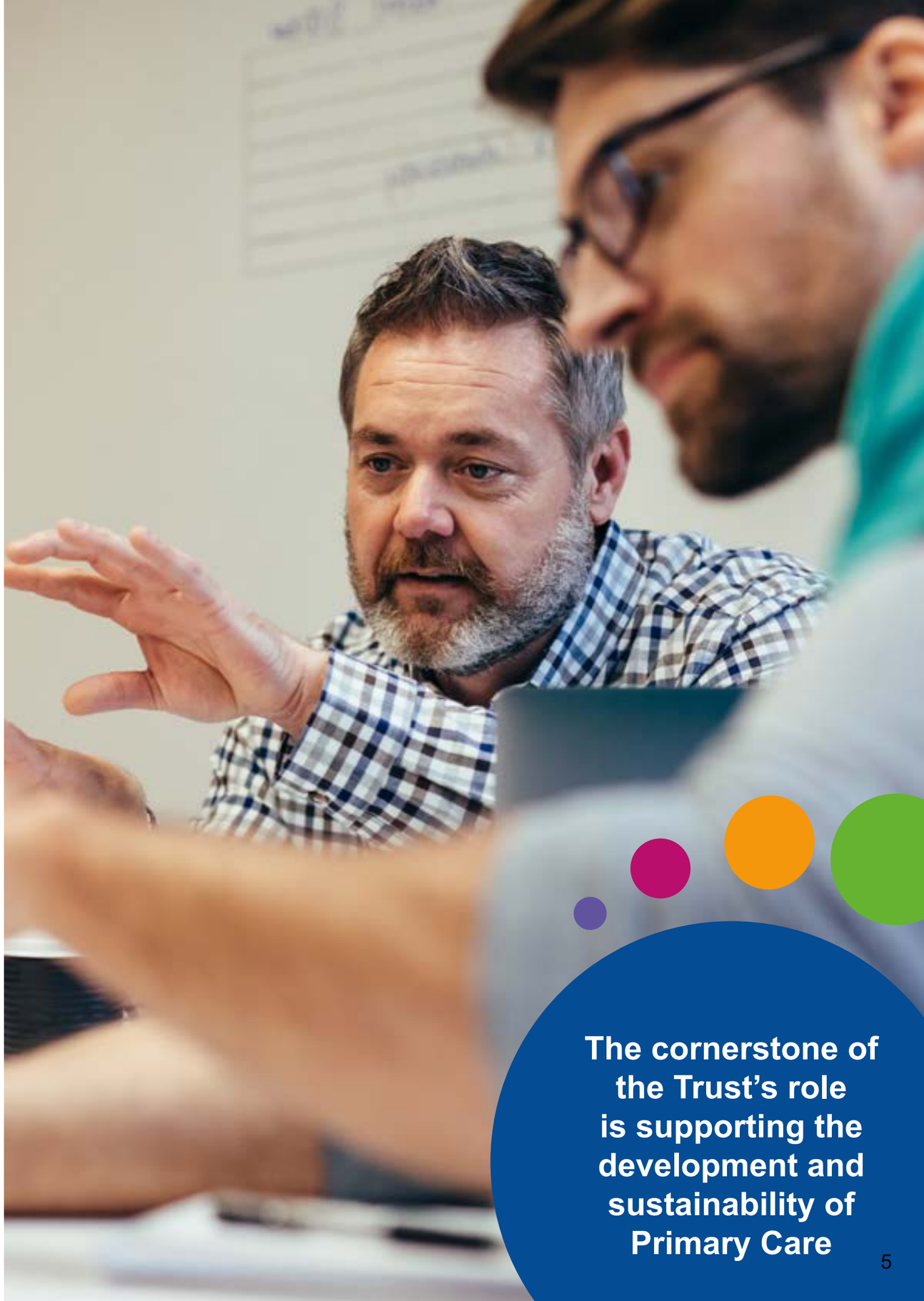
The cornerstone of the Trust's role is supporting the development and sustainability of Primary Care both within Dudley, and across the Black Country ICS.

In developing this Primary Care Strategy, the Trust has been working with its key partners:

- In Dudley - to develop the future strategy for Primary Care delivery as a key component of the Dudley integrated model of care, together with proposals for how DIHC can further support Primary Care practices and PCNs achieve their goals and,
- Across the Black Country - with Primary Care Network Clinical Directors (PCN CDs) and Primary Care Collaborative members in response to a request from them to explore and determine the potential role for DIHC in supporting the development and sustainability of Primary Care across the Black Country ICS.

As the only NHS Trust in the Black Country entirely focussed on out of hospital services, the ambition for its future role set out in this Strategy is:

- In Dudley, to ensure people are cared for within their communities and proceed to hospital only, when necessary, based on integrated teams, organised around sustainable modern Primary Care, achieved with the Trust's support
- Across the Black Country, to support the success of the clinically led Black Country Primary Care Collaborative to discharge the full range of its purposes and functions including expressing the single Primary Care voice in the Integrated Care System (ICS), shaping the Primary Care and



The cornerstone of the Trust's role is supporting the development and sustainability of Primary Care

Responsive to the specific needs of the population, focussed on prevention, self-care and shared health outcomes

supporting out of hospital strategies and plans, and implementing agreed plans. The Trust would adapt accordingly to provide the governance and managerial support to the Collaborative.

The Strategy highlights:

- The achievements of the Trust and Primary Care in Dudley, together building trusted enduring relationships, and delivering service sustainability and improvements to patients and communities
- Proposals for the further development of Primary Care in Dudley addressing the challenges of access, workforce and estates whilst embracing the opportunities afforded by national policy, including the Fuller recommendations.
- Our vision to support and enable general practice and PCNs to offer a sustainable model of Primary Care that is multi-disciplinary and responsive to the specific needs of the population, focussed on prevention, self-care and shared health outcomes.
- The approach to implement an operating model that achieves consistently high standards of access, quality and health outcomes as measured by the Dudley Quality Outcomes for Health Framework (DQOFH); that optimises the totality of the workforce, supported by appropriate estate and facilities, and enables the service development and sustainability of Primary Care,
- Proposals, co-produced with Primary Care in Dudley, for a range of support offers to practices and PCNs which DIHC can provide in support of Primary Care, taken up based on practice and PCN wishes
- An outline proposal, co-produced in response to interest expressed from Primary Care across the Black Country, for DIHC to partner with the clinically led Black Country Primary Care Collaborative. The Trust, as partner, would provide the governance, managerial and administrative support to the Black Country Primary Care Collaborative. It is proposed to work collaboratively to explore and develop these proposals further.
- A proposal that the support offers developed with and in support of Dudley practices should be made available, on request, to those Black Country Practices who would find such support of value; and to respond constructively to further requests for support from Black Country practices.
- Our approach to programme and resource management to take forward this Strategy, based on agreed priorities and available resources, within annual programmes of support.

This strategy describes the work undertaken so far with regards to the development of Primary Care in Dudley, and the plans to both further develop Primary Care in Dudley and the support that can be offered to wider Primary Care across the Black Country.

Introduction and Purpose of the Strategy

DIHC is an NHS Trust created at the request of general practice in Dudley to support Primary Care sustainability and development.

Our principal role is to support Primary Care to play its full role locally, and in the wider system, to support population health improvement and health and care services delivery and improvement, supporting Primary Care in addressing local challenges and meeting local needs within a national and ICB policy context.

The Black Country Integrated Care System (ICS) has delegated its functions in developing and supporting Primary Care in Dudley to DIHC.

This strategy has been developed with the engagement of Primary Care in Dudley and demonstrates their support, confidence, and ownership.

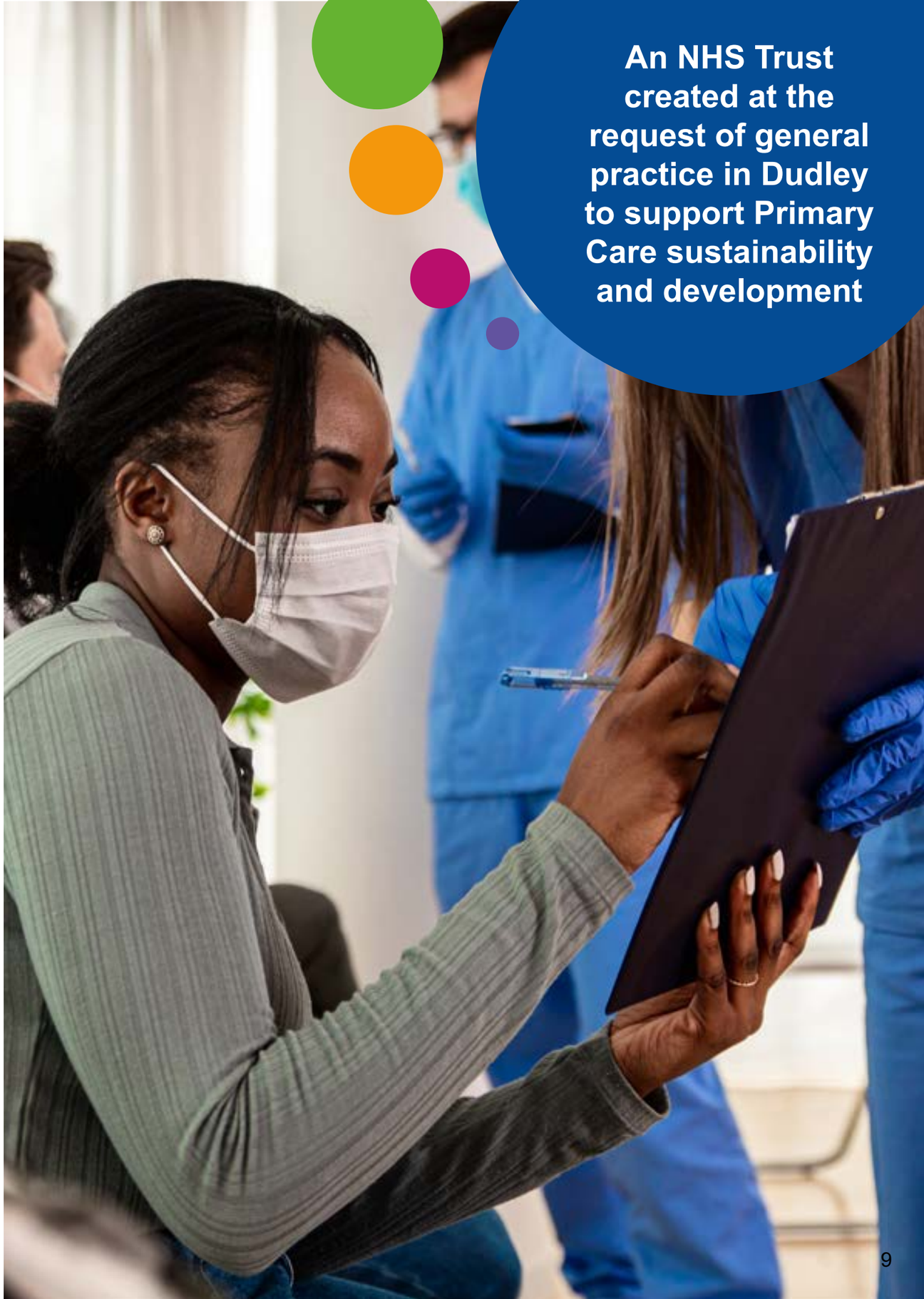
There has also been effective engagement with Primary Care leaders from across the Black Country in shaping our proposed role across the ICS.

Primary Care involvement in DIHC is strong; with extensive Primary Care participation in the Trust's governance structures (including the Trust Board and Primary Care Integration Committee), a formal Integration Agreement between practices and the Trust, and formal agreements for provision of support services to Primary Care Networks (PCNs).

There is strong and effective engagement with Primary Care through multiple engagement channels and together this means that Primary Care has a strong and influential voice in shaping how DIHC supports Primary Care and how they hold the Trust to account for this.

This strategy describes

- An overview of Dudley as a place and within the Black Country: its geography, demographics, characteristics and overall health and care services indicators and priorities; together with an overview of general practice and PCNs.
- The "Dudley approach and model" to Primary Care and system sustainability and development; including our role in the system and success to date.
- Proposals for the further development of Primary Care in Dudley addressing the challenges of access, workforce and estates whilst embracing the opportunities afforded by national policy, including the Fuller recommendations.
- Our vision to support and enable general practice and PCNs to offer a sustainable model of Primary Care that is multi-disciplinary and responsive to the specific needs of the population, focussed on prevention, self-care and shared health outcomes.
- The approach to implement an operating model that achieves consistently high standards of access, quality and health outcomes as measured by the Dudley Quality



After being in existence since 2020, Primary Care in Dudley now wants DIHC to go further

Outcomes for Health Framework (DQOFH); that optimises the totality of the workforce, supported by appropriate estate and facilities, and enables the service development and sustainability of Primary Care.

- The future role of DIHC in supporting Primary Care and the offers of support that we intend to develop and implement within Dudley.
- The future role of DIHC in supporting Primary Care across the Black Country.
- Our approach to programme and resource management and to collaboration with ICS partners in delivering this strategy.

GP leadership and involvement / The Journey to create DIHC

Prior to the formation of PCNs, practices in Dudley were organised into locality groups along a similar geographical distribution. In 2017, GPs in Dudley elected a GP from each locality group to form a GP collaborative steering group with a remit to represent the views of general practice in the development of a new organisation which has now become DIHC. The GP collaborative was deliberately not a federation or GP provider organisation at the request of the local GPs.

The view of Dudley general practice was they wanted a collaborative approach that focussed on the integration of primary and community-based services, within a single NHS Trust focussed solely on the delivery of out-of-hospital care and improving the sustainability of Primary Care. They made commitments to lead and develop the way in which general practice would integrate with the Trust.

The GP collaborative steering group was responsible for leading on the engagement with general practice, negotiating the details of the Primary Care Integration Agreement between Dudley General Practices and DIHC, and representing the views of general practice in the development of DIHC as an NHS Trust. The PCN Clinical Directors Group have over time taken over the role previously held by the GP collaborative steering group.

The outcome is that over the course of the last five years, general practice has been involved in developing the first of its kind in the country; a new NHS Trust in the form of DIHC and has shaped the way in which DIHC and general practice(s) work with one another to create a sustainable model of Primary Care in Dudley.

The strength of GP leadership in the creation, and now governance, of the Trust is that practices and PCNs feel a sense of ownership, trust and buy-in to an NHS Trust that collaborates with them. General Practices in Dudley understand and have been part of a long journey in creating and developing the organisation that understands and supports Primary Care.

After being in existence since 2020, Primary Care in Dudley now wants DIHC to go further in the way that DIHC supports and enables them to deliver sustainable, high quality, integrated services. They have actively contributed and engaged in the development of this strategy because it is a natural evolution of joint thinking in the way that DIHC operates as a Trust in support of Primary Care.

Our Strategic Vision for Primary Care

Access

To address the challenges of access, workforce and estates whilst embracing the opportunities afforded by best practice and national policy, including the Fuller recommendations.

Sustainability

To support and enable general practice and PCNs to offer a sustainable model of primary care that is the first point of contact and principle point of continuing care for the population

Population Health

To support and enable general practice and PCNs to provide a consistently high level of care, address unwarranted variation, and improve access, quality and population health outcomes as measured through the DQOFH.

Multi-disciplinary

To develop a model of care that is multi-disciplinary and responsive to the specific needs of the population, focussed on prevention, self-care and shared health outcomes and supported by appropriate estate and facilities

Personalisation

To support patients to take a more active role in improving and managing their own health and be better informed about which professional is best able to help them.

Collaboration

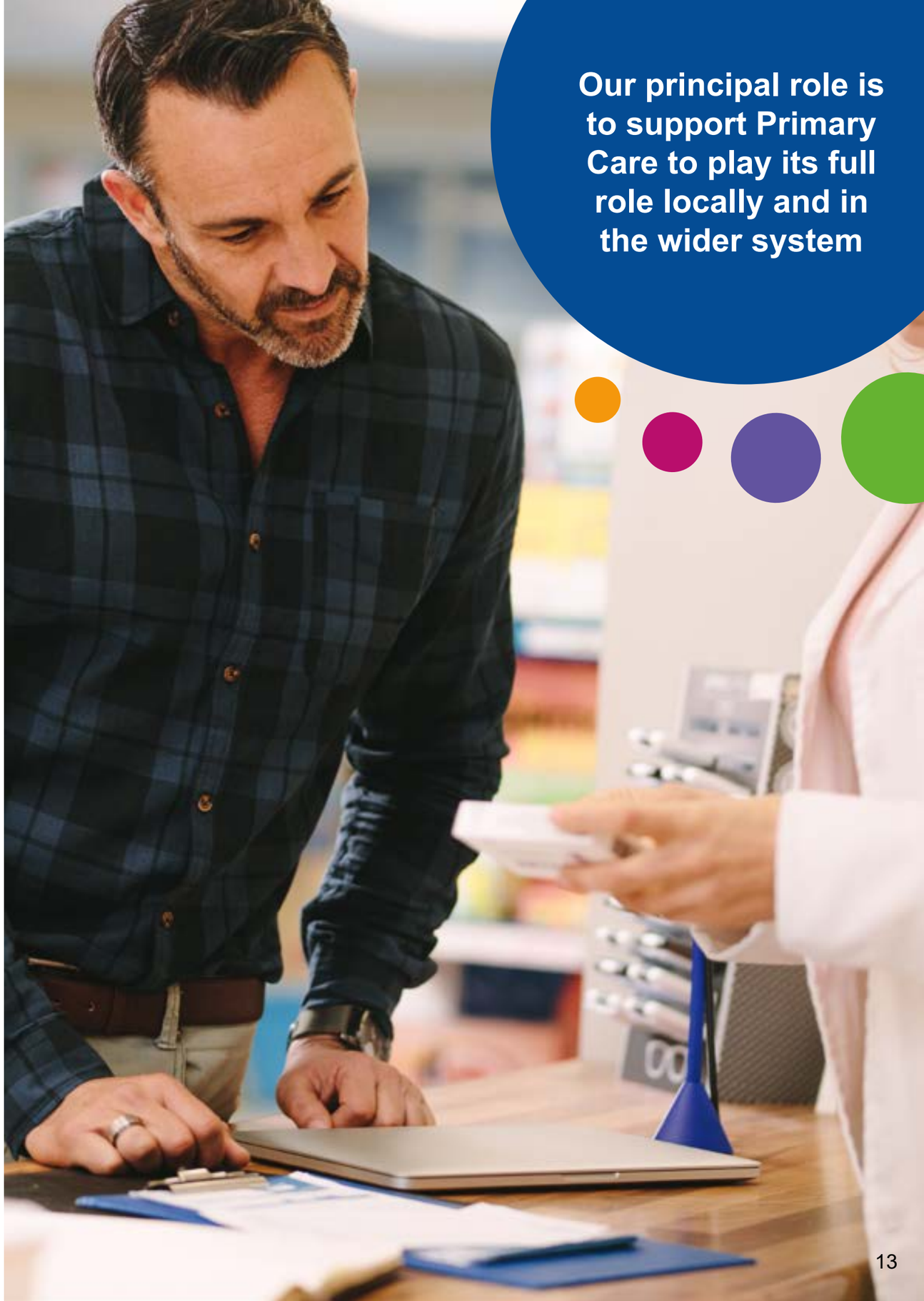
To deliver the national, regional and local requirements in partnership with the ICB and general practice.

Development

To represent and enable primary care to lead the development of the transformation strategy for primary care within the ICB.

Resilience

To provide an organisational model to support the resilience and sustainability of primary care with innovative workforce models and a range of support offers



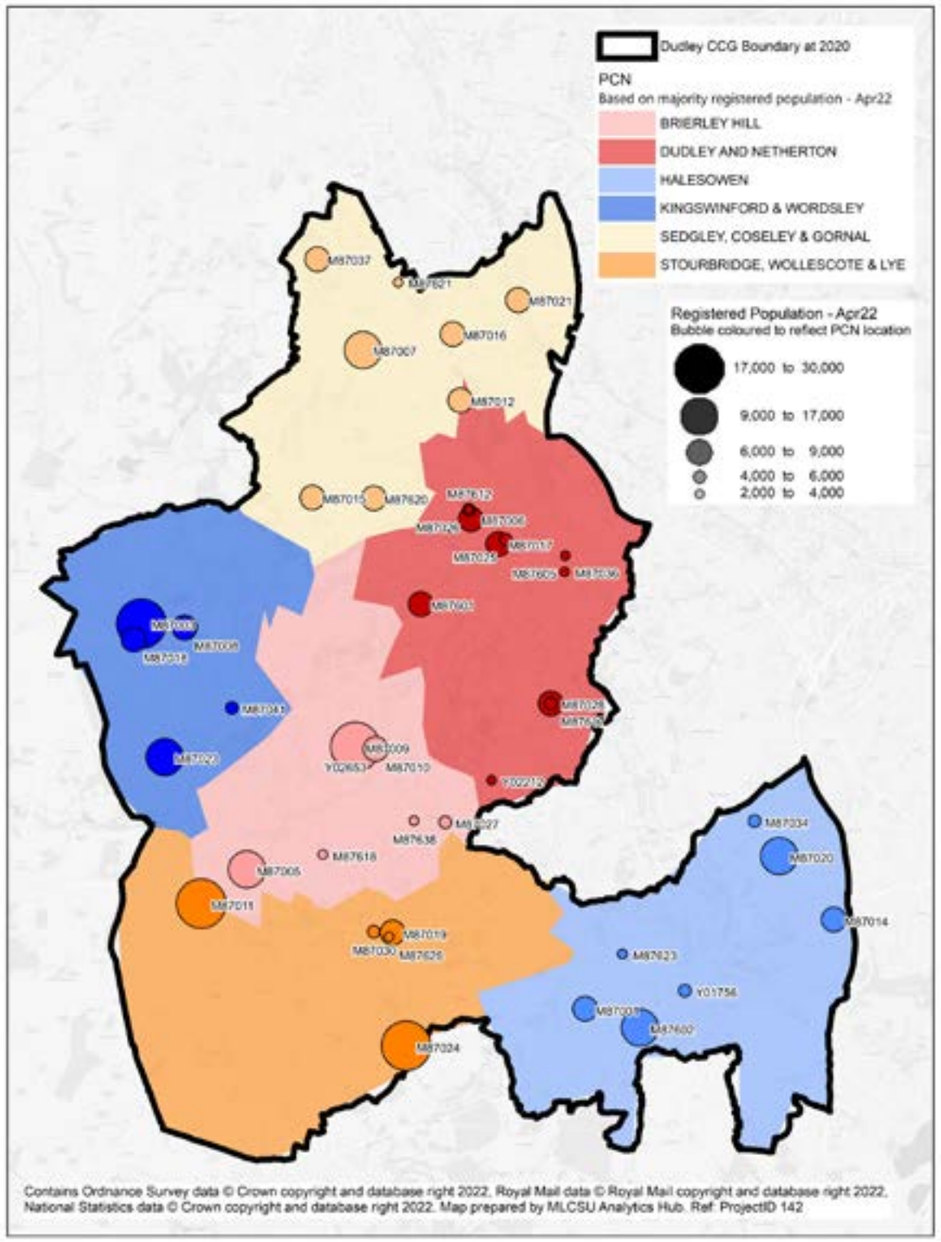
Our principal role is to support Primary Care to play its full role locally and in the wider system

An Overview of Dudley as a Place

Within Dudley there are 43 practices (two of which are directly provided by DIHC) within 6 PCNs serving a population of approximately 331,000 people as set out in map below.

The diagram below sets out the boundaries for each PCN, and the practices within each PCN are denoted by a bubble based on the registered list of the practice.

Visit: www.dihc.nhs.uk/publications/primary-care-strategy to learn more about the appendices



Appendix One: Dudley PCN Profiles

The profiles contained within appendix one set out a map of the PCN area, number of practices, age profile, Care Quality Commission (CQC) status of each practice, life expectancy and access measures from the GP survey 2020-21.

DIHC exits to support the sustainability of Primary Care, and to help and enable the practices and PCNs understand the different needs of their population and their practices and provide a range of offers and support to enable them to meet these needs. Examples of this are described in more detail further into the strategy.

Appendix Two: Black Country Integrated Care System (ICS) Summary

DIHC is part of the Black Country Integrated Care System (ICS). ICSs bring together the organisations responsible for providing health and care across an area, so that they can work in collaboration for the benefit of the system and place population.

The ICS has an Integrated Care Board (ICB) that brings together 13 organisations in planning and providing NHS services. The ICS takes a collaborative approach to agreeing and delivering ambitions for the health of our population across Dudley, Sandwell, Walsall and Wolverhampton.

The summary contained in appendix two sets out some key statistics regarding the population needs across the ICS and challenges with health inequalities and life expectancy.

Appendix Three: Workforce and Workload Challenges

GP practices across the country are experiencing significant and growing strain with declining numbers of GPs and other practice staff and a rising demand in terms of patient numbers, complexity and workload. The combination of workforce and workload pressures have significant effects on patients experience of care, the ability of general practice to deliver sustainable services, and the wellbeing of the Primary Care workforce. The position in Dudley is no different and reflected in appendix 3 are a series of charts and graphs which in summary show that:

- The overall number of GPs has seen little growth since 2015, with the number of GP partners declining by 20% over that time.
- In the year between March 2021 and April 2022, Dudley lost 7 GP partners and 9 salaried and locum GPs. This means that the number of fully qualified GPs by headcount decreased by 16 net in just under a year.
- Each practice has on average 642 more patients than in 2015, with some individual practices experiencing a large shift in registered population
- General practice appointment bookings reached record highs over the winter of 2021 with GPs seeing more patients than ever, which did not drop at the end of the winter period.
- The ratio of F2F (face-to-face) versus remote appointments has shifted with the waves of the pandemic, but the majority of appointments have been delivered in person. Currently, two thirds of appointments are face to face.

The “Dudley Approach and Model” to Primary Care and System Sustainability and Development

We are the first NHS Trust to have integrated with general practice – that is, we have 40 practices with a registered list size of 300,000 patients that have committed and entered into an Integration Agreement to collaborate with us to achieve a set of health improvements for the registered population of Dudley.

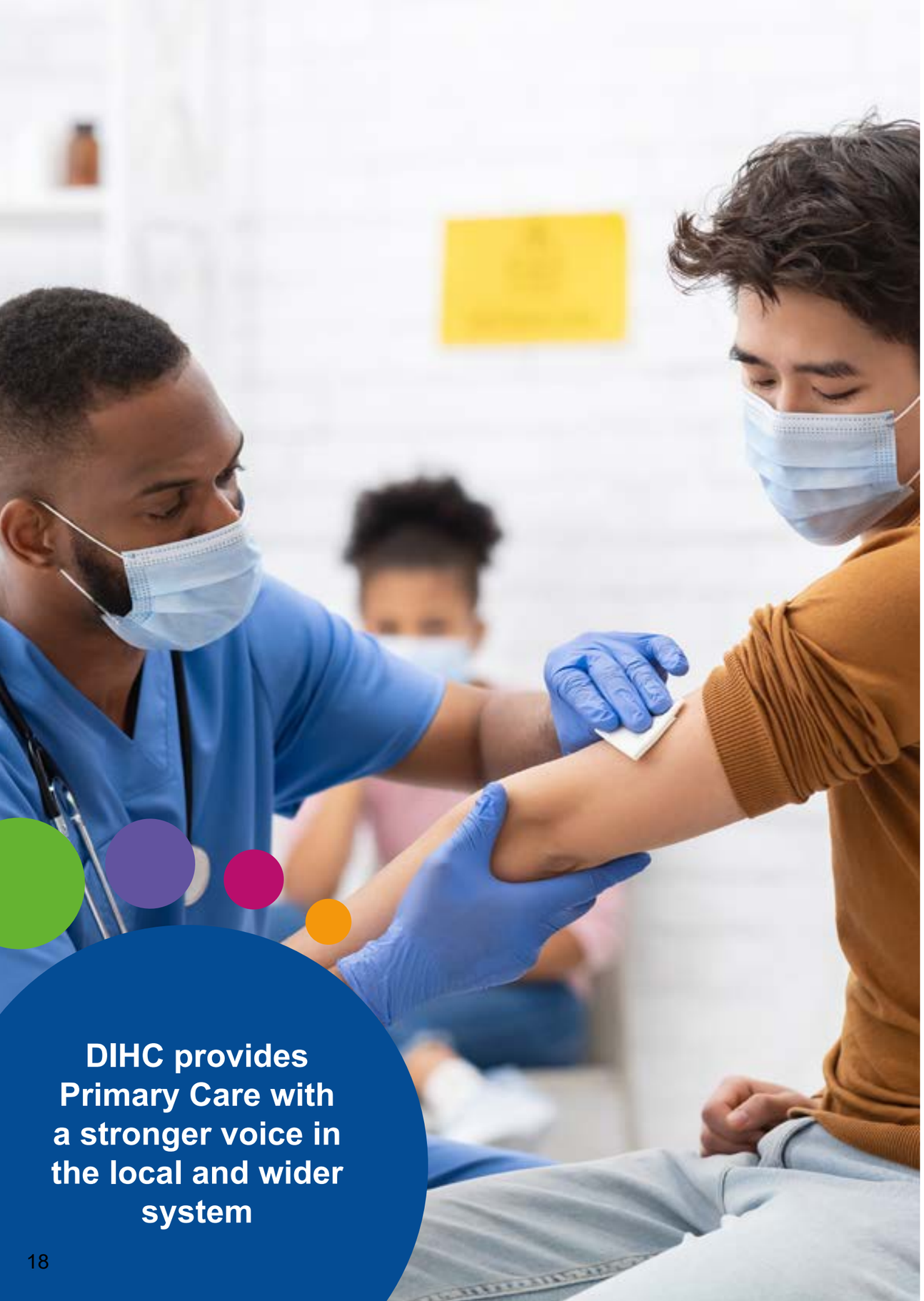
In addition to our role in supporting Primary Care practices and PCNs we also directly deliver a range of community-based services, commission a range of other services on behalf of the ICB; and enable and facilitate collaboration and integration of local services with a range of statutory and voluntary partners.

An organisation established by General Practice, for General Practice

DIHC was established at the request of general practice, to support and enable general practice to deliver a more integrated and sustainable model of Primary Care.

The key components that enabled GP support, confidence and ownership has been achieved through our culture of engagement and understanding of the issues that mattered most to general practice and PCNs and responding to these. For example;

- GP participation in the Trusts Governance structures, including the Trust Board (there are currently 5 GPs on the Trust Board) and the Primary Care Integration Committee (a committee where all 6 PCN Clinical Directors are members)
- Our clinical services and teams are organised in ‘Integrated Community Teams’ (ICTs) around the needs of each of our PCNs, with clinical and operational teams from across the Dudley system working together to look after the most vulnerable in the population. DIHC provide the GP leads to the ICTs who lead and co-ordinate the ICTs.
- A formal agreement (referred to as the Primary Care Integration Agreement) which 40 practices, representing 300,000 registered patients, have voluntarily entered into with DIHC. This agreement sees those practices opting out of the National Quality and Outcomes Framework (QoF) to collaborate with DIHC in delivering a more integrated model of Primary Care that sees a greater focus on care planning, prevention and outcomes delivered by multidisciplinary teams focussed on the needs of the population of Dudley. We are the first and only NHS Trust in the country that has this arrangement in place with general practice.
- An agreement in place at the request of each PCN, with each PCN, that sees them pass on their responsibility and resources for the management of staff and provision of services that can be best organised and delivered at a scale that they would not otherwise



DIHC provides Primary Care with a stronger voice in the local and wider system

be able to achieve. The provision of extended access GP appointments from winter 2021 onwards and the employment and operational management of all additional role reimbursement scheme (ARRS) staff are two examples. This method of employment sees DIHC, on behalf of PCNs, achieve the highest levels of ARRS recruitment and service provision within the ICB.

- The responsibility for the direct provision of primary medical services for the patients of High Oak surgery and Chapel Street surgery. Since assuming responsibility for both services, we can evidence improvement in some clinical outcomes and patient experience, with plans in place to address and improve specific areas of population health need. Both surgeries were in difficulty before being taken on by DIHC, and as well as the improvements made to patient care, this has also prevented further pressure on other local practices, which would have been an inevitable consequence if a disbursement of registered patients had occurred.

These examples illustrate that general practice and PCNs have a strong and influential voice in shaping how DIHC supports Primary Care. It also demonstrates how DIHC can provide the governance of an NHS Trust, and consequently how PCNs and the Trust can mutually hold each other to account. The examples demonstrate how DIHC has responded to practice requirements to the extent that general practice is prepared to commit and trust DIHC to partner with them to deliver improvements in the way that services are provided, organised, developed and supported in the future.

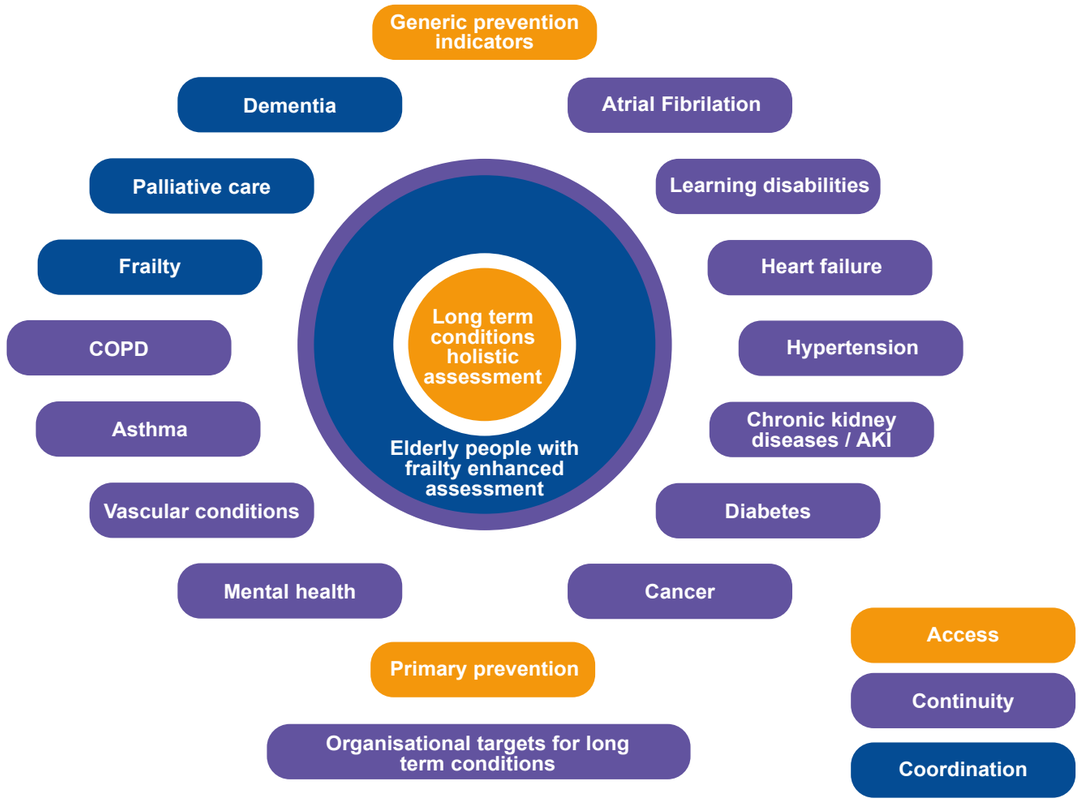
National Recognition

The role of DIHC and its creation as an NHS Trust to support the sustainability of Primary Care is unique. The Dudley approach is recognised in the 'next steps for integrating Primary Care' Fuller stocktake review as an example of good practice. DIHC is an NHS Trust established by local GPs for the purpose of supporting them to develop a more sustainable model of Primary Care and will provide Primary Care with the support required to implement the recommendations of the Fuller stocktake review. This will be undertaken by further developing high quality Primary Care as the bedrock of NHS care, to enable integration of services in the community, to ensure provision of same day access and long-term continuity of care, and to better serve local people and improve their health services and outcomes through integrated neighbourhood teams. DIHC provides Primary Care with the opportunity to develop a wider range of service provision and provides Primary Care with a stronger voice in the local and wider system.

1 Black Country Healthcare NHS Foundation Trust, Black Country Integrated Care Board, Dudley Metropolitan Borough Council, Sandwell Metropolitan Borough Council, Sandwell and West Birmingham Hospitals NHS Trust, The Dudley Group NHS Foundation Trust, Walsall Council, Walsall Healthcare NHS Trust, City of Wolverhampton Council, The Royal Wolverhampton NHS Trust, West Midlands Ambulance Service University NHS Foundation Trust

Driving a more preventative approach that supports and enables patients to take a more active role in managing their own health

The Dudley Quality Outcomes for Health Framework (DQOFH)



DQOFH was co-created with Public Health and acute consultants, bringing in NICE evidence-based targets over and above the national Quality Outcomes Framework. It rewards “Evidence-based Holism,” promoting patient education, patient-led goal setting and lifestyle support for anyone with any long-term condition. The DQOFH was developed to drive up standards, address unwarranted variation and facilitate the holistic management of patients with long term conditions. This includes an increased focus on care planning, measures and incentives for holistic reviews and personalised care planning, along with outcomes defining access requirements that exist over and above the National GP contract and Quality and Outcomes Framework (QoF).

The DQOFH was developed as part of a wider system outcomes framework and is a key component to the way in which Dudley general practice contributes to population health outcomes, supported by DIHC in the provision of a range of services that enable patients to manage their own long-term conditions.

The DQOFH provides DIHC and general practice with the mechanism to reduce variation- through standardising the way in which DQOFH is supported with DIHC clinical services, developing and sharing best practice and the Primary Care operating model from DIHC operated practices, providing centralised functions for DQOFH support e.g., clinical coding, templates, call and recall, policies and procedures.

The Primary Care Integration Agreement

This agreement sets out how DIHC and general practice will work together, including adherence to the objectives for service integration and the principles for joint working including the Dudley Quality Outcomes for Health Framework. The purpose of the agreement is to improve quality and drive a more sustainable model of Primary Care with a workforce and clinical model organised around the needs of each PCN.

Key Elements – for Practices

Delivering the DQOFH – a core requirement is that each practice participates in a framework that is based on addressing health inequalities and improving outcomes for the patients of Dudley, rather than the national QOF.

Working to common clinical protocols and with other DIHC services, for example with the pharmaceutical public health team within formulary, with the integrated care teams (ICTs) to reduce hospital admissions, with health coaches to support delivery of DQOFH outcomes for setting and achieving personalised health goals (to achieve weight management, control blood pressure, manage cholesterol and HbA1c levels).

Agreeing to improve areas where data suggests practice activity is abnormal – e.g., high use of A&E or high rates of secondary care utilisation.

Delivering general practice access requirements with the support of DIHC – e.g., having a consistent method of online access for signposting and triage, delivering on the access requirements of DQOFH in respect of delivering urgent same day access for children and those over the age of 75, provision of a minimum of 75 contacts per week per 1000 population, utilising the support of extended access appointments provided by DIHC.

Key Elements – for DIHC

To support and enable the development and sustainability of Primary Care to deliver improvements to the health of the Dudley population and to build a robust out of hospital care model; put simply: community where possible, hospital when necessary.

To support and enable general practice and PCNs to deliver a consistent model of care that that is multi-disciplinary and responsive to the specific needs of the population, focussed on prevention, self-care and shared health outcomes.

To support patients to take a more active role in improving and managing their own health and be better informed about which professional is best able to help them.

To support individual practices with bespoke support through a range of offers including back-office support, management arrangements, turnaround support etc.

We employ and provide services to PCNs achieving the highest level of ARRS employment compared to others across the ICS

Achievements to Date

A Primary Care Integration Agreement co-produced between DIHC and general practice and signed by DIHC and 40/43 practices covering 300,000 patients. It describes the mutual ambition and commitment to addressing population health improvement and how Primary Care and DIHC work together to achieve this common purpose.

A quality improvement framework (DQOFH) in place that addresses the population health needs in relation to access, continuity and co-ordination – a framework that sees Dudley general practice operating to standards over and above those that are Nationally defined.

One of the largest pharmaceutical public health team employed in the country operating to achieve population health outcomes at a practice, PCN and borough level demonstrating quality improvement and return on investment on £4.73 for every £1 spent on prescribing efficiencies.

An agreement in place with PCNs that sees DIHC rapidly employ and deploy ARRS staff and services – achieving the highest level of ARRS employment for Dudley PCNs compared to all other PCNs across the ICS.

A team of health coaches employed and operating in support of the DQOFH standards that sees every patient with a long-term condition supported to have holistic review and goals identified as part of a personalised care plan – in 2021/22 45,594 patients had a review and were set personalised goals, with pilot studies showing demonstrable improvements in blood pressure, cholesterol, weight loss and HbA1C levels.

Integrated Community Teams (ICTs) established and successfully managing the health and wellbeing of patients with high clinical risk.

The commissioning of 'Integrated Plus' from the Dudley Council for Voluntary Services – a service that works within the ICTs to co-ordinate the voluntary sector and community assets – resulting in demonstrable improvements to the wellbeing of patients and reductions in attendances to hospital - at 6 and 12 months pre and post referral data shows a 37% reduction in A&E attendances at 6 months, and 50% reduction in A&E attendances at 12 months.

Two practices (High Oak and Chapel Street Surgery) in deprived communities taken into direct provision and management by DIHC to ensure continuity of provision for populations with significant challenges.

Improvements in the delivery of Primary Care medical services at the two practices provided by DIHC – including relative improvements in DQOFH outcomes and patient satisfaction as measured in the National GP survey.

Clinical and managerial support provided to general practice - putting in place robust systems and process that address issues identified by the CQC and enable the practice to operate whilst maintaining GP ownership.

Establishing an extended access GP service mobilised and operating at two weeks' notice that sees in excess of 1200 patients a month since January 2022 with capacity for direct booking from 111 and GPs, with 91% of patients being seen within 5-15 minutes of arrival, and 88% of patients being very satisfied with the service. Capacity for this service was increased within 24 hours for locally driven need such as heat wave and winter capacity.

A Covid Assessment Centre rapidly mobilised on behalf of practices and PCNs that provided 6,668 face-to-face consultations and an oximetry at home monitoring service for patients with confirmed or suspected Covid during the first 15 months of the pandemic. 95% of patients were very satisfied with the service they received, and the at-home digital monitoring service won the 'Driving Digital Transformation Innovation Award' from the West Midlands Academic Health Science Network along with the Covid assessment centre team being awarded the Freedom of the Dudley Borough.

Supported practices and PCNs with the co-ordination, management, and delivery of the Covid vaccination programme – achieving the highest achievement of COVID vaccinations and boosters in the ICS.

Produced development, workforce development and estates plans for all PCNs that have enabled DIHC to achieve the highest level of ARRS employment and service provision for Dudley PCNs across the ICB.

Enabled PCNs to secure additional investment to support training, education, and support to maintain sustainable service provision.

At the request of the Brierley Hill PCN, employed the PCN Clinical Director and provide management support for all aspects of the PCN under a service level agreement (SLA).

Provide the leadership and co-ordination of regular GP Education and Engagement sessions to both enable professional development and to support the knowledge base in a range of subjects across Primary Care. This includes operating an arrangement with the local Urgent Treatment Centre to enable practices to close early to guarantee attendance.

Establishment of new services including a community-based headache clinic led by a GPSI which provides a quicker route to assessment for people suffering with headaches, and a team of Primary Care mental health first contact practitioners to support general practice on a daily basis with additional mental health\ support

Successfully managed service transfers for school nurses, safeguarding and Primary Care mental health teams into Brierley Hill and Stourbridge Health and Social Care Centres.

On behalf of general practice, and in consultation with patients, selected a Digital First system (Footfall) and supported its roll out and introduction across general practice in Dudley.

Created additional clinical rooms to support High Oak surgery, and created additional non- clinical rooms to support PCN staff in Brierley Hill and Dudley and Netherton.

Improved the estate condition, security, and compliance for services operated from Chapel Street surgery

Provided estate and supporting infrastructure to deliver the extended access Hub.

Provided estate and supporting infrastructure to support the Special Assessment Service (a service for patients that have been removed from the registered list of general practice).

Worked collaboratively with PCNs and practices to produce estates strategies for each PCN, these strategies.

- Have ensured that all ARRS staff employed by DIHC have the clinical and non-clinical space that allows them to work closely as part of the extended Primary Care services in support of practices and PCNs.
- Have identified the additional space and capital required to meet the additional requirements for the increasing number of ARRS staff from 2024 onwards.
- Have informed the development of the DIHC Estates Strategy expected to be finalised in 2022.

A Primary Care Integration Agreement signed by 40 practices, covering over 300,000 patients

A framework that sees Dudley general practice operating to standards over and above those that are Nationally defined.

Two practices taken into direct provision and management

Extended GP access service seeing over 1,200 patients a month with 91% seen 5-15 minutes of arrival

A return on investment of £4.73 for every £1 spent on prescribing efficiencies

One of the largest pharmaceutical teams in the country

The Future Strategy for Primary Care in Dudley – Implementing the Fuller Review

Vision

Our strategic vision for Primary Care is:

- To address the challenges of access, workforce and estates whilst embracing the opportunities afforded by best practice and national policy, including the Fuller recommendations.
- To support and enable general practice and PCNs to offer a sustainable model of Primary Care that is the first point of contact and principle point of continuing care for the population.
- To support and enable general practice and PCNs to provide a consistently high level of care, address unwarranted variation, and improve access, quality and population health outcomes as measured through the DQOFH set out in Appendix 4.
- To develop a model of care that is multi-disciplinary and responsive to the specific needs of the population, focussed on prevention, self-care and shared health outcomes, supported by appropriate estate and facilities.
- To support patients to take a more active role in improving and managing their own health and be better informed about which professional is best able to help them.
- To deliver the national, regional and local requirements in partnership with the ICB and general practice.
- To represent and enable Primary Care to lead the development of the transformation strategy for Primary Care within the ICB.
- To provide an organisational model to support the resilience and sustainability of Primary Care with innovative workforce models and a range of support offers.
- That general practice is supported and enabled to achieve.

Our approach to implementing the Fuller stocktake review: next steps for integrating Primary Care in Dudley

In order to deliver our vision, our fundamental approach is to fully embrace the Fuller stocktake review, building on the progress we have already made. We have set out below our progress to date and our next steps for fully realising the opportunities that exist for the population and the sustainability of Primary Care. We have described our developing service model, together with our progress and future plans for workforce, estate and digital enablers to support delivery.

The Fuller stocktake report: Next Steps for Integrating Primary Care reflects on the current model of Primary Care delivery and outlines a vision for Primary Care that reorientates the health and care system to a local population health approach through building neighbourhood teams, streamlining access and helping people to stay healthy.

The Fuller stocktake report recognises and references our role and the role of the Black Country Primary Care Collaborative in supporting the development of Primary Care, describing the way in which DIHC has provided the opportunity to enable general practice and PCNs to operate at scale – delivering improvements in sustainability, access and population health improvement – all of which are aligned to the recommendations contained within the report.

The three key areas described in the report are set out below, along with progress to date and next steps for further development:

Personalised Care

Providing more proactive, personalised care with support from a multidisciplinary team of professionals - integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks (PCNs) and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between Primary Care and other system partners and communities.

Progress:

- Dudley has the expertise and experience of implementing multidisciplinary teams (MDTs) within each General Practice since 2015 as part of the NHS New Models of Care Vanguard Programme.
- DIHC has evolved and developed the MDT model (teams without walls) to an ICT model – these are neighbourhood teams operating within each PCN to manage those with the greatest needs and at the highest risk of admission.
- The ICT comprises a core team within each PCN as follows:
  - ICT lead - GP or designated AHP/community nurse
  - Community nurse
  - Long term conditions nurse
  - Mental health nurse or specialist
  - Social work and local authority
  - Voluntary sector lead from integrated plus
  - Care coordinator
  - Integrated Plus Voluntary Sector Link Worker
- The ICT comprises an extended team that includes, but is not limited to
  - Specialist Palliative Care nurses
  - Respiratory specialist nurses
  - Diabetic specialist nurses
  - Clinical pharmacists
  - Allied Health Professionals
  - Safeguarding support (social services)
  - Health Visitor – where there are complex cases or children
  - Specialist consultant support for key ICT sessions including (Cardiology and Heart failure, Diabetes and Endocrinology, Learning Disabilities, Nephrology, Respiratory Medicine, Vascular Conditions, Palliative Care and Mental Health)
- Within the DQOFH (operating since 2016) Dudley general practice and patients are now familiar with annual holistic reviews and personalised care planning, supporting with health coaching those patients with long term conditions.

We are addressing the challenges of access, workforce and estates

Next Steps:

The DIHC Primary Care operating model to be shared with wider Primary Care to optimise the way in which personalised care planning is supported and delivered e.g., developing the way in which all clinical teams are aligned and operating to support patients achieve their personalised health goals.

The ICT model will be enhanced and developed to include a broader and more wide-reaching input from community asset and council/public health provided teams.

Same Day Access to Urgent Care

Providing streamlined access to urgent, same-day care and advice from an expanded multi-disciplinary team, using data and digital technology to enable patients to quickly find the right support to meet their needs.

Progress:

- The DQOFH already sets access requirements over and above the National GP contract i.e., provision of a minimum of 75 contacts per week per 1000 population, practices offering same day access to children under 5 years and adults 75 years and over ensuring they are assessed by a clinician and seen within 6 hours of contact, practices actively identifying patients at high risk of admission, participating in ICT meetings to ensure patients at high risk of admission have an appropriate preventative strategy.
- The DIHC extended access hub for the provision of urgent same day GP and Advanced Nurse Practitioner (ANP) appointments was rapidly mobilised and is in place and accepting referrals from GPs and directly booking from 111 the Dudley Urgent Treatment Centre, seeing over 1200 patients a month since January 2022. This has significantly supported urgent care capacity across the Dudley system.
- DIHC has mobilised a digital-first platform (Footfall) across all practices – an online offer, accessed through an individual practice's website, which is available to all patients and capable of enabling them to navigate their way to find help in exactly the way they would if they walked into reception.

Next Steps:

DIHC will develop and expand the provision of the access hub, to increase the provision of GP and ANP appointments to cover a more extensive range of primary medical services e.g., phlebotomy, diagnostics, imaging that will be accessible for direct booking for 111, Urgent Treatment Centre and GPs.

DIHC will provide an enhanced access offer to Primary Care across Dudley to assist them in providing their enhanced access requirements.

DIHC will be reviewing, with patients and practices, the best way to utilise the digital-first platform for the purposes of navigation and triage.

DIHC will develop a standard way in which Footfall is used for triage, consultations and all other aspects of the 'digital offer' to patients in Dudley.

Prevention

To ensure that those who would most benefit from continuity of care in general

practice (such as those with long term conditions) can access more proactive, personalised support from a named clinician working as part of a team of professionals.

To help people to stay well for longer as part of a more ambitious and joined-up approach to prevention -taking a more active role in creating healthy communities and reducing incidence of ill health by working with communities, making more effective use of data and developing closer working relationships with local authorities and the voluntary sector.

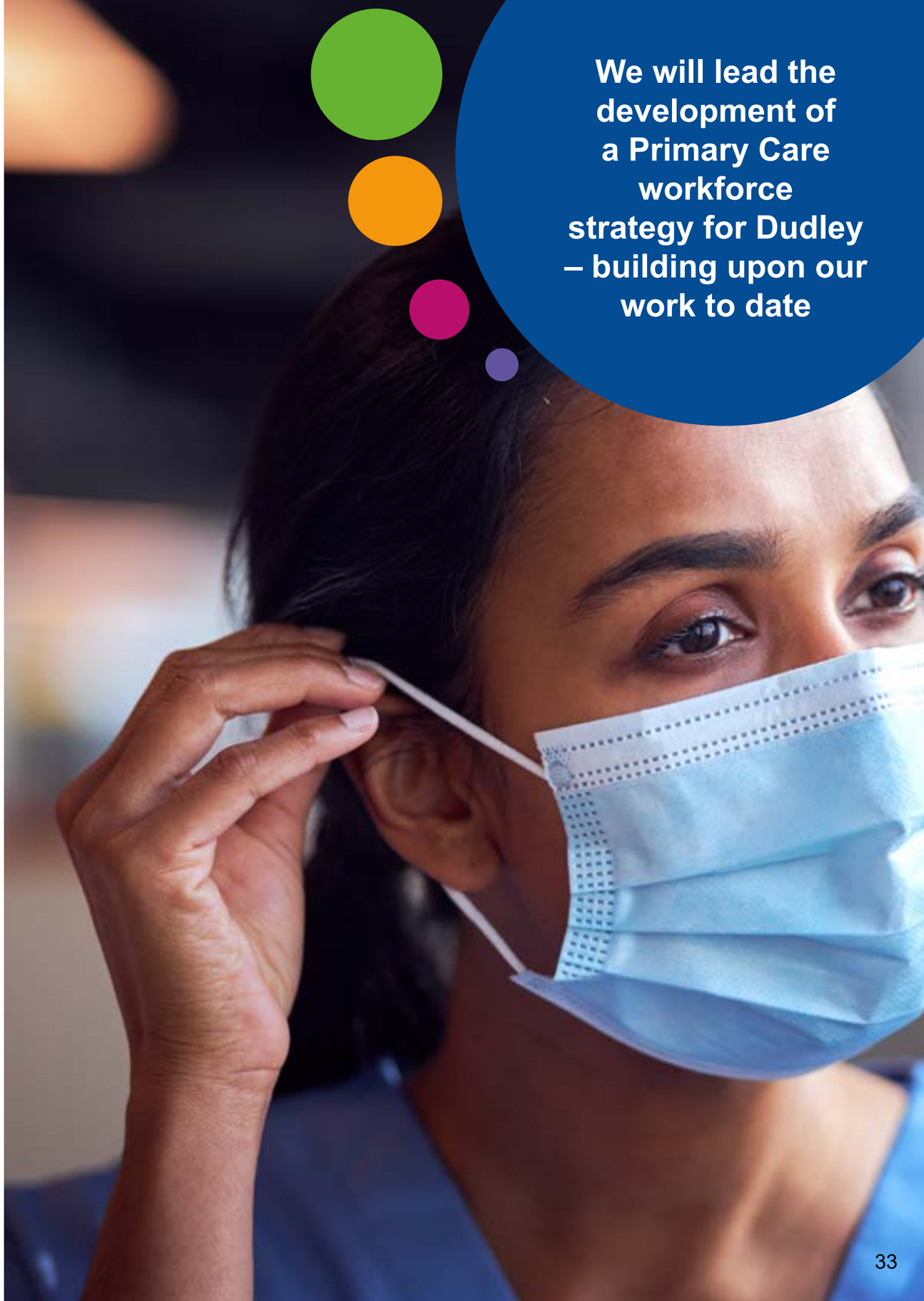
Progress:

- The DQOFH was developed with a specific focus on addressing and reducing variation in population health outcomes, driving a more preventative approach that supports and enables patients take a more active role in managing their own health.
- DIHC commissions a service called 'Integrated Plus' that supports people aged 16 and over who frequently visit their GP, who are at high-risk of hospital admission and/or who are vulnerable and could benefit from social prescribing and/or community asset-based interventions. The service aims to look at the whole needs of a person, regardless of what those needs might be and jointly find solutions to problems they face.
  - The Integrated Plus team operates within each PCN and accepts referrals from GP surgeries and via weekly ICT meetings.
  - The team also works closely with Russell's Hall hospital and West Midlands Ambulance Service to provide longer and more intensive social prescribing support to frequent attenders of A&E services and frequent callers of 999.
  - A project development worker oversees and manages the voluntary sector social prescribing fund and develops and maintains relationships between the voluntary and community sector, link workers, GPs and NHS teams.
  - The PCNs support DIHC to commission this service at a scale because of the significant benefits that are seen in operating one team, which supports people to become less reliant on medical services and encourages and supports people to get connected into wellbeing services and activities, often delivered by the voluntary sector.
  - The team work closely with the DIHC Listening and Guidance and Social Prescribing service.

Next Steps

There is a consensus between patients, general practice and National policy that access to and continuity of care is a challenge, with frustrations shared by both patients and staff alike.

There is a recognition and desire from general practice that in order to progress and develop a population health approach to prevention and continuity of care for long term conditions, urgent same day access could be organised and delivered at scale – either at PCN or borough-wide level; with long term conditions management (prevention and continuity) continuing to be delivered at a practice level. The view of general practice is that such a change would support a sustainable model of care going forwards.



Embracing opportunities afforded by best practice and national policy, including the Fuller recommendations

DIHC will take a lead in collaboratively developing/co-producing a Primary Care operating model for general practice and Primary Care that ensures that same day access, personalisation and prevention could be delivered efficiently, sustainably and to a high standard; ensuring agreement with general practice and patients alike.

DIHC will work with the ICB and the national Primary Care transformation team to be a Fuller Review accelerator site to drive transformation and help shape national policy to embed these changes into business as usual – particularly in areas such as existing legislative, contractual, commissioning, and funding frameworks.

Enablers

In order to deliver our vision, and the implementation of the Fuller recommendations, we recognise the importance and critical inter-dependencies of having the following enabling strategies in place.

Workforce

Our achievements to date reflect the way in which we have developed integrated care teams around the needs of the population, and how we are organising and operating those teams in support of practices and PCNs to enable improvements to access, quality and population health (as measured through the DQOFH). These teams will be transformed to include the full neighbourhood team approach described in the Fuller recommendations.

We have made significant progress in developing ARRS workforce plans on behalf of each PCN, and the development and implementation of a nursing and allied health professional strategy.

We recognise the significant challenges presented by a reducing GP workforce alongside an increasing demand for Primary Care services. We will lead the development of a Primary Care workforce strategy for Dudley – building upon our work to date to ensure that there is a collaborative, multiskilled workforce, working cohesively to implement a co-designed model of care with general practice, PCNs, and the wider system.

Estates

Our achievements to date reflect our progress in working collaboratively with PCNs to develop their estates strategies, providing additional estate for new services (access hub, chapel street surgery) and supporting PCNs to plan and identify opportunities for capital.

We are in the process or developing an Estates Strategy that will be in place in 2022 built upon the PCN strategies that we have already developed. The DIHC Estate Strategy will outline the future estate required to support our Primary Care operating model. The strategy will ensure that the PCN's are in a position, with our support, to access funding through the premises costs directions to create additional accommodation to support the PCN extended activities and deliver the Primary Care operating model. The Estates Strategy will include a prioritised list of estates projects in readiness for any capital funding becoming available.

The fundamental principles that guide our Estates Strategy for Primary Care are consistent with those set out in the NHS Long Term Plan (LTP) and align with the ICS priorities for

- Boosting out of hospital care delivering it closer to the community.
- Supporting the development of the PCN's.
- Redesigning and reducing pressure on emergency hospital services.
- Providing more personalised care.
- Providing digitality enhanced care.
- Increasing focus on population health with a more integrated approach to health.

Digital First

Digital First is a nationally funded, transformational programme of work with a focus on delivering equitable access to digital services, for all patients.

There is a Digital First Primary Care programme across the ICS that aims to embed and build on the digital transformation advances made in Primary Care as part of the pandemic response.

The role of DIHC is to work in support of the ICS to deliver a strategy and programme of support to general practice and PCNs to optimise and enhance their current level of Digital First solutions and improve overall patient access in the following areas:

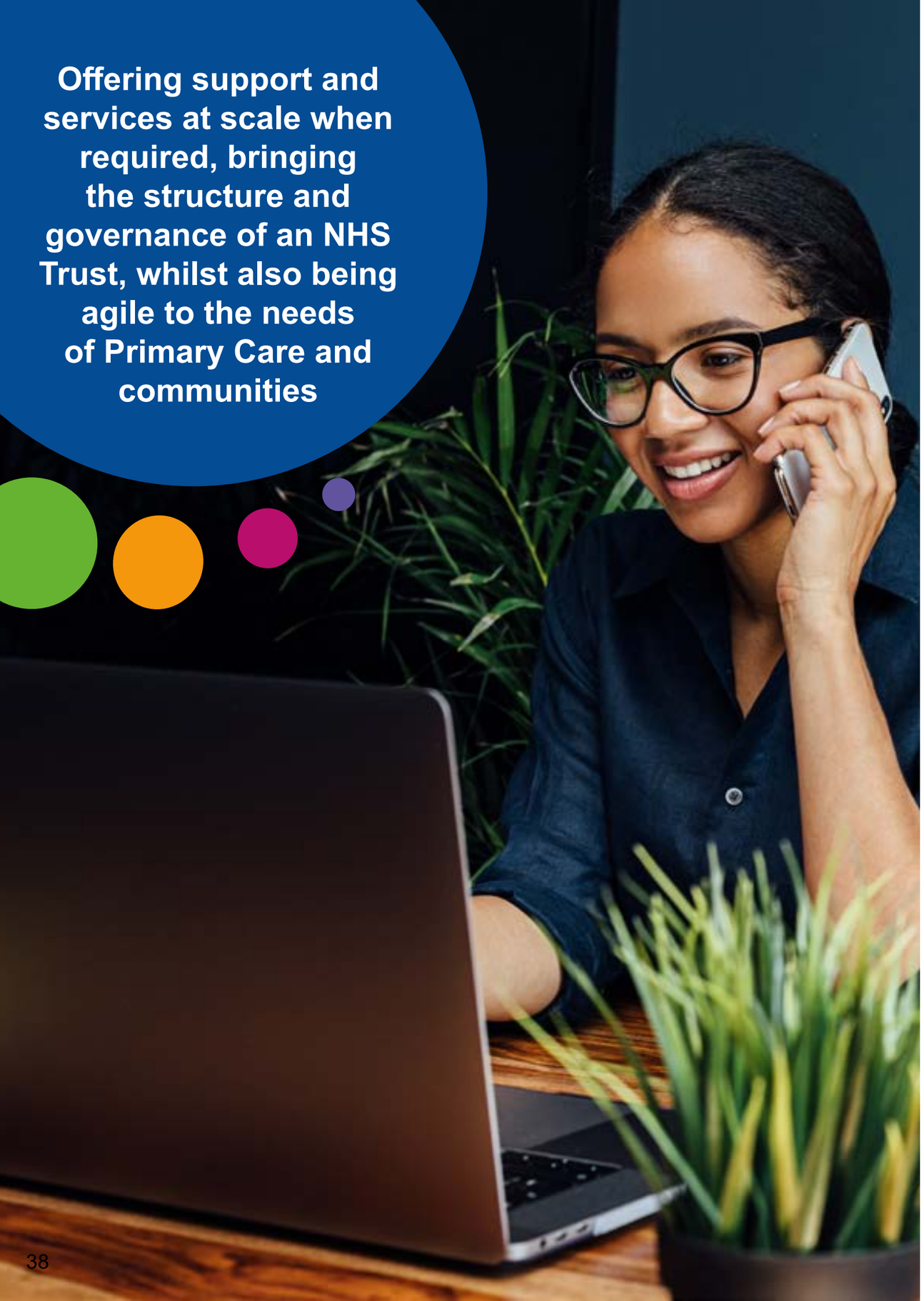
- Offering online consultations that can be used by patients, carers and by practice staff on a patient's behalf.
- To gather submitted structured information and to support triage, enabling the practice to allocate patients to the right service for their needs.
- The ability to hold a video consultation between patients, carers and clinicians.
- Two-way secure written communication between patients, carers and practices.
- Shared record access, including patients being able to add to their record.
- Request and management of prescriptions online.
- Online appointment booking.

A Digital Strategy will be developed in 2022, along with a programme of work and projects that will see DIHC continue to develop and enhance the range of support to general practice and PCNs to include:

- Reviewing the existing range of Digital First solutions.
- Developing a digital operating model or "digital blueprint" that supports and enables improved access through definition of and driving towards best practice and consistency of digital services.
- Developing and enhancing existing support functions to general practice and PCNs to identify key areas for improvement and training to implement and optimise a digital operating model.

We are fully committed to aligning our enabling strategies and functions with the ICB to achieve a whole system benefit and have agreed a process where there is one strategic action plan between DIHC and the ICB that is overseen by the Dudley Primary Care Collaborative Group.

DIHC will work with the ICB and the national Primary Care transformation team to be a Fuller Review accelerator



The Future Role of DIHC Supporting Primary Care Sustainability and Development in Dudley

DIHC has solid credentials on which to build further on its relationship with Primary Care; these are based on insight into the Primary Care world, established trust and a joint ambition with Primary Care to see it not only sustain but to flourish, step into and up to the roles set out in the Fuller review, working at scale and collaboratively within Primary Care and with wider partners.

DIHC already has responsibility to support the development of Primary Care within Dudley; within each of the other places within the ICS that responsibility still remains with the ICB.

The benefit of having DIHC assume this responsibility in Dudley has been our ability to engage with general practice and PCNs to co-produce and provide a range of support offers that are valued and support the sustainability of general practice and PCNs.

Support provided to date

We have engaged extensively with general practice and PCNs in order to respond to their challenges and needs over the past two years. The consensus in respect of what is most appreciated and valued is:

- The way in which DIHC has embraced having GPs involved in its leadership and governance at the highest levels, in its Board, its Committees and its Executive Team; ensuring a strong Primary Care voice in the leadership of the Trust.
- The way in which DIHC engages with practices and PCNs in the development of its services.
- The way in which DIHC understands the challenges and the opportunities for the development of Primary Care – a feeling that they are supported to lead the transformation of Primary Care as opposed to being led.
- The ability for DIHC to offer both support and services at scale when required, bringing the structure and governance of an NHS Trust, whilst also being agile to the needs of Primary Care and communities.
- The provision of the extended access GP through the DIHC access hub – this has created capacity for general practice to triage and refer patients in need of same day urgent appointment when practices urgent access slots are already fully booked. It has also supported diversion of patients from 111 and Urgent Treatment Centre, supporting urgent care throughout place.
- The provision of the pharmaceutical public health ‘practice-based pharmacists’ with structured medication reviews, clinical audit, patient consultations, management of medicines-related correspondence, problem solving and reviewing patients’ repeat prescriptions. This adds value to the Primary Care pharmaceutical offer and supports enhanced patient safety and cost reduction in prescribing. The

pharmacists also provide support for ICTs who ensure that appropriately co-ordinated care is provided to patients with complex healthcare needs – having one team with one work plan has achieved productivity gains of 20% and achieved a £4.73 return on investment for every £1 spent on achieving prescribing efficiencies. The teams also model health inequality work and lead the governance of non-medical prescribers.

- The DQOFH is valued as a better set of population health and clinical outcomes and targets than the National QOF. It is focussed on jointly agreed local priorities, remains consistent over time and drives a more multi-disciplinary approach in general practice that is more responsive to patient need.
- The quality improvement support to practices that have been at imminent risk of closure. The GP Partners and their surrounding practices within the PCN have appreciated the intervention and support from DIHC that has seen the turnaround of these practices, thus avoiding the loss of service to communities in need and an unmanageable influx of patients into other practices in the PCN due to closure / list dispersal.
- The support in co-ordinating and delivering the Covid vaccination programme, working closely with PCNs and Dudley MBC to set up vaccination sites and provide a comprehensive range of management support.
- The support to undertake contacting those that had refused vaccination from ethnically diverse groups, using people proficient in different languages and able to address specific concerns through in-depth calls where uptake was often lower in areas of social deprivation and resulting in a 60-70% conversation rate.
- The Service Level Agreements in place with PCNs that sees DIHC employ and deploy ARRS staff, along with the operational management of those staff with professional leadership, workforce provision and planning, supervision and training all provided as an NHS employer under Agenda for Change Terms and Conditions. The PCNs appreciate and value this service and consider it to be excellent value for money based on the overhead charged by DIHC. The ARRS staff appreciate, and value employment protections and rights provided by working for an NHS Trust under Agenda for Change terms and conditions.

General practice and PCNs have told us where they require further support

Opportunities

The areas of support described above have been valued and appreciated by general practice and PCNs. Building on this, our engagement activities within individual practices, with PCNs and specific engagement events exploring the implications of the Fuller review and next steps have identified a number of areas where general practice, PCNs and DIHC have identified the opportunities for further DIHC support. These are:

- Leading the design of a Primary Care operating model that supports the sustainability of general practice on a day-to-day basis.

- The separation of urgent same day access and long-term conditions management – with suggestions that this is tested and evaluated in one PCN with support from the ICB and National support as part of an accelerator programme to assess new ways of working resulting from the Fuller review.
- A CQC support function for all practices – up until now intervention and support has been provided to those practices where there are challenges – the practices and PCNs would like to see a universal offer of support to provide standardised policies and procedures, with readiness assessments and audits.
- A greater focus on growing our own workforce with a workforce strategy that provides incentives and offers to retain GP trainees with career portfolio, training, supervision and support. Working in partnership with our Urgent Treatment Centre providers and West Midlands Deanery and other providers locally such as Mary Stevens Hospice developing innovative GP training roles for post GP training to support new doctors into local jobs.
- A greater role to provide back-office support in particular, a model that sees DIHC take on employment and functions of practice administrative staff as part of a business partnering offer, for those practices that would be interested.
- A greater level of management support functions for all PCNs to include; workforce planning, estates planning, training needs analysis, development planning, business case development, project management and implementation.

- DIHC and PCNs to align their clinical workforce and teams to deliver the health outcomes set out in the National requirements of the PCN impact and investment fund (IIF)
- Service provision for the enhanced care in care homes as per the NHSE framework and specification requirements.
- DIHC and Primary Care to partner and offer to take on newly commissioned community and out of hospital services.
- Support the development of an operating model for online triage and appointment booking – beginning with the review of the existing system (Footfall) that was mobilised rapidly at the beginning of the pandemic.
- DIHC to further develop the role and functions of the Urgent Treatment Centre (UTC) with a view to integrating it with the DIHC extended access services, and primary medical service provision.

The role of DIHC in supporting Primary Care development

We will support and develop Primary Care in the context of building upon what we have achieved to date, where the direction of National Policy and the Fuller review is directing us, and the response of general practice and PCNs in how they see our role supporting them. This role exists in the following four areas:

https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-investment-and-impact-fund-2022-23-updated-guidance/
https://www.england.nhs.uk/wp-content/uploads/2020/03/the-framework-for-enhanced-health-in-care-homes-v2-0.pdf

To support and develop Primary Care devolved from the ICB

As a provider of community-based services, both clinical and non-clinical

As a commissioner of a range of community services, devolved from the ICB

As a collaborative leader in the system, alongside others and in support of the place-based leads

The offers to general practice, PCNs, place and system

The offers described below are the output of extensive engagement with general practice, PCNs, place-based system leads and the leaders across the ICS.

The offers are constructed to meet the requirements of National Policy and the Fuller review and consequently the ICB priorities for Primary Care whilst at the same time, providing practical support that has been identified by practices and PCNs in supporting them achieve a sustainable model of Primary Care in the context of increasing demand, and reducing GP workforce.

The offers provide support at every part of the system – starting with the registered list of patients at a practice, through to PCNs, place and system and reflect the clinical and non-clinical support requirements. They would include support on the following basis:

- No support – where support is not required.
- Advisory/mentorship.
- Educational/facilitative - learn from others and each other.
- Direct support/creation - doing it with you or for you on a project basis.
- Ongoing delivery of a function or service, or suite of functions/ services, either clinical or back office/ administrative.
- A fully managed suite of services and practice management.
- Assuming responsibility for the provision of the GMS contract.

DIHC can provide the following range of offers; expressed for clarity as “we will” statements.

General Practice

Clinical and Operational Service Support	Managerial
• We will ensure that our clinical teams and ARRS staff are operating in support of practices to deliver the population health outcomes set out in the DQOFH i.e., health coaching to support patients achieve personalised health goals. • We will develop proposals and service offers at the request of GP partners that enable us to take on the provision of services that practices may wish to sub-contract to DIHC i.e., the enhanced care in care homes. • We will provide a quality improvement support function to support and enable practices to reach good and outstanding in every CQC domain and high levels of DQOFH performance i.e., a more preventative and proactive approach to quality improvement. • We will provide a range of clinical governance support to practices, sharing standard policies and operating procedures supported with training and education. • We will develop a Primary Care operating model within our directly provided practices and share the learning and resources with all other practices. • We will negotiate with any practice wanting to move to a salaried model with DIHC taking on full responsibility for the provision of the GMS contract (based on our learning from taking on direct provision for two practices). This is entirely at the discretion of any individual practice. • We will ensure that clinical staff have personal and professional development support by partnering with the training hub to provide peer mentorship support, portfolio career development and access to financial support to develop and upskill clinical staff. • We will lead the process of annually reviewing and making recommendations to the ICB on the indicators within the DQOFH.	• We will develop and provide practices with templates, reports and training on EMIS for managing the DQOFH. • We will develop a standard operating model for Footfall i.e., the 'digital offer' for patients. • We will co-produce and provide a range of business partnering offers with practice staff i.e., CQC and other regulatory requirements, finance, staffing, quality improvement and assurance support. • We will ensure that all practice staff are supported with professional and personal development as part of place-based training needs analysis and plan, as part of a workforce strategy. • We will work with practices via the Dudley Practice Management Alliance (DPMA) to create a bank of clinical and non-clinical staff. • We will support practices with their estates planning – contributing to the development of a PCN estates plan and place-based estates strategy developed by DIHC. • We will support practices by co-ordinating access to GP training and retention schemes – partnering with the Black Country Training Hub. • We will support practices in developing and operating their patient participation groups (PPGs).

PCNs

Clinical	Managerial
• We will provide workforce planning and training needs analysis on behalf of each PCN. • We will continue to employ and operationally manage ARRS staff at scale to achieve agreed population health outcomes on behalf of the PCNs. • We will support the delivery of the ICTs by employing clinical leads to organise and co-ordinate the ICTs within each PCN. • We will review and evaluate the ICT operating model, with a view to standardising the way the ICT operates across all PCNs to optimise the way in which they support patients. • We will ensure that our clinical teams and ARRS staff are organised to support the delivery of the PCN impact and investment fund (IIF). • We will operate in support of PCNs to directly provide the enhanced access components of the PCN DES i.e., the provision of primary medical services beyond 6.30pm weekdays and on Saturdays (where required by PCNs). • We will operate in support of PCNs as a sub-contractor to provide other aspects of the PCN DES beyond enhanced access, at the request of the PCN.	• We will review and update our SLAs with each PCNs on an annual basis to reflect our offers of support and the key outcomes to be expected from our arrangements. • We will provide each PCN with business intelligence and population health data analytics. • We will support each PCN in producing an annual development plan to secure development funding from the ICB. • We will support each PCN by producing an estates plan (as required by NHSE). • All PCN Clinical Directors will have the option to become 'hosted' and employed by DIHC. • We will work with the ICB to 'host' Primary Care development resources on behalf of PCNs and ensure that all PCNs are maximising the opportunity to access development resources. • We will support PCNs in developing and operating patient participation groups (PPGs) at a PCN level.

Place

Clinical	Managerial
• To represent and reflect the 'voice' of Primary Care when responding to policy direction and opportunities – to operate in a way that is understanding and supportive of the needs of Primary Care. • To develop and implement a range of supporting and interdependent strategies in relation to workforce, estates, training and education that are co-produced and carry the support of Primary Care. • To develop a Primary Care operating model for DIHC practices for clinical and non-clinical activities supported by an independent academic evaluation. • To work with the office of public health to undertake a qualitative study and economic impact assessment on the benefits of the DQOFH. • To actively lead and participate in National accelerator and development programs to attract additional resource and support for strategy implementation. • Facilitating shared clinical and non-clinical practice education, learning and development to maximise individual and collective performance and shared learning. • Developing potential models of operating at scale across Primary Care and with partners to achieve and deliver on the requirements of Fuller review. • Responsible for the employment, leadership, management, development and governance responsibilities of additional Primary Care and aligned services e.g., ARRS, access hub using the structure and scale of an NHS Trust to discharge these.	• To lead the Dudley Primary Care collaborative, supported with a mutually agreed workplan with place- based leads and the ICB. • To support wider Black Country Primary Care place collaboratives to enhance the voice of Primary Care at place and to support with Primary Care expertise the place development agenda. • To develop place-based functions for the training hub to support the development of one workforce plan and training needs analysis for Dudley. • To develop and implement the programme management governance for the implementation of this strategy – scoping and mobilising key projects for delivery. • Developing and implementing a range of leadership and development programmes for Primary Care in partnership with training hub and ICB in support of the implementation of this strategy. • Leading a programme of GP engagement and development sessions supported and incentivised in partnership with PCNs specifically related to the implementation of this strategy. • Supporting Primary Care to be informed and influential in the system e.g., to facilitate the collective informed voice of Primary Care at place and at system level, to chair the place based and system based Primary Care collaborative. • To develop and produce, in partnership with practices and PCNs, a place-based estates strategy for Primary Care.

The Programme Management Approach to Delivery

The strategy will be delivered by organising all the required activity into a defined set of projects and workstreams that are aligned into one programme plan to deliver the overall vision and intended outcomes of the strategy.

All the offers within the Dudley strategy have been categorised into 12 themes. The programme will work with stakeholders to identify and agree all the key priorities and dependencies within and between these themes to create one plan then continue to engage and update all stakeholders throughout delivery.

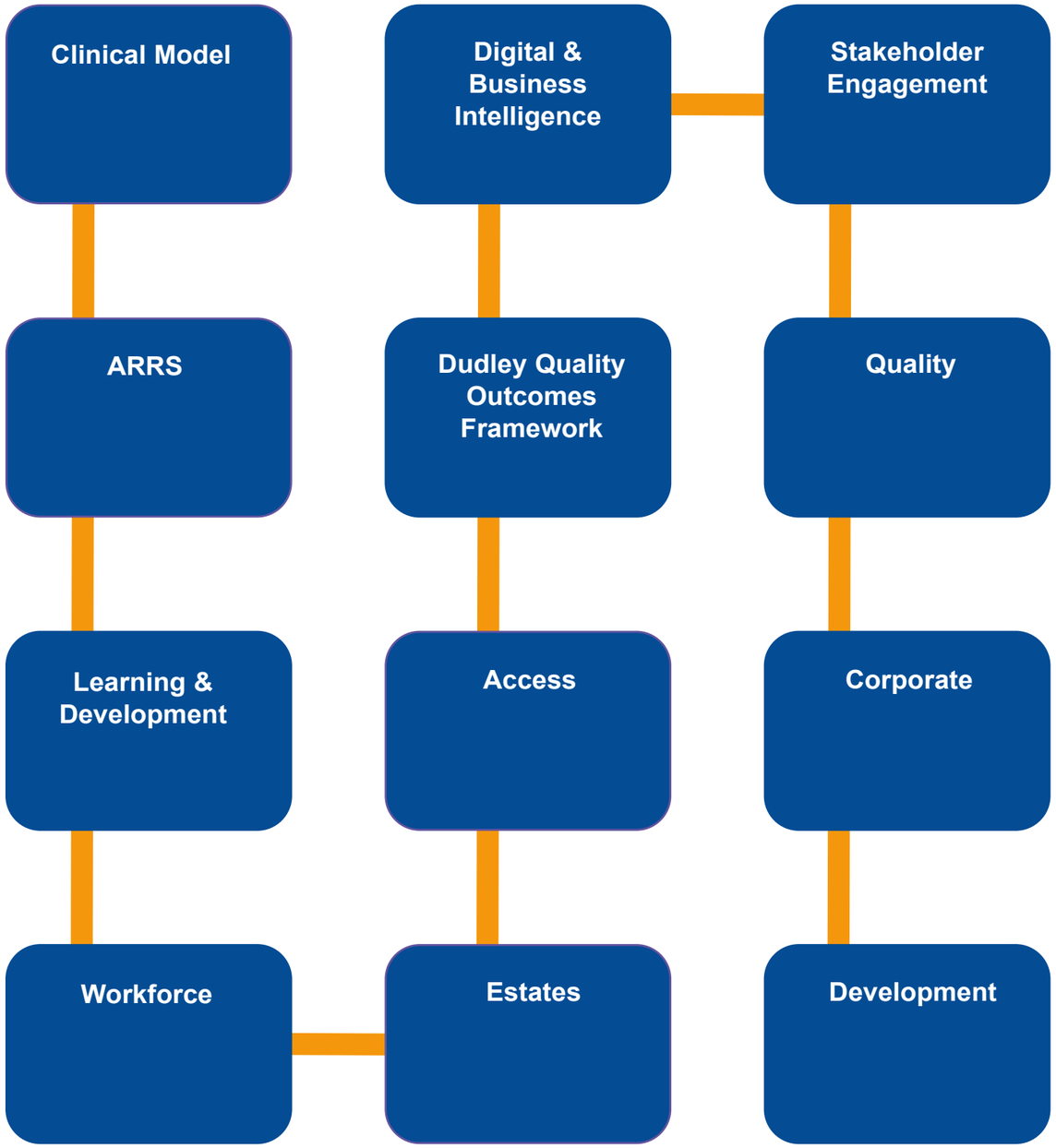
All the defined projects and workstreams will report progress regularly into key forums and committees to ensure all activity is proactively managed, dependencies tracked, and risks can be escalated promptly. A series of benefits will be defined and reported on to enable us to track progress against the vision and intended outcomes of the strategy so we know not only if we delivered the defined project or workstream but whether it delivered the required change to patients and/or staff.

A resource plan will define all the roles and responsibilities of all required staff to deliver this programme of work who will adopt the working practices of the programme into a one team approach.

Appendix 6 sets out the action plan used to support the delivery of the strategy.

A 'virtual team' working to one strategic action plan with consistent reporting will be established.

Workstreams and Priorities



Collaborative Working

We recognise that Primary Care cannot be supported and developed in isolation. The way in which we describe our support to Primary Care is dependent on having a model of care (and operating model) that is designed, supported, enabled and operated between all NHS providers and system partners with a view to delivering the Triple Aim of improvements to population health, quality of services and use of resources.

Within Dudley, all system partners recognise the importance of developing an integrated care model that builds upon our existing ways of integrated working.

In 2022 the Dudley Health and Care Partners (DHCP) comprising the organisations set out below, commissioned Capgemini Invent consulting services and their Accelerated Solutions Environment (ASE) to create and plan two separate two-day events to bring clinicians and wider health and care providers together to redefine and design a new model of integrated care for the local system.

- NHS Black Country and West Birmingham Clinical Commissioning Group (CCG)
- The Dudley Group NHS Foundation Trust
- Dudley Integrated Health and Care NHS Trust (DIHC)
- Black Country Healthcare NHS Foundation Trust
- Dudley Primary Care Networks
- Dudley Metropolitan Borough Council
- Dudley Council for the Voluntary Sector

There are five key target outcomes set out below that have been agreed between DHCP:

Integration	The system works seamlessly as one around the needs of citizens, so that they do not notice organisational boundaries. Every contact counts and positively impacts our citizens.
Clinical Outcomes / Better Health and Wellbeing	Prevention is inherent across the system and quality of care when it is needed is high. Dudley has a happier and healthier population.
Universal Proportionalism	Everybody in the borough has equal access, quality of care and improved wellbeing. Sometimes this will mean warranted variation to support those who have unequal access or poorer quality of care now.
Collaboration	Collaborative and MDT ways of working are effective and support the integrated system at both a strategic and operational level.
Sustainability	The system is sustainable financially, environmentally and in terms of the workforce pipeline.

There are four priority transformation groups that have been established as follows:

Integrated Care Teams (ICTs) and Care Co-Ordination	To lead the review and development of our existing ICT structures, considering staff feedback and national best practice with a view to refreshing the ICT operating model to realise the benefits of the Fuller stocktake review.
The Clinical Hub	To implement a coordinated system of demand and risk management which delivers safe and effective care in the community by default and in hospital when necessary.
Children and Young People	To develop the clinical model based on an increase in the universal offer to help Dudley's children to thrive, and with intervention aimed early in the life of the child and early in the problem. To recognise the central role of parents and carers and aim to "think family." The model will be integrated across the Dudley system, utilising the multidisciplinary team, sharing knowledge, and creating seamless transitions for families.
Mental Health	To review, explore and define the Dudley Mental Health model, with a seamless delivery of service by enhancing the connection across primary, secondary care, and the range of community-based interventions to support a reduction in escalation of needs.

Governance of Collaborative Working between Providers

Each workstream has clinical and executive leadership with dedicated management support – there is a programme management approach in place with each workstream having clear terms of reference with accountability through to the Integrated Model of Care Implementation Group which reports directly into the Dudley Health and Care Partnership Board.

Primary Care is committed to and is actively engaged in shaping the design work of integrated services through the Capgemini process and in being an active partner in future collaborative delivery. Our commitment is to support Primary Care to ensure they have an equal and influential voice and role in both design and future delivery.

The Potential Role of DIHC within the Black Country

The pressures in relation to rising demand and decreasing GP workforce presents the same fundamental challenge to general practice in the Black Country as that experienced in Dudley, and indeed across England.

The aspirations for the roles of Primary Care in the future NHS, as expressed in the Fuller Review and national policy, and the opportunities to support Primary Care and communities to seize those aspirations are similar too.

While the specific population health needs, and specific local challenges and solutions vary across places, fundamentally there is a significant opportunity for Primary Care providers to work together, and with others, to address those challenges. This will benefit communities, patients and both Primary Care practitioners and system partners.

DIHC exists to support Primary Care in its future development, building on the Trusts early success in Dudley and partnering with Primary Care providers across the Black Country.

Our intention is to be the trusted partner of the Black Country Primary Care Collaborative, and a resource on offer to practices, to PCNs, to places, collaboratives and to the ICS to support the sustainability and the positive development of Primary Care as a crucial component of the health and care system.

The Black Country Primary Care Collaborative (the Collaborative), PCNs, and practices from across the Black Country have proactively approached DIHC to request their support to take forward the work of the Collaborative, to enable them to be on an equal footing and to develop and sustain Primary Care across the ICS.

We recognise that our relationship with Primary Care across the Black Country is not as well developed as it is in Dudley, and we are committed to developing these relationships over the foreseeable future by drawing on our knowledge and experience.

As an organisation, we:

- Were created by Primary Care to support Primary Care.
- Have extensive Primary Care clinical leadership in our Board, Committees and Executive team.
- Have the benefit of our local and practical experience.
- Have mutually respectful and trusted relationships with Primary Care.
- Have the credentials and capabilities of an NHS Trust.
- Have a track record of early success.

We have a positive contribution to offer, alongside others, to the future sustainability and development of a thriving Primary Care offer across the ICS.

In further developing our relationship with Primary Care across the Black Country we will be respectful that:

- As independent Practices, PCNs, and Collaboratives, Primary Care has a choice of whether to seek support, and if so, from whom.
- Different places across the Black Country have developed differently in response to local circumstances and preferences. They have different arrangements for supporting practices, PCNs and Collaboratives, for provision of the ARRS staff, and for developing ICTs. That diversity is to be respected and embraced. We have no intention of promoting a “Dudley model” to other places. Our offer is to work in partnership to co-design and implement the best models in response to local circumstances.
- A number of the support roles we fulfil in Dudley, and can offer more widely, are currently the role or function of another organisation in the other Places (e.g., the ICB, federations etc). We would wish to explore any potential changes with Primary Care, and with those organisations, on a collaborative basis.
- Our relationship with Primary Care, and our support for Primary Care is based on an inclusive, mutually respectful, and trusted partnership. As we develop our relationship and work with Practices, PCNs and Collaboratives across the ICS we recognise the need to adapt both our name and our governance systems to reflect our changing role. We will wish to explore with new Primary Care partners how we ensure their voice is heard in the leadership and governance of the Trust, how they can bring their talents to our collective work, and how partners will hold the Trust to account for the support we offer. One option currently being explored is a membership model, together with appropriate representation on a new Primary Care led leadership Committee and wider Black Country representation on the Trust Board.

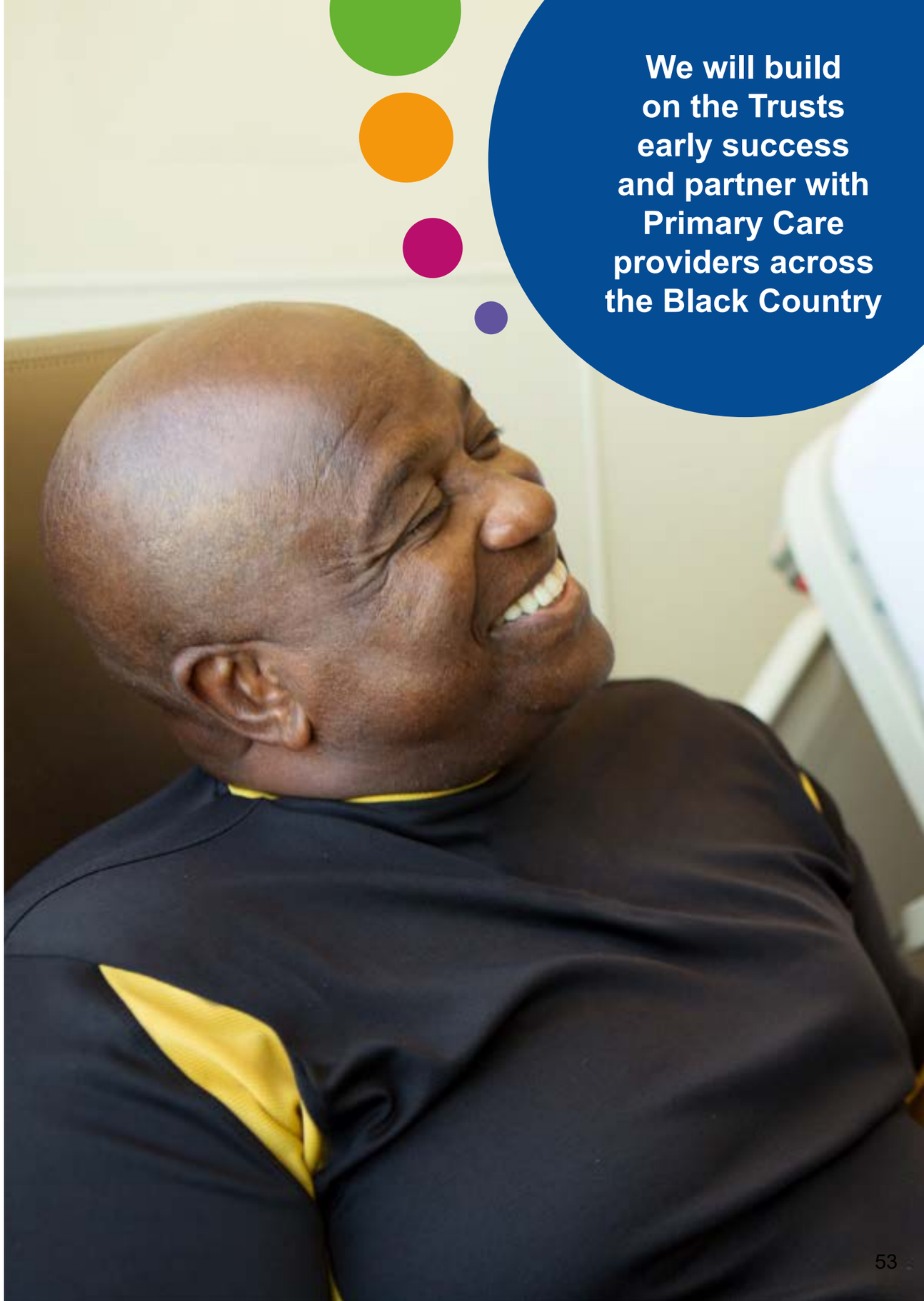
Our Proposals

In response to enquiries and requests from Primary Care practices, PCNs and the Black Country Primary Care Collaborative we have been working with Primary Care colleagues to explore and co-produce our possible future roles in supporting Primary Care across the ICS.

There are 2 areas of possible future support and development that we have co-produced together:

- 1. A role to support the strategic development of the Black Country Primary Care Collaborative as their trusted partner.
- 2. A role in supporting Practices and PCNs with operational and development support where this is requested by Primary Care:
- a. Adapting and offering those services provided in Dudley to Black Country partners.
- b. Responding positively to new requests for support and development, and co-producing new solutions.

Each of these is set out in the next section.



Primary care clinical leaders have expressed trust and confidence in DIHC to partner effectively with them

Support to the Black Country Primary Care Collaborative

It is widely recognised that Primary Care is a key player in determining the success of the overall health and care system and that those areas which have strong and effective Primary Care have both better outcomes and lower costs. Primary Care is also a key focus of risk and development priority nationally as recognised by the Fuller Review and emerging national policy and priorities.

The clinical leadership of Primary Care across the Black Country ICS has signalled a clear desire to engage fully and positively with the ICS to influence the strategic development of the overall health and care system; to ensure that patients Primary Care needs are heard, acknowledged, and resourced; and to have a leading role in the development and implementation of the future strategy for Primary Care across the Black Country.

Primary Care leaders have established the Black Country Primary Care Collaborative, a clinically led leadership forum with an agreed Terms of Reference and defined “Purposes.” It aims to achieve the above goals, whilst also connecting with and representing the Primary Care voice across all 181 GP Practices. As other Primary Care services (Optometry, Dentistry and Pharmacy) commissioning is delegated to the ICS those professions will also be invited to join the Collaborative.

The Terms of Reference of the BC PCC have been agreed and include the following “Purposes”: extracted below. The full Terms of Reference are attached at Appendix 7.

- To act as an expert reference group to the ICB on all Primary Care issues, initially representing all GP practices
- To expand the above to include Pharmacies, Optometry and Dentistry, and out of hospital services as part of “extended” Primary Care as part of the integration programme.
- To act as a single point of contact for Primary Care engagement in the Black Country system.
- To effectively influence ICS changes and have a single co-ordinated Primary Care voice at system, place and neighbourhood level.
- To have a key role in the design and development of the out-of-hospital model.
- To play an active and leading role in the design and development of the Primary Care transformation strategy and support the implementation programme once it is approved.
- To act as the out-of-hospital clinical reference group for other formal ICS Boards and groups.
- To act as the clinical network for the development of strategic commissioning and drive the transformation of Primary Care in the future.
- To represent grassroot general practice views and public and patient needs and inequalities in the planning and delivery of services.

Primary Care clinical leaders have expressed trust and confidence in DIHC to partner effectively with them. They wish the Trust to complement their own clinical leadership with governance, leadership and the managerial and administrative capabilities which DIHC

can offer; and which will be essential to the success of the Collaborative. To enable this DIHC will:

- Transition to a Black Country NHS Trust whose role is the support and development of Primary Care.
- Provide Primary Care, the Primary Care Collaborative, and the ICS with the much-needed support that Primary Care and the wider system needs.
- Act as trusted partner for the Black Country Primary Care Collaborative.
- Enable the Collaborative to take forward its agenda with the associated governance and infrastructure of the NHS Trust supporting the Collaborative to mature and operate as an equal partner in the ICS.

DIHC has confirmed its willingness to work with the Collaborative and to amend both its name and its governance arrangements to reflect such a role.

The next steps in taking this forward are to seek the confirmation of this role with the ICB, consistent with the expressed wishes of both Primary Care leaders and DIHC; and to co-produce the proposed arrangements in more detail, including working with the ICB.

Support to Practices and PCNs

As referenced above, in addition to being approached to support the development and work of the Collaborative the Trust has also been approached by practices, PCNs and federations across the Black Country to explore the potential for the Trust to provide operational and development support to Primary Care.

We can both expand the range and scale up our support to Primary Care, in response to such interest. In doing so we can adjust and flex our governance and our operations to: maintain a local Primary Care focus and expertise, maintain our culture of Primary Care support and mutual trust, and achieve economies of scale in respect of business partnering support, providing value to practices and PCNs.

Our approach will always be to respond positively to requests for support and to work in partnership with Primary Care leaders to adapt or co-produce solutions that meet the real needs of practices, PCNs and collaboratives.

In part we will be able to build forward from the support services already offered and provided in Dudley, whilst flexing them to local circumstances specific to practices and PCNs needs. Our current support offers, co-produced with practices and PCNs in Dudley, is set out in Chapter 5. We understand the realities and issues of Primary Care and can provide the necessary support that meets the real needs of Primary Care practitioners and practices.

Resourcing and Delivery

We recognise that the development of our role across the Black Country will mean expanding both the range and scale of our activities.

We are currently in discussion with the ICB, ICS and Primary Care partners about the extent to which the additional resources to support this role can be legitimately sourced from a refocussing of DIHCs existing resources, or the extent to which they will need to be met from existing or new resources from within the wider system.

A range of possible resource/ funding streams have been identified to support the roles above, either from existing mainstream budgets or developmental funding.

We recognise that resources are constrained and that, irrespective of the size of resource available, there will be a need make decisions on priorities, to organise work to achieve maximum positive impact in addressing Primary Care needs, and to ensure effective accountability.

Our commitment is that we will work with Primary Care leaders, as partners, in pursuing all appropriate opportunities for support and development resource, that we will co-produce annual support and development plans to take forward our shared strategy and priorities, and that we will develop both effective programme management and accountability arrangements to ensure we succeed in our joint plans.

Conclusion and Next Steps

This bold and ambitious strategy embraces and develops existing ways of working in Dudley that have been built by and are trusted and valued by practices and PCNs; builds on our track record of positive impact; and have been referenced as good practice within the Fuller stocktake review.

Our intention is to support Primary Care in Dudley to both sustain and develop, and, building on this; to offer similar support to Practices, PCNs, Places and the system across the Black Country. We aim to support Primary Care, as a critical part of the health and care system not only to sustain, but to flourish, overcoming the challenges of workload, workforce and estates and embracing the new roles and opportunities set out in the Fuller Review and national policy.

Our strategy is matched by:

- An innovative, tested, and credible model of support and collaboration between Primary Care and DIHC which will support Primary Care and the system to deliver the strategy for the benefit of patients, system partners and Primary Care professionals.
- The opportunity to roll out the same support and collaboration offer between DIHC and practices, PCNs and place within the ICS at pace - appropriate to their needs and aspirations, choosing from the menu of support offers to match their own needs.

For further information about the strategy, please contact:

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Visit: www.dihc.nhs.uk/publications/primary-care-strategy

Appendices

Appendix One: Dudley PCN Profiles

Appendix Two: Black Country Integrated Care System (ICS) Summary

Appendix Three: Workload and Workforce Challenge Profile for Dudley

Appendix Four: The Dudley Quality Outcomes for Health Framework

Appendix Five: The Development of a Population Health Management approach in DIHC and Dudley place

Appendix Six: Action Plan (to support Dudley)

Appendix Seven: Black Country Primary Care Collaborative Terms of Reference

Visit: www.dihc.nhs.uk/publications/primary-care-strategy **to learn more about the appendices**

Contact dihc.communications@nhs.net to request this document in another language or a different format.

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