BOARD MEETING

Title	Primary Care Strategy Implementation Update		
Paper Date:	1 November 2024	**Board Meeting Date:**	19 November 2024
Purpose:	Information	**Agenda Item:**	08
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Executive Summary

The Primary Care Strategy sets out details of the ambition for a new model of primary and community-based care and describes how primary care should streamline access, provide continuity of care for those with complex conditions and focus more on prevention. In so doing it is expected that as an ICS we will improve health outcomes for our population, tackle variation and reduce inequalities, using the resources available to us across the system in the most effective and efficient way. In May 2024, the ICB Board ratified the final Primary Care Strategy as the way forward in BOB ICS after months of engagement with system partners to identify the way forward for sustainable, resilient Primary Care

- This paper complements a recent previous paper to the Board providing an update on the Primary Care Access Recovery Plan (PCARP)
- As the NHS reviews the 'left shift' of care into the community and addressing inequalities, the Primary Care Strategy will be a key way to deliver on that ambition

Each priority area has different levels of focus at either Place or between General Practice, Pharmacy, Optometry and Dentistry (POD). This paper will provide examples of programmes of work happening to deliver on the ambitions of the Primary Care Strategy, such as:

- Access to primary care, with two examples in Berkshire West
- Integrated Neighbourhood Team working with examples in Buckinghamshire and Oxfordshire
- CVD prevention, with an example of work happening in dentistry across BOB

This paper also provides a general update on initiatives within POD as well as on the enablers of the strategy work, including a spotlight on Partnership working.

Looking ahead, the ICB Primary Care team will continue to progress delivery of priorities with system partners and Place teams

Action Required

The Board Members are asked to note and discuss contents of report and the progress of the delivery of the Primary Care Strategy across BOB.

Conflicts of Interest:	No conflict identified

Date/Name of Committee/ Meeting, Where Last Reviewed:	BOB SMT Primary Care Operations Group on Wednesday 6 November 2024

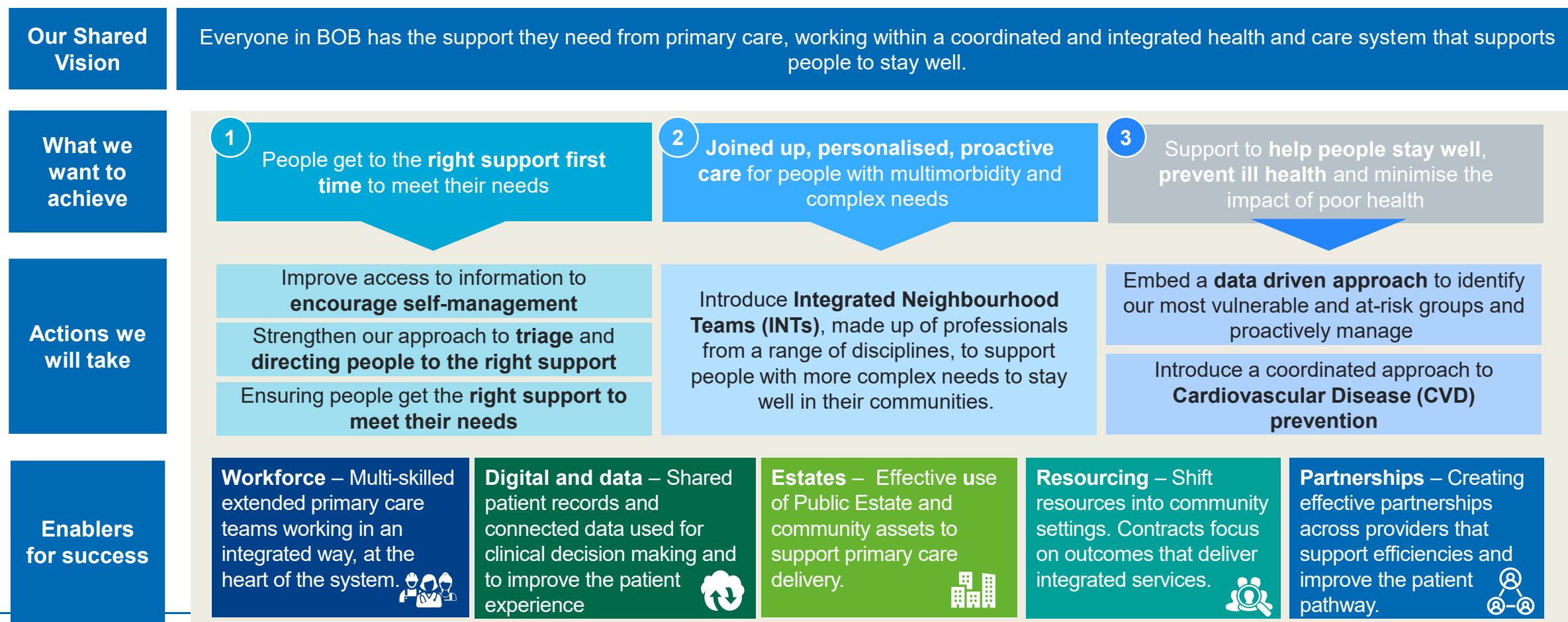# Primary Care Strategy – Implementation ICB Board Paper

October 2024

Overview

1) Primary Care Strategy Overview

2) Governance of the Primary Care Strategy

3) Implementation Overview

4) Priority area case studies

5) POD Integration

6) Primary Care Resilience

7) Enabler Spotlight – Partnership Working

1) Our shared system vision for primary care

Our Primary Care Strategy for BOB ICS has put the four pillars of Primary Care – General Practice, Community Pharmacy, Optometry and Dentistry at the heart of transformation to deliver a shared ambition and vision for a new model of care and a more integrated way of working across the system.

This is our future vision for primary care:

Our Shared Vision	Everyone in BOB has the support they need from primary care, working within a coordinated and integrated health and care system that supports people to stay well.		
What we want to achieve	**1** People get to the **right support first time** to meet their needs	**2** **Joined up, personalised, proactive care** for people with multimorbidity and complex needs	**3** Support to **help people stay well, prevent ill health** and minimise the impact of poor health
Actions we will take	Improve access to information to **encourage self-management** Strengthen our approach to **triage** and **directing people to the right support** Ensuring people get the **right support to meet their needs**	Introduce **Integrated Neighbourhood Teams (INTs)**, made up of professionals from a range of disciplines, to support people with more complex needs to stay well in their communities.	Embed a **data driven approach** to identify our most vulnerable and at-risk groups and proactively manage Introduce a coordinated approach to **Cardiovascular Disease (CVD) prevention**
Enablers for success	**Workforce** – Multi-skilled extended primary care teams working in an integrated way, at the heart of the system.	**Digital and data** – Shared patient records and connected data used for clinical decision making and to improve the patient experience	**Estates** – Effective use of Public Estate and community assets to support primary care delivery.	**Resourcing** – Shift resources into community settings. Contracts focus on outcomes that deliver integrated services.	**Partnerships** – Creating effective partnerships across providers that support efficiencies and improve the patient pathway.

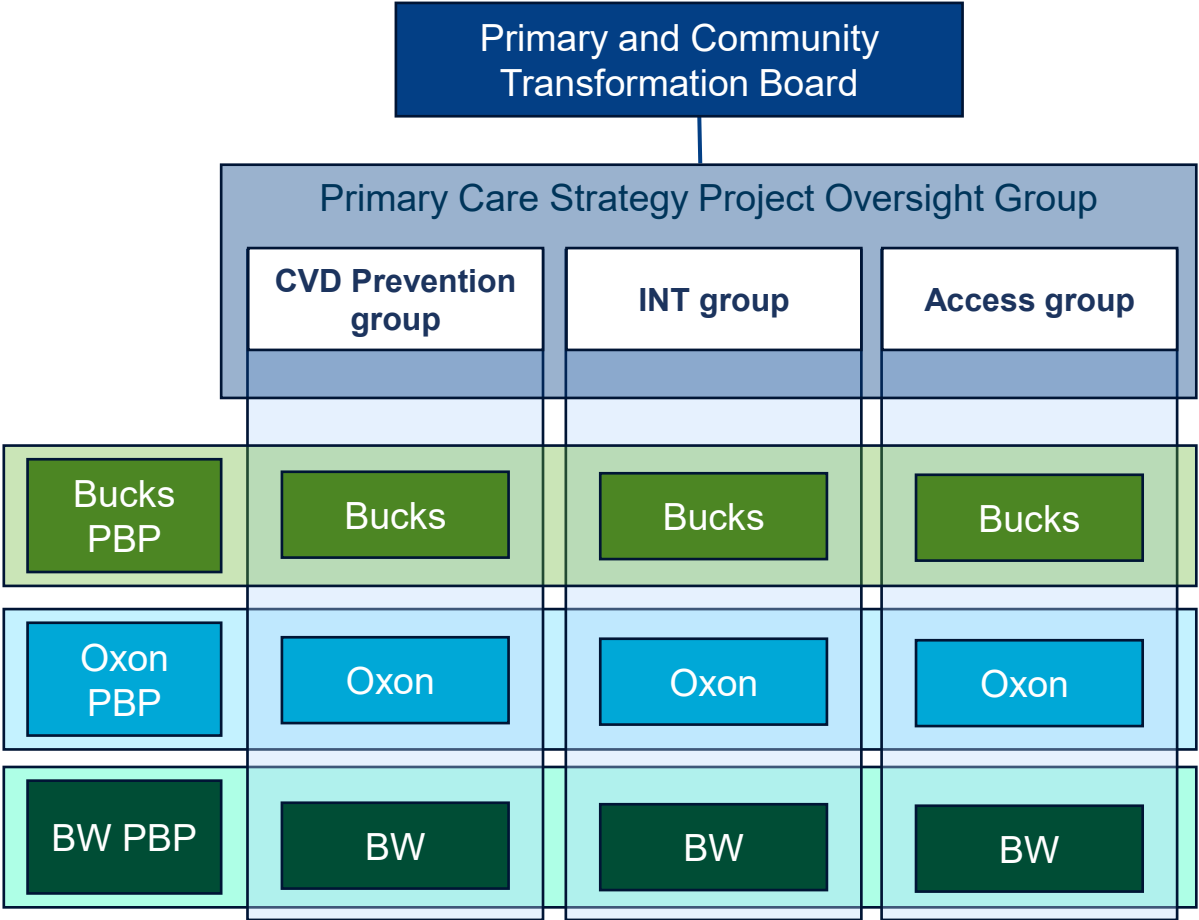Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

2) Governance and Working Groups

- **System-level**: We will have a robust governance structure for the Primary Care Strategy to oversee the direction and implementation across all 3 priority areas at a system-level. Assurance will be through reporting to the Primary and Community Transformation Board (quarterly)

- **Primary Care Strategy Project Oversight Group** is established and meets on a monthly basis.

Working Groups

- **CVD Prevention** working group is established, meeting on a monthly basis, with terms of reference (ToR) and reporting mechanisms established.

- **Access Working groups has** had first meeting in October, draft ToR in place.

- **Integrated Neighbourhood Team (INT) working group** to have first meeting in November, draft ToR in place.

- **Representation**: Seeking to ensure the comprehensive representation at each of the working groups, without duplication and to encourage action. Next steps:
  o Partnering with GP Leadership Group (GPLG) on how they will be represented in these forums.
  o POD: work with POD colleagues to ensure coordinated approach to strategy implementation
  o Enablers: review how best to incorporate enablers into the relevant working groups
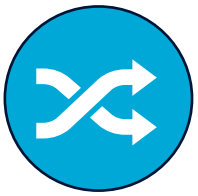
Governance Structure

	Primary and Community Transformation Board		
	Primary Care Strategy Project Oversight Group		
	CVD Prevention group	**INT group**	**Access group**
Bucks PBP	Bucks	Bucks	Bucks
Oxon PBP	Oxon	Oxon	Oxon
BW PBP	BW	BW	BW

3) Primary Care Strategy – Implementation Overview

October 2024

Access	SRO: Sanjay Desai	RAG overall		Objective	The programme aims to improve non-complex same day care for patients, ensuring that they are seen by the most appropriate clinician first time

Measures for Success	1. Improve capacity in primary care to enable those who need it most to be seen 2. Improve patient experience of accessing primary care services
Milestones 24/25	1. PCARP milestones 2. Pilot new models of care in the 3 places 3. Building segmentation into triage pathways
Progress Update	1. Berkshire West- Interim solution in final stages of development. Procurement in process for longer term solution 2. Bucks- Project Initiation Document has been finalised and is being submitted for sign off in early September. 3. Oxfordshire- new single point of access (SPA) to be launched in November

CVD	SRO: Shairoz Claridge	RAG overall		Objective	Support to help people stay well, prevent ill health and minimise the impact of poor health, starting with cardiovascular disease

Measures for Success	1. People 18+ with hypertension managed to treatment 2. Cumulative decrease in CVD-related adverse events: heart attacks and strokes 3. Increase referrals to NHS Diabetes Prevention Programme
Milestones 24/25	1. Mobilise the communications and engagement plan 2. Improve hypertension case finding through POD 3. Improve management/control of hypertension through different approaches with GP practices and explore other options 4. Improve intensification of pharmacological management to achieve national planning guidance 2. 5. Improve clinician knowledge and understanding of lipid management and its importance 6. Targeted work with CORE20 PLUS 5 groups to improve CVD prevention inequalities through CVD champions 7. Improve health check uptake in those with SMI and LD across BOB 8. Improve services delivery of personalised, person-centred approaches to CVD prevention 9. Improve provision of lifestyle interventions (provision scoping, pathway modelling, stakeholder engagement) 10. Review of familial hypercholesterolemia (FH) service and levelling up of service access across BOB
Progress Update	1. Achievement of management hypertension 70.34% (Mar 24) compared with 65.4% (Jun 23)and lipid management 57.73% (Mar 24) compared with 55.65% (Jun 23) (CVD Prevent) 2. CVD prevention work plans for 24/25 developed. Focus remains on hypertension and lipid management targets with new approaches to community engagement, funding opportunities and workforce solutions 3. Dental bid approved for hypertension case finding 4. Cholesterol resources, developed with the HIN, are now translated and freely available to all ICS partners. 5. Hypertension case finding service - 217 pharmacies signed up. 26000+ opportunistic BP checks to date. 8000 checks in Reading central 6. Integrated Neighbourhood Working project begun in Bucks with focussed work on improving target performance with key PCNS. 7. Primary Care CVD Champions (40/51 Primary Care Networks PCNs) provide local clinical leadership through practice-based initiatives - focusing on Hypertension and Lipid Management. 51 CVD projects underway, 24 have completed first phase projects. 8. Education webinars continue with a forthcoming webinar on Hypertension.

INT	SRO: Anna Marcus	RAG overall		Objective	The programme aims to provide more joined up, proactive and accessible care for people with complex needs by bringing together teams and resources across organisations into INTs

Measures for Success	1. Increased proactive prevention services and care to keep people well longer 2. Levelling up of outcomes e.g. people in deprived areas experience better outcomes 3. Reducing the need to access emergency or other unplanned services
Milestones 24/25	1. Current state assessment of each of the 3 places 2. BOB INT framework and support, including principles of INT working, maturity matrix, and measures of success 3. Test models of care 4. Identify potential uses of existing funding to support integrated working
Progress Update	1. Place level review of ICB funding streams available to support INT development ongoing across BOB 2. Early engagement with Connected Care team to develop aligned data and informatics intelligence across INT projects 3. Oxfordshire/Buckinghamshire - INT/Integrated working projects and governance structure alignment underway 4. Berkshire West – MDT working baseline assessment underway, promoting and embedding of segmentation to support future INT development

4) Primary Care Strategy – Case Studies

October 2024

Access – Case study

Embedding Segmentation for same day triage
Berkshire West (BW)

- Brookside Medical Practice are using *segmentation* (see next slides), a method of risk stratifying patients to understand underlying health conditions and better triage patients to the right place

- Staff triaging have a spreadsheet listing conditions, which gives instructions on where to book and signpost depending on the patient's segment and presenting condition

- This supports getting less complex patients the care they need as well as providing better continuity of care for more complex patients

- Segmentation is helping the practice to also review their capacity vs. demand and how to better allocate resources, such as ARRS practitioners
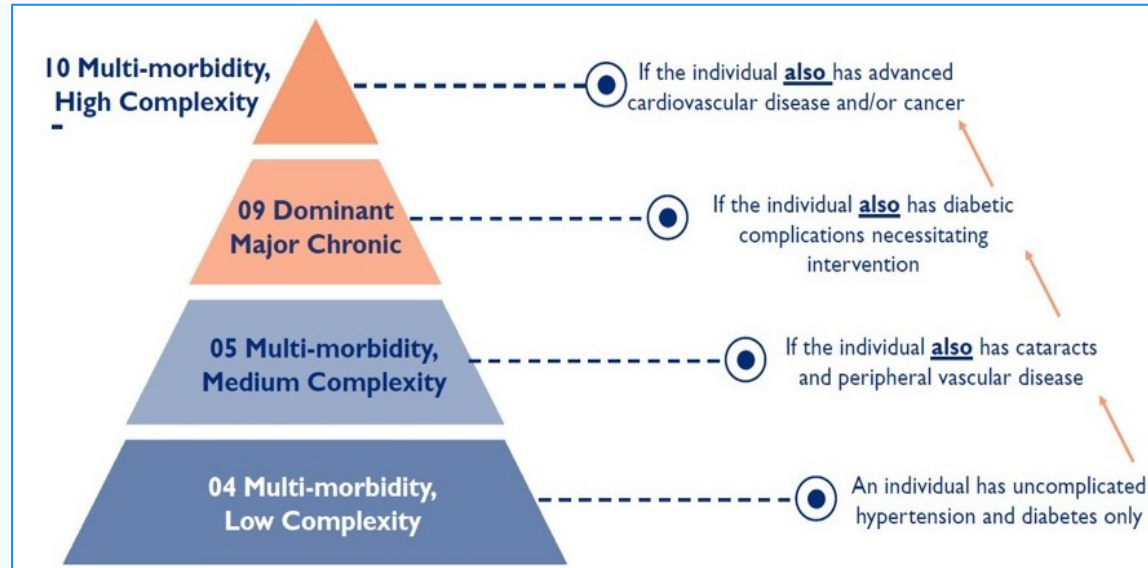
Urgent Care Centre
Reading

- For area of need, the Berkshire West Place team and system partners are collaborating to form an Urgent Care Centre (UCC) in Reading

- **The new service** launched on 1 October, maintaining some capacity at the current UCC location in Broad Street Mall while simultaneously providing a co-located, primary-care led service based at Royal Berkshire Hospital.

- An average of **36 patients per day** throughout October were streamed from ED into the new service at RBH, put on by the GP federation in BW.

- When reviewing UCC and out of hours activity, it demonstrates an average of **9%** of ED attendances per day are **streamed out of ED** into the two clinical services

- The service has started building up a **strong core primary care workforce** including, General Practitioners, Advanced Nurse Practitioners, Prescribing Paramedics, Pharmacists and Physician Associates.

- We will actively consider in addition to options for ED to send patients from overnight to same day access opening up and including 111 and also to practices ensuring maximum utilisation of appts.

Example of how PNG Segments work

ACG System software stratifies a population by the risk associated with their current morbidity burden + expected resource use… The so called "Kaiser Pyramid".
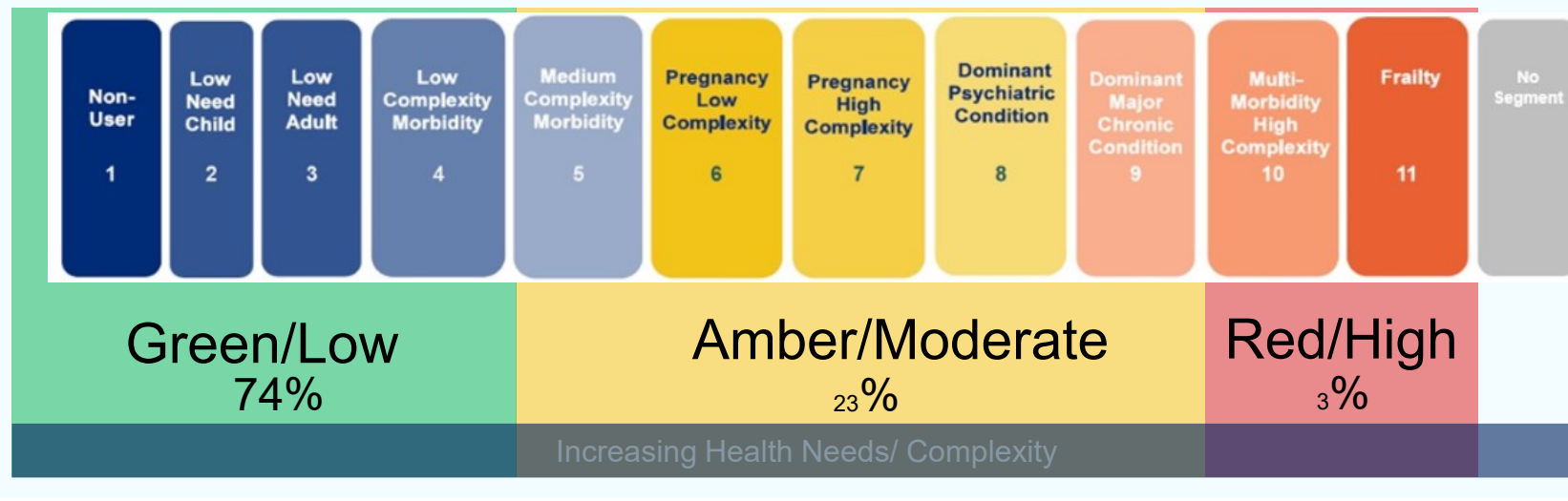
10 Multi-morbidity, High Complexity — If the individual **also** has advanced cardiovascular disease and/or cancer

09 Dominant Major Chronic — If the individual **also** has diabetic complications necessitating intervention

05 Multi-morbidity, Medium Complexity — If the individual **also** has cataracts and peripheral vascular disease

04 Multi-morbidity, Low Complexity — An individual has uncomplicated hypertension and diabetes only

Patient Needs Group (PNG) Segmentation Overview

Used globally for over 30 years and **calibrated for the UK population.**

Stratifies patients into clinically-relevant categories; **11 mutually exclusive and hierarchical groups, aggregated into 3 traffic light 'signals' of patient broader needs (Red, Amber, Green).**

RAG makes it easy to understand and apply in a reactive or 'unscheduled' care setting.

PNG 11 is useful when strategising for 'scheduled' care.

Non-User 1	Low Need Child 2	Low Need Adult 3	Low Complexity Morbidity 4	Medium Complexity Morbidity 5	Pregnancy Low Complexity 6	Pregnancy High Complexity 7	Dominant Psychiatric Condition 8	Dominant Major Chronic Condition 9	Multi-Morbidity High Complexity 10	Frailty 11	No Segment

Green/Low 74%   Amber/Moderate 23%   Red/High 3%

Increasing Health Needs/ Complexity

Existing Use Cases:
- ✓ *Strategic service design* (e.g. Urgent Care)
- ✓ *Improving access and demand management* (e.g. Primary care)
- ✓ *Case finding for proactive interventions* (e.g. Virtual Care)

Segmentation in Practice: Early Adopters Summary

Creating a 'clinical currency' – a signal/marker that everyone in your practice can understand…

RAG	LOW				MODERATE					HIGH	
	1	2	3	4	5	6	7	8	9	10	11
PNG	Non-User	Low Need Child	Low Need Adult	Multi-Morbidity, Low Complexity	Multi-Morbidity, Medium Complexity	Pregnancy, Low Complexity	Pregnancy, High Complexity	Dominant Psychiatric/ Behavioral Condition	Dominant Major Chronic Condition	Multi-Morbidity, High Complexity	Frailty

Unscheduled (Urgent & Routine)

- Online consultation navigation and triage
- Redirect to CPCS
- Apps (Healthier Together App, Get U Better, Sleepio)
- Same Day Service / Minor Injury Unit

- Senior ANP/PA/GP navigation & triage
- Same Day in- practice review if required
- Maternity assessment unit
- Talking therapies/MHP/CRISIS

- Senior GP triage -telephone/F2F
- UCR
- ICT referral
- Home visit – paramedic

Scheduled

- Digital invitations to QOF
- Nurse/HCA/PCN Pharmacist/ARRS Led QOF
- Paeds QOF
- SMRs - Pharmacist

- Pre-natal Health Optimisation
- QoF prioritisation for LD and SMI
- SMRs – Senior Pharmacist
- DMARDs

- Senior Nurse/GP lead QOF prioritisation based on risk prior to winter
- SMRs reviews by senior pharmacists

Proactive

- NHS health check ups (PNG 1 &3)
- Immunisations
- Health Promotion/Weight Management
- Quit Smoking
- Cancer screening
- NHS login /Social Prescribing

- Identifying non-attenders for QoF
- Immunisations
- Prediabetes /Health Promotion /Weight Management /Quit Smoking
- Cancer screening
- Pre-conception advice
- NHS login /Social Prescribing

- Remote Monitoring
- Secondary Care MDTs
- ICT/ Post admission home visit
- Health Promotion/smoking/ weight management /cancer screening/Imms
- NHS login/Social Prescribing

Unscheduled Care: Triage and Care Navigation

Understand your baseline data → Develop your SOP/areas of focus. → Train and communicate with your teams. → Set up EMIS segmentation signal. → Monitor and adapt.

Embedding knowledge of the patient's boarder **needs** into triage and care navigation models as a soft signal alongside why they are **presenting** helps professionals ensure patients get signposted and/or booked into appointments that make best use of practice workforce and other resources.

Benefits

✓ Empowers care navigation
✓ Appropriate clinician
✓ Appropriate timescale/timeslot
✓ Continuity of Care
✓ Reduce 'bounce-back' duplicate appointments (60% reduction in Reds and Ambers for CPCS)

Need vs Acuity vs Clinical Skillset

Need (PNG)				GP
	Red			
	Amber			
	Green	Pharm First UC Team		
		Green	Amber	Red

Acuity (presenting reason)

Cardiovascular Disease (CVD) - Case Study

Hypertension Case Finding in Dentistry

BOB-wide

- In 24/25, BOB is piloting hypertension case finding in dental settings through a national award supporting this work

- The aim of the work is to improve overall detection of hypertension in the population and offer an alternative route to have blood pressure checks outside of other routine health and care settings

- This work is also aimed at reducing inequalities in BOB for the 150,000+ people living in areas that are in the bottom 20% of deprived areas across the country

- BOB has received £50,000 to carry out this work. This covers start up equipment costs to purchase blood pressure monitors, training, communications campaign, and incentivising blood pressure case findings in oral health teams

Integrated Neighbourhood Teams [INT] – Case Study

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Early Years
Buckinghamshire

- Wycombe is an area of Buckinghamshire which has patients living in high deprivation
- An INT is forming to identify patients who have declined or not engaged with child one-year health reviews and/or childhood immunisations to understand barriers and improve uptake
- Outcome measures the INT seeks to impact include: increased uptake of 1 year child health development checks and childhood immunisations by non-attendees as well as improved awareness, engagement and access to wider CYP/family/parental support services and offers
- The INT includes PCNs, Healthwatch, Family Hubs, Education and Health Visitors
- Interventions explored include partner communications campaign, MDT approaches outside of the usual health locations

Reducing Health Inequalities
Oxfordshire

- There are INTs across the three deprived areas in Banbury and some of the areas of deprivation within Oxford City.
- The two PCN's in Banbury are focusing on those who meet the frailty criteria or those with long term conditions who live within one of the three deprived areas.
- One aspect of the project in Banbury, is a focus on all those who had an admission to hospital for their respiratory condition, looking at the EPC rating of their house and other variables to assess the skills set of those who need to carry out a home visit.
- The Banbury INTs have expanded to include people from Cherwell District council, Public Health, Primary Care, and the community specialist nursing teams. In additional diagnostics for assessing people with respiratory conditions will start in November within one PCN but will take referrals from both PCN's.
- Oxford City, the Brazilian model has been implemented to look at a wider range of issues within people's home environment.
- One PCN within Oxford city which covers the most deprived area within the city, is focussing on children and young people who have been referred to CAMH's. This INT will provide additional support with social prescribers and those who have the skill set to support the young person (YP) and their family. The aim is to reduce the need for the YP to be seen by CAMH's, promote the well being of the person and their family and create capacity within CAMH's for those who will benefit the most from it.

5) Pharmacy, Optometry and Dentistry (POD) updates

Community Pharmacy

Roll out of the **Pharmacy First** initiative so patients can access some prescription medicines without needing to visit a GP –102k Pharmacy consultations of which 35k were for one of the 7 common conditions that can be treated by a Pharmacist saving many appointments with a GP. Remaining consultation linked to minor illness and urgent medicine supply (data Feb to Sept 24)

A **dedicated PCN Community Pharmacy** lead has been recruited **for every PCN (47)** in BOB with the aim of working with local GP practices to embed community pharmacy pathways including Pharmacy First and oral contraceptive into general practice tirage processes.

GP Connect is now in place to enable Community pharmacy to input directly into the patients record. Work is now underway to enable this operability

Delivery of **winter vaccination programme** including flu and covid (210k appointments booked from 30 Sept to 4 Nov 2024) with acceleration of uptake across BOB due to the number of pharmacies offering vaccination

Optometry

Process to implement **sight tests and oral health checks in Special Educational Needs Schools** from April 2025 started.

Electronic referral platform in place to allow community optometrists to send urgent and routine referrals directly to the patients chosen single point of access with over 3000 referrals made via this route in August 24

Dentistry

An additional **70,000 units of dental activity commissioned** to improve access to high street dentistry

Golden Hello offer to practices struggling with recruitment of NHS dentists

Flexible commissioning scheme expanded to include pregnancy and nursing mothers and patients needing a dental checkup as part of a hospital appointment

Financial assistance scheme launched for those practices struggling to provide NHS services

Engagement in national pilot CVD Prevention pilot – **Hypertension case finding** in dental practices – see slide 12

Further commissioning with increased focus on **Children's Oral Health** Improvement
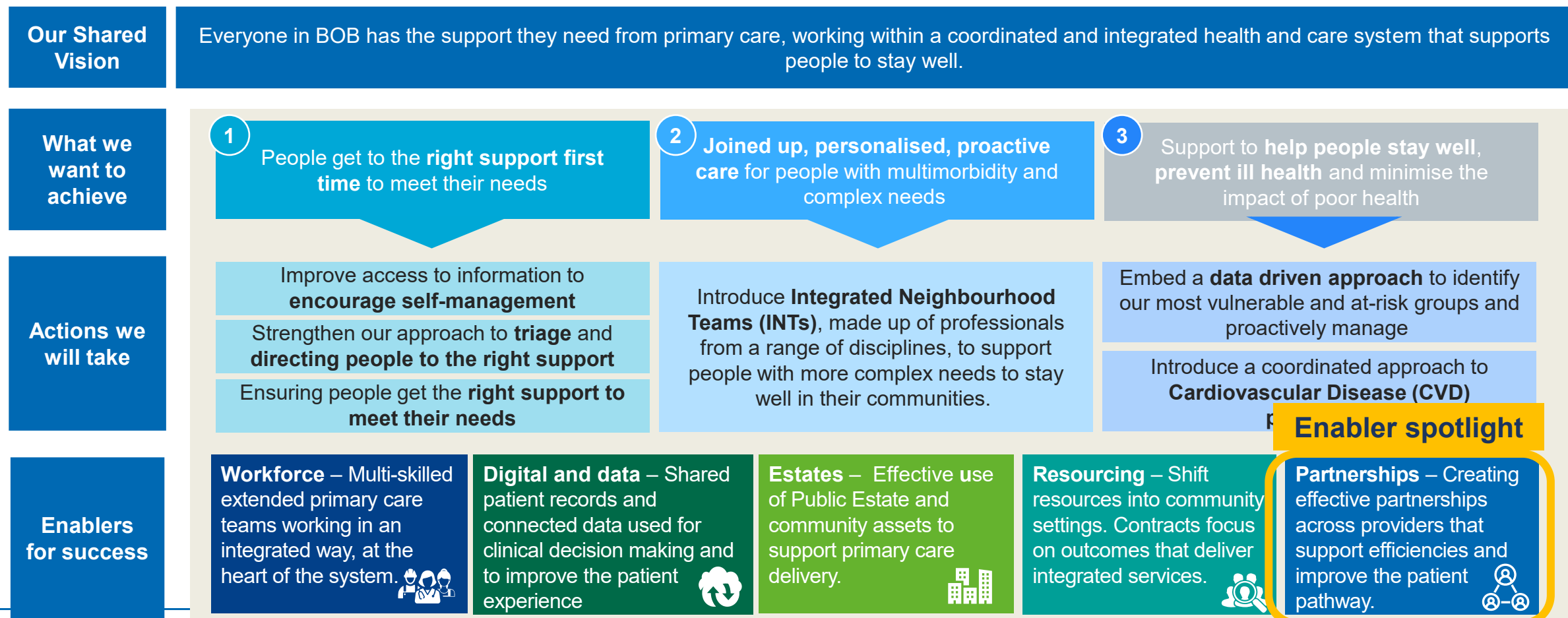
6) Primary Care Resilience

The Primary Care Strategy was developed to ensure sustainable and resilient primary care. Outside of the three priority areas of access, INT working and CVD prevention, BOB ICS is actively working to ensure primary care stability through:

Workforce	• The ICB is continuing to support the **New to General Practice Fellowship Programme** and currently has 76 fellows participating in the programme, which is a key retention programme that the ICB is investing in • The ICB has funded **25 practices to register with the skilled worker sponsorship programme**, which is allowing practices to employ GPs and other healthcare professionals through this route • PCNs are being supported to become **Learning Environments** which will support the expansion of GP training places in primary care
Digital	• Developed and using tool in partnership with LMC to support review of **demand and capacity** within primary care • BOB is ensuring continuation of digital tools that support **interoperability** and working across providers, such as EMIS clinical services
Resourcing	• BOB continues to invest in **Locally Commissioned Services** and decreasing variation of services provided at each place • **Post-operative wound care** is an area that has recently been identified as a commissioning gap, and a system-level working group has been established to identify the pathways needed and how to support primary care providing this service to patients

7) Our shared system vision for primary care

Our Primary Care Strategy for BOB ICS has put the four pillars of Primary Care – General Practice, Community Pharmacy, Optometry and Dentistry at the heart of transformation to deliver a shared ambition and vision for a new model of care and a more integrated way of working across the system.

This is our future vision for primary care:

Our Shared Vision	Everyone in BOB has the support they need from primary care, working within a coordinated and integrated health and care system that supports people to stay well.

What we want to achieve

1 People get to the **right support first time** to meet their needs

2 **Joined up, personalised, proactive care** for people with multimorbidity and complex needs

3 Support to **help people stay well**, **prevent ill health** and minimise the impact of poor health

Actions we will take

Improve access to information to **encourage self-management**

Strengthen our approach to **triage** and **directing people to the right support**

Ensuring people get the **right support to meet their needs**

Introduce **Integrated Neighbourhood Teams (INTs)**, made up of professionals from a range of disciplines, to support people with more complex needs to stay well in their communities.

Embed a **data driven approach** to identify our most vulnerable and at-risk groups and proactively manage

Introduce a coordinated approach to **Cardiovascular Disease (CVD)**

Enabler spotlight

Enablers for success

Workforce – Multi-skilled extended primary care teams working in an integrated way, at the heart of the system.

Digital and data – Shared patient records and connected data used for clinical decision making and to improve the patient experience

Estates – Effective use of Public Estate and community assets to support primary care delivery.

Resourcing – Shift resources into community settings. Contracts focus on outcomes that deliver integrated services.

Partnerships – Creating effective partnerships across providers that support efficiencies and improve the patient pathway.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

7) Enabler Spotlight – Partnership Working

Background

- As part of the strategy engagement period, frustrations were raised about the interface between system partners and the lack of joined-up working between services

- Recognising this feedback, **a fifth enabler** has been included in the strategy - **Partnership Working**.

Scope

After a deep dive engagement event, consensus emerged to focus on **Oxfordshire** for an initial phase to establish a primary secondary interface group, given that Buckinghamshire and Berkshire West both have robust, established interface working groups

Progress to date

- Core members of the interface group include Oxford University Hospitals (OUH), the GP Leadership Group (GPLG), the Local Medical Committee (LMC) and the ICB

- Learning has been sought from the experience in the Berkshire West and Buckinghamshire Interface Groups to inform the work in Oxfordshire

- Oxfordshire was supported in their successful application to participate in the **Interface Improvement Collaborative at NHS Confederation**.

- One project to promote interface working is to **develop a video training resource** on the primary/secondary care interface. OUHFT have committed to using the resource as **part of its mandatory training requirements for its staff** and it will also be shared with General Practice.

Looking Ahead

- Developing a **communication plan for co-designing campaigns** with service users, such as how to access primary care services within the evolving model of care
- Development of an **Evaluation Plan** to assess what is having a positive impact on patient outcomes and experience
- Further refine Place **engagement and priorities** as well as planning for 25/26
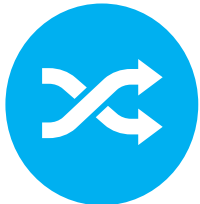
Appendix

Terms explained

Term	Explanation
Additional Roles Reimbursement Scheme (ARRS)	A financial scheme that enables Primary Care Networks (PCNs) to recruit additional complimentary professional healthcare roles into their existing workforce to expand its capability and capacity. The roles eligible for funding include clinical pharmacists to social prescribing link workers.
Brazilian Model	Community health workers (who live in the communities they service) visit households once a month and address needs in a personalised manner, signposting to and connecting to services as needed. This model brings primary care to the citizen and makes it part of everyday life
Co-morbidity	The presence of two or more diseases or medical conditions in a patient.
Complex needs	A term used to describe the health and care needs of individuals who often have multiple requirements often as a result of a single of multiple disease states
Connected Care	A digital care record system which contains information held at GP practices, hospital departments, community services, mental health trusts, out of hours services and local authorities. Supporting the identification of patients, and groups of the population, who could benefit from additional support or a different approach
Core20PLUS5	Link here. An NHS approach to informing and taking action to reduce healthcare inequalities in the most deprived 20% of the population (CORE20) and the PLUS population groups including ethnic minorities, inclusion health groups, learning disabilities, those with multimorbidity and protected characteristics etc. The approach defines a target population group (Core20PLUS) and then identifies 5 focus clinical areas requiring accelerated improvement (maternity, severe mental illness (SMI), chronic respiratory disease, early cancer diagnosis and hypertension case finding).
GP Leadership Group (GPLG)	The ICB has established a GP Leadership Group, whose remit is to represent the voice of general practice and elevate elected members of each Place to represent GPs alongside other system leaders such as Trust leaders.
NHS IMPACT	NHS ImPaCT (Improving Patient Care Together) is the new, single, shared NHS improvement approach. By creating the right conditions for continuous improvement and high performance, systems and organisations can respond to today's challenges, deliver better care for patients and give better outcomes.
Operational Pressures Escalation Levels (OPEL)	The NHS system used to effectively understand and manage day to day variations in demand and capacity across the health and care system, where OPEL 1 is low level pressure on NHS services and the system is functioning normally and level 4 is high pressure requiring additional intervention and action.
Patient Segmentation	The use of health and care data to divide a patient population into distinct groups based on specific needs, characteristics, or behaviors which then allows care delivery and policies to be tailored for these groups
Primary Care Access and Recovery Plan (PCARP)	The Primary Care Access and Recovery Plan is a national plan aimed at empowering patients, implementing Modernised General Practice, building capacity, reducing bureaucracy, all with the aim of improving access to primary care.
Pharmacy First	A national initiative - consultation service enables patients to be referred into community pharmacy for a minor illness or an urgent repeat medicine supply.
Pharmacy, Optometry and Dentistry (POD)	This is a term used to describe three of the four pillars of primary care – community pharmacy, optometry and dentistry.
Population Health Management [PHM]	A data driven tool / methodology that brings together data to understand and identify specific patient populations including their state of health and some of the factors that may drive this, so that health and care systems can design and prioritise particular services to support these.
Primary Care Network (PCN)	Groups of practices working together to deliver patient care to the local population who often have shared characteristics and supporting health and care services.
Triage	Sorting of patients according to the urgency of their need for care.
Units of Dental Activity (UDA)	The unit of payment / value given to a course of dental treatment. E.g. simple course of treatment such as an examination is 1 UDA. A treatment involving fillings or extractions is 3 UDAs. A course of treatment that needs lab work such as dentures or crowns is 12 UDAs.
Voluntary Community and Social Enterprise (VCSE)	An incorporated voluntary, community or social enterprise organisation that serves communities and is seen as an important partner for statutory health and social care agencies as it plays a key role in improving health, well-being and care outcomes.

Metrics: CVD and Access

Outcomes	Current Measure	Where we are today	Where we will be by 2025	Where we will be by 2027
Priority 1 - People get to the right support first time to meet their needs	1. Pharmacy First consultations [commenced 31 Jan '24] *	2,000 / month*	4,000 / month*	5,000 / month*
	2. No. of self-referral pathways accepting referrals	57%	85%	100%
	3. Improve patient experience of accessing primary care services **	TBC**	TBC**	TBC**
	4. Use of NHS App	60%	65%	80%
	5. No. of unique adult patients seen by an NHS Dentist	490,000	515,000	528,000
	6. No. of unique children patients seen by an NHS Dentist	215,000	225,000	235,000
	7. Improve capacity in primary care to enable those who need it most to be seen with easier access***	TBC***	TBC***	TBC***
Priority 3 – Supporting people to stay well, prevent ill health and minimise the impact of poor health, CVD Focus	1. People 18+ with hypertension managed to treatment target	66%	70%	77%
	2. Cumulative decrease in CVD-related adverse events: heart attacks [MI] and strokes [CVA]	82 fewer MI 124 fewer CVA	121 fewer MI 181 fewer CVA	210 fewer MI 313 fewer CVA
	3. Increase referrals to NHS Diabetes Prevention Programme	4,464 / year	4,700 / year	4,900 / year
	4. Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies	55%	58%	60%
	5. Increase in NHS health checks****			
	6. Increase in number of people identified earlier with hypertension****			

*There were 11,000 CPCS consultations in 23/24

** Metrics to be developed with new benchmarking surveys

*** Metrics to be developed with primary care partners

**** These are system-wide targets and require further discussion. We will partner with Public Health colleagues as well as primary care to determine a baseline and a trajectory for these measures

Metrics: INTs

Outcomes	Considerations	Indicative Measures
Priority 2 – Joined up, personalised, proactive care for people with multimorbidity and complex needs, INTs	For INTs, the outcome ambition will be dependent on the population identified; their needs, and type of service developed to support them. As such any measurement of outcomes and data to create a baseline will be dependent on that group. Therefore, we will not have an established baseline in the same way as we do for same day access and prevention, but rather will have a menu of measures and outcome options that INTs can choose to focus on, allowing the form and function of the INT to be determined locally but with guiding outcomes to achieve. The INT outcomes will be focused around: 1. Increased proactive prevention services and care to keep people well for longer, rather than waiting for illness to set in 2. Levelling up of outcomes e.g. people in deprived areas to experience better outcomes, equivalent to those in other areas 3. Reducing the need to access emergency or other unplanned health services because patients are provided integrated, personalised care in the community setting	These outcomes may look like the below and will be determined at Place and by service. 1. Increase in preventive service provision for target population 2. Proportion of people with long term conditions with shared care plans and increased enablers for the improved sharing of those care plans 3. Reduction in unwarranted variation in population outcomes 4. Increase alternative services to reduce emergency admissions 5. Reduction in emergency admissions for target population
More sustainable and resilient primary care	Whilst the BOB system like other parts of the country is under significant pressure in terms of workforce, funding and estates etc, supporting a more sustainable system is going to be critical to the delivery of the strategy, ensuring strong foundations so that primary care can thrive, and our population receives high quality care. Measuring sustainability will require further engagement with system partners to determine the priority areas that we want to impact and monitor and will be built into the delivery plans. Areas that we may choose to focus on could include: 1. Workforce – Making primary care a good place to work, recruiting and retaining staff; staff satisfaction with their work; fewer sickness absences and newly qualified leavers 2. Funding – shifting resource from acute providers to the community to invest in keeping people in the community for longer 3. Estates – efficient use of space for staff and services to support our growing population 4. Efficiency – reducing the administrative burden on providers so that teams have more time with patients	These outcomes may look like the below and will be determined at Place and by service. 1. Clinician (incl GPs) retention and growth rates 2. Patient overall satisfaction with primary care 3. ARRS % budget utilisation 4. Sickness absence rates 5. Leaver rates among newly qualified staff 6. Retirement rates 7. Higher proportion of clinical vs. administrative average number of EMIS entry types 8. NHS Staff survey (when introduced for primary care)