# The Big Primary Care Conversation Report

September 2024

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# Executive Summary

- During the summer of 2024, a series of engagement sessions were planned and undertaken with primary care to understand the current challenges and proposed solutions to support the achievement of the ICS vision of ‘creating a high-quality, community-centred health and care system’
- Sessions were well attended for GP practices with 57% of practices covering 63% of the patient population represented at the 6 Place-based half-day sessions; In addition, virtual sessions with pharmacy, optometry, dental and PCN nurses were conducted
- The priority areas identified for action across all 6 GP practice sessions highlight funding, workforce and workload as the top 3, with a further 7 focus areas. Communication and engagement ran as a thread through the majority
- The emphasis varied by place session, likely to be influenced by the patient population and specific structural challenges both historic and present in each Place
- Across the GP sessions, 44 outline solutions were developed. 75% of solutions proposed are major projects; 68% of all solutions proposed are for implementation across Lancashire and South Cumbria with 25% national
- 11 potential ‘simpler’ solutions/short projects were shared during the sessions
- All of the proposed solutions will require detailed review, comparison to work already planned or underway to identity where these can be incorporated, merged or added

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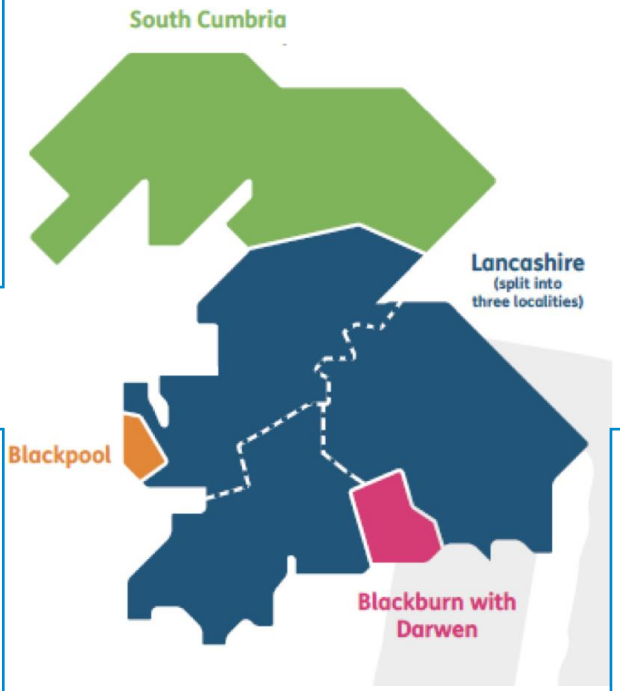

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# 1. Place-Based GP Practice Overview

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**South Cumbria**

- 27 practices
- 6 PCNs
- 195k Patient population
- Mix of coastal and rural areas, with some wealthy and some disadvantaged communities
- England's most sparsely populated local authority area, which makes it hard to deliver services and to provide public transport and transport connections




**Blackpool**

- 15 practices
- 5 PCNs
- 179k Patient population
- An urban coastal area, with a thriving tourist economy and a strong sense of community
- High levels of deprivation and a transient population, Blackpool residents have some of the most complex health needs in the country

**Blackburn with Darwen**

- 22 practices
- 4 PCNs
- 185k Patient population
- A semi-rural borough with urban areas around the towns of Blackburn and Darwen, and several small rural villages and hamlets
- A multicultural borough, the area is home to many people with diverse ethnicities
- and identities

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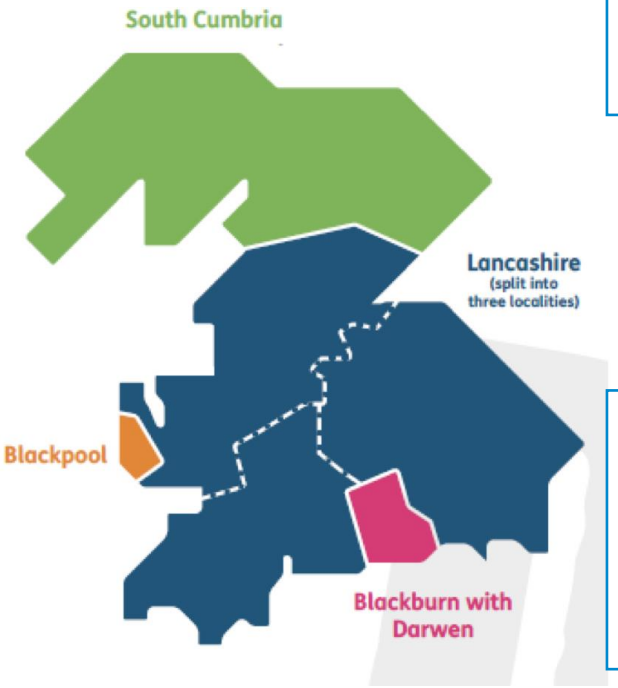
# 1. Place-Based GP Practice Overview

Qualitas

**Central and West Lancashire**

- 62 practices
- 11 PCNs
- 539k Patient population

- Lancashire is a varied place from the high moorland of the South Pennines to the flat expanse of the Fylde Coast and the countryside of the Ribble Valley and Forest of Bowland
- A combination of urban areas including Preston and Lancaster, former textile towns
- such as Burnley, coastal resorts, and market towns
- A mixture of wealthy and disadvantaged communities. In the more rural areas, poverty and social exclusion happen alongside people living in luxury
- Large areas of deprivation can be found in East Lancashire, Morecambe, Skelmersdale, and Preston




**North Lancashire**

- 22 practices
- 8 PCNs
- 347k Patient population

**East Lancashire**

- 47 practices
- 9 PCNs
- 406k Patient population

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# 2. Big Primary Care Conversation: Overall Approach

The ‘Big Primary Care Conversation’ was developed to bring primary care providers together as part of a series of structured engagement sessions to:

1. *Understand and shape what is important to primary care professionals in Lancashire and South Cumbria.*
2. *Understand and outline what role Primary Care can play as part of the ICB vision of creating a high-quality, community-centred health and care system.*

6 half-day engagement sessions were facilitated at each Place for GP practices across July and early August 2024 in addition to a number of online sessions with Pharmacy, Optometry, Dentistry and PCN lead nurses.

The workshop objective for each of these sessions was:

- To develop an understanding of what role Primary Care can play as part of the ICB vision of creating a high-quality, community-centred health and care system.

Context:

- Working together for the good of the community in Lancashire and South Cumbria.

Led by independent experienced facilitators for the GP engagement sessions, the workshops were designed to include two key facilitation methods:

1. Focused Conversation Method: Provides a setting and context for meaningful communication and allows groups to share diverse perspectives and gain insights.
2. Consensus Workshop Method: Used to facilitate decisions that respect the diversity of the perspectives within the group and inspire action.

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# 3. Workshop Methodology: GP Sessions

Each of the six half-day sessions were conducted using the same framework to ensure consistency in experience and to enable pan-ICB and place-based comparative analysis of the feedback and suggestions coming from the GP practice participants.

Each workshop took participants through the below four stage process (A-D):

**A: Hopes and Expectations:** Participants asked to share (using Post-It notes) their hopes and expectations for the session. This was followed by discussions in groups on the trends, concerns and frustrations in the sector and the importance of working together.

**B. Pre-Mortem:** Participants asked to project into the future to identify why the vision of 'creating a high-quality, community-centred health and care system' hasn't been achieved why would that be? Firstly, identifying all the issues that will lead to the vision not being achieved and then flipping those into areas to make changes to ensure the vision can be met.

**C: Identifying Priority Areas:** Through grouping and prioritising the areas identified requiring change, each group within each session captured their top 5 priority areas. These were clustered in each place session and the top 5 agreed with the group as the areas for solution development.

**D: Solution Development:** With the groups mixed and provided with a priority area to focus on, a simple framework was shared for each group to develop a proposed and actionable solution relating to their priority area. The instructions to the groups was to identify incremental changes that could be actioned. These were presented back within each Place-based session for comments and questions.

All notes from each session have been collated and analysed within this report.

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# 4. Session Participation

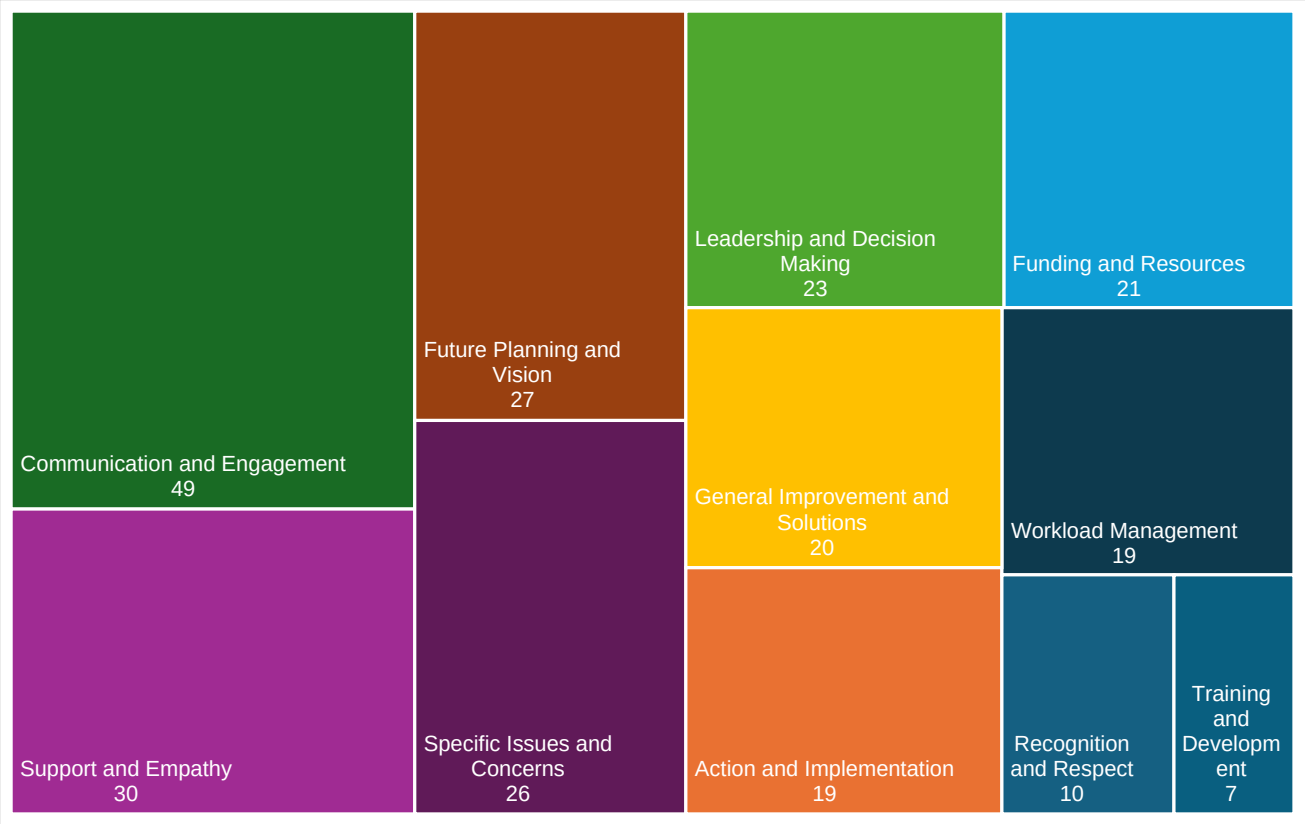
*57% of practices representing 63% of the patient population within Lancashire and South Cumbria engaged with the sessions*

| Place | Date | Venue | Total no. of practices | No. of practices attended | Practice Attendance % | No. of Participants |
|---|---|---|---|---|---|---|
| Central & West Lancs | 10-Jul-24 | Preston North End FC | 62 | 32 | 52% | 70 |
| East Lancs | 11-Jul-24 | Burnley FC | 47 | 28 | 60% | 65 |
| North Lancs | 17-Jul-24 | Ashton Hall, Lancaster | 22 | 9 | 41% | 23 |
| Blackpool | 23-Jul-24 | Blackpool FC | 16 | 11 | 69% | 28 |
| BwD | 24-Jul-24 | Blackburn Rovers FC | 22 | 17 | 77% | 44 |
| South Cumbria | 01-Aug-24 | Kendal Town Hall | 27 | 14 | 52% | 37 |
| **Overall** | | | **196** | **111** | **57%** | **267** |

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# 5. Hopes and Expectations

*For each Place-based session, participants were asked to share at the outset their hopes and expectations for the session.*



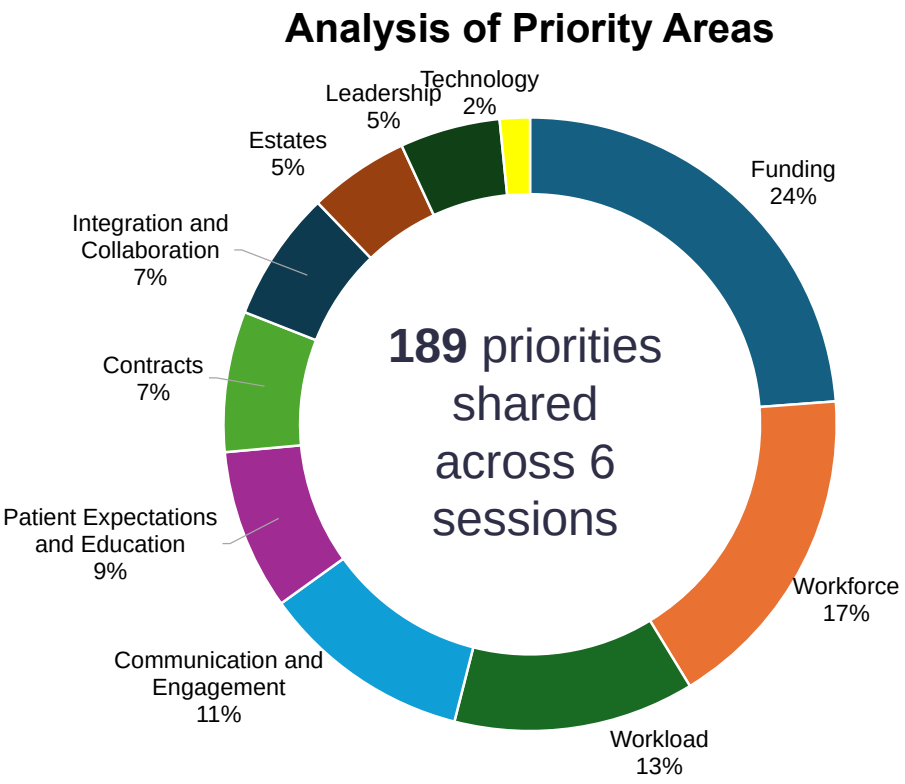

The hopes and expectations were categorised into the themes in the diagram.

**There was an overwhelming feeling amongst the participants for the need for action not just listening and discussion**

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# 6. Priority Areas

*The priority areas for action across all 6 sessions highlight funding, workforce and workload as the top 3, with a further 7 focus areas*




*Across all 6 sessions, participants were asked to work in groups to identify current challenges and then agree the top 3-5 priorities. This provides analysis of the top 3-5 priorities shared by each group across 6 sessions – resulting in 189 priorities, categorised into the 10 priority areas shown here.*

**FUNDING**

Critical need for increased and fair funding across estates, workforce, and infrastructure, with a call for more autonomy and flexibility in how funds are allocated and used at more a local Place/population level.

There is a clear demand for sustainable financial support that keeps pace with inflation and operational costs, allowing practices to adequately staff, manage workloads, and address health inequalities effectively. The quality contract was raised across all 6 sessions as a source of frustration with expectations and funding not adapting to local challenges and differing patient populations.

**WORKFORCE**

Concern and urgency around workforce issues highlight severe challenges including low morale, burnout, low remuneration, recruitment, retention and staffing shortages.

Demand for better recruitment and retention strategies, comprehensive support for clinical and administrative and management healthcare workforce, appropriate pay structures, increased and long-term investment in training and development. The importance of valuing staff, supporting partnership models, and implementing long-term workforce planning is underscored as essential for sustainable healthcare delivery.

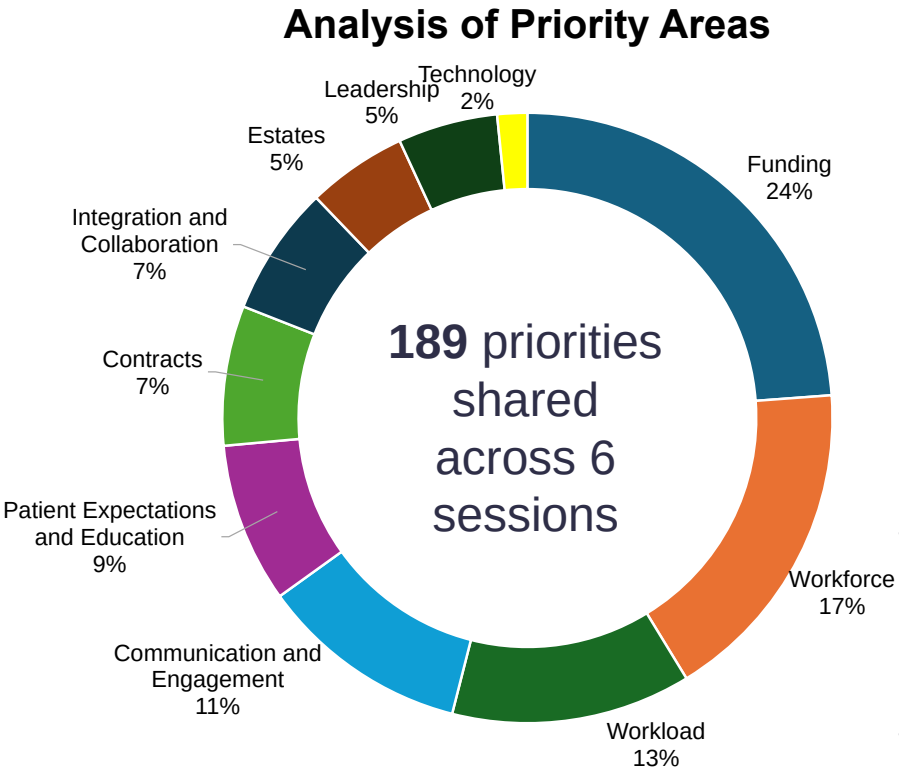
**WORKLOAD**

Significant frustration with increasing workloads being inappropriately transferred from secondary to primary care, leading to an unmanageable burden on GPs. Requirement for more realistic expectations, better sharing of responsibilities, and for secondary care to manage their own follow-ups, while emphasising the need for better support and understanding from the ICB regarding the pressures faced by primary care.

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**COMMUNICATION AND ENGAGEMENT**
Need for transparent, respectful, and consistent communication and collaboration between GP practices and the ICB, advocating for a supportive and engaging culture that values GP practice input and autonomy, and ensures meaningful consultation and cooperation.

**PATIENT EXPECTATIONS AND EDUCATION**
Critical need for public education campaigns and positive media coverage to manage patient expectations, promote the value of general practice, and counteract negative narratives, ultimately fostering a better understanding and appreciation of primary care services.

**CONTRACTS**
Simplified, clear, and achievable long-term contracts developed in consultation with GP practices, with realistic targets and expectations, and the removal of unrealistic and burdensome requirements.

**INTEGRATION AND COLLABORATION**
Better integration and collaboration across healthcare services to provide accessible, timely, and coordinated care, with a strong emphasis on involving GP practices and their PCNs in long-term strategic planning and making GP practices the central hub for comprehensive care delivery.

**ESTATES**
Significant investment in estates and premises to ensure adequate space and resources for expanding roles, training, and delivering primary care services efficiently.

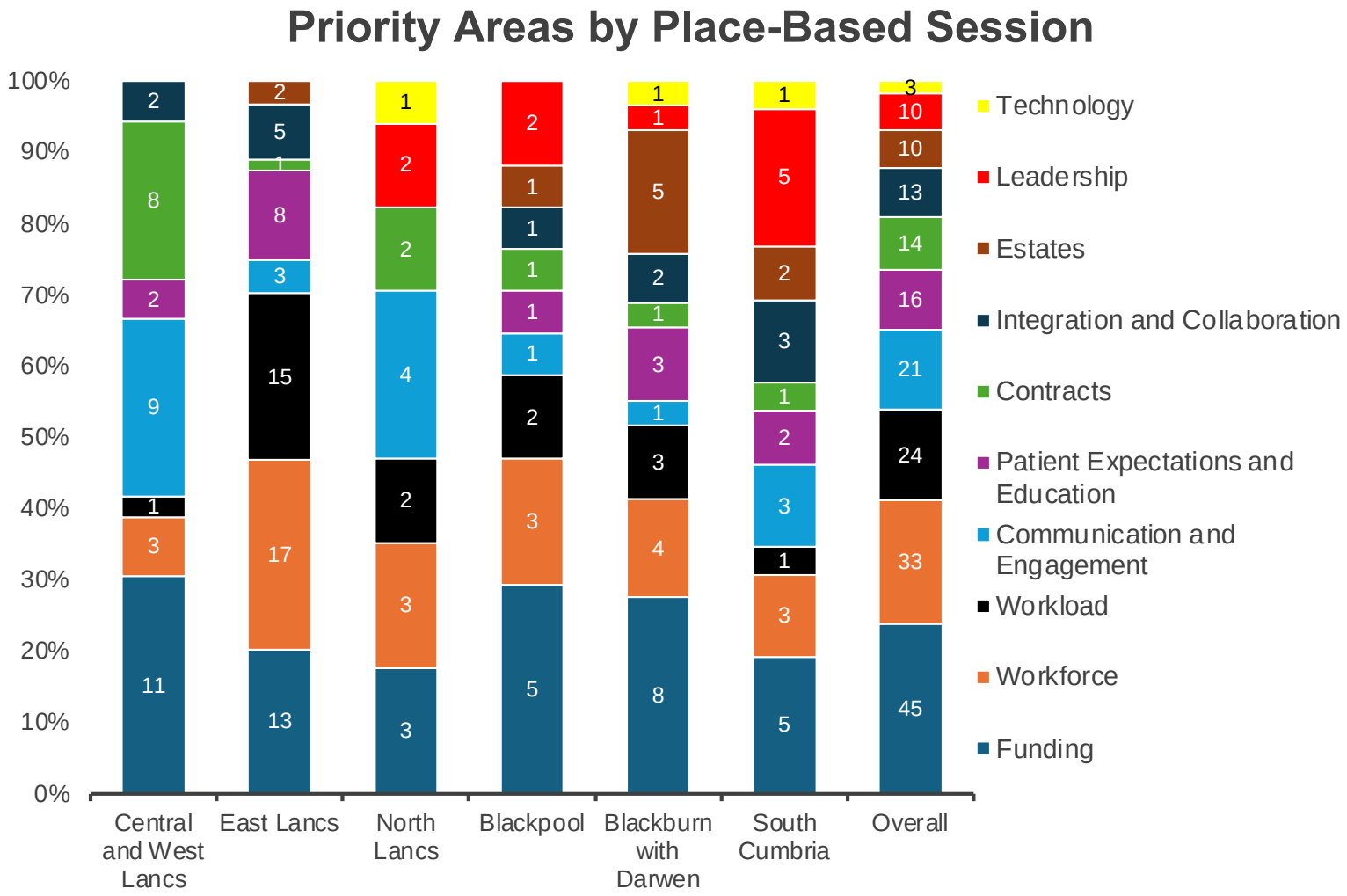
**LEADERSHIP**
Invest in local clinical and managerial leadership and granting more autonomy and trust to primary care and general practice, allowing GP practices and ICB leaders to collaborate on decision-making and implement community-level changes effectively.

**TECHNOLOGY**
Better integrated technology and standardised IT systems and processes across service providers to enhance efficiency and consistency across primary care services.

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# 6. Priority Areas by Place

*For each Place-based session, the emphasis between the priority areas showed some variation*

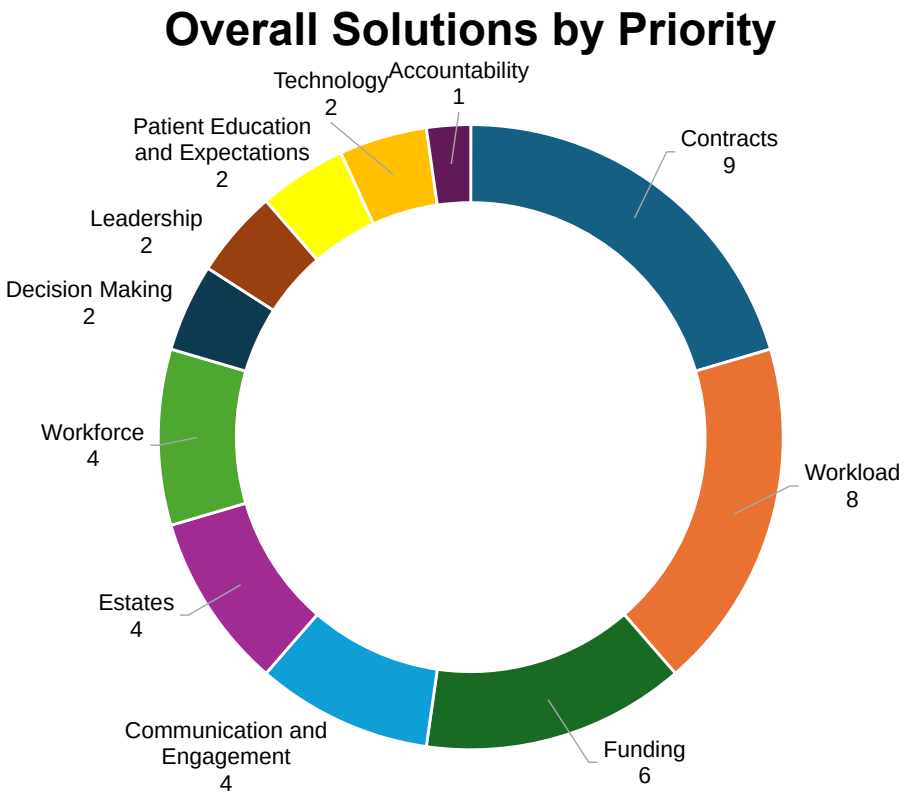


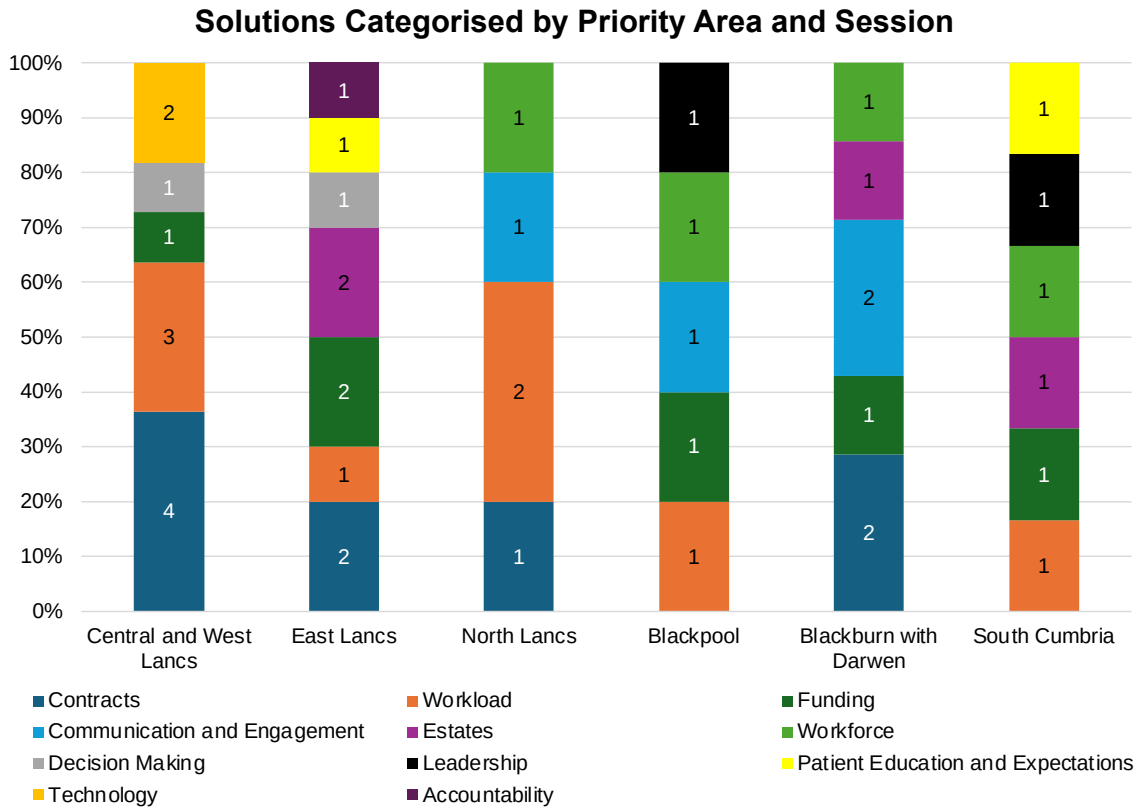

- There was considerable overlap between themes and priorities
- These have been categorised as a ‘best fit’
- In moving to the next stage of planning, prioritisation and implementation, the priorities shared will continue to be reviewed at a detailed level

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# 7. Proposed Solutions

*Based on the shortlisted priority areas, small groups in each session developed a total of 44 proposed solutions*



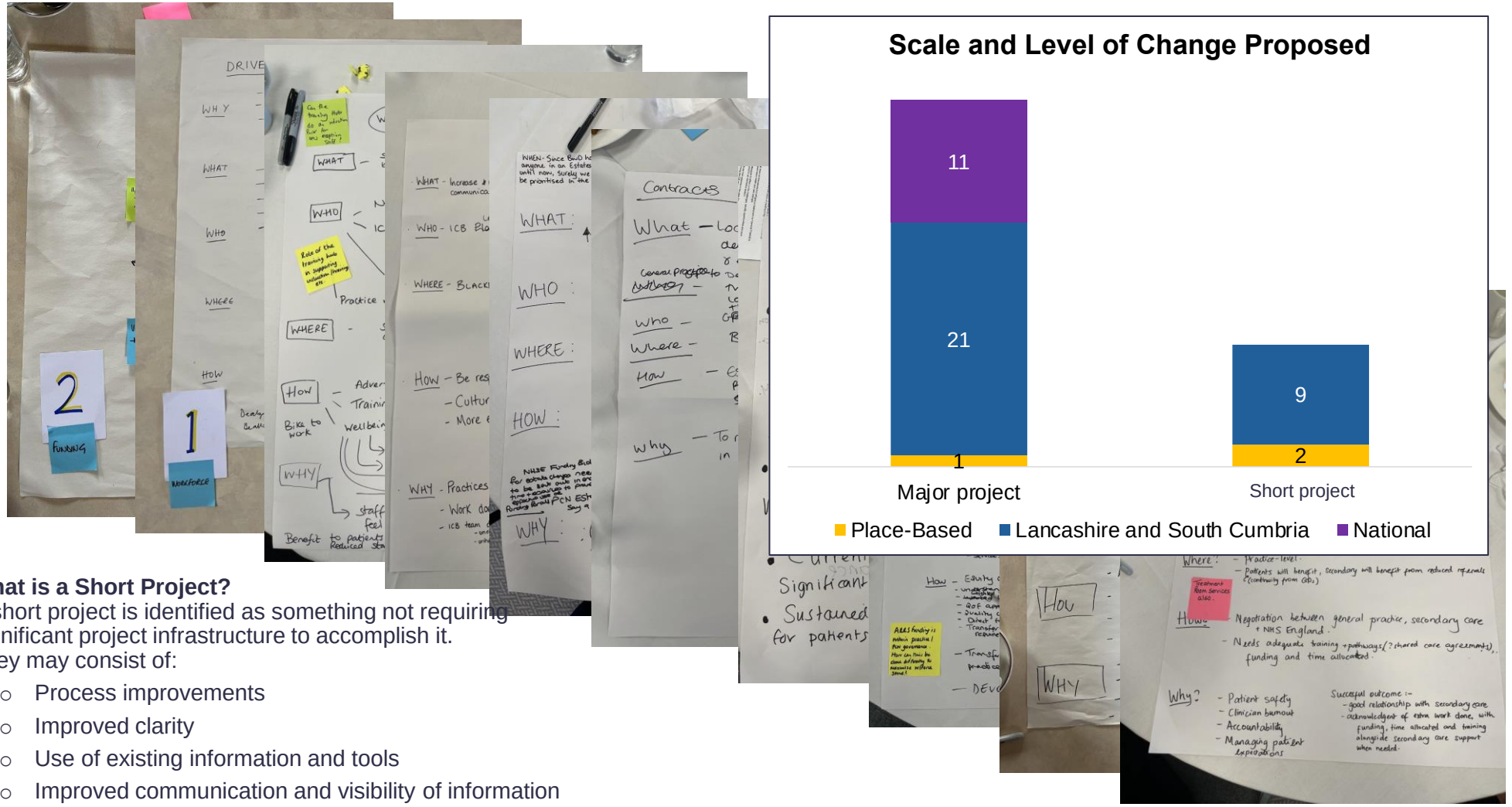




- During the sessions, the groups agreed the top 5 priority areas and then each group worked on a developing a tangible solution to one priority area
- During this process, some of the solutions shifted more towards other priority areas hence the difference between the priorities identified and the proposed solution categories
- Several solutions could have been categorised against more than one priority area. As the process progresses, the detail within each of these solutions needs to be further explored

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# 7. Proposed Solutions

*75% of solutions proposed are major projects; 68% of all solutions proposed are for implementation across Lancashire and South Cumbria with 25% national*




**What is a Short Project?**
A short project is identified as something not requiring significant project infrastructure to accomplish it.
They may consist of:

- Process improvements
- Improved clarity
- Use of existing information and tools
- Improved communication and visibility of information
- Or already be in progress.

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# 8. Proposed Short Projects

*The solutions identified as short projects are categorised across a range of priority themes*

| | PRIORITY AREA | NO. PROPOSED SOLUTIONS |
|---|---|---|
| ICB Level | Communication and Engagement | 3 |
| | Workload | 3 |
| | Workforce | 1 |
| | Decision Making | 1 |
| | Leadership/Engagement | 1 |
| Local / Place Level | Patient Education and Expectations | 1 |
| | Communication and Engagement | 1 |
| **Total** | | **11** |

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# 8. Proposed Short Projects

*The solutions identified as short projects are categorised across a range of priority areas at Lancashire and South Cumbria level*

The proposed solution action plans created at the workshops identify nine 'simpler' opportunities for the ICB. The titles of these are shared below:

**Communication and Engagement**

- ICB lead in each practice/regular meeting/creating network and platform - this person has a who's who contact details at level of ICB.
- Delegate responsibilities i.e. ICB, Federation. Appropriate person - Decision making. Correct representation. One point of contact - consistency locally.
- Increase and improve two-way communication thread which is responsive, transparent and local.

**Workload**

- Abolish expedite letters and chasing referrals. Could an intermediate service be set up?
- Feedback to ICB on case where clinical leadership with new structure was lacking, resulting in lack of support at sub place level. Clear pathways for escalating of clinical issues that are consistent. A review of the clinical leadership roles within the ICB to align with PCN & general practices priorities
- Pathway, work plan / secondary to primary, clarity.

**Decision Making**

- Transparent individual decision making at practice level for everything (e.g. quality contract parts).

**Workforce**

- Successful recruitment and retention of the required workforce for General Practice.

**Leadership/Engagement**

- An ICB Leadership that listens and involves General Practice in decision making

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# 9. Proposed “Major Projects”

*The majority of solutions developed in the sessions were major projects; more than half linked to funding, contracts and workload*

The priority areas with the greatest number of proposed solutions are:

- Funding
- Contracts
- Workload

Elements of these projects would be kickstarted by actioning the Short Projects.
There were core themes related to the Quality Contract running throughout.

There is a need to understand what is already underway and who the current stakeholders are internally. Once this is established, project owners and place representation can be aligned to the workstreams.

All of this is platformed by a Communications and Engagement Strategy as identified in the recommendations.

The titles of the proposed solutions developed in the 6 general practice sessions are set out on the next 2 pages.

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# 9. Proposed “Major Projects” list (1/2)

The proposed solution action plans created at the workshops identified 22 opportunities within the scope of implementation within the ICB footprint.

These will all require more detailed work, alignment with current work underway, some being combined/merged and prioritised. The titles of these proposed solutions, as set out by the groups at the sessions, are shared below and on the next page:

**Contracts**

- Consultation with practices and sign off long (12 months) before implementation of contracts
- Coproduced collaborative design of locally enhanced service and quality contract built bespoke to our communities
- ICB not enforcing secondary care contracts
- Immediate release of quality contract monies to practice level
- Local quality contract engaged in the development to reflect local needs and environment
- Long Term stability – All encompassing (Wrapping QC’s first etc) (pull costs not just staff) Global contract – funded appropriately with realistic targets /achievable (outcomes do not tick boxes)
- Looking at locality and population needs . Locally sourced q. Contracts Funding for this is essential for GPs
- One stable long-term contract (includes GMS + local contract all in one)

**Funding**

- Appropriately fund General Practice. Taking into account current underfunding, deprivation and needs of local population, high levels of inequalities
- End unfunded work
- Equality in funding - getting paid for the same work & parity across ICB/primary and secondary . Ability to direct funding to locally identified needs – flu vaccine
- Increase (ARRS) funding in primary care and remove restrictions
- Pay for work we do
- To understand what high quality care costs

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# 9. Proposed “Major Projects” list (2/2)

**Workload**

- Developing a system to stop the workload dump from secondary care. ICB investment in education, AI, culture change, trust, stopped at source
- Engagement with Local Authority (LA) and Integrated Care Board (ICB) for processes. SystmOne to share information across the ICS. Community pharmacy involvement in ICS. 24/7 urgent care service coordination with ICS. JUST (Joint Understanding and Shared Treatment) framework adoption. Establish access to patient records across ICS
- ICB not enforcing secondary care contracts
- Reduce inappropriate unfunded work trickling into general practice
- Work is dumped on Primary Care and is: Not funded, disrespectful, patients are passed from pillar to post, patronising, waste of time, costly, dangerous (lack of skill to manage safely)
- Currently one size fits all. Workload dumping from secondary without funding. Expedite letter suggestions from secondary care / cancellations

**Estates**

- Appropriately built/automated primary services purpose-built buildings. Increase capacity. NHS vs. private estates. Expansion. Rent cost comparisons. NOT centres. Consolidated clinics/cottage hospitals”
- For practices to have a greater influence on estates allocation and utilisation
- Improving capacity and current premises – utilisation of existing estates eg property services . New estates?
- Primary care estates that are fit for purpose

**Workforce**

- Ability to use ARRS money as the surgery deems fit for core roles
- Make GP Attractive to All Staff
- Practices are funded equally/ equitably to fund staff at the same rates/ with the same T&Cs as secondary care

**Technology**

- Clinical system accessible and standardised across primary and secondary care
- Interoperable, reliable, IT systems. Resolving IT support queries – accessible and timely

**Leadership**

- Allow each practice/PCN greater autonomy over service development and funding

**Decision Making**

- Accountability for service commissioning - transparent decision making

**Patient Education and Expectations**

- Patient education - Liaison between primary and secondary care

**Accountability**

- ICB to make services accountable for their own contracts and fairer share of the funding

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# 10. POD Sessions

- The six in-person workshops focused on General Practice within Primary Care.
- There were also seven online sessions:
  - Two for Pharmacy
  - Two for Optometry
  - Two for Dental
  - One for PCN Nurse Leads
- The common themes from the seven online sessions align strongly with the ones from General Practice:
  - Funding
  - Workforce (including education and training)

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# 10. POD Thoughts and Recommendations

- The POD engagement sessions took a different structure (partly due to numbers attending and online vs. Face to face) to the GP engagement the 6 in-person workshops.
  - This appears as quite a contrast, but it's the start of a process and future sessions are required.
- The POD themes that were output broadly align with the general practice sessions, but the context is different.
- PCN Nursing appear to sit distinct from POD and should be brought closer to the General Practice conversation.

- The next stage will require more sessions using the principles of Communication and Engagement as outlined in the General Practice recommendations to:
  - Gather additional data to ensure it is statistically representative.
  - Bring in broader perspectives.
  - Ensure the POD voice is represented in the big conversation.
  - Build on existing, successful engagement events that have happened. They are more likely to be well attended if they have happened this way before.
- Document and feedback the outputs using the same model as the report for general practice.

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# 10. POD Facilitator's Comments

- The Pharmacy, Optometry and Dental sessions started from a different place. The intention was to create a space that gave participants an understanding of the ICB and the Primary and Community Care Team as well as enabling them to articulate the hopes and challenges that impact them as professionals working within each sector.

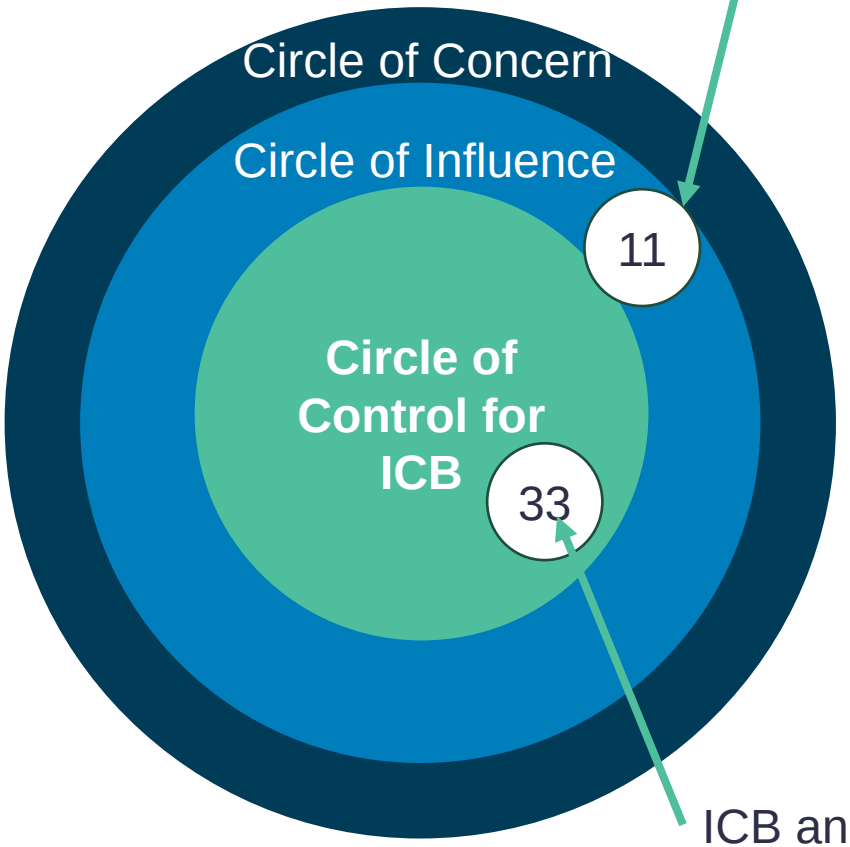
- Despite the small numbers of attendees at each of the sessions the conversations were all positive, constructive and insightful. Commonality of themes evolved and significant concerns about sustainability via funding and workforce were highlighted. It was possible to begin to draw some lines between sector specific concerns and how this could be linked up with existing ICB work (e.g. receipt of clinic letters for Optometry).

- The PCN nurse leads forum gave insight into the passion, commitment and frustration demonstrated by a part of General Practice services that doesn’t always get to contribute to system development. Following this up specifically in a more structured and inclusive manner will be critical.

Dr John Miles, August 2024

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# 11. Next steps




The proposed solution action plans created at the general practice workshops identified a range of solutions from shorter projects and major projects within the control of Place, practices or within the ICB to achieve.

Other solutions and priorities are outside the control of the ICB with the potential for the ICB to work with other stakeholders to advocate for primary care.

The major projects identified were typically high level solutions to significant priority areas. The next steps require these proposed solutions to be explored further alongside work already planned or underway to identify:

1. Opportunities to absorb these ideas into existing plans/projects
2. Opportunities to combine proposed solutions and create new projects/ workstreams to address identified issues
3. Opportunities to influence and advocate for primary care for priorities and challenges outside of the control of the ICB

The approximate timeline for these activities is on the following page

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# 11. Next steps timeline

**Report Sign Off** *August* | **Engagement** *September* | **Planning, Prioritisation and Implementation** *October onwards*

- CCPL Session
- LMC Session
- L&SC GPs Session
- POD Session
- ICB Primary Care Team Session

- ICB Executives
- Claire Fuller Visit

- Alignment Mapping
- Workstream prioritisation and sign-off
- Workstream initiation/ continuation
- Working groups per workstream

**Constraints:**
- Funding
- National changes (including contractual)
- October budget
- Other 'unknown unknowns'

Ongoing communication and engagement focus and improvement

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