Primary Care (1/6)

South East London Integrated Care System

Vision

The vision is for all residents of South East London to have access to high quality, personalised, integrated primary care services when they need it, delivered in a sustainable way.

Deliverables / Improvements since 2023/24

- Delivering an additional 288,000 general practice appointments
- Increasing use of the NHS App across SEL
- Increasing the number of self-referrals into community services by 17.5% between Q1 and Q3
- Increased uptake of Pharmacy First, hypertension and contraceptive services provided by community pharmacies across SEL.
- Implementing patient on-line triage consistently
- 80 GP Practices across the six boroughs using analogue or hybrid telephony solutions supported to transition to a new cloud telephony service
- Fully utilized ARRS budget across SEL to increase the primary care workforce
- Delivering the Support Level Framework (SLF) for practices, ensuring practice-based developmental plans are in place
- Publishing our plans to develop our collaborative approach to neighbourhood working

Key Challenges / Opportunities Remaining

Key challenges include;

- Limited availability of data on inequalities within primary care, and population health data tools
- An ageing primary care workforce, high turnover within certain roles and increasing stress within the workforce.,
- Growing sustainability and resilience challenges for primary care providers driven by a combination of finance, capacity and demand, infrastructure and relational factors.

Key opportunities include:

- Moving away from counting activity within primary care, to measuring the sectors impact on patient, staff and system outcomes
- A focus on collaborative neighbourhood working and shifting our approach to grow primary care's role within neighbourhood models.
- The expansion of the universal care plan beyond end of life care and to enable patient editable access
- Maximising additional roles as part of the Neighbourhood Health Service model - NHS England » Neighbourhood health guidelines 2025/26

Primary Care (2/6)

	What are our priority areas for 2025/26 (Max 4)	Why has this been identified as a priority areas?
1	**We will improve access by** understanding the drivers of poor access for population groups and co-develop approaches that tackle the complexity of the issue.	Successive initiatives that focus entirely on capacity have failed to address key issues for patients and their carers. Patient satisfaction with general practice continues to deteriorate. GP numbers are reducing but we have seen growth in the multi-disciplinary primary care team.
2	**We will make the shift to neighbourhoods,** working collaboratively with communities, health & care providers, voluntary organisations to improve the health and wellbeing of a local community	Neighbourhood working is a continuation of local, regional and national initiatives that have aimed to bring Primary and Community Care closer together.
3	**We will deliver high quality, equitable primary care that** minimizes unwarranted variation in clinical and care outcomes across all our communities,	Primary care delivers high quality care, but there is unwarranted variation in access, experience and outcomes driven by a range of factors. We need to better variation in outcomes and unwarranted variation and work collaborative with primary care to tackle the drivers behind this.
4	**We will improve the sustainability of Primary Care a**s part of the neighbourhood health service	Primary care is the cornerstone of the NHS, but the sustainability of services is at risk due to a combination of factors across finance, workforce, infrastructure and service demand, With limited resources, we need to more effectively target our support in the areas of most need and have a universal offer for all providers that maximises the levers under our local control

Primary Care (3/6)

South East London Integrated Care System

Priority Area:

We will deliver high quality, equitable primary care that minimizes unwarranted variation in clinical and care outcomes across all our communities,

What are the actions we will deliver in 2025/26

- Develop our primary care outcomes framework to better measure progress
- Expand clinical guidelines and support tools for general practice
- Use the new framework for immunisations and vaccinations to build in improved outreach
- Expand the use of the Universal Care Plan to improve personalized care
- Specific projects reducing variation in hypertension, diabetes, cardiovascular disease, respiratory diseases and chronic kidney disease.
- Scoping of approaches to reducing variation in chronic pain management

Population Health and Inequalities Impact

Inequalities are a key driver of unwarranted variation in clinical and care outcomes, and equally unwarranted variation in access and experience can drive broader inequalities. By taking a systematic Through a more systematic programme of work we will identify the areas where we can have the greatest impact for our population

System Sustainability Impact

By reducing unwarranted variation in clinical and care outcomes, we will improve the earlier identification and management of ill health within our population and better support our population to stay well within their own homes. This will help to dampen future growth in demand across all parts of the health system.

Priority Area:

Improve Access -We will work to increase capacity and improve access for all residents and achieve positive experiences of care through new technologies, innovative models of care, fit-for-purpose estate and direct access to care and diagnostics.

What are the actions we will deliver in 2025/26

- Review options to further widen the upstream services for patients include community pharmacy, voluntary sector services and self-referral pathways
- Identify the components of access and where there is significant impact on certain populations and groups of patients and develop a population health driven framework for same day access in primary care
- Work with practices and PCNs to improve the experience for patients in booking and accessing primary care
- Continue to deliver on the Primary Care Access Recovery Plan commitments

Population Health and Inequalities Impact

- Delivering improved access to primary care services for those people who currently may struggle to receive services
- To offer care that is patient centred and culturally sensitive having considered the barriers to access for this group

System Sustainability Impact

- Ensuring the effective and efficient use of both the services and the service users time and resources
- Reducing the numbers of people who experience poor access and therefore are making decisions to access other less-appropriate services

Primary Care (4/6)

South East London Integrated Care System

Priority Area:

We will improve the sustainability of Primary Care as part of the neighbourhood health service

What are the actions we will deliver in 2025/26

- Targeted projects to improve recruitment and retention of primary care staff
- Develop a workforce hub on the general practice extranet providing practical support
- Facilitate a PCN Clinical Director Learning Network
- Provide evidence on most effective use of ARRS staff to improve patient care
- Develop a primary care sustainability and commissioning framework
- Test and share learning from automation approaches within primary care
- Develop approaches to better target primary care resources at areas of greatest need
- Clarify the primary / secondary care interface via a collaborative agreement.

Population Health and Inequalities Impact

Primary care is the cornerstone of the NHS and the entry point to care for our population. The sector is under unprecedented strain which risks its future sustainability. Through this priority we want to ensure our services remain sustainable and areas with most need receive targeted, proactive support to maintain equitable access.

System Sustainability Impact

Through this priority, we expect to systematically tackle the issues within our control affecting the stability of primary care, so that services are able to meet the growing needs of our population for both episodic and proactive care. In turn we expect this to help us a retain our primary care providers within South East London and enable

Priority Area:

Neighbourhood working – we will continue with the collaborative approach that brings together communities, health and social care providers, and voluntary organisations to improve the health and wellbeing of a local community

What are the actions we will deliver in 2025/26

- Develop a population health management approach to enable proactive identification and management of residents
- Identify and agree workforce, skills and resource requirements for INTs to meet population need
- Scale the 3 population Integrated Neighbourhood Teams (INTs) in all boroughs
- Design and agree integrator functions and arrangements
- Agree and track measures for success
- Putting in place a collaborative learning environment

Population Health and Inequalities Impact

Use population health data to proactively identify residents within target populations and connect them into the services that they need to reduce the risk of escalating poor health and stay well for longer. To address inequalities effectively, INTs will need to be wider than health e.g., addressing social determinants like housing and be community-based

System Sustainability Impact

- There are significant costs associated with the failure to prevent ill health, to detect and intervene and to mitigate complications.
- Strong and shared economic case especially for the working age adult population – to prevent people becoming economically inactive and to support people back to work.

Primary Care (5/6)

South East London Integrated Care System

Priority	What are the outcomes we are aiming to achieve?	How are we measuring impact?
Primary Care Access	• A deep understanding of the different components of access to primary care and the barriers that some of the population experience • A co-developed and agreed plan with practices, PCNs and local communities to tackle the barriers that does not focus on capacity in its entirety but recognizes the complexity of the issues • Our population know how and are support to access the right care, in the right place and the right time and are able to access appropriate care via digital, telephone and face to face routes as aligned to their need.	• GP Patient Access Survey • Friends and Family Test • Data sources with patient experience insight • GP Appointments Data • Pharmacy First data • NHS App utilization • % and number of patients receiving treatment in community pathways who self-referred
Neighbourhood working	• Our population receives holistic, person-centred care, closer to home • Support and enable cross-system leadership, holding collective responsibility for ensuring that the infrastructure, systems and processes needed to deliver integrated neighbourhood working are in place and remain fit for purpose • We understand our populations health need and proactive identify residents that need the most support.	• An outcome based framework will be produced with a range of consistent and clearly defined metrics • A set of quality improvement metrics • A process for evidence gathering and rigorous and rapid evaluation • There is a SEL Population Health Management solution available consistently across SEL.
High quality, equitable primary care	• Patients receive a high quality of care and this does not vary by population group or geographical location. • We identify disease earlier and optimise treatment and this does not vary by population group or geographical location • We deliver more proactive, personalised care (including prevention and screening* within population groups currently experiencing health inequalities	• Changes to disease registered under the Quality Outcomes Framework • Key clinical markers – i.e blood pressure control and diabetes control • Care plan creation within health inequalities groups • CQC rating improvement • Immunisation and vaccinations within health inequalities groups • Referrals into preventative services within health inequalities groups • Smoking status, weight and alcohol use data
Sustainability of primary care	• Primary care providers feel more confident about their future viability • Staff have increased satisfaction in their roles and improved wellbeing • The size of the primary care workforce aligns with increased demand for care • We have better systems to identify and support providers who are finding it challenging to maintain their services • We work in a trusted and collaborative way with our primary care providers	• A reduction in the number of primary care providers choosing to hand back their NHS contracts • An increase in the whole time equivalent workforce per 100,000 population and a reduction in the variation between different areas

Primary Care (6/6)

South East London Integrated Care System

What do we need from enablers and partners to deliver?

Workforce
- Integrated workforce planning support at neighbourhood level
- Developing a neighbourhood first culture across the health and care workforce

Digital and Data
- Population health analytical tools to segment and stratify patients at practice and neighbourhood levels used linked data
- Tools to support more efficient proactive care management via integrated teams, ideally moving to automated processes over time.
- Increasing functionality of shared care records to support neighbourhood working

Estates
- Investment in long term estates planning for neighbourhoods

How will we work in collaboration with our system?

We will work across out 6 local care partnerships to co-produce common frameworks, standards and outcomes and to enable effective shared learning. We will use the Neighbourhood Based Care Board to ensure plans are developed and approved with key system trust partners and with enabler programmes

We will work with primary care providers and representatives at place level, and through the SEL Primary Care Leadership group to codevelop solutions to the challenges we are trying to address. We will use primary and secondary care interface groups to improve relationships and ways of working across sectors. We will also build collaboration across primary and community care, secondary care and the Voluntary and Community Sector via Local Care Partnerships and neighbourhood working.

How will we engage with our population?

We will be embarking on significant engagement with our population around integrated neighbourhood working and what this means for our services will be delivered in the future. This will predominantly be undertaken within boroughs and through a variety of mode.

We will be co-producing targeted campaigns for specific areas of our plan e.g. vaccinations and screening. We will also be using our guide to healthcare to support patients in accessing the right care, in the right place at the right time.

How will we monitor and share progress?

We will be producing a quarterly primary care assurance report that will be used to track our progress in delivering our local and South East London wide plans. This will be shared with our public via the Integrated Care Board and via our Local Care Partnership meetings.

Longer term, we have set out in our plan ambitions to develop a South East London outcomes framework for primary care and neighbourhood working. As part of this work, we will be exploring how we can improve access to outcomes data for our residents so that we can share where we are making progress and where there is more that we need to do.