South East London Integrated Care System

Primary Care

NHS South East London

Overview of our current system

South East London is made up of 6 boroughs with a range of primary care services serving our population including 195 general practices, 35 primary care networks, 7 GP federations and 324 community pharmacies. General practice across the system have been configured in a variety of ways including some 'at scale' arrangements, partnerships of GPs and other health care professionals and corporations. Community pharmacy, dental and optometry contracting and commissioning will be delegated from NHS England to the ICB from April 2023. Primary Care serves a diverse population made up of some of the most deprived and most affluent communities, more than 200 ethnicities and speakers of 150 languages, and from all social and economic backgrounds.

Strengths / opportunities

- General Practice is all about **relationships** and has built a significant amount of **trust** with their registered lists and despite some people finding it hard to access services the feedback through the GP Patient Survey remains broadly positive and provides the opportunity for developing the dialogue about integrated neighbourhood teams with local communities
- **Established local partnerships** - supporting the growth and development of neighbourhood teams
- Relationship with community pharmacy and their position in local communities
- Local Care Partnership appetite to **develop primary care leadership** alongside partners other than general practice
- Well established virtual provision and a range of **digital** tools to support PC
- Further opportunity to develop **collaborations** from good working relationships between boroughs and with SEL teams
- **Additional Roles Reimbursement** investment
- **Next Steps for Integrating Primary Care –** Fuller Review recommendations
- **Primary Care Leadership Group**
- The delegation of **community pharmacy, optometry and dental commissioning** and contracting from NHS England to the ICB

Challenges

- **Workforce recruitment and retention** – aging workforce (GPs and nurses) challenging to attract new workers and trainees, relative to more metropolitan boroughs
- **Complexity** - Increasingly, more complex care is being delivered in the community
- **Resilience** - Supporting GP practices to improve their sustainability
- and resilience
- **Estates –** older GP estate with lease challenges and limited opportunities to accommodate an expanded workforce
- **Inequalities –** significant in borough variations in health outcomes based on geography and demography
- **'Access' –** getting people the right support, in the right place at the right time
- **Continuity** – for patients requiring with long term conditions and/or multiple complex comorbidities
- **Covid backlog –** management of Long Term Conditions and onward referrals
- **Reducing the variation** in clinical care and increasing the quality of care consistently across providers of primary care services
- **Collaboration** across pathways between primary, secondary and community care
- Maturity of the primary care system as PCNs continue to get established, federations working to understand their role and practice resilience issues being addressed
- **Organisational development** – primary care system having the time to develop their partnerships, collaborations and leadership

Primary care - Our vision and objectives

Our vision

All residents of South East London access high quality, personalised, integrated primary and community care services when they need it, delivered in a sustainable way. Continually improving people's experiences of health and care services, making primary and community care a great place to work, and take proactive action against health inequalities to support our local communities to enjoy better health and wellbeing outcomes throughout their lives.
Primary Care services will work with partners to actively identify inequality and its causes and address them collectively and sustainably by:

- Helping people stay well for longer – as part of an ambitious and joined-up approach to prevention
- Delivering proactive, personalised care – supported by integrated neighbourhood teams for people with more complex needs, including those with multiple long-term conditions.
- Streamlining access to care - providing people who use health services infrequently with much more choice about how they access care, and ensuring care is always available in their community when they need it.

Our key objectives – what we want to achieve over the next five years

- **Improve patient experience** when using primary and community care services through integrated health and care services
- Deliver **integrated health and care closer to home** for individuals with multiple long-term conditions to support them to achieve better quality of life, supported by digital tools
- **Reduce health inequalities** by improving access, experience and outcomes for our Core20PLUS5 population
- Reduce avoidable use of unplanned care and avoidable exacerbations of ill health
- **Embed population health management** approaches in care delivery, using data to identify need and how to address it
- Achieve high levels of **staff retention and job satisfaction**, through opportunities for development, multidisciplinary working and effective coordination
- **Grow a health and care workforce** that collaborates to support people to stay independent and healthier for longer and is supported through integrated digital tools
- **Embed personalisation and supported self-care** into our service model
- Maximise the opportunities to support all of our primary care contractors being able to secure these objectives

Primary Care Themes

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 care for the population

Partnership/Collaboration: To deliver the national, regional and local requirements in partnership with the ICB, Local care partnerships, and general practice

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

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

Integrated: To support the development of integrated neighbourhood teams and integrated same day urgent care services

Equity: Supporting primary care to continue to build trust and relationships with their patients, two key ingredients to mitigating the social and structural drivers of inequities

Personalisation/proactive: To support patients to take a more active role in improving and managing their own health and be better information about which professional is best able to help them

Development: To enable Local Care Partnerships to lead the development of the transformation strategy for primary care within the ICB

Primary care - Our priority actions

Our priority actions – what we will do

★ ICS Strategic Priority

1. **Integrated neighbourhood teams** - Through our local care partnerships we will develop and embed integrated neighbourhood teams to support populations, establishing a workforce spanning primary, community, voluntary sectors and beyond, utilising technology and systems.

2. **High quality primary and community care** - We will deliver high quality primary and community care, and minimise unwarranted variation in clinical care and outcomes across all our communities, using data and digital solutions effectively.

3. **Sustainability of general practice** - We will improve the sustainability of general practice as part of a place-based, integrated systems, building a pipeline of skilled clinicians and professionals. This would include developing further the flexible staffing pool arrangements across SEL, increasing the number of clinical and non-clinical roles (including those funded by the Additional Roles Reimbursement Scheme), while helping existing staff to continuously learn and develop. We will continue to support opportunities for voluntary, community and social enterprise sector partners to become a meaningful part of the primary care team.

4. **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.

Priority action – integrated neighbourhood teams

Integrated neighbourhood teams

★ ICS Strategic Priority

Through our Local Care Partnerships we will develop and embed integrated neighbourhood teams to support populations, establishing a workforce spanning primary, community, voluntary sectors and beyond, utilising technology and systems.

How we will secure delivery

Actions for 23/24

- Develop and agree an approach to population health management which will support boroughs to identify their population cohorts
- Develop and pilot a workforce planning tool in Lewisham which all boroughs will be able to utilise
- Engage workforce expertise for each borough to enable them to utilise the planning tool and therefore plan the current and future workforce requirements for their integrated neighbourhood team
- Develop a shared description of an integrated neighbourhood team and a set of common outcomes and standards

Actions for 24/25

- Develop and agree approaches to align financial and contracting models to support integrated neighbourhood teams
- Develop Population Health Management tools which support delivery of care by INTs, including risk stratification and proactive case management
- Develop and test approaches to enhance INT working with digital innovations and tools

Intended outcomes in 5 years time

Collaboration between all providers across defined geographical areas, working seamlessly to support their local population's needs.

- Alignment of the clinical and operational workforces of community health providers with neighbourhood areas or 'footprints' working alongside dedicated, named specialist teams from acute and mental health trusts, particularly community mental health teams.
- Collaboration between previously siloed teams and professionals doing things differently and improving patient care for whole populations.
- Teams from across PCNs, wider primary care providers, community care, mental health, secondary care, social care teams, and Voluntary, community and social enterprise sector (VCSE) staff working together to share resources and information.

Priority action – high quality primary and community care

High quality primary and community care

★ ICS Strategic Priority

We will deliver high quality primary and community care, and minimise unwarranted variation in clinical care and outcomes across all our communities, using data and digital solutions effectively.

How we will secure delivery

Actions for 23/24

- Agree with boroughs the priorities for Clinical Effectiveness SEL in 23/24
- We will further develop and utilise the primary care quality dashboard
- Embed personalisation into our primary and community services
- Develop and agree a SEL wide immunisation and vaccination strategy which sets out agreed standards to be delivered locally
- We will develop tools, resources and reports for Local Care Partnerships and ICBs on unwarranted variation across key clinical outcomes
- We will further embed and develop our CESEL approach
- We will mobilise our population health management approach across SEL
- We will further develop our relationships with community pharmacy

Actions for 24/25

- We will develop aligned system-level approaches to incentivising shared outcomes, with a focus on reducing variation in access, experience and outcomes for health inequalities groups
- We will develop tailored approaches to delivering high quality and effective personalised care for those who experience the most barriers in accessing care
- Develop a menu of self-care and self-management options for patients living with our most prevalent long term conditions

Intended outcomes in 5 years time

Improved understanding of our population's needs, identification of causes and actions to address health inequalities as place-based systems, underpinned by data accessible to primary and community care providers, and partners.

- Active contribution healthy lifestyles prevention pathway
- Support for the prevention and early diagnosis of chronic conditions
- Use of personalised care to support patient groups, for example immunocompromised, long term conditions
- Supported self-care
- Improved immunisation uptake
- Development of a neighbourhood-level response to outbreaks and incidents
- Further development of antibiotic stewardship
- Accessible and integrated population health data and clinical effectiveness dashboards

Priority action – improve sustainability of general practice

Improve sustainability of general practice

★ ICS Strategic Priority

We will improve the sustainability of general practice as part of a place-based, integrated systems, building a pipeline of skilled clinicians and professionals. This would include developing further the flexible staffing pool arrangements across SEL, increasing the number of clinical and non-clinical roles (including those funded by the Additional Roles Reimbursement Scheme), while helping existing staff to continuously learn and develop. We will continue to support opportunities for voluntary, community and social enterprise sector partners to become a meaningful part of the primary care team.

How we will secure delivery

Actions for 23/24

- Further develop the flexible staffing pool model across SEL
- Develop and agree a strategic approach to the recruitment, retention and employment of ARRs roles to support PCNs to fully utilise the resource available to them.
- Embed within the SEL workforce plan a campaign to attract and recruit additional primary care staff
- Undertake a workforce planning exercise in one borough
- Explore opportunities to work closely with community pharmacy in SEL

Actions for 24/25

- Scale and spread integrated workforce planning models across SEL
- Test and evolve shared employment models that support integrated neighbourhood team development
- Review opportunities to move towards equalised pay across out of hospital staff working within the health and care sector
- Review opportunities to move towards the London Living wage.

Intended outcomes in 5 years time

Primary Care workforce and estate meet the capacity to provide high quality care, closer to patients' homes, making SEL a great place to work and live.

- Integrated services being delivered in the home and in localised settings including GP premises and community facilities.
- New models of care to improve services and reduce costs (including estate costs) and deliver sustainable services going forward, taking a flexible approach to estate provision.
- Recruitment of more newly qualified GPs, practice nurses and other primary care roles to address an ageing workforce and future shortages
- All staff roles embedded and utilised effectively, underpinned by collaborative workforce planning and data driven decisions
- Primary care is an attractive place to work, with staff recruited from and reflective of the populations that they serve.
- VCSE organisations are part of the primary care team, providing additional skills and knowledge

Priority action – improve access

Improve access

★ ICS Strategic Priority

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.

How we will secure delivery

Actions for 23/24

- Each borough will work with SEL enabling functions to clearly define the requirements of their practices for
  - Estates
  - Digital applications
  - Telephony
- Agree a borough access improvement plan down the practice level
- Deliver the requirements of the primary care recovery plan
- Identify options by borough of options for shared back office services

Actions for 24/25

- Identify and test options for the delivery of same day access to general practice services at-scale, integrated with other services at a neighbourhood level
- Increase access to online GP registration to improve the ease of registration for out population
- Building on learning from vaccinations, test innovative models to the delivery of proactive care through outreach and digital innovation

Intended outcomes in 5 years time

Digital enhancements will enable service transformation in South East London to deliver the best healthcare outcomes for our citizens at all stages of their lives.

- Reduce unnecessary variation and duplication – take what works best and make it available across SEL to optimise existing investment
- Seamless access to online and video consultation appointment booking and health records via a single entry point utilising the NHS App
- An equitable offer and experience of primary care services
- Streamlined access and reduced appointment wastage using online triage
- Shared and joined up of back office functions to improve efficiencies across PCNs
- Increased digital maturity and optimised online presence
- Work at scale across PCNs utilising cloud based telephony

Primary care - Enabler requirements

Workforce

- Data-led workforce planning; understanding workforce profile (including ageing workforce) and developing plans in response
- Making SEL an attractive place for staff to work and stay
- ARRS workforce planning and Training Hubs to support PCNs to understand their workforce, how it can be maximised, and support them to recruit to new roles
- Training hubs to support practices and PCNs to consider how to attract staff and act as supportive employers
- Utilising supply routes such as Training Nursing Associates/Nursing Associate ARRS roles
- Develop plans with training hubs for involving VCSE providers in the primary care team to support retention, reduce burnout of wider primary care workforce and benefit from their strengths within local communities

Digital

- Continue working with PCNs to explore innovative ways to improve digital maturity and collaborative working to manage demand and improve patient pathways
- Efficient scaling and adoption of digitally sustainable solutions across the wider system
- Support PCNs to collaborate with broader health and social care teams, acute trusts, mental health and community services
- Improve patient access by supporting PCNs to optimise processes for more online consultation (when appropriate) to improve referral to the right clinician first time
- Further improve on the good utilisation of the NHS mobile app across primary care
- Improve use of individual and group video consultations, social media, practice websites, telephony, record access, repeat prescriptions and online appointment booking
- Develop clear support around social media use and best practices guidance for optimising website design and use
- Support practices and PCNs to manage access to patient records in a safe and robust way and empowering patients to take control of managing their health
- Identify opportunities to utilise Remote monitoring and the universal care plan

Estates

- Produce baseline data packs for each PCN
- Complete space utilisation studies across primary care sites in South East London
- Develop PCN estates strategies that are aligned to PCN clinical strategies
- Support practices and the ICB with strategic planning to optimise the current GP estate and provide further evidence to support business cases as required
- Ensure a pipeline of prioritised schemes for the London Improvement Grant (LIG) and other capital funding opportunities

Data

- Improving the accuracy and quality of reporting of primary care activity - working with each practice to analyse, diagnose and facilitate how appointments should be mapped and coded to ensure accurate reporting in-line with National Slot Categorisation
- Development of more robust workforce data and capacity/demand data
- Use of demand and capacity tools to improve insight at practice and PCN levels to ensure workforce planning is optimal
- Use of risk stratification tools to give clinicians better opportunities to identify and prioritise people who may benefit from an proactive care offer
- PHM tools with actionable dashboards for integrated neighbourhood teams that enable drillable patient level data
- Dashboards which clearly demonstrate unwarranted variation in access, experience and outcomes. Outcomes/clinical effectiveness - variation