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. We will work with practices, PCNs and their patients to develop models which support delivery of same day demand in the most efficient way.

5. **Cutting bureaucracy –** We will improve the primary care secondary care interface by standardising approaches to pathway and service design, convening and supporting interface forums and enhancing mutual understanding of clinical and operational pressures across organisational boundaries

Primary care - Our progress to date

Key Successes in Delivery in 2023/2024

- Focussed work on improving utilisation of ARRS funding has resulted in a significant increase in utilisation [include %]
- Completion of population health data packs and workshops in 5/6 boroughs, with identification of key focus areas across each PCN
- Co-production of integrated neighbourhood teams in all boroughs for patients with multiple long term conditions (starting with cardiometabolic diseases)
- Closer working with community pharmacies i.e the delivery of Pharmacy First
- Implementation of primary care workforce plan
- Delivery of the Primary Care Access Recovery Plan, particularly telephony improvements, access improvement plans and self-referral pathways.
- Local Support Level Framework and GPIP plans in place tailored to local requirements
- Development of BI tools to support primary care: Quality, Access, LTC and ARRS
- SEL Dental Transformation and Development group established

Key Challenges Delivery in 2023/2024

- Varying levels of primary care system maturity and development
- Capacity / capability to support strategic planning at all levels of the system.
- Having the necessary infrastructure for expansion of workforce and development initiatives, and the required links into the People programme.
- Differing levels of quality in read coding of activity in primary care which impacts on data quality feeding strategic planning and population health analysis.
- Developing effective integrated models between general practice, primary care and wider community/social care.
- Reducing unwarranted variation in clinical outcomes across SEL.
- Impact of management cost reduction on system capacity and ways of working
- Developing effective collaborative system leadership across primary care
- Lack of clarity regarding future GP contract
- Systematic and sustainable improvements to the primary and secondary care interface.

Learning and Implications for Future Delivery Plans

- Collaboration across primary care, PCNs, Federations and LCPs will be key to delivery of plans in light of capacity constraints. This needs to be supported through delegation and effective collaborative decision-making structures
- PCNs need continued support and dedicated time to mature structures, developing strategy and cohesion – particularly in developing our networks beyond general practice.
- Our practices are open to change and are receptive to data highlighting areas where improvements can be made, but demand continues to grow limiting space for transformation
- We need to continue to develop the relationship between the ICB and primary care, with the ICB acting as an enabler and supporter of primary care and PCNs.
- New models of care require significant investment in OD and cultural change with our front-line teams

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 24/25

- Develop a systematic approach to integrated workforce planning using learning from pilots delivered in 2023/24
- Support the Neighbourhood-based Care Board to develop a shared vision for the future of primary care and model of proactive, neighbourhood based care.
- Develop standardised approaches to population segmentation, stratification and proactive care that enable Integrated Neighbourhood Teams to flourish.
- Develop and agree approaches to align sustainable financial and commissioning models that support integrated neighbourhood teams
- Undertake a stocktake of Fuller implementation for the ICB Board.
- Deliver key improvements to the primary and secondary care interface

Actions for 25/26

- Test digital innovations that support integrated neighbourhood team delivery (subject to funding)
- Delivery priority actions arising from the stock of Fuller implementation
- Understand and manage impacts of new GP contract settlement on Fuller implementation and maximise opportunity
- Deliver further improvements to the primary and secondary care interface

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 24/25

- Develop aligned system-level approaches to incentivising shared outcomes, with a focus on proactive care and reducing variation in access, experience and outcomes for health inequalities groups. This will include reviewing learning from hypertension and diabetes initiations
- Develop a self-care hub bringing together key information for patients on self-care and self-management tools that support long term condition management
- Improve system-wide reporting on quality and outcomes in primary care
- Improving community waiting times
- Continued relationship development between the Community Provider Network and Local Care Partnerships

Actions for 25/26

- Review and maximise opportunities from new commissioning framework for immunisations and vaccinations, ensuring this builds in learning on outreach models
- Developing integrated delivery models for out of hospital services (between primary, community and secondary care) where system capacity and capability is currently unable to meet demand.

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 24/25

- Embed within the SEL workforce plan a campaign to attract and recruit additional primary care staff
- Optimisation of pharmacy first, and wider integration with pharmacy
- Work with front-line teams on an Organisational Development Plan for primary care
- Review impact of pay variation and London Living Wage on workforce
- Finalise the SEL primary care resilience tool to ensure targeted support
- Develop a general practice extranet that reduces administrative burden for practices and the ICB .

Actions for 25/26

- Understand impact of new GP contract settlement on general practice sustainability and develop appropriate support
- Develop a workforce hub on the general practice extranet that provides practical support
- Work with the primary care system to develop and test approaches to succession planning and shared employment models that support greater sustainability for practices.
- Continued discovery and proof of concept around automation of primary care

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 24/25

- Continue to deliver the requirements of the primary care recovery plan
- Deliver the requirements of the NHSE Dental Recovery Plan
- LCP engagement with practices on approaches to the delivery of same day access that support practice sustainability, meet patient need and that complement integrated urgent care services.
- Make improvements to the primary and secondary care interface to reduce unnecessary burden on primary care
- Roll-out of new remote consultation tools and cloud-based telephony

Actions for 25/26

- Implementation of primary care led approaches to same day access.
- Review options to further widen the upstream options for patients, including the role of the voluntary and community sector, community pharmacy and additional new self-referral pathways

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

South East London Integrated Care System

Primary care - Enabler requirements

NHS South East London

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 (including Lloyd George digitisation)
- 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 a 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