



Primary Care in London: Now and into the Future

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Contents

- London and the London health system: population demographics, inequalities, life expectancy etc
- A slide on structure of primary care in London
- The national and regional strategy/policy context (Fuller/GPFV/ARRS/access recovery plan/NHS funding etc) and what we are doing in London in response
- GP professional perspective: what it's like in London - challenges for staff/mood music/demand/workforce etc
- Examples of good things that we are doing already and other things planned/needed



Picture of Health in London



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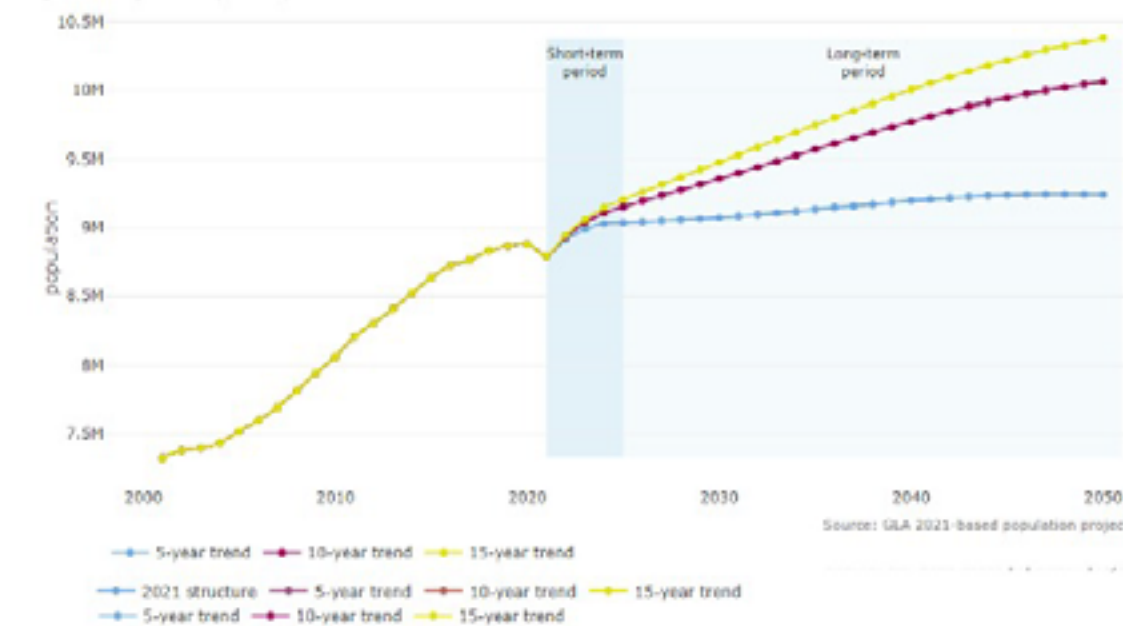
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London's population is growing, ageing and transient

- GLA 2021 based projections suggest London's population will grow from an estimated 8.8 million in 2021 to between 9.2-10.4million by 2050.
- Whilst the population is growing, the rates of future growth has been declining since 2016 due to: impacts of COVID-19 pandemic including effects on census records, declining fertility rates, a reduction in net international migration due to Brexit, and recovery in domestic outflows since the 2008 Financial Crisis.
- London is a relatively young city compared to the rest of the UK, but it is still growing older, with the number of people aged 65 and over predicted to grow from 1million in 2021 to between 1.8-1.9million by 2050.
- While births and deaths are the largest direct contributor to London's population growth, migration plays a large part in London's changing population, and in particular, our working age population (16-64), where the growth we've seen since 2000 is projected to level off or even reverse from 2040.
- COVID-19 saw significant disruption to migration flows both domestically and internationally, and global crises such as the war in Ukraine continue to add to an ever-changing picture of migration in and out of the city.

Figure 1: Projected Population, London



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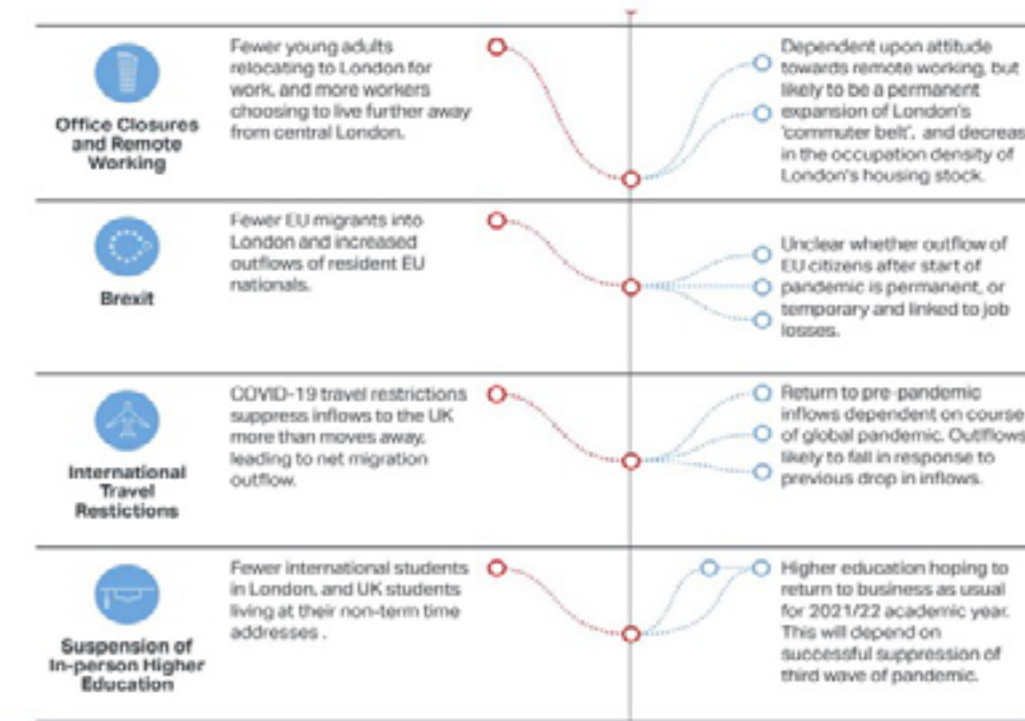
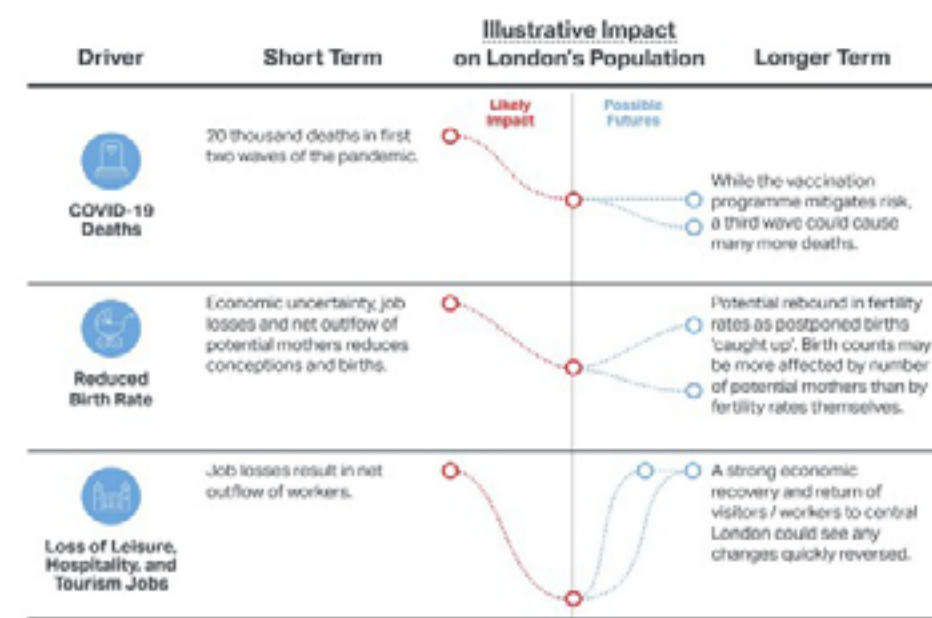


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Impact of Covid-19 on London's Population



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2 in 5
children in London
live in poverty.

1/4
of Londoners buy
less food and essentials
to manage, due to the
cost of living crisis.

**45% of Black
33% of Asian**
Londoners reported being
treated unfairly due to
ethnicity.

**Low income
and ethnic**
Londoners have fewer
opportunities for good health
(active travel, green space, air
pollution, poor housing).

**Inclusion health
groups**
such as rough sleepers, asylum
seekers and Gypsy, Roma and
Traveller communities have high
health needs.

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Increases in Average Life Expectancy in London have slowed down

London
80.3 years
79.4 years
England



London
84.3 years
83.1 years
England



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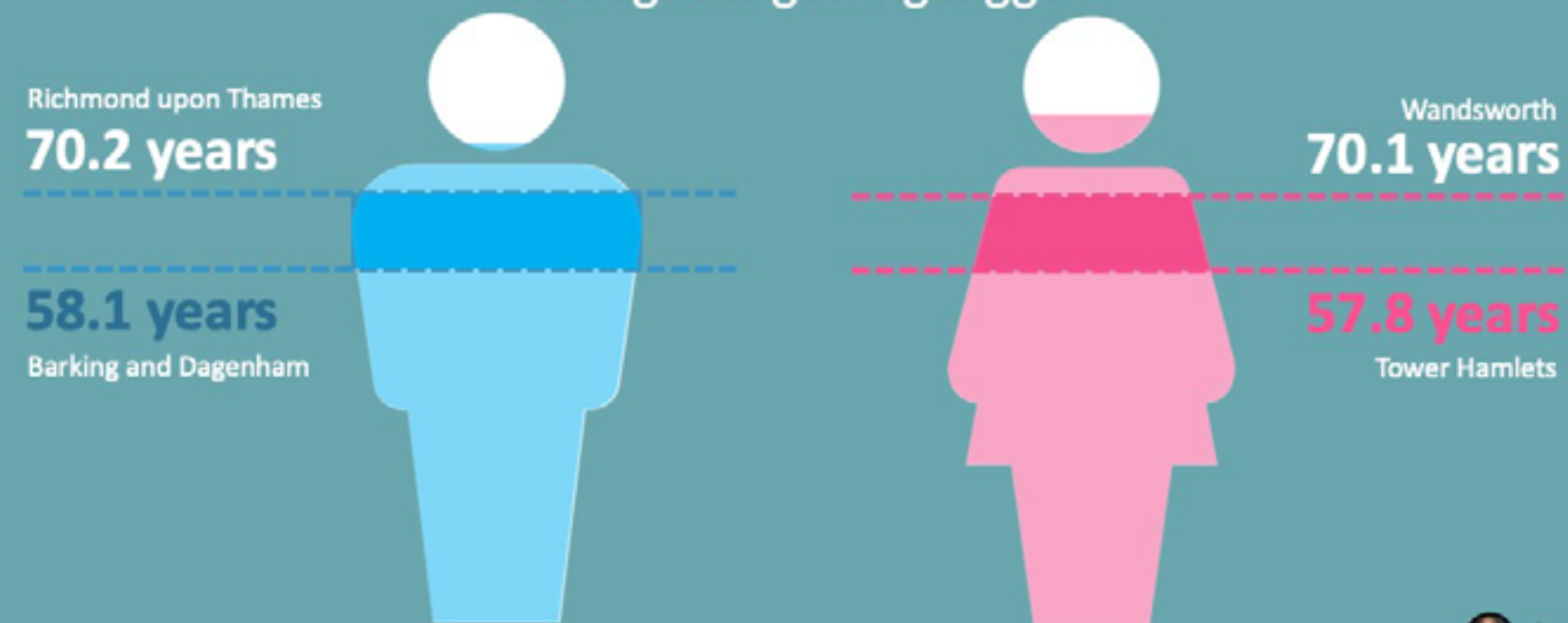
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The gap in Healthy Life Expectancy between the least and most deprived London boroughs is getting bigger



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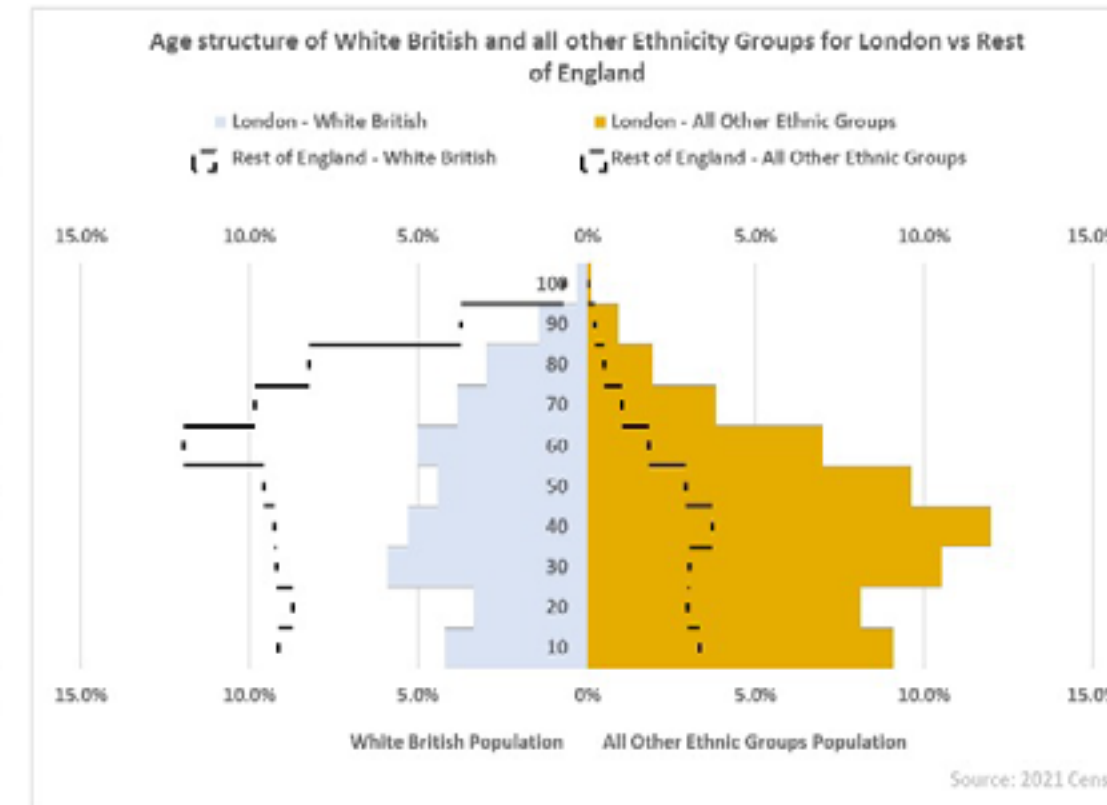




Population pyramid

Rest of England		
Age Band	Rest of England - White British	Rest of England - All Other Ethnic Groups
10	9.1%	3.3%
20	8.7%	3.0%
30	9.2%	3.0%
40	9.3%	3.7%
50	9.6%	2.9%
60	12.0%	1.8%
70	9.8%	1.0%
80	8.2%	0.5%
90	3.7%	0.2%
100	0.7%	0.0%

London		
Age Band	London - White British	London - All Other Ethnic Groups
10	4.2%	9.1%
20	3.3%	8.1%
30	5.9%	10.5%
40	5.3%	12.0%
50	4.4%	9.6%
60	5.0%	7.0%
70	3.8%	3.8%
80	3.0%	2.0%
90	1.4%	0.9%
100	0.3%	0.1%



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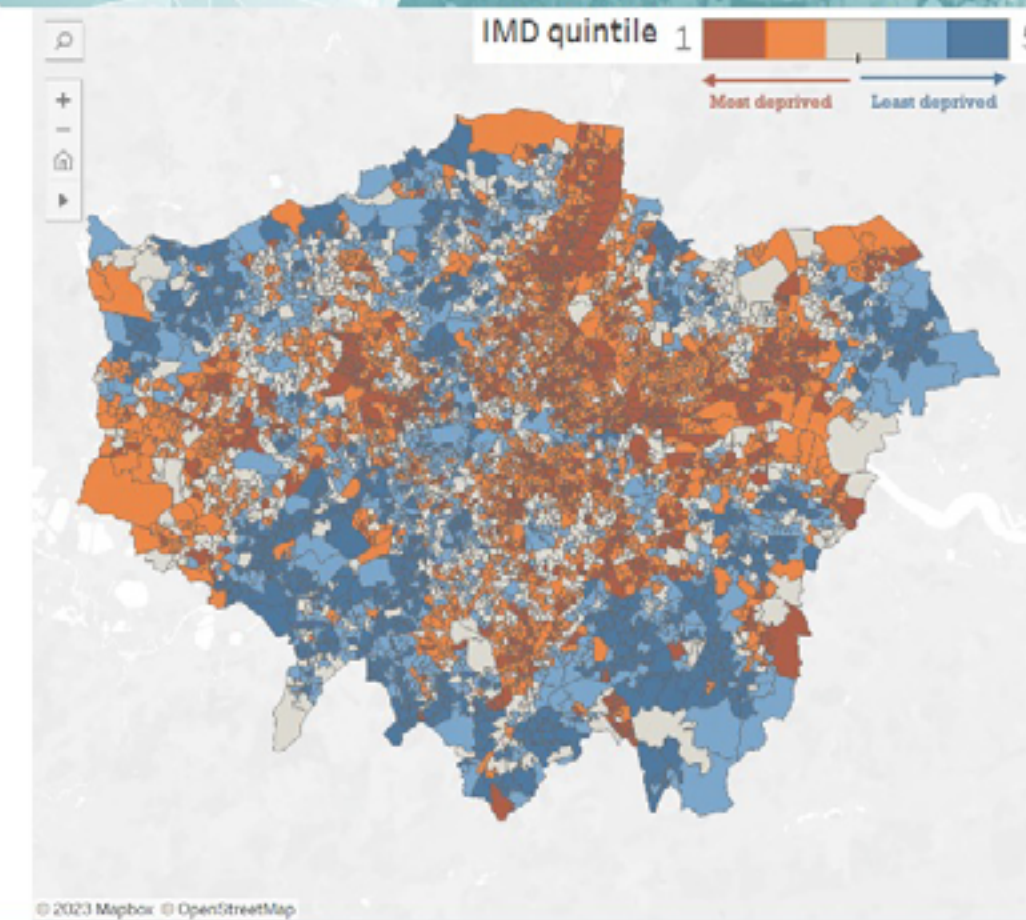


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Deprivation Indices of Multiple Deprivation (quintiles)



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Primary Care in London



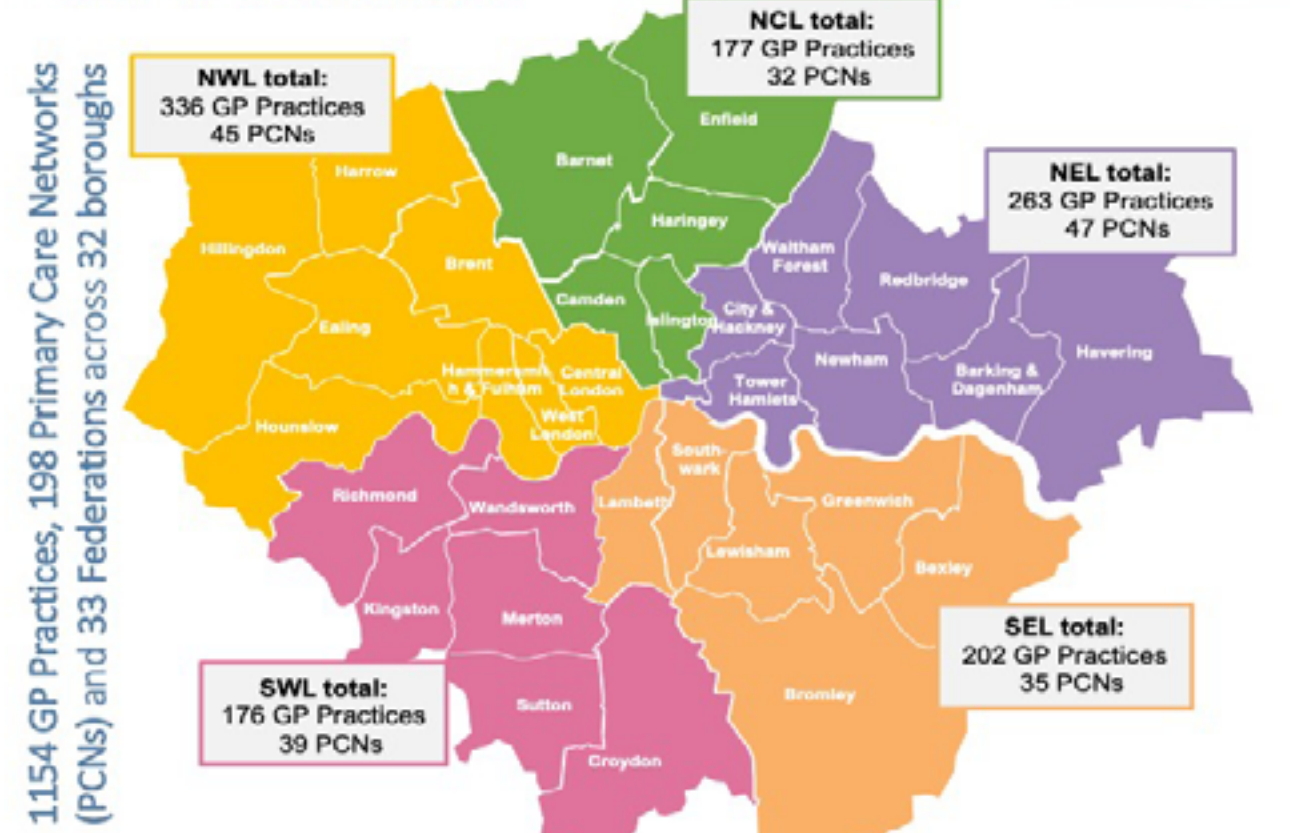
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Most GP Practices hold a GMS/ PMS' lifelong contract. Across London, there are 58 practices which have time limited APMS contracts. All contracts can have either a single site delivery model or can be delivered across multiple sites. AT Medics/Operose managing 32 contracts, Hurley Group managing 10 practices, Penrose managing 4, Omnes managing 3 and various others managing 1 each.

CQC Ratings at 3rd April 2023

Overall rating	Outstanding	Good	Requires Improvement	Inadequate	Total
NCL	1	165	9	2	177
NEL	4	241	11	7	263
NWL	5	306	25	0	336
SEL	1	188	12	1	202
SWL	1	168	7	0	176
London	12	1,068	64	10	1,154
Overall rating	Outstanding	Good	Requires Improvement	Inadequate	
London	1.0%	92.3%	5.6%	0.9%	
England	4.9%	90.1%	4.1%	0.9%	

In April 2023, 1% of London practices were rated outstanding, compared with nearly 5% of practices nationally. Over 92% of London practices were rated good, slightly higher than the national average of 90%. There is unwarranted variation in outcomes, together with inequity across London in funding, estate, investment in technology and enhanced service offers. There is also huge variation in demand which seems to correlate with deprivation.



London Overview: Key statistics

ACCESS ACTIVITY

Increasing trend in no. booked appts in London since April 2020. >3.9m appointments offered Feb 2023 (GPAD). Medium/high confidence that national target of 50m additional appts will be met by March 24

London has the lowest number of booked appointments per working day per 1,000 population when compared to other regions

London had 56% booked appts with a GP in Feb 2023 (England average 48.1%)

27% of practices enrolled in national 'accelerate' Access Improvement Programme

64.9% Face-to-face 2.6m delivered in Feb 2023 (compared to 69.8% nationally) Region with lowest % F2F appts despite increasing trend since April 2020

London has the highest percentage of appointments (54.4%) that look place on the same/next day %, compared to other regions. Same / next day

6m OC since March 2022, with an average of 115,000 OC per week across London Online consultations

London has developed a national eLearning programme for staff interested in improving patient access to general practice (May 23)

HEALTH INEQUALITIES

On 09/01/23 90.1% of patients had an ethnic category recorded (England average at 88.6%). 49.6%

London is not meeting the 60% target for people on the General Practice severe mental illness (SMI) register to have received a physical health check. 63.9%

London is on track for meeting the 22/23 75% target for patients with a learning disability on the LD register to have received an annual learning disability health check. England average = 56.4%

MENTAL HEALTH CHECKS

49.6% physical health checks for severe mental illness. England average = 47.8%

PATIENT EXPERIENCE

89.9% of patients across London rated their GP experience as "very good" or "good" in December 2022 (Friends & Family Test). England average = 90.1%

69.1% of patients in London reported having a good or very good overall experience of their GP practice (80.8% in 2021).

CANCER SCREENING

62.6% Cervical cancer screening coverage in London was at 62.6% in Dec 2022. England average = 69.2%

WORKFORCE

31/12/2022

GPs 4.98 FTE GPs per 10k pop* (England Average = 5.90)

Nurses 1.50 FTE nurses per 10k pop* (England Average = 2.70)

22.4% aged 55+, (England Average = 17.4%)

42% aged 55+, (England Average = 33.9%)

ADDITIONAL WINTER METRICS

89.6% Appointments taking place within 14 days of booking in Jan 23. London consistently has the highest percentage appointments that took place within 14 days of booking across the regions.

Community pharmacy Monthly 111 & GP referrals to the CPCS scheme have risen steadily from the initial introduction of both schemes. In Sept 22, GP CPCS referrals were above the national average while 111 CPCS referrals were below the national average.



GP Numbers

- ↓ Participation rates for all GPs are **lower** for London (72%) than England (76%) as a whole.
- ↓ For qualified GPs Participation rates are lower in 2023 compared with 2019
- ↓ In March 2023, the number of GPs FTE per 10k patients is **lower** in London (4.92 FTE) than England (5.84 FTE) as a whole.
- ↔ Range of GP FTEs per 10k patients across London boroughs, from 6.13 FTE (Camden) to 3.78 FTE (Newham).

Practice Nurses

- ↓ Nurse FTE per 100k patients has **decreased** year-on-year.
- ↑ The age profile is shifting gradually to an **older workforce** with percentage within 60-64 is increasing year-on-year.
- ↔ Range of Nurse FTE per 10k varies by borough from 2.04 in Bexley to 0.79 in Hammersmith.

GP Roles

- ↓ The proportion of GP Partners FTE is **dropping** year-on-year
- ↑ London has a **greater proportion of Salaried GPs FTE than England** as a whole
- ☐ Trends in GP roles aligns with strategic changes made to the partnership and the preference to increasingly develop portfolio careers.

Direct Care Roles

- ↑ There has been a steady **increase** within all ICBs of **direct patient care roles** in General Practices.
- ↓ In June 2022, the FTE of direct patient care roles for General Practice and PCNs is **lower** in London than England as a whole.
- ↔ Range of direct care roles FTEs per 10k patients varies by borough from 2.54 in City and Hackney to 0.68 in Havering

Patient Experience

- ↓ Overall, **patient experience metrics** have fallen for 2022, across all London systems.
- ↓ In 2022, 70% of people in London rated their overall experience of GP practice as 'very good' or 'fairly good'. This is a **10% decrease** compared to 2019

Deprivation

- ↓ Practices in **more deprived areas** of London have **lower GP FTE** per 10K patients than less deprived areas

Future lines of enquiry

- Relationship with patient survey data
- Correlations with access and public health interventions

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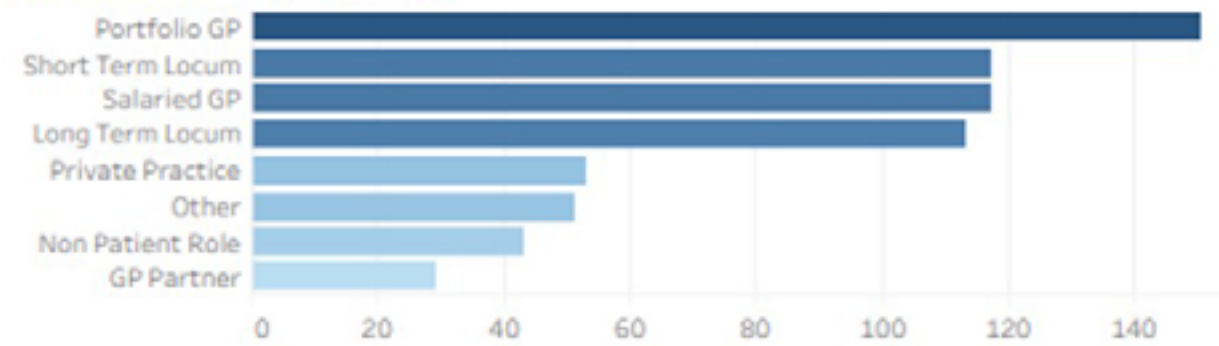


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Future employment for GPs in training: Ideal Role and Geography

Q10c Ideal Roles - Aggregate Score



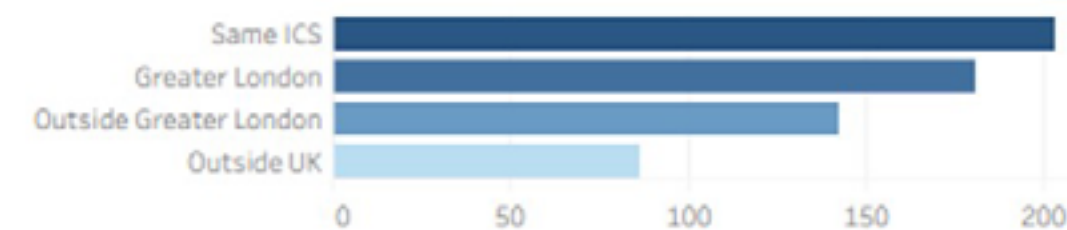
The top 4 ideal employment modalities on qualifying were cited as:

1. Short Term Locum
2. Salaried GP
3. Long Term Locum
4. Private Practice

For those who stated 'other', some respondents commented that due to burnout and stress they were looking to leave medicine, while others were looking for a combination of different roles e.g. research and academia, clinical lecturer.

In terms of Geography, the same ICS and Greater London scored highest on the aggregate score.

Q10c2 Ideal Geography - Aggregate Score



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Note: Respondents were asked to score their top 4 ideal roles, with their most ideal being awarded 4 points, second ideal role 3 points etc. The portfolio GP option indicated is, by definition, a composite role and is therefore supplementary to the key question about the preferred mode of employment.



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Policy context and challenges



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Challenges and Opportunities	To deliver the strategic vision, a systemwide approach is required, as holistic, integrated care cannot be delivered by General practice alone. The overarching opportunities below need alignment with Trusts and other partners to be delivered. NHS		
	<u>OVERARCHING CHALLENGES IN THE SYSTEM</u>	<u>OPPORTUNITIES FOR THE FUTURE</u>	
	DEMAND, CAPACITY AND COMPLEXITY OF POPULATION	<ul style="list-style-type: none"> ❑ There is a 30% increase > 70 since 2010 with one or more Long Term conditions (LTCs) and a mismatch in demand vs capacity. ❑ The 2021 census records London's population increasing 7.7% in 10 years which will impact all services. ❑ The average number of patients each GP is responsible for has increased by 348 – 18% – since 2015, and now stands at 2,286. With the highest proportion of registered population under 35 years of age (48%, against 42% in the rest of the country) and the lowest share of over 65s (11%, compared to 19% in the rest of the country) ❑ London has 11M registered patients and is 4th in the Index of Multiple Deprivation (where 1 is the most deprived) ❑ There is variation in demographics, service delivery models and patient outcomes within each ICB 	<ul style="list-style-type: none"> ❑ Addressing the increase in population and demographic challenges requires a systemwide lens incorporating Extended access, 111, UTC and A&E, together with clinical pathways and discharge ❑ Optimal use of data, shared care and workforce to support addressing capacity issues ❑ Improved communication flows which minimise patients having to be seen multiple times for their condition/s ❑ Maximise use of community assets- local champions, voluntary sector, faith bodies and spaces ❑ Develop referral pathways and processes which are easily assessable for GPs and reduce bureaucracy and save time, where possible, enabling more time for care.
	WORKFORCE	<ul style="list-style-type: none"> ❑ One in five practices are single-handed and the ratio of practice staff to GPs is lower than in other parts of England. Some parts of London have the lowest rate of Full Time Equivalent (FTE) GPs per patient and London has the highest number of GPs over 60 nationally (13.5%). ❑ General practice is increasingly moving to a multidisciplinary model of working, however there is high turnover in Additional Roles Reimbursement roles (ARRS)- (14%) in London and GPs/ senior clinicians must take on additional clinical supervision requirements, which increases workload pressures ❑ In December 2022, the FTE of direct patient care roles for general practice and primary care networks (PCNs) is lower in London than England as a whole, despite this there is silo working and duplication across the system. 	<ul style="list-style-type: none"> ❑ Develop integrated Neighbourhood teams which support local populations and can work across organisational boundaries to deliver holistic care in the community. ❑ Develop Joint roles, joint training and development opportunities and support for ARRS roles. ❑ Ensure local recruitment and retention strategy aligns with the upcoming workforce plan ❑ Allow for more flexible portfolio careers to support retention.
	ESTATES AND INFRASTRUCTURE	<ul style="list-style-type: none"> ❑ Whilst there has been some investment in new facilities, some practices continue to operate from premises that are no longer fit for purpose. Estate is not always optimally utilised. There is not always space for training and team development and the 'premises directions' do not always support innovative solutions. ❑ Shared care planning, risk stratification and interoperability are not adequate and there is a lack of time and resource to undertake a PHM approach effectively 	<ul style="list-style-type: none"> ❑ Deliver improvements on space and utilisation, allowing for 'One Public Estate' approach and sharing where possible. ❑ Develop and incorporate technology effectively. Enable shared records and care, joint care planning (Urgent Care Plan) and interoperability across systems and time for a PHM approach
INTEGRATED DELIVERY MODELS	<ul style="list-style-type: none"> ❑ Contractual limitation, organisational structures, together with workforce and resource pressures currently impact on the ability for General practice to actively engage with integration and 'new models of care'. 	<ul style="list-style-type: none"> ❑ 'New models of care' developed based on a shared vision, integration and a reflective of changing demographics ❑ Easy access to advice and guidance and streamlined processes which reduce workload ❑ Working with the regional clinical networks, to 1. develop New Models of Care and test a coordinated preventative approach within each ICB 2. Support a focus on Prevention in Cardiometabolic Long Term Conditions (LTCs) and addressing Health Inequalities. 	

Further exploration of opportunities specific to the Fuller Stocktake recommendations within Slides 8 and 9.



**Next steps for integrating primary care:
Fuller stocktake report**
London region



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The Fuller Stocktake Report, commissioned by NHS England, was published in May 2022. It sets out a vision for integrating primary care, improving access, experience and outcomes for communities, centred around:



Improve access - streamlined urgent care pathway bringing together out of hours, NHS 111, clinical assessment services, crisis response etc triage at scale and digitally enabled – Develop a more targeted and responsive offer for patients who are otherwise healthy



Separate reactive and proactive care - providing more proactive, personalised and multi disciplinary care for people with more complex needs in an integrated manner.

Freeing up capacity in primary care to focus on complex/ chronic conditions that require continuity and on working with local government, VCS and community leaders on prevention and tackling the wider determinants of health



Enable through population segmentation
 Helping people to stay well for longer, through a joined-up approach to prevention, through population segmentation and systematic use of population health data to identify patients most at risk – underpinned by shared care records and interoperable IT systems

These are all underpinned by the requirement to optimise workforce, digital tools and estate

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Fuller stocktake report - overview

Partnership, collaboration and new ways of working is at the heart of making ICSs a success. By drawing on insights, resourcefulness and innovation of patients and their carers, local communities, local government, other care providers and wider system partners as well as primary care leaders, a thriving integrated primary care system can be developed.



Next steps for integrating primary care: Fuller stocktake report

Improving access, experience and outcomes for the community

Enable PCNs to evolve into integrated neighbourhood teams with shared ownership for improving health and wellbeing

- Support preventive healthcare with generalist and specialists from all sectors for a holistic approach to health
- Adopt population-based approach by wider health and care systems and align secondary care to neighbourhood teams
- Develop models of personalised care
- Proactively identify and target those who can benefit from interventions and committing to COREZOPUSS populations

Work with local people and communities to tackle ill health

- Genuine co-production and personalisation of care that are tailored to local needs and preferences
- Bring local people into the workforce to establish integrated teams that are rooted in the community

System-wide approach to a single integrated urgent care pathway

- Provide same-day access to urgent care from the most appropriate local service, whether remote or face-to-face
- Develop new metrics and standards for access including new patient-reported experience measures
- Deliver better continuity of care by having better urgent care access
- Co-locate teams around the needs of the population with blended expertise and easy access to diagnostics

Create a clear development plan to support primary care sustainability

- Focus on unwarranted variation in access, experience and outcomes
- Understand current spending distribution compared with system allocation and health inequalities
- Support collaboration with other providers including community services
- Work in partnership with local authorities, communities and system partners to pool data and resources

Primary care workforce should be an integral part of system and national level strategy

- Develop system-level workforce data to inform long-term strategy
- Support innovative employment models and creatively maximise skills and experience of existing workforce
- Extend NHS Staff Survey across primary care
- National workforce strategy to focus on primary care

System leadership to become driver of primary care improvements

- Develop and support clinical directors to drive change, allowing protected time to meet the leadership challenge
- Establish primary care forums to ensure credibility and breadth of views

Encourage multi-professional workforce and leadership

- Establish greater financial flexibility for systems on primary care
- Maximise system decision-making on future discretionary investment

System-wide estates plan to support fit-for-purpose buildings

- Adopt 'one public estate' approach by using perspectives on access, population health and health inequalities
- Maximise use of community assets and space

Improve data flow and embed digital transformation in holistic care

- Address patient data sharing challenges to improve co-ordination of care
- Develop digital transformation that focuses on patient experience and outcomes, made in partnership with staff and patients whilst addressing barriers to digital tools

Legislative, contractual, commissioning and funding frameworks

- DHSE and NHSE enable and support new models of integrated primary care, provide practical support and build ICS estates expertise
- Consider how to improve equity in resource distribution and improve health outcomes
- Ensure primary care estates is central in the next Health Infrastructure Plan



The Delivery Plan for Recovering Access to Primary Care is one of three recent NHS strategic recovery plans addressing priority areas

Elective recovery plan

Key ambitions:

- That the waits of longer than a year for **elective care are eliminated** by March 2025
- **95% of patients needing a diagnostic test receive it within six weeks** by March 2025.
- 75% of patients who have been urgently referred by their GP for suspected cancer **are diagnosed or have cancer ruled out within 28 days** by March 2024
- **Improve both waiting times and patients' experience of waiting** for first outpatient appointments over the next three years.

Urgent and Emergency recovery plan

Key ambitions:

- **Patients being seen more quickly in emergency departments:** with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.
- **Ambulances getting to patients quicker:** with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.



Primary Care recovery plan

Key ambitions:

- **To tackle the 8am rush and reduce the number of people struggling to contact their practice.** No longer will patients be asked to call back another day to book an appointment.
- **For patients to know on the day they contact their practice how their request will be managed.**



Primary Care recovery plan – the Headlines

1	 Empower patients	<ul style="list-style-type: none"> Improving NHS App functionality Increasing self-referral pathways Expanding community pharmacy
2	 Implement new Modern General Practice Access approach	<ul style="list-style-type: none"> Roll-out of digital telephony Easier digital access to help tackle 8am rush Care navigation and continuity Rapid assessment and response
3	 Build capacity	<ul style="list-style-type: none"> Growing multi-disciplinary teams More new doctors Retention and return of experienced GPs Priority of primary care in new housing developments
4	 Cut bureaucracy	<ul style="list-style-type: none"> Improving the primary-secondary care interface Building on the 'Bureaucracy Busting Concordat' Reducing IIF indicators and freeing up resources

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Overview of the Primary Care recovery Plan

Commitment	Detail	Planned national enablers
Empower patients Tools for patients to manage own health using NHS App and community pharmacy expansion	<ul style="list-style-type: none"> Patients can see records & practice messages, book appointments and order repeat prescriptions via NHS app (90% practices by Mar 24) ICBs to expand self-referral pathways (Sept 23) Expand pharmacy oral contraception and blood pressure services Launch Pharmacy First – supply prescription only medicines for 7 common conditions (Dec 23) 	<ul style="list-style-type: none"> Expand NHS.uk content Planned changes to VAT, flexibilities around supervision, dispensing Focus on interoperable digital solutions From 2026 updated training standards will ensure all newly qualified pharmacists are independent prescribers
Implement 'Modern General Practice Access' Tackle 8am rush - Patients know on the day how request will be handled, respecting appointment type preferences	<ul style="list-style-type: none"> Support all practices on analogue lines to move to digital telephony, if they sign up by July 2024 - Transition all who sign up by Mar 24, All remaining practices must transition by Dec 25 Provide all practices with the digital tools, care navigation training & fund transition cover for those that commit to Modern General Practice Access before March 2024 Deliver training and transformation support to all practices from May 2023 through National General Practice Improvement Programme (GPIP). 	<ul style="list-style-type: none"> Financial and procurement support for digital telephony Fund uplifted framework tools for online consultation, messaging, self-monitoring, and appointment booking tools Care navigation training – every practice and PCN allowed to nominate one member of staff to undertake training ICBs invited to nominate and support practice take up GPI offers, funding TBC
Build capacity Practices can offer more appointments & add flexibility to the types of staff recruited and how they are deployed	<ul style="list-style-type: none"> Employ 26,000 more direct patient care staff and deliver 50 million more appointments by March 2024 Expand GP specialty training – and make it easier for newly trained GPs who require a visa to remain in England. Retain experienced staff through pension reforms and simpler routes back to practice for recently retired. Raise the priority of primary care facilities when allocating funds from new housing developments (LA planning guidance) 	<ul style="list-style-type: none"> Increase flex. by including apprentice physician associates and Advanced Clinical Practitioners Nurses Long Term Workforce Plan and additional ARRS support resources (to be published) Care navigator & digital & transformation staff training Campaign for GPs to return to general practice
Cut bureaucracy Reduce workload across interface between primary and secondary care & medical evidence requests, so there is more time to focus on patients' clinical needs	<ul style="list-style-type: none"> Reduce time spent liaising with hospitals Reduce requests to GPs to verify medical evidence, including by increasing self-certification, by continuing to advance the Bureaucracy Busting Concordat. Streamline the Investment and Impact Fund (IIF) from 36 to five indicators – retarget £246 million – and protect 25% of Quality and Outcomes Framework (QOF) clinical indicators. 	<ul style="list-style-type: none"> Streamlined the IIF from 36 to 5 indicators and repurposing funding as part of the Capacity & Access Payment

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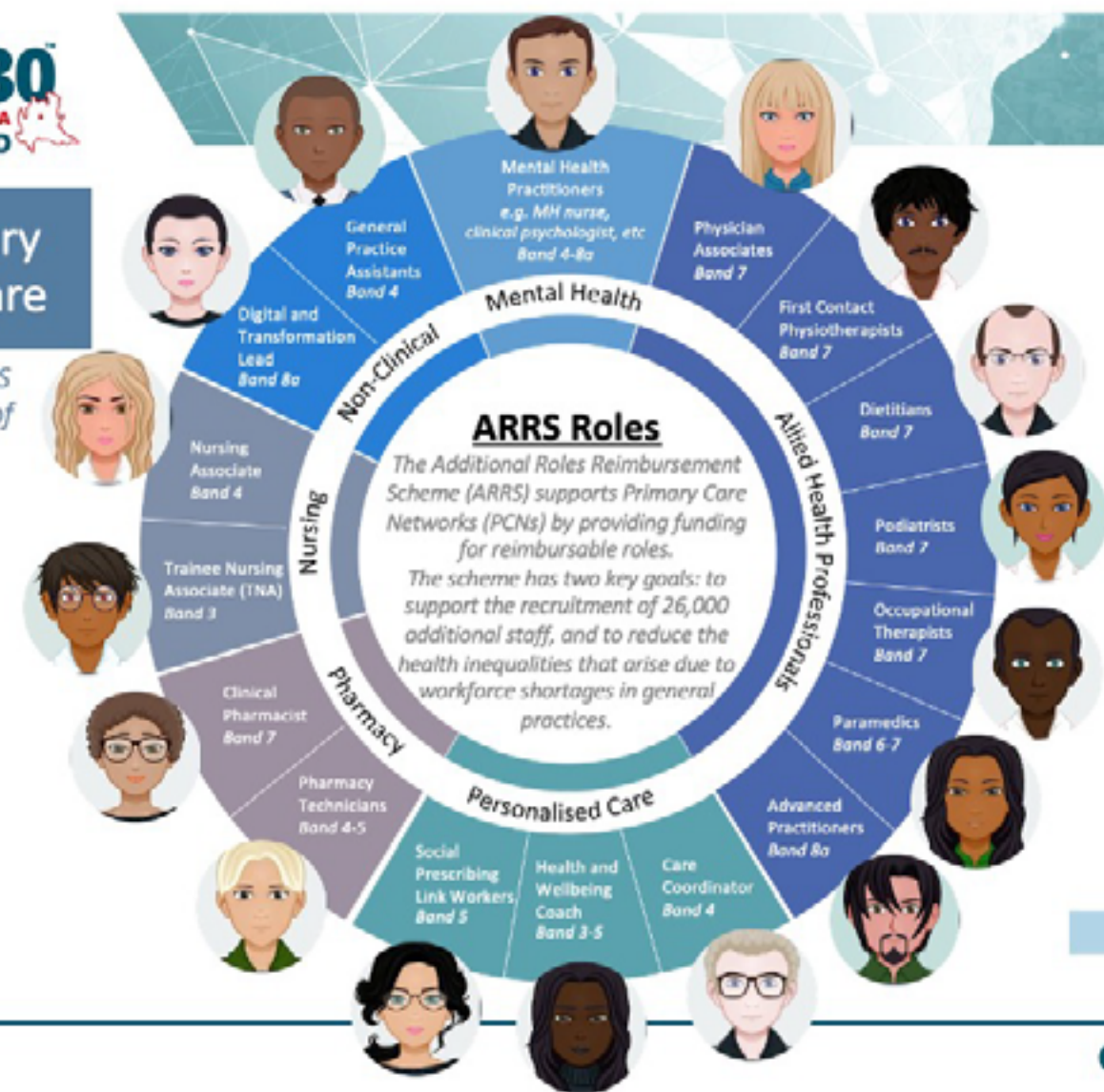
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The multidisciplinary team in Primary Care

Staff employed through the ARRS scheme will be considered part of the core general practice cost base beyond 2023/24



Changes to the ARRS scheme in 23/24

- Removing all recruitment caps on Mental Health Practitioners
- New role - Advanced Clinical Practitioner Nurses can now be reimbursed
- Increased cap on Advanced Practitioners from two to three per PCN
- Clinical Pharmacists can now be supervised by Advanced Practice Pharmacists

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Professional perspective
Dr Helene Brown



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Shaping the future



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- New models of care/delivery
- New models of contracting/commissioning
- Integrated neighbourhood teams – key role for CPs
- Primary/secondary care interface
- Digital front door/NHS App
- Data on primary care – presenting diagnoses/outcomes
- Workforce: recruitment and retention



Challenges and Opportunities:
 Fuller Stocktake - Key Workstreams

CURRENT CHALLENGES IN THE SYSTEM

STREAMLINING ACCESS TO CARE, AND ADVICE TO MEET THE NEEDS OF INFREQUENT USERS OF HEALTHCARE SERVICES

One of the key challenges facing General Practice is ensuring patients receive the right access – right care in the right setting at the right time.

Currently, there are record numbers of General practice appointments being made available, however patients are continuing to experience inadequate access to services, with decreases in both patient and staff experience and satisfaction.

Multiple touch points and a lack on coordination and joined up pathways exacerbate issues with failure demand and DNA's.

PROVIDING MORE PROACTIVE, PERSONALISED AND MULTI DISCIPLINARY CARE FOR PEOPLE WITH MORE COMPLEX NEEDS

Providing holistic care, which meet the needs of patients throughout their lives represents a sea change in the way that health care services are delivered from reactive and siloed delivery of care to a planned and targeted approach.

The Integrated Neighbourhood Team (INT) will be the multidisciplinary (MDT) team, comprising primary care providers, secondary care, social care and VSCE, dedicated to delivering proactive care which improves the health of a local community and tackles health inequalities via a population health management, data driven approach.

The immense workforce shortages, issues with Data, interoperability, Estate and silo working does not always support this approach.

HELPING PEOPLE TO STAY WELL FOR LONGER, THROUGH A JOINED-UP APPROACH TO PREVENTION

There is a need to tailor services to local communities. Increasingly focus on interventions that will pre-emptively tackle poor health outcomes, including the wider determinants of health.

Delivering interventions which focus on psychosocial aspects, and which are designed/personalised with local populations and their advocates is challenging, with variation in infrastructure and maturity of VCSE sectors, together with workforce capacity constraints across health and non- health sectors.

General practice is to promote the use of community assets and space to develop services that promote the health and wellbeing of local populations, whilst also tackling Health inequalities.





OPPORTUNITIES FOR THE FUTURE

- ❑ Repurpose funding to free up time to plan and focus on local service redesign and improvements to access systems
- ❑ Increased focus on improving patient access and experience as part of the General Practice Access Recovery Plan (slide 14), including focus on same/next day urgent care
- ❑ Focus on developing services locally to best meet the needs of patients at a PCN, and Integrated Neighbourhood Team level
- ❑ Incorporate pathways which facilitate same day access via a scaled approach and 'continuity of care' via General practice
- ❑ Develop integrated pathways underpinned by technology/ BI and workforce to support patients being seen in the right place at the right time.
- ❑ Support practices to better understand their demand and capacity (urgent vs continuity) with BI tools
- ❑ Formalising a regional PC/IUC group to focus on end-to-end patient pathways, and same day access to support system solutions being developed.
- ❑ Review and cross referencing of the General Practice Access Recovery Plan with the Elective Recovery Plan to identify areas of alignment

- ❑ Investment in Business Intelligence (BI) tools, shared care planning and risk stratification
- ❑ Developing Integrated Neighbourhood teams which work across organisational boundaries and can prioritise proactive care, with effective tools and supporting infrastructure.
- ❑ Growing the GP workforce through increasing trainee numbers and targeting areas of deprivation for placements.
- ❑ Development of fellowships that enable newly qualified GPs to develop skills in transformation, Quality Improvement (QI) and multidisciplinary working across organisations.
- ❑ Recruitment of an additional 4.4k health professionals into primary care through ARRS
- ❑ ICB primary care teams working with Lead Training Hubs to ensure that new health interventions/pathways are supported by training needs analysis and the procurement of training and development interventions
- ❑ Increasing use of population health data sets to identify and target priority groups, including those in the most deprived neighbourhoods.
- ❑ Multidisciplinary working across primary, secondary and community care within INTs to provide bespoke care and support for complex patients



Challenges and Opportunities:
 Fuller Stocktake - Enabler Functions

DATA/DIGITAL/INTEROPERABILITY	CURRENT CHALLENGES IN THE SYSTEM	ESTATES
<p>A large number of disparate local IT systems, coupled with an absence of clear quality standards has historically constrained the potential collection of high quality, consistent and timely data on general practice, hindering understanding and Quality Improvement (QI). Changing service requirements, IT development lead in times, funding and change management support has impacted the roll-out of interoperable solutions.</p> <p></p> <ul style="list-style-type: none"> ❑ Focus on improved data sharing incl. patient records across organisations (e.g., One London Health Information Exchange, Universal Care Plan) in development ❑ >98% GP appointments have been mapped to national categories ensuring greater consistency. Increased focus on improving data flows, data quality & reporting, including PCN & ARRS appointment data into the <u>General Practice Appointments Dashboard</u>, so we really understand the capacity issues faced ❑ Work with I.T system providers to continue to support the development of essential digital & interoperable solutions (including automation) across PCNs, and support local implementation. ❑ New data and transformation lead roles have been added to the Additional Roles Reimbursement Scheme (ARRS). ❑ Cloud based telephony with functionality for intelligent routing to support patient navigation to right place, first time. 	<p style="text-align: center;">WORKFORCE/RESOURCES</p> <p>Workforce is a key enabler and the complex challenges of an ageing workforce and a gap with recruitment and retention are detailed on slide 15. There are investment constraints with meeting the myriad challenges. ICBs are asked to think more creatively about how to maximise available funding, and prioritise it locally as systems to achieve the greatest impact</p> <p style="text-align: center;"></p> <p style="text-align: center;">OPPORTUNITIES FOR THE FUTURE</p> <ul style="list-style-type: none"> ❑ Investment into an additional 26,000 direct patient care roles (funded through ARRS) and a target to recruit 6,000 additional GPs (nationally), should supports resilience and more 'system based, integrated' roles ❑ Existing budgets (e.g., <u>system development funding</u>) have been consolidated to provide ICSs greater flexibility to deliver transformation aligned to integrated working ❑ £246m national primary care funding has been freed up for PCNs to improve patient experience and satisfaction of access. ❑ The development on Integrated Neighbourhood teams, should focus resources to where they are needed most, and reduce duplication of effort and 'silo' working ❑ Rotational working and joint learning opportunities. 	<p style="text-align: right;"></p> <p>Around 1 third of GP practices in London need to be rebuilt, with 41% built prior to 1965 (29% nationally) . 70% of GPs regard their premises as too small to deliver more services.</p> <p>There are several barriers including affordability, building regulations, suitability and funding. Empty space costs London £25m/year and maximising use of bookable, void and sessional space across London could serve a population of approximately 600,000, or 5% population of London.</p> <p style="text-align: right;"></p> <ul style="list-style-type: none"> ❑ To better support access and house the additional workforce, primary care is leading a 'one public estate' approach linked to local clinical strategies, focussing on better understanding of utilisation, mapping estate and exit strategies, maximising use of void/vacant estate, rethinking use of existing spaces, consolidating centralised back-office functions, sharing innovations (co-located / satellite clinics) and good practice around estate redesign to best meet current requirements ❑ There is an opportunity to develop joint infrastructure and Estate plans ❑ The London Estates Delivery Unit (LEDU) has compiled a GP premises 6 facet survey to learn more about Estate in London. The report will be available in May and will provide an overview of current Estate and investment requirements.



General Practice/ Trust interface

Good organisation of care across the interface between general practice and secondary is crucial in making the best use of clinical time and resources in both settings. The **Health and Social Care Select Committee report (Oct 22)** into the **Future of General Practice** states: "GP retention needs to be improved" adding "...GPs are facing unsustainable workloads, which increase burnout and make GPs more likely to leave the profession. This creates a vicious circle of workforce and workload pressures for the GPs who remain...". In stemming the spiralling attrition rates for GPs **we need to work closely with and collaborate with general practice.**

Whilst the visions and direction within the Fuller Stocktake provides strategic direction, there are practical issues, which if resolved effectively in the short term, could help with accelerating transformation, these include:

- Reducing the bureaucracy and shift of workload from secondary to Primary care, building on the [Bureaucracy busting concordat](#)
- Making referral pathways simple and easy to navigate
- Timely discharge summaries/clinic letters with immediate care needs met
- Develop systems for appropriate information exchange to and from general practice care
- Effective communication flows across settings, allowing for relationships to develop and more streamlined care
- Clear Shared Care Protocols
- Facilitate team building across the interface and incorporate joint learning and development
- Assess and reduce the amount of work that is inappropriately transferred from secondary care to primary care
- Co-development of secondary care role within integrated neighbourhood teams
- Collaborative design of innovative pathways to reduce inappropriate referrals into secondary care, improve case finding and optimise prevention
- Self-service processes for patients and public where appropriate



Workforce

Rate of FTE GPs per 10k population, March '23

Borough	Rate of FTE GPs per 10k population
North Central London	5.21
North East London	4.76
North West London	4.53
South East London	4.82
South West London	5.63

- The number of GPs across London has increased from March '20 to '23 by 149 (FTE)
- The better resourced boroughs have 66% more GPs per 10k population than under-resourced areas of the capital
- NHS London are working with ICBs to understand the factors that drive this variability and address them through national and local recruitment and retention schemes

Rate of FTE Practice Nurses per 10k population, March '23

Borough	Rate of FTE Practice Nurses per 10k population
North Central London	1.16
North East London	1.37
North West London	1.21
South East London	1.59
South West London	1.60

- The number of Practice Nurses across London has decreased from March '20 to '23 by 48 FTE
- The better resourced boroughs have over 100% more practice nurses per 10k population than under-resourced areas of the capital
- The regional vision and delivery plan for practice nursing is focussed on growing the next generation, enhancing their role and career prospects and use them as a catalysts for change

The Additional Roles Reimbursement Scheme (ARRS)

Month	Direct Patient Care Roles (ARRS)
March 2022	1,500
April 2022	1,600
May 2022	1,700
June 2022	1,800
July 2022	1,900
August 2022	2,000
September 2022	2,100
October 2022	2,200
November 2022	2,300
December 2022	2,400
January 2023	2,500
February 2023	2,600
March 2023	4,460

- The number of Direct Patient Care roles including those funded through ARRS has grown to 4,460 (FTE).
- London's share of the national target of 26k is approximately 4.4k above baseline meaning that the workforce would need to grow to 5,346 fte by March 2024. Local plans show that PCNs expect to achieve this target although turnover rates of 14% highlight the recruitment and retention challenges they face.

WORKFORCE PRIORITIES FOR 23/24

- Supporting the development and planning of Integrated Neighborhood Teams to facilitate London's response to the Fuller Stocktake
- Working with ICBs and at scale providers to develop innovative models of care and associated workforce models that make the most effective and flexible use of our existing workforce resources
- Promote SPIN fellowships for all newly qualified GPs and Practices Nurses
- Promoting mentoring, enabling experienced GPs to gain portfolio working opportunities by supporting newly qualified GPs
- Working in partnership with NHSE colleagues to implement the regional primary care workforce strategy including to ensure that primary care provides training, education and continuing professional development for all members of the multidisciplinary team
- Support the development of communities of practice to support workforce in deprived areas
- Addressing Discrimination and Harassment through the implementation of the WRES primary care employer's framework



Primary / Secondary Care Interface



Onward referrals

If a patient has been referred into secondary care and they need another referral, for an immediate or a related need, the secondary care provider should make this for them, rather than sending them back to general practice



Complete care (fit notes and discharge letters)

Trusts should ensure that on discharge / after an outpatient appointment, patients receive everything they need, rather than leaving patients to return prematurely to their practice. Where patients need them, fit notes should be issued. Discharge letters should highlight clear actions for general practice (including prescribing medications required). By 30 November 2023, secondary care services should have implemented the capability to issue a fit note electronically.



Call and recall

Trusts should establish their own call/recall systems for patients for follow-up tests or appointments



Clear points of contact

ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly: eg single outpatient department email for GP practices or primary care liaison officers in secondary care

See: [The interface between primary and secondary care - key messages for NHS clinicians and managers](#)

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Bureaucracy Busting Concordat

Seven principles to reduce bureaucracy in General Practice



All policies should be designed with the patient / journey at the heart of the process, to ensure a minimum administrative burden for people accessing services



General practice should only be required to provide evidence of a medical nature when it is unavailable by other means. Always consider why factual medical evidence or opinion is required and only request if it is absolutely necessary



When introducing or reviewing an existing requirement for a medical certificate or examination, ensure that the most appropriate professional for the job is able to certify, promoting alternatives to the GP, including other members of the primary care team whenever possible and appropriate



When requesting medical information, ensure standardised forms are available for use and ensure that all information requests are as clear / concise as possible



Always consider digital forms rather than paper-based approaches, with standardisation and the potential for automation or data sharing where appropriate, though digital solutions in themselves do not always reduce bureaucracy. Where possible these solutions should be integrated into general practice systems.



When changing or designing a new process or form, ensure it has been co-designed with those who will be using it, for example GPs or other appropriate healthcare professionals, to ensure it is user friendly and supports our aim to reduce bureaucracy.



If only medical history is required, where appropriate make provision for the option for patients to provide this themselves rather than requiring it from a GP or health professional. Where possible, this process should be designed without need for GP ratification.



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Fuller review and strategic development

- **The Fuller Review is a stocktake report undertaken by Dr Claire Fuller**, Chief Executive Surrey Heartlands Integrated Care System looking at what is working well, why it's working well and how we can **accelerate the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry)** across systems
- The report provides a catalyst and opportunity to reflect and focus the direction of travel for primary care. It challenges areas to be bold and innovative in creating ***"both the conditions to enable locally led change and the supporting infrastructure to implement it"***
- Primary Care has been under considerable strain for some time – this was exacerbated by Covid-19 and the backlog created during the pandemic. A significant and growing proportion of patients require complex care co-ordination for multiple co-morbidities. While the pandemic also widened existing health disparities and points to an urgent need to focus on primary prevention, starting with Core 20+5 populations.
- **London systems are already delivering elements of the vision and the direction of travel aligns to local strategies.** Much of what was set out in London strategies such as the 'Next Steps to the strategic commissioning framework' links closely with the content of the report and a range of local and regional work such as within the Estates area is already attempting to make progress in line with the identified actions.
- There will be a requirement to take an integrated whole system approach to this. London stakeholders such as NHSE, ICSs, partners such as LA's, GLA, LMCs and national will need to consider any key thinking the report highlights and how to take forward some of the asks set out in the report if they are not already being planned for. **There is scope to consider how London can prioritise areas of work, collectively manage any challenges working with all key stakeholders and within this support progress and share good practice.**
- There is a growing consensus that providing the same degree of person-centred continuity of care to all patients, from cradle to grave is no longer sustainable. At the same time, many people – particularly those who are generally fit and well – prioritise faster access over continuity of care and have embraced 'digital first' primary care accelerated by the pandemic. The current model of care, which has largely been unchanged, requires adaption...

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- Messa a disposizione del pubblico, in un sistema di reti telematiche, mediante connessioni di qualsiasi genere, di un'opera dell'ingegno protetta, o di parte di essa (art. 171, legge n.633/1941 comma 1 lett. a) bis)
- Reati di cui al punto precedente commessi su opere altrui non destinate alla pubblicazione qualora ne risulti offeso l'onore o la reputazione (art. 171, legge n.633/1941 comma 3)
- Abusiva duplicazione, per trarne profitto, di programmi per elaboratore; importazione, distribuzione, vendita o detenzione a scopo commerciale o imprenditoriale o concessione in locazione di programmi contenuti in supporti non contrassegnati dalla SIAE; predisposizione di mezzi per rimuovere o eludere i dispositivi di protezione di programmi per elaboratori (art. 171-bis legge n.633/1941 comma 1)
- Riproduzione, trasferimento su altro supporto, distribuzione, comunicazione, presentazione o dimostrazione in pubblico, del contenuto di una banca dati; estrazione o reimpiego della banca dati; distribuzione, vendita o concessione in locazione di banche di dati (art. 171-bis legge n.633/1941 comma 2)
- Abusiva duplicazione, riproduzione, trasmissione o diffusione in pubblico con qualsiasi procedimento, in tutto o in parte, di opere dell'ingegno destinate al circuito televisivo, cinematografico, della vendita o del noleggio di dischi, nastri o supporti analoghi o ogni altro supporto contenente fonogrammi o videogrammi di opere musicali, cinematografiche o audiovisive assimilate o sequenze di immagini in movimento; opere letterarie, drammatiche, scientifiche o didattiche, musicali o drammatico musicali, multimediali, anche se inserite in opere collettive o composite o banche dati; riproduzione, duplicazione, trasmissione o diffusione abusiva, vendita o commercio, cessione a qualsiasi titolo o importazione abusiva di oltre cinquanta copie o esemplari di opere tutelate dal diritto d'autore e da diritti connessi; immissione in un sistema di reti telematiche, mediante connessioni di qualsiasi genere, di un'opera dell'ingegno protetta dal diritto d'autore, o parte di essa (art. 171-ter legge n.633/1941)
- Mancata comunicazione alla SIAE dei dati di identificazione dei supporti non soggetti al contrassegno o falsa dichiarazione (art. 171-septies legge n.633/1941)
- Fraudolenta produzione, vendita, importazione, promozione, installazione, modifica, utilizzo per uso pubblico e privato di apparati o parti di apparati atti alla decodificazione di trasmissioni audiovisive ad accesso condizionato effettuate via etere, via satellite, via cavo, in forma sia analogica sia digitale (art. 171-octies legge n.633/1941).

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