Next steps for integrating primary care: Fuller Stocktake report

Commissioned by NHS England and NHS Improvement from Dr Claire Fuller, CEO (designate) Surrey Heartlands ICS

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Introduction from Dr Claire Fuller

For generations, primary care has been at the heart of our communities. Health visitors, community and district nurses, GPs, dentists, pharmacists, opticians, and social care workers are among the most recognisable of a multitude of dedicated staff delivering care around the clock in every neighbourhood in the country.

Every day, more than a million people benefit from the advice and support of primary care professionals – acting as a first point of contact for most people accessing the NHS and also providing an ongoing relationship to those who need it. This enduring connection to people is what makes primary care so valued by the communities it serves.

Despite this, there are real signs of genuine and growing discontent with primary care – both from the public who use it and the professionals who work within it.

Inadequate access to urgent care is having a direct impact on GPs' ability to provide continuity of care to those patients who need it most. In large part because of this, patient satisfaction with access to general practice is at an all-time low,[i] despite record numbers of appointments: the 8am Monday scramble for appointments has now become synonymous with patient frustration.

At the same time, primary care teams are stretched beyond capacity, with staff morale at a record low.[ii] In short, left as it is, primary care as we know it will become unsustainable in a relatively short period of time. It is against this backdrop that the Chief Executive of the NHS, Amanda Pritchard, asked me to lead this major stocktake of integrated primary care from the ground up.

I want to start by thanking all primary care staff – and staff right across the health and care system – for their magnificent efforts during the pandemic. Since the inception of the NHS, there has not been a generation of leaders and staff who have faced the kind of overwhelming challenges as those working in our system today, and despite the very real toll COVID-19 may have taken on them personally and professionally, they will forever be able to wear their contribution as a badge of honour.

When I agreed to lead this work in November 2021, I don't think I fully appreciated the amount I would personally gain. As a GP for over 25 years, a clinical commissioning group (CCG) chair, a CCG accountable officer and an integrated care system (ICS) CEO designate, I have been involved in numerous system reviews and reforms. However, I do not think I have ever had such an opportunity to share ideas, listen and learn from others, build relationships, and challenge my own understanding, as I have during this process. It's been a pleasure to have met and worked with so many fantastic colleagues during the past six months.

During that time, we have had over 12,000 individual visits to our engagement platform, over 1.5 million Twitter impressions of *#FullerStocktake*, and close to 1,000 people directly involved through workstreams, roundtables and one-to-one meetings. The levels of engagement have been unlike anything I have seen for many years – all driven by a collective desire to create the conditions by which primary care can be supported to thrive in the future.

A moment of real opportunity

Despite the current challenges, there is real optimism that the new reforms to health and social care

– *if properly supported to embed and succeed* – can provide the backdrop for transforming how primary care is delivered in every community in the country.

We are weeks away from the inception of the new ICSs and with it the biggest opportunity in a generation for the most radical overhaul in the way health and social care services are designed and delivered. Primary care must be at the heart of each of our new systems – all of which face different challenges and will require the freedom and support to find different solutions. In an extraordinary and welcome display of common purpose across health and care, each of the CEOs of the 42 new systems has added their signature to this report.

But these new systems alone can't fix all the problems: we need action at every level. This report sets out a limited number of recommendations for NHS England, the Department of Health and Social Care (DHSC), and other national bodies that will enable local systems to drive change in their communities and neighbourhoods. This includes ensuring future national policy is designed to *support and enable* local systems to do what they need to do rather than apply a one-size-fits-all approach.

Support, enablement and respect have been among the most common themes throughout this stocktake. Emerging from the pandemic, it is clear that we all want to build on the best elements of our response to COVID-19 and work together wherever possible: delivering what works locally in step with our communities. As leaders, we have to ensure that we lead in an inclusive, compassionate and respectful way: setting the right tone will accelerate and embed the kind of change we all want to see delivered.

Some – but not all – of the changes needed in this report will require us to grow overall primary care capacity. Additional investment is by no means the main or only answer to the issues we need to solve: we will also need to think differently about how we design integrated primary care services that better anticipate the needs of different groups of people.

It is vital that we retain continuity as one of the core strengths of primary care, but we must also recognise that people's needs and expectations are changing. On the one hand, a growing number of people have complex needs, such as multiple long-term conditions, requiring highly personalised care and support. On the other, many people who are normally in good health would prioritise faster access to advice from a wider group of professionals.

A vision for integrating primary care

At the heart of this report is a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

- **streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community **when they need it**

- **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to**,** those with multiple long-term conditions

- **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

It is the collective judgement of the people who have engaged closely in our stocktake that the vision for integrating primary care set out in this report is achievable if we create both the conditions to enable locally led change *and* the supporting infrastructure to implement it: indeed, as demonstrated by many of the case studies contained in this report, systems are already working in this way.

Primary care has always had an entrepreneurial and innovative spirit. We have recently seen the significant, rapid and life-saving adaptations that were made during the pandemic response; including through the COVID-19 vaccination programme delivered together with local authorities, pooling resources to establish COVID-specific 'hot hubs', safeguarding care home and domiciliary visits, ensuring community pharmacy kept its doors open to the public throughout, and shifting to virtual consultations to protect patients, carers and staff.

Locally led, nationally enabled change is a consistent theme in these pandemic success stories. This report offers a vision for transforming primary care led by integrated neighbourhood teams that will be supported to lead change, drawing from the wealth of positive change already underway.

There are no quick fixes, and we have tried through this report to set out pragmatic actions for ICS leadership teams that move us further on the journey, as well as some broader recommendations for national policymakers that will unlock the longer-term changes we need to see.

Improving the experience of accessing primary care is essential to restoring the confidence of the public, who rightly expect us to be there when they need us. Even more important in my view, is the opportunity this new vision for integrating primary care presents in helping people to stay well for longer. This will not only have the greatest impact on the future sustainability of health and care services overall but can genuinely help to transform lives.

All too often, the vast majority of our effort is focused on treating people who have already become sick. We need to create a sense of urgency around providing proactive care and improving outcomes for our population – not only will this help our citizens to lead more active and happier lives, it will help us to reduce the pressure on the NHS and social care in the medium to long term.

This is only achievable if we work in partnership addressing health inequalities through the Core20PLUS5 approach, and taking action to address the wider determinants of health.

Aligned leadership

In my view, ICSs come just at the right time, tasked with achieving four aims: improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and helping the NHS support broader social and economic development.

The ICS CEOs believe that achieving these aims will only be possible if we support and develop a thriving integrated primary care system. This will need to be built as locally as possible, drawing on the insights, resourcefulness and innovations of patients and their carers, local communities, local government and NHS teams, other care providers and wider system partners, as well as, of course, primary care leaders. *This philosophy of partnership is at the heart of my report.*

I am hugely grateful to our workstreams and task and finish groups. By rapidly bringing together a wide range of experience and expertise, they informed our understanding of the current landscape

and what the future should look like. For those who gave us 10 minutes or 10 hours of your time, your input has helped shape this report and I hope you are encouraged by its conclusions. Thank you particularly to all our workstream and task and finish group chairs: Tracey Bleakley, Dr Nick Broughton, Glen Burley, Daniel Elkeles, Professor Kevin Fenton, Professor Simon Gregory, Dr Jaweeda Idoo, Fatima Khan-Shah, Joanna Killian, Dr Neil Modha, Thirza Sawtell, Dr Harpreet Sood, Jan Thomas, and Rob Webster. I'd also like to thank Adam Doyle, who has acted as a critical friend throughout the production of this report.

This report has also been informed by the findings of a King's Fund literature review on levers for change in primary care, commissioned as part of the stocktake, which has provided invaluable insights into what truly drives change: a leadership culture that promotes an enabling and psychologically safe environment, and the capacity, time and skills for people to learn and experiment.

Leading this work has been a privilege, and meeting so many enthusiastic and solution-focused leaders across the health and care system has solidified my optimism for the future.

This report is only the start. To implement these recommendations requires the continued input and effort of my ICS CEO colleagues, the integrated care board (ICB) and integrated care partnership (ICP) chairs and primary care leaders, as well as the support of our system partners. I look forward to being on this journey with you all.

Building integrated teams in every neighbourhood

At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations.

This is usually most powerful in neighbourhoods of 30-50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

The development of PCNs, established just prior to the pandemic, has already enabled many neighbourhoods to make progress in this direction. However, we've heard consistently that a lack of infrastructure and support has held them back from achieving more ambitious change.

Healthy Hyde PCN employs 34 people across many different disciplines, all of which are working to tackle health inequalities. The PCN covers 77,000 people, over 60% of whom live in the top two deciles of most deprived postcodes in England. It has six health and wellbeing coaches working in foodbanks, schools, allotments, and providing ESOL lessons to asylum seekers and refugees. Healthy Hyde is working with local voluntary organisations, statutory bodies and community services to provide a full holistic approach to a person's needs. It has set up groups that are run weekly and monthly by professionals ranging from GPs, nurses, social care, citizen's advice bureau, health visitors and mental health professionals. These groups run for people aged 0 to 100. The team has clinical leadership, managerial and admin support, and works together to identify people via clinical systems, local knowledge and working with multiple agencies.

Integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks (PCNs), and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.

This requires two significant cultural shifts: towards a more psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community; and realignment of the wider health and care system to a population-based approach – for example, aligning secondary care specialists to neighbourhood teams.

The key ingredient to delivering this way of working is leadership – fostering an improvement culture and a safe environment for people to learn and experiment. We heard consistently throughout our engagement that a 'top-down' approach of driving change and improvements risks alienating the workforce and communities and hinders development of trusting relationships: something emphasised in the King's Fund literature review.

Many ICSs are already thinking about how to ensure neighbourhood teams have, for example, sufficient leadership capacity and support to develop a collaborative multiprofessional workforce. Delivering integrated neighbourhood teams will require a step-change in progress, with a systematic cross-sector realignment to form multi-organisational and sector teams working in neighbourhoods. For example:

- full alignment of clinical and operational workforce from community health providers to neighbourhood 'footprints', working alongside dedicated, named specialist teams from acute and mental health trusts, particularly their community mental health teams
- making available 'back-office' and transformation functions for PCNs, including HR, quality improvement, organisational development, data and analytics and finance – for example, by leveraging this support from larger providers (eg GP federations, supra-PCNs, NHS trusts)
- a shared, system-wide approach to estates, including NHS trust participation in system estates reviews, with organisations co-locating teams in neighbourhoods and places.

This will not only unlock improvements in patient care but will also help individual PCNs and teams better manage demand and capacity, building resilience and sustainability.

Integrated clinical pharmacy service in Wirral

Staff working across PCNs and the hospital trust in Wirral Place deliver a shared clinical pharmacy service, hosted by Wirral University Teaching Hospitals NHS Foundation Trust. The service was co-designed and developed with partners, resulting in an environment where those actually delivering the service are 'system thinkers' focused on the patient, regardless of their organisation. Their ability to link with clinicians and other professionals across the local system through the shared use of IT systems, as well as the trust and relationships which have developed, support the speedier resolution of any issues which might impact on patients and the local population – team members are always cognisant of the impact their actions may have in another part of the system.

As well as supporting members of general practice to resolve medicines issues encountered, the joint pharmacy team are also invaluable assets in the day-to-day running of practices. They have their own clinical caseload, run medicines optimisation clinics and support implementation of medicines safety strategies. While working in hospital, they undertake clinical ward rounds across a range of specialties, with a particular focus on admissions and frailty to support safe transfer of care.

The service grew out of an initial pilot, involving just four members of staff, to a team of 25 within just two years. Some staff rotate across the sectors, while some are permanently working in split roles across both sectors.

The pace at which these teams can be built will depend in part on the pace at which we can deliver the national and system changes set out later in this report. However, with the right support, we heard that systems should aim to have them up and running in neighbourhoods that are in the Core20PLUS5 most deprived areas by April 2023.

This will not only ensure that we can start to better support those communities who need it most, it will create the necessary pace and ambition to move to universal coverage throughout 2023 and by April 2024 at the latest.

Working with people and communities

Throughout the stocktake, we heard that the PCNs that were most effective in improving population health and tackling health inequalities, were those that worked in partnership with their people and communities and local authority colleagues. This partnership focuses on genuine co-production and personalisation of care, bringing local people into the workforce so that it reflects the diversity of local communities, and proactively reaching out to marginalised groups breaking down barriers to accessing healthcare.

Community Health and Wellbeing Workers (CHWWs): Westminster City Council, Pimlico Health at The Marven and Imperial College London have launched a pilot scheme of trained CHWWs to run from May 2021 to June 2023. CHWWs visit local households monthly, irrespective of need, and deliver a broad range of activities including promotion of healthy lifestyles, reminders for vaccinations and screening and management of chronic diseases. In this pilot, CHWWs are available to talk to residents about their health, offer social care support where appropriate and inform them about available services, whether they have existing health issues or not. This proactive, universal and comprehensive role helps to capture health and social care issues as they arise. CHWWs in the pilot have identified undiagnosed serious mental illness and domestic violence and improved cervical screening uptake in Muslim women. Due to the initial success of this pilot scheme, this model is now being adopted by the National Association of Primary Care to promote nationally.

We have a fantastic opportunity to build on the outreach model that characterised the COVID-19 vaccination programme: developing meaningful and sustained relationships within communities, using the expertise, resources and relationships held by the NHS and local government, voluntary, community and social enterprise (VCSE) sector teams and community groups and leaders to understand the local social, demographic and cultural factors.

As a part of this drive, our workforce needs to be given the time and resources to meaningfully undertake this work. Outreach should not be considered a bolt-on to the day job – it's central to people's roles and should be reflected in protected time and job plans, for both current and upcoming roles.

Growing Health Together in east Surrey is a place-based approach to prevention and health creation, which uses ecological design principles to support population health, health equity and the environment. Clinicians in each PCN have regular protected time to work collaboratively with local citizens and partners to co-create evidence-based conditions for health and wellbeing. Solutions differ according to the location, reflecting the unique priorities, needs and strengths of each community. Listening to and building relationships within communities form the foundation of this work. Quality improvement methodology is utilised, and the work is supported by population health data and a community of practice. A comprehensive independent evaluation is underway, exploring quantitative and qualitative impacts on both the health system and wider community.

ICSs have a real opportunity to use their scale and convening power to foster meaningful partnerships between sectors, emphasising the importance of health and care organisations as anchor institutions: for example, with schools and higher and further education (HFE) providers, through outreach, work experience programmes and apprenticeships, to drive the recruitment of a more diverse and representative primary care workforce, including health inclusion groups, people with a learning disability and autistic people.

Working in this truly integrated way with people and communities offers the NHS a real opportunity to deliver more effective and sustainable change and paves the way for a much bigger prize: creating the space and opportunity to do far more on the most pressing challenge for health and social care systems: tackling the determinants of ill health and helping people to live happier and healthier lifestyles.

Ultimately, these integrated teams – rooted in the community and working across the spectrum of health and care – are the central conduit through which we can deliver the new model of integrated care.

Stort Valley and Villages PCN has created a **Young People's Social Prescribing Service** to support young people aged 11 to 25 with their physical and mental health. The PCN developed this model because they recognised that services for young people can be confusing and difficult to navigate. The service aims to signpost young people and their families to appropriate community-based and statutory services after they have been assessed by a GP; support general wellbeing among young people and their families in the local community; highlight how effective community interventions can be within PCNs; offer preventative interventions such as the Family Wellbeing Health Coaching Service provided by Mental Wellbeing in Schools; and work alongside other services with a view to creating activities and groups for those who have been referred. The service has had over 500 referrals since its creation in September 2019 and received positive feedback from young people and their families.

Delivering the change our patients and staff want and need: improving same-day access for urgent care

The two issues that have dominated the debate throughout this stocktake are the need for people to access same-day urgent care *and* the need for GPs to be able to provide continuity of care to those patients who need it most.

In reality, they are two sides of the same coin. Creating a resilient infrastructure and resilience around GP practices that enables same-day access to urgent care to be delivered *creates* space to deliver more continuity of care.

To get there, we are going to need to look beyond a traditional definition of primary care and understand that NHS urgent care is what patients access first in their community – typically from their home or high street and without needing a GP referral. That might be online advice on symptoms and self-care, going to a community pharmacy, a general practice appointment, an urgent treatment centre, or the 111 out-of-hours clinical assessment service. As part of accessing urgent care, a patient may then get immediate referral into emergency care or go online or talk to somebody before walking into a hospital emergency department.

People waiting for an appointment with their GP prioritise different things. Some *need* to be seen straightaway while others are happy to get an appointment in a week's time. Some people – often, *but certainly not always*, patients with more chronic long-term conditions – need or want continuity of care, while others are happy to be seen by any appropriate clinician, as long as they can be seen quickly.

Equally, for some patients it is important to be seen face to face while others want faster, more convenient ways of accessing treatment and there is emerging evidence of a growing appetite (even before COVID-19) for patients to access care digitally.[iii]

We saw throughout the stocktake some fantastic case studies of practices and PCNs that are already working as a single urgent care team, including allied health professionals, community nursing teams and others to offer their patients the care appropriate to them when they call the surgery or book an online appointment.

The Foundry Health Centre is a single practice PCN in Sussex with 28,500 patients. Since 2019, it has sought to improve access and keep patients out of hospital. Patients are streamed using systematic triage and clinical judgement and identified as green (generally well – continuity less important), amber (long-term conditions – continuity important; appropriate reactive care delivered), and red (vulnerable or complex – continuity paramount; proactive care given). Combined with creating a dedicated 'green' site for those needing on-the-day access (and 'amber' overflow), capacity across the multi-site practice is easier to plan and manage, drawing on MDTs so patients see the right health professional at the right time.

This approach has improved continuity of care, improved access to a range of services through partnership working, and better utilised additional roles, such as pharmacists, nurses, paramedics, physiotherapists, social workers and those working on behalf of the voluntary sector. Compared with other practices on South, Central and West Commissioning Support Unit programmes, and based on the GP clinical system data, Foundry's top 5% of frequent attenders only use 30% of GP consultations compared with 40% elsewhere, and it has reduced the number of appointments being 'avoidable' from 9% to 6.5% in late 2021, with other primary care services reporting an average of 27% as 'avoidable' appointments.

Managing access for multiple services at a practice level is achievable and scalable if we create the right conditions for this to happen. Working together to make better use of capacity and workforce – as well as creating resilience to deal with demand – can not only help to significantly relieve the burden on practices struggling to cope with finding appointments for their patients, it can also help to reduce demand on other urgent care services across the NHS.[iv]

The truth is, we *can* create a much better offer for all our patients, but it requires effective collaboration across primary care and with the wider health system in a way that we have not managed to date.

Implementing the vision for integrating primary care will enable local systems to plan and organise a coherent urgent and emergency care service by developing an integrated urgent care pathway *in the community*.

Humber Coast and Vale ICS implemented an Operational Pressures Escalation Levels (OPEL) system to understand and manage demand and capacity across primary care. Practices log their on-the-day status online, and if a practice reports capacity issues, the CCG will support and work with it to find a solution.

Though some practices were initially wary of reporting their data, through the relationships of trust between GPs and the CCG and the intelligence that OPEL provides to the system, practices now confidently report their pressures.

This has been particularly successful in Vale of York CCG where all 11 practices report OPEL escalations daily, following three years of relationship development. York CCG's practices have now gone further to improve this system by developing their own anticipated pressures reporting system through the GP Federation, to get ahead of expected demand and capacity issues the day before. Thanks to joint contributions to a shared budget, practices can confirm additional resources are in place before a busy day even begins.

How do we get where we need to be?

We should start by recognising the current system is not fit for purpose – it is fragmented and causing frustration among patients and staff. In the face of rising demand, we need to move to a streamlined and integrated urgent care system – and primary care has an essential role in achieving this.

We need to enable primary care in every neighbourhood to create single urgent care teams and to offer their patients the care appropriate to them when they pop into their practice, contact the team or book an online appointment.

The importance of improvement support, data and leadership is central to making this work and we set out some key recommendations on these later in this document.

Critically, we need to create the conditions by which they can connect up the wider urgent care system, supporting them to take currently separate and siloed services – for example, general practice in-hours and extended hours, urgent treatment centres, out-of-hours, urgent community

response services, home visiting, community pharmacy, 111 call handling, 111 clinical assessment – and organise them as a single integrated urgent care pathway in the community that is reliable, streamlined and easier for patients to navigate.

This will require some shifts to national policy too, specifically the approach to NHS 111, which we heard via the stocktake can often result in duplication of effort for patients, carers and clinicians. At the moment, we do not have a clear and consistent way of counting and measuring same-day urgent access, or unplanned waits for routine appointments. NHS England should consider developing these to support local improvement activity, linked to its wider work with systems in bringing together a set of key primary care standards.

The ultimate arbiters of the success of this approach will be our patients. We should measure patient satisfaction rates throughout this journey, and there should be a move to roll out the new National Patient Reported Experience Metric as quickly as possible. If patients are happier tomorrow than they are today because they are receiving more appropriate care when they need it, then we will be heading in the right direction.

Personalised care for people who need it most

Continuity of care, specifically the relationship between a named GP and their patient, is directly linked to improvements in patient experience and lower mortality, especially for more complex patients.[v,vi] This is a core strength of primary care and we repeatedly heard the fundamental importance of this from staff across primary care and patients alike.

As described earlier, not all patients want or need continuity of care; equally some patients may want continuity of care more generally but be happy to see different professionals as part of their overall care.

By managing urgent care differently and supporting the growth and development of integrated neighbourhood teams, we can create the capacity for team-based continuity, focusing specifically on those people most likely to benefit – aligned to the Ageing Well agenda, for example.

Determining which patients benefit most from more personalised continuity of care can depend on a range of medical, psychological or social reasons and should be determined through conversations with patients and using clinical judgement, as well as supported by risk stratification using the wealth of data increasingly available to primary care teams.

A personalised care approach means *'what matters to me, not what's the matter with me'.* We heard a strong message via the stocktake that we must start with people's abilities and work with them to support self-care and self-management of complex and long-term conditions.

This means shared decision-making with patients and carers and improving availability and usability of patient-held records – for example, ensuring that reasonable adjustments for people with a disability are seen and accessed by all people involved in their care. It also means the further planned expansion of personal budgets and building on the progress made to date in expanding the role of social prescribing in primary care teams.

As integrated neighbourhood teams develop, they will then play a vital role in supporting people with multiple long-term conditions, who we know benefit from a team approach,[vii] drawing in

expertise from primary care, secondary care, social care providers and the VCSE sector to ensure there is comprehensive and co-ordinated care around the patient.

Teams should be collocated and built around the needs of the local population, with a blended mixture of primary and secondary care expertise to provide holistic care for people with more complex and chronic long-term conditions. There should be easy access to a range of diagnostics from phlebotomy, electrocardiogram and spirometry to more complex diagnostics like MRI and endoscopy, without having to bring patients into hospitals, capitalising on the nationwide rollout of community diagnostic centres.

Connecting Care for Children (CC4C) is a partnership between hospital and community health providers, GP federations, PCNs, local authorities, charities, patients and citizens in north west London. Nine child health GP hubs have been set up to provide an integrated child health model of care across multiple agencies and community-based services, with GPs and paediatricians providing specialist clinical input.

MDTs come together to discuss and manage clinical cases, sharing learning on a regular basis. As these teams have matured, they have expanded and now also focus on quality improvement, planning and identifying opportunities for proactive, preventative care: for example, bringing together child health professionals and dental experts to improve children's oral health for the GP practice population. More than 35 CC4C systems have also been established across the UK.

The programme can evidence that it has improved outcomes across patient and family experience of care; staff experience and learning; population health through preventative interventions; and reducing per-capita cost.

At place level (which we recognise will often mean local authority footprints covering populations of around 250-300,000), neighbourhood teams working together and with wider system partners, will provide more intensive support to patients. This should consolidate the multitude of existing models and teams focused on discharge to assess, virtual wards, mental health crisis response, enhanced health in care homes and urgent community response to support people who are unwell to be cared for safely at home, and for those requiring hospital treatment, to ensure safe and effective transfers into and back from hospital. Carers – and the fantastic role they play as well as the additional capacity they provide – will be essential partners to these teams.

This reorientation of our existing workforce to support our most vulnerable and complex patients to stay at home and access care in the community will, over time, contribute significantly to efforts to reduce growth in hospital demand and signal a shift away from a hospital-centric model of care that is no longer suited to the population we serve.

We have seen some excellent examples of good practice from outreach work and joint MDTs for child health, to population-based approaches to management of chronic disease, and partnership working on end-of-life care. All these were characterised by strong relationships, trust and mutual understanding between primary and secondary care clinicians. Capacity and organisational development support for changing clinical models must be identified as part of the implementation of these new teams, supported by practical tools such as job planning and e-rostering across the whole workforce.

In Frimley, an anticipatory care model was introduced to support people with either moderate frailty with eight or more co-morbidities or moderate/severe frailty with no GP encounter in the last six months. The aims are to maximise people's wellbeing, maintain independence and empower people to make their own decisions about care.

People identified as eligible for anticipatory care have a holistic assessment and then comprehensive MDT review, which is led by a geriatrician. Recommendations from the MDT are based on an individual's needs and wishes. The MDT brings together a range of professionals, including older people's mental health services, social care and reablement, pharmacy, community health, occupational therapists, a geriatrician and the GP clinical lead for frailty.

There are a range of interventions provided for people on the pathway, based on what matters to them. Typical interventions include medication reviews, falls prevention, social prescribing referrals, end-of-life planning, nutritional advice and referrals to VCSE services. Anyone in the MDT is able to input into the shared care record, which is then accessible to urgent care services.

The enduring connection to people is what makes primary care so valued by the communities it serves: creating the conditions where we can use integrated neighbourhood teams to support practices by providing personalised care to those people with greatest need, and on-the-day urgent care where appropriate, keeps the connection in place for the future.

Improving urgent care and providing more personalised care to those who need it the most will be central to improving the access issues that have beset the NHS for some time now. Beyond that – and just as importantly – it will create the backdrop and headroom for local systems and teams to work together with communities to tackle the wider determinants of health.

Preventative healthcare

As a nation, life expectancy since 2010 has been stalling, while the amount of time people spend in poor health has been increasing.[viii] This trend is driven in large part by wider socio-economic determinants and a failure to address the health inequalities that result, and it masks significant variability in outcomes, especially between more affluent and more deprived areas where healthy and overall life expectancy are lower.
Primary care has an essential role to play in preventing ill health and tackling health inequalities, working in partnership with other system players to prevent ill health and manage long-term conditions.

People in the most deprived areas of England develop multiple health conditions 10 years earlier than people in the least deprived areas.[ix] The incidence of multiple conditions is rising; without concerted, targeted responses in our most deprived communities, progress on inequalities in healthy life expectancy will continue to stall.

We have known about the inverse care law,[x] where services are often under-resourced in areas with high deprivation compared to areas with no deprivation, for over 40 years, but efforts to address inequalities in the provision of GP services have not eradicated them.

The Core20PLUS5 approach provides a focus for reducing healthcare inequalities across systems, identifying a target population comprising the most deprived 20% of the population of England (the

Core20) and other groups identified by data (plus groups), alongside five clinical priorities for action to reduce inequalities.

Primary care already plays an essential role preventing ill health and tackling health inequalities. Through the stocktake, we have identified three areas in which primary care is taking a more active role in creating healthy communities and reducing the incidence of ill health: by working with communities, more effective use of data, and through close working relationships with local authorities.

We know that health starts at home, and we need to continue to build on successful national programmes providing lifestyle advice, from stop smoking campaigns to 'Couch to 5k'. Alcohol awareness campaigns, national messaging and campaigns on improving health and wellbeing will also remain important.

This needs to be matched with positive action in local communities; health coaches and social prescribing link workers provide a fantastic opportunity for neighbourhood teams to take a more active role in improving health, and where successfully incorporated into primary care, teams are transforming not just the lives of people and families they work with but also the culture and function of the clinical teams they work alongside. Where used most effectively, these roles can help form an effective bridge into local communities, building trust, connecting up services and galvanising the wealth of expertise in the VCSE sector.

We heard very clearly through the stocktake that the wider primary care team could also be much more effectively harnessed, specifically the potential to increase the role of community pharmacy, dentistry, optometry and audiology in prevention, working together to hardwire the principles of 'making every contact count' into more services. For example:

- on early years and children's services: working with nurseries to tackle dental caries in the under-fives and improve MMR vaccine delivery; working with school immunisation services on HPV vaccination uptake and child and adolescent mental health services; community health service teams improving diagnosis of autism and helping improve the health and life chances of children with special educational needs, as well as safeguarding
- on cancer diagnosis: community pharmacy playing a more active role in signposting eligible people to screening and supporting early diagnosis, building on a number of successful pilots such as those from the Accelerate, Coordinate, Evaluate (ACE) programme
- on positive lifestyle choices: eye checks where people are offered brief advice on alcohol and smoking and referred for smoking cessation as appropriate.

Combined with insights drawn from the community, data can empower neighbourhood teams to increase uptake of preventative interventions while also tackling health inequalities by identifying those populations and groups that may currently be underserved.

Reena Barai, a community pharmacist in Sutton, proactively attended a Director of Public Health presentation on local health and social demographics where she learned of the higher than average rates of mental health problems and suicide among young people and males in Sutton when compared to the rest of London.

Having been previously unaware of the severity of the issue locally, her pharmacy team immediately enacted a simple but crucial change in their dispensing behaviour – they endeavoured to check that any young person prescribed anti-depressants was asked how they were feeling and whether they felt the medication was helping. This opportunity to ask for help allowed many people to feel that they could talk to a pharmacist about their mental health and the pharmacy team were able to refer patients back to their GP if they felt they or the patient had concerns.

The trick for ICSs will be to normalise this sort of interaction and subsequent intervention, rather than relying on individuals going the extra mile and stumbling across crucial insights. There is also scope for efficiencies in pharmacies being able to refer onward directly, eg to mental health or other neighbourhood services.

At a place level, we have seen primary care increasingly working in partnership with local authorities (in particular public health and housing teams), local communities and other local system partners, to pool information and population health data. This means sharing expertise to understand what factors lead to poor health and wellbeing in their communities and agreeing how to work together proactively to tackle these. We have seen this type of joint working become commonplace during the pandemic, where a combination of national data tools, collaboration with local authorities and hyper-local engagement were critical success factors. This enabled teams to try different approaches to outreach and communications, get immediate feedback on what is working, and course-correct accordingly. This was essential in minimising the uptake gap by deprivation and ethnicity.

We should build on this, specifically ensuring that we have data made available to integrated neighbourhood teams on uptake of key prevention and population health measures. This will contribute to the effective co-ordination and delivery of vaccination and immunisation, screening and health checks at *place*, in line with national standards, working with NHS ICS partners, local authorities, in particular directors of public health and their teams, over the life course.

Protect Now in Norfolk and Waveney is a proactive care model which focuses on building a detailed data profile of the most deprived populations and offering tailored health interventions to meet their needs. Building on a model called Covid Protect introduced during the pandemic, it is a clinically led collaboration of more than 20 local organisations and partners including local authorities and the VCSE sector. Through the scheme, 100% of those in the top 10% most deprived areas were contacted and information about 1,764 people (49%) was collated. During COVID-19, those who engaged with Covid Protect had statistically better outcomes in terms of COVID-19 infections, mortality and admissions. This methodology has now been successfully expanded to encompass other areas such as vaccination uptake, falls prevention, pain management, diabetes prevention, cervical screening and IAPT uptake.

At a system level, ICSs, particularly through their local authority members, have the opportunity to shape and co-ordinate cross-sector efforts to support people to stay well by working with the voluntary sector, local business and education providers to provide a more consistent offer for socially excluded and most disadvantaged groups, for homeless and inclusion health services. For

example, we heard very clearly the benefit of system-level (and in some instances regional) co-ordination, and co-design of services for **inclusion health groups** will be essential to ensure equity of access and address the needs of people for whom traditional models may work less well.

This principle of equity extends to the life course approach taken through the stocktake. In particular, we heard that there is often insufficient attention and resources directed toward providing effective support for children and young people, and to people with a learning disability and autistic people. Ensuring integrated primary care models are able to effectively adapt their offer will be vital in improving health outcomes and reducing unnecessary future demands on the health service. A real measure of success for this and other ICS strategies will be whether ICSs have meaningfully improved outcomes and experience for these groups which are often not well-served by traditional models.

Creating the national environment to support locally driven change

Making the vison for integrated primary care a reality in every neighbourhood will not happen overnight, and additional workforce and resources – as much as they *are* needed – will not, on their own, get us to where we need to be.

We need a change in how national policy is designed and implemented, which pivots to enabling local teams to be supported to do the job they need to do. We encourage national partners including NHS England and DHSC to continue to consider how to create and support conditions for success and local flexibility, as determined by local leadership and delivery partners in service of local populations.

There are three major areas where we heard very clearly that with the right approach, we can make the biggest impact in creating the environment for local systems to succeed in delivering the new vision for primary care: **workforce, estates and data**.

These three policy areas are crucial to the delivery of the new model because they can enable the flexibilities on workforce that will be central to creating integrated neighbourhood teams, provide the opportunity to co-locate those teams in hubs to ensure greater accessibility for patients and a positive working environment for staff, and equip them with the information to target services where they are most needed.

It is worth noting that most of the recommendations contained in this report are by systems for systems, as well as requiring more national action on workforce, estates and data; and not all the recommendations require additional funding. It is just as important that we create an environment that *supports* local change not *dictates* it: we need to energise local ambition if the new vision for integrating primary care is to succeed.

But there is a simple reality: the pace at which we create the right environment on workforce, estates and data, both at a national and system level, directly impacts on the speed at which the model can be delivered in every neighbourhood.

Confronting workforce gaps

Primary care has never been busier, and capacity gaps lie behind most of the challenges that the NHS faces. These gaps – and the increased demand for services – were growing in the decade before COVID-19 due to workforce pressures and reduced staff satisfaction, the increasing number of people living with multiple long-term conditions, and changes in public expectations.

Layer on the demands of treating COVID-19 patients and vaccinating the nation, and we now have an extremely busy urgent care system, big backlogs of work across elective, community, mental health, social and primary care, and staff unable to offer what they think patients reasonably need. These challenges, while consistent around the country, are more pronounced in areas of greater deprivation, which risks further contributing to health inequalities.[xi]

A new care model will not magic away our workforce challenges: we need to continue to grow the MDTs in primary care and recruit and retain as many extra GPs as we can possibly get. The plain fact is that the aggregate numbers of GP full-time equivalents (FTEs) are simply growing too slowly and we will need more action at every level to address the gap.

In headline terms, the record number of trainees masks the loss of fully trained GPs, particularly experienced partners, who also on average work more hours than salaried GPs, who in turn on average work more hours than those who work solely as locum GPs.[xii] We also face a big potential retirement bulge, and as a nation we should certainly be doing all we can to encourage all our international medical graduates – who make up 40% of all our GP registrars – to settle in England as an NHS GP on a permanent basis. We also heard that looking again at the role of the GP Performers List could enable us to increase capacity if it enables other appropriately qualified clinicians to contribute more easily as part of the primary care workforce.

Addressing the shortfall in GPs is essential and urgent. We have heard through the stocktake that there are also recruitment and retention challenges across the wider primary care workforce, particularly NHS dentistry and community pharmacy, and that there is significant variation across different parts of the country and across employers.

But the workforce picture in primary care is not all bleak. PCNs have been more successful than we all hoped in hiring extra staff in new roles. The latest data as of Q4 2021/22 shows that over 18,000 FTEs were in post by end of March 2022 – significantly ahead of the trajectory towards the 26,000 March 2024 target. This is very welcome, and progress must not stall. We welcome the clarity from NHS England that staff in post will continue to be treated as part of the core PCN cost base beyond 2023/24 when any future updates to the GMS contract are considered.[xiii]

We also heard a strong message through the stocktake that improving the supervision, development and career progression of individuals in Additional Roles Reimbursement Scheme (ARRS) roles is crucial to retain them and make the most of their skills and experience as part of integrated neighbourhood teams. We came across some great examples of practices and PCNs using additional roles to improve patient care, but we know there is variation across the country, something highlighted in the recent King's Fund report. Some local systems have not yet been able to make best use of the scheme due to a lack of local capacity for clinical and managerial supervision, inadequate space in practices, confusion around the purpose of some roles, administrative complexities, and lack of expertise on organisational development and role redesign to embed new roles.

Reforms to education and training to build our workforce pipeline will take time, and we acknowledge that there are no quick fixes when it comes to workforce supply, which is why a long-term workforce strategy is required. The forthcoming national workforce strategy should include a focus on primary care and support ICSs to deliver this report. However, what we also heard loud and clear through the stocktake is that given the right discretion and flexibility, systems can get on with building the right local teams *now*.

Systems working differently to shape their workforce

Creating the environment where we can be flexible and nimble in managing the broader workforce can provide some quick wins. Systems need the flexibility to think creatively about how they maximise the skills and experience across the current primary care workforce and elsewhere in the system. As well as working with system partners to promote education, apprenticeships and new local employment opportunities, ICSs should be supported in the process of appropriately de-medicalising 'care' to help deliver a more personalised offer for patients but also to help with immediate workforce supply issues.

Systems should also support the development and rollout of innovative employment models such as joint appointments and rotational models that promote collaboration rather than competition between employers, particularly where skills are scarce.

To support improved workforce planning, the electronic staff record or a similar integrated workforce solution, should be used throughout primary care to inform demand and capacity planning and enable team-based job planning and rostering to become the norm.

Not only will this support integrated neighbourhood teams to make more effective decisions, the aggregated data would support a greater national understanding of workforce pressures that should guide the development of future national workforce and estates strategies.

Berkshire, Oxfordshire and Buckinghamshire commissioned support to develop an online workforce planning tool for their PCNs. The aim was for general practice recruitment strategies and workforce plans to be better informed by population needs. They used quantitative and qualitative data to provide tailored insights to each PCN on how to meet population and workforce needs one, three and five years into the future. Subject matter experts, including data analysts, supported making sense of the information and identifying pragmatic solutions to current and future workforce challenges. These data packs have been used to inform targeted interventions, including maximising the use of ARRS roles. An insight paper was also provided to the ICS to inform their system-wide workforce strategy. PCNs have already requested to repeat the process next year to capture progress and develop increasingly sophisticated approaches to workforce planning.

ICSs developing system-level workforce data will also enable a better understanding of workforce pressures across primary care: for example, the impact of likely changes in GP numbers in each practice, allowing them to identify what actions they might take to improve recruitment and retention of GPs, such as GP returner and retainer schemes, GP mentors and mentorship schemes, and leadership schemes.

NHS England should work together with systems – recognising they will all have locally driven workforce plans – to identify what measures can be introduced to better *support local recruitment and training* of key community healthcare teams such as community nurses, care support, community psychiatric nurses and district nurses to work alongside primary care in integrated neighbourhood teams.

Extending the agenda beyond headcount

We do not just need to attract new staff into primary care; we need to create the backdrop that allows their roles to be reimagined and made more flexible and attractive – ultimately supporting increased participation and retention in primary care.

This was particularly evident in conversation with the next generation of primary care leaders, who are clear about the need for a sense of parity with specialist careers, a realistic work-life balance, their desire to work in MDTs, and having the ability to pursue a variety of roles to create a diverse working week and, ultimately, career.

There should be a more consistent and comprehensive training, supervision and development offer across primary care – including a focus on medical and non-medical staff and existing staff such as receptionists, practice managers and practice nurses, and retention strategies across early, mid and

late career. Systems will want to work with primary and community care training hubs to ensure 'the offer' they provide is broad enough to help integrated neighbourhood teams flourish.

We need to recognise that PCNs will only be able to meet the challenge set out in this report if they are properly supported. There should be a strong focus on supporting PCNs and GP practices with supervision of the ARRS roles and others, for example, making the most of multiprofessional and remote models of supervision where appropriate.

Birmingham and Solihull (BSoL) has a primary care 4Rs workforce strategy (Recruit, Retain, Returners and Role Allocation). This includes a PCN development plan co-designed with PCNs that complements the training hub, leadership academy and system peoples board. It supports recruitment and retention of ARRS roles across the system – for example, facilitating joint working between PCNs and Birmingham Mental Health Trust on mental health practitioner roles and integrating the community mental health transformation programme. All 29 PCNs have signed up to deliver PCN development plans for three consecutive years.

The strategy has an underpinning framework consisting of a range of joined-up and proactive workforce schemes for early, mid and late-career GPs and nurses. BSoL also has a thriving general practice Equality, Diversity and Inclusion Staff and Allies Network with over 300 members and 29 PCN health inequalities champions. In addition, there is a general practice flexible pools scheme locum bank.

These steps, taken together, will support ICSs to have a fighting chance of improving recruitment and retention in primary care going forward. But this will only get us so far.

Listening to and supporting our frontline staff

We also need to improve the experience of working in primary care for everyone by making the employment culture more compassionate and inclusive, and listening much more effectively to what primary care staff are telling us.

The NHS staff survey is already being piloted in some areas of general practice and now needs to be extended nationwide and considered for NHS-funded primary care. Identifying ways to support and listen to staff who are working as carers would also be very welcome, and primary care staff should have access to Freedom to Speak Up guardians, promoting an open and listening culture. Workforce data, staff surveys and other feedback mechanisms for staff, should be used by ICSs and local leaders across primary care to take action to improve equality, diversity and inclusion across the primary care workforce.

We must tackle racial discrimination and harassment[xiv] because it is the right thing to do, it is crucial to retain our staff, and to further strengthen how the primary care workforce reflects and strengthens its connection with the diverse communities it serves. We must value the important contribution that individuals with protected characteristics, including age, sex, religion or belief, people with disabilities, those from the LGBTQ+ community, black and minority ethnic backgrounds, and with caring responsibilities, make as part of our workforce. Ensuring flexible working and other forms of support are available to these groups and any others that experience discrimination in the workplace should be central to local, system-level and national workforce strategies.

Systems should drive a more standardised and improved employment offer for primary care in line with the NHS People Promise: for example, by ensuring parity of access to system staff health and

wellbeing hubs and occupational health services, and by encouraging employers to adopt NHS terms and conditions by sharing existing good practice and model contracts.

Investing in local leadership to drive change

The role of PCN clinical directors in the future will be essential to the leadership of integrated neighbourhood teams: and when leadership is strong and purpose is clear, retention rates improve.

More focus needs to be given to the development and support of clinical directors beyond the current basic arrangements provided through the national contract, including the local provision of sufficient protected time to be able to meet the leadership challenge in integrated neighbourhood teams.

Some systems will want to go beyond this and use even more innovative ways to support clinical directors to expand and develop their integrated neighbourhood teams, for example:

- some neighbourhood teams may offer an opportunity to develop different areas of focus and specialisation, with senior GPs serving as the 'consultant in general practice' – working across prevention, chronic and urgent care as part of wider teams
- securing the specialist input from secondary care required in neighbourhood teams, as part of job planning for consultants
- supporting community partners to operationally embed relevant teams as an integral part of existing PCN teams, recognising that the integration of community and mental health services with primary care is crucial to delivering more integrated care for patients in the community, as set out in the NHS Long Term Plan.

We also need to consider the leaders of tomorrow. Aspiring leaders already within systems and those coming though the national talent pipeline in the NHS – for example, the NHS Graduate Management Training Scheme – should, in future, be able to access development programmes that promote integrated working across systems. There should be a consistent leadership development offer accessible to primary care staff that is comparable to other NHS family providers and promotes multiprofessional leadership across the breadth of primary care. This should increase diversity across primary care and system leadership. The welcome mindset change we are seeing in the leadership of the emerging ICSs needs to be embedded and tested in what we expect of our future leaders. It is important that primary care leaders can see a career path that extends into system roles in neighbourhoods, provider collaboratives and beyond.

Suffolk and North East Essex One Clinical Community leadership development programmes aim to cross multi-organisational boundaries, support a common purpose across practitioners in the community, develop trust and improve outcomes, and build a network of effective leaders who can together address the key challenges in the wider health and social care system. Since it was commissioned in 2018, the programme has evolved to support leadership development across the eight integrated neighbourhoods teams (INTs) within the Ipswich and East Suffolk Alliance. The core members of INTs on the programme come from community services, social care and mental health, with additional participation from staff working in general practice, secondary care, charity and voluntary sectors, public health and district and borough councils. An evaluation by the University of Suffolk found that the programmes' objectives to enhance leadership skills, support personal development and for the skills and knowledge developed to be applied through the practice of integration impacting teamworking, were met.

Reimagining our approach to primary care estates

In parallel, we need to address and rethink our second capacity constraint: space.

Next steps for integrating primary care sets out a vision of integrated neighbourhood teams, providing joined up accessible care. But much of the general practice and wider primary care estate is frankly not up to scratch.

There are 8,911 premises in England, 22% of which are pre-1948 and 49% of which are owned by GPs, 35% owned by a third party, and 14% owned by NHS Property Services.[xv] Around 2,000 premises have been identified by GPs as not being fit for purpose,[xvi] and there was strong feedback throughout the stocktake that we do not start thinking about estates early enough in our planning and frequently regret it.

Estates are so much more than buildings. We must move to a model that makes estates a catalyst for integration rather than a barrier to it. This new model should focus on patient needs, create a positive working environment for staff and provide adequate space for key activities like training and team development. Creating the right environment has to start with understanding what we have got in terms of estates, something that is best undertaken locally.

In **Dorset**, the primary care estates team has undertaken an 18-month programme to pull together practice profiles for its 120 general practice sites. These profiles include ownership models, square footage, utilisation etc, and are supporting the development of a broader strategic network plan that allows PCNs and practices to take a holistic approach to estates planning.

The focus of capital investment has been weighted towards secondary care – something that now needs to change. Layered onto this is the fact that the GP owner-occupier model includes perverse incentives which can make cross-system collaboration more difficult.
As with workforce, we need to recognise that the current mindset and approach to estates need to change, and that we need to create the permissions and support for local systems to build estates models that better align with delivery of clinical, digital and workforce strategies. Despite investment constraints, there is real opportunity locally to start to deliver improvement now.

We need a detailed review of the space available in each system, service by service, to inform the ICS estates infrastructure strategies. These reviews should help us understand what we have got and what we can fix locally, as well as help us prioritise funding as and when capital becomes available.

ICSs have the reach to take a 'one public estate' approach and think creatively about primary care estates, considering:

- developing primary care estates plans from the perspective of access, population health and health inequalities
- making use of local authority, third sector and community assets, building on the approach to COVID-19 vaccination, including places of worship, community centres, and allotments
- making creative use of void and vacant space in the NHS Property Services and Community Health Partnerships portfolio
- opportunities for co-locating primary care when bringing forward secondary care estates plans

- pragmatic, low-cost opportunities to repurpose existing space, within local funding streams, as well as making use of the potential ability of the local authority to raise capital beyond NHS limits to fund new estates
- opportunities for locating primary care onto the high street as part of local economic regeneration.

In **Waltham Forest, north east London,** a new state-of-the-art health centre following partnership working between the borough council and local NHS has been built. The £1.4 million building, located within the Sutherland Road development in Walthamstow, is due to open in spring 2022 – providing a modern and spacious new home for GPs and other staff at the Lime Tree and Sinnott Healthcare medical practice.

The project formed part of the council's capital plan for regeneration, which included the desire to improve healthcare infrastructure across the borough, in response to demographic changes and increased local demand for primary care services.

The new purpose-built centre will enable the GP practice to relocate from its existing premises and allow it to expand its current registered list from 6,500 to 10,000 patients over the next 15 years. The new-look practice will also benefit from investment in digital technologies to facilitate self-monitoring – allowing patients to take greater control of their own care, alongside convenient access to a wider range of health services in the community.

As systems, we should already be thinking about tackling those issues that create barriers to change. 'Last partner standing' scenarios may require systems to find innovative solutions that maintain service quality and continuity when partnerships propose handing back Primary Medical Services contracts. For example, where the overall benefits to patients and avoided costs of replacing provision would justify it, there may be options such as to transfer ownership to public or commercial system partners. In scenarios such as this, NHS England needs to give permission to systems to make difficult choices, but ones which will ultimately benefit our patients and the taxpayer.

Data, data, data

Integrated neighbourhood teams can only flourish if we ensure information about patient care can be properly shared – for use in providing and improving the co-ordination of care at an individual level, and for wider planning and research. Working across the whole of primary care, PCNs should be given the tools to make routine use of population data to inform how they design care for the people they serve.
PCNs and wider neighbourhood teams need to be able to read and write seamlessly into a shared patient record that provides a single version of events for each patient with appropriate information governance arrangements in place. They also need to be able to access real-time data on demand, activity and capacity so that they are able to improve services, identify gaps and take action to redistribute resources and plan workforce accordingly.

Data sharing is often not the norm in the NHS or other public services, despite the fact that most patients expect relevant information about their care to be shared between different professionals and organisations involved in their care. A number of ICSs are already working through plans for improving data sharing in their area and working with providers collaboratively to co-produce this**,**

looking at how to best invest in the essential IT infrastructure that underpins this – including establishing IT systems that can do the difficult work of linking datasets to enable population health management.

It has always been true that if you give clinicians the data they will respond. Systems can enable this by putting in place a local transformation function which includes joined-up intelligence, improvement and other support functions with a deep understanding of primary care, organised and funded at system or place level, but wholly orientated to provide support for their neighbourhood teams.

System P in Cheshire and Merseyside utilises multiple sources of intelligence to categorise population segments, and then explore the way in which these different groups of people interact with health and care services, and whether their needs are being met in the most effective and person-centric way. The initial focus is on two priority segments: Complex Lives and Frailty & Dementia, both of which have a unique set of needs and risk factors, which must be taken into consideration if outcomes are to improve. Partnership working with the University of Liverpool and utilisation of the CIPHA (Combined Intelligence for Public Health Action) platform is putting both the data and expertise in place.

For much of the country, neither of these things exist and need to be put in place. As part of this, systems will need to consider how they can develop sufficient expertise in data analytics at the right level, including retraining existing staff and planning to increase recruitment in key roles. This means a change of mindset – from a previous focus on using data to inform commissioning and monitoring of contracts, to a two-way process of using data to drive improvement.

Systems have a role to play in articulating a clear plan for data sharing across the system to support the development of population health management approaches at neighbourhood and place level, enabled by a clear information governance framework and work closely with providers and patients to co-produce data sharing agreements where appropriate.

Creating the digital infrastructure needed to underpin integrated primary care

Digital technology has the potential to transform how people access primary care, how services are delivered and how we plan care to better meet the needs of local communities. Often, however, the underlying infrastructure to enable this transformation is lacking – with wide variation in digital maturity, knowledge of digital transformation and procurement across and within systems.

In Brent, London, 20 practices created a centralised 'eHub' for online consultation management. The eHub supports practices to manage increasing levels of patient demand; leverage economies of scale; share existing and additional workforce, resources and flex capacity; optimise additional roles by distributing work to the right person; collaboration and peer support.

The eHub enables clinicians to view patients' 'home' practice records and write to the 'community' record. Notes are shared with the 'home' practice through a 'discharge summary'.

The eHub closes around 90% of online consultations. Face-to-face appointments remain available through patients' 'home' practice and local, face-to-face extended access hub. Many patients reported that they like the improved convenience and speed of the new online access system. The eHub helps reduce pressure on 'home' practices, reduce patient waiting times and enables a faster response. Most requests sent to the eHub are 'closed' by it, increasing time for practices to focus on patients with more complex needs.

During the pandemic, digital technology played an increasingly important role in maintaining services for patients who were happy to use it. We also learned that we can roll out digital technology at pace when circumstances demand. Having created a greater appetite for digital services – both among patients and staff – we should continue to offer a greater diversity of services in this way.

ICSs have a vital role to play in developing a more coherent approach to digital transformation in primary care that focuses on improving patient experience and outcomes. Some are already conducting baseline assessments of the current state of digital infrastructure in their area and understand current needs and gaps and exploring how cloud telephony and online consultation tools, for example, can help to deliver more streamlined systems for accessing general practice.

ICSs can support the development of more interoperable IT systems by following 'what good looks like' principles and the GPIT operating model when making decisions about IT investments and products, and they can leverage their larger scale and purchasing power to improve value for money and quality of service.

Systems will also have a vital role in providing a digital training offer for clinical and non-clinical primary care staff. They will need to consider how digital expertise and leadership inform decision-making at every level. Some have already chosen to appoint a chief information officer (CIO) or chief clinical information officer (CCIO) at executive level, as well as named leads for primary care digital transformation. Digital transformation needs to be embedded as part of a more holistic approach to primary care transformation.

Critically, decisions about digital infrastructure in primary care need to be made in partnership with those who will use them – including engagement with both staff and patients. Ensuring that potential barriers to using digital tools, such as digital exclusion, are understood and addressed will be particularly important. Establishment of digitally enabled primary care hubs on a neighbourhood footprint will be a priority.

Hard-wiring the system to support change

Throughout the course of the stocktake we had a number of themed working groups with expertise from every part of the system coming together to think about the kind of changes we would need to see both to inform the new model but critically how to make it deliverable.

There are a range of near-term and longer-term actions – for systems, national organisations and government – that we can be getting on with now to directly support the delivery of the new model.

Taken together the actions outlined in this section will not just create the conditions for the new vision of integrated primary care to succeed, they will create a common sense of purpose for the ICSs to maximise the impact of new ways of working that the reforms create the opportunity for.

The recommendations in this section are by no means exhaustive and while the majority of this report places the onus on new ICSs to deliver the new model, this can only be done if national policy aligns to enable them to deliver it. To that end, we encourage national partners/DHSC and NHS England to undertake further work to consider the existing legislative, contractual, commissioning, and funding frameworks, which were out of scope for this stocktake. This work should consider what further changes could enable and incentivise this integrated model of care and new models of primary care; and how to improve equity in distribution of resource to ultimately improve health outcomes.

Workforce

The forthcoming national workforce strategy should focus on primary care and identify the wider skills and roles required for successful neighbourhood and place-based teams. This strategy should build on Health Education England's (HEE) Strategic Framework 15 and must inform any future national estates plans to ensure adequate space for training, development and service provision. NHS England should simplify guidance and address common misunderstandings regarding ARRS, as well as consider further flexibilities that could be introduced that support recruitment in the short term. NHS England should work with DHSC and HEE to consider how the scheme should operate after March 2024, including the role of ICSs in working with national colleagues and PCNs in delivering it.

The NHS Staff Survey should be rolled out nationally across primary care, building on current pilots in general practice to provide parity across the NHS family – as soon as funding permits.

Estates

DHSC and NHS England should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues, and practical support to work through them, as well as building ICS estates expertise. DHSC and NHS England should consider what flexibilities and permissions should be afforded to systems to allow shaping and influencing of the physical primary care estate, including through reviewing the Premises Cost Directions. DHSC should ensure that primary care estate is central in the next iteration of the Health Infrastructure Plan.

The estates reviews, aided by the national plan, are central to creating coherence across services and sectors, and they should drive the transition to a modern, fit-for-purpose primary care estates offering – including future development of hubs within each neighbourhood and place to co-locate

integrated neighbourhood teams, as well as linking into the wider rollout of community diagnostic hubs, for the provision of more integrated services.

Data and digital

National action is needed to help put in place the data and digital infrastructure necessary to transform primary care.

NHS England will need to work with ICSs and IT suppliers to ensure business intelligence tools and timely data are made readily available to practices and neighbourhood teams in an easy-to-use format, supported by the development of real-time data visualisation and standardisation of approaches to data to enable comparability tools.

NHS England can also support ICSs to improve data sharing for direct care, service improvement and research by publishing a revised national template data sharing agreement, making clear that practices will not be liable for General Data Protection Regulation breaches relating to data shared under the agreed terms – an issue that is proving a barrier to setting up such agreements in some areas. It will also need to provide systems with guidance on minimum standards for procurement of analytical software and ensure training, tools and a comprehensive support offer are available.

Both NHS England and systems need to work together to engage both communities and staff in why sharing data is so important and will help improve patient care.

Access

NHS England should consider the implications of a neighbourhood-based approach to urgent same-day access in future national guidance on the wider urgent and emergency care pathway, specifically NHS 111 and integrated urgent care.

NHS England should consider the development of new metrics and standards on urgent and routine access, and introduce as planned, the new patient-reported experience measure for access to general practice.

Pivoting to locally led investment and support

This report marks a strategic pivot to system-led approaches as a key way of driving up access experience and outcomes in primary care.

National contractual arrangements, including for PCNs, have provided essential foundations including for chronic disease management and prevention. But they can only take you so far. As already highlighted in the report, getting to integrated primary care is all about local relationships, leadership, support and system-led investment in transformation.

ICSs putting in place the right support locally will be enabled by maximising what control ICSs have over the direction of discretionary investment. This should be looked at by NHS England as part of the implementation of recommendations.

It is also generally accepted that the distribution of primary care funding to neighbourhoods is not always well aligned to system allocations and underlying population health needs – and we need a concerted local effort to try and fix this. ICS leaders have already started to review discretionary investment in primary care to address this issue, working with clinical colleagues to understand the data and make the case for alternate approaches**.**

ICBs have an opportunity to establish a firm understanding of current spending distribution across primary care weighted by deprivation and other elements of the Core20PLUS5 approach, which can then inform discussions on how discretionary investment can be more purposefully directed to address health inequalities and form the basis of work to secure collective commitment from all system partners to this redistribution.

In Leicester, Leicestershire and Rutland action has been taken to address inequalities in the existing primary care funding model, which is primarily driven by age and gender and not reflective of actual patient need at practice level. They are also tackling disparities in service provision; a population health-based model found that underfunded areas were the most deprived.

The new model calculates practice payments by setting aside the core staff components, based on the current practice core contact income. The remainder of core contract funding and other funding in the model is distributed to practices based on needs and deprivation (90:10). As a result, approximately £3 million was identified to rebalance a fairer level of baseline funding across all practices, based on need and demographics, and the model enables future investments in primary care to be transparently distributed at practice and place, based on population health need.

Beyond national contract entitlements, there are also too many small national pots of programme and system development funding money, ringfenced for particular purposes, which undermines how efficiently resources are allocated. NHS England should consider combining and simplifying central programme and transformation budgets for primary care.

Backing existing practices and new models of provision for primary care

The successful delivery of the new model can only be optimised if systems ensure they bring GP practices of all different shapes and sizes with them. We need to recognise that maintaining stability in general practice will be central to being able to deliver the new model of integrated care.

We need to ensure the right arrangements are in place to support primary care where it wants to work with other providers at scale by establishing or joining provider collaboratives, GP federations, supra-PCNs, or working with or as part of community, mental health and acute providers. Both the contract and funding arrangements were out of scope of this review. But it is clear that changes to these could support this vision. We recommend that DHSC and NHS England rapidly undertake further work to understand how changes to these could support the implementation of integrated and new models of primary care.

Where there are gaps in provision, or individual providers are rated ‘inadequate’ by CQC, ICSs should provide tailored support to practices to improve and, where appropriate, actively commission new providers of integrated list-based primary care, in particular for the least well served communities. ICSs should more generally also provide a primary care support offer for all providers, that includes a focus on quality improvement.

The role of ICSs in supporting the development of integrated primary care as part of a national support and development offer should be explicit with accountability for delivery of integrated primary care reflected in the ICS accountability framework, including the respective roles of ICS and place-based leaders.

Enabling primary care at a system level

System-level expertise on primary care should go beyond contracting to building relationships and developing capabilities within systems as they build their new teams. We heard throughout the stocktake of the importance of a core set of capabilities to support improvement and transformation, with quality improvement; digital, data and analytics; understanding local communities and user experiences; physical infrastructure; workforce planning and transformation; service design; and the development of the primary care provider landscape coming up most frequently.

These key primary care capabilities need to be in place for all systems, but not all need to be provided in-house – some may be brokered or commissioned from other providers at scale: eg GP federations, acute, community or mental health providers, or commissioning support services.

Dudley Integrated Health and Care NHS Trust (DIHC) was created in 2020 by local GPs to provide out-of-hospital care by integrating primary care with community-based services and providing strategic and operational support. Forty-one practices signed an integration agreement with DIHC, committing general practice to deliver a primary care operating model in return for DIHC providing wider workforce and support to enable the model and the Dudley Quality Outcomes Framework to be achieved.

Primary care is at the centre of all DIHC planning and development. Through a management agreement, DIHC supports the running of services and provides a turnaround team to address quality of service or management issues. DIHC produces workforce and estates plans on behalf of the PCNs each year, which PCNs tailor to their population's needs. DIHC employs, trains, supervises and operationally manages all ARRS staff on behalf of PCNs and has established a pharmacy team of 50 to support all practices.

DIHC working with primary care is improving population health outcomes, providing a consistent service offer and supporting delivery of a sustainable model of general practice by providing support though extended access, community services, care home support, and PCN Direct Enhanced Service delivery. Dedicated management capacity and clinical leadership capabilities support primary care planning and development and enable the development and expansion of the range of commissioned services.

All systems should carefully consider the breadth and level of their organisational capacity and capability to turn this framework for integrated primary care into local reality, taking account of responsibilities for commissioning NHS community dentistry, pharmacy and optical services from April 2023.

Embedding primary care leadership throughout systems

ISCs come into being on 1 July this year and have the opportunity to ensure that primary care is deeply embedded in the new governance arrangements they are designing. There are some well-established existing forums for bringing clinical leaders and professions together, in particular for general practice.

ICSs will want to ensure that primary care leadership across all four pillars is embedded across systems – this might be through the creation of a primary care forum or network with credibility and breadth of views to be able to advise the ICS. Building relationships with existing local professional

committees across all four pillars of primary care, such as *local medical, pharmaceutical, dental and optical committees and primary care audiology,* will ensure the support and collaboration of key local leaders in improving access, experience and outcomes for patients and communities.

To ensure that primary care and the views of the communities it works in are heard throughout systems, integrated neighbourhood teams should be well linked to – and represented on – all place-based boards. The connections integrated neighbourhood teams will build both with their respective communities and between them will be invaluable in the planning and decision-making that happens at a place board.

The Black Country and West Birmingham Primary Care Collaborative was established to promote the interests and sustainability of primary care services and ensure a single voice for primary care in decision-making at all levels within the ICS.

It represents grassroot primary care views, and in turn reflects patient and public needs and focuses on tacking inequalities in the planning and delivery of services.

It joins all primary care professionals at a Black Country level, including GP practices, GP federations, primary care providers, local medical committees and PCNs. The collaborative plays a leading role in the design and development of the ICS primary care transformation strategy and acts as an expert reference group to the ICB around primary care issues.

In its next phase, other independent contractors (including pharmacy, optometry and dentistry) will be included as delegation of statutory responsibility shifts to the ICS and is also intended to extend to include community services.

Conclusion

Throughout this stocktake I have been overwhelmed by the energy, hope and appetite for improvement and change that exist today in the NHS. This is all the more remarkable given what everyone has been through for the last two years in supporting patients, families and neighbourhoods through the pandemic.

There is real evidence that the experiences of individuals and teams over the last two years – alongside the enormity of challenge we face in recovery – are forging a new determination to work together to fix the issues that sometimes hold us back from delivering the best services and care.

We arrive at this moment with an opportunity – through the creation of ICSs – to be brave in embracing new ways of working: to reimagine how we might deliver care in the future. To organise ourselves differently and better. To work together, no matter what part of the NHS we're in.

We've learned through the pandemic the true value of bringing people together and working in partnership to come up with local solutions. Communities up and down the country rallied as they never have before to support the COVID-19 vaccination programme and save lives. Harnessing that energy and working with those same communities to rebuild services to be more effective in delivering what they need has to be at the heart of everything we do.

That's why shifting our focus now onto developing integrated neighbourhood teams, places and systems gives us such a great opportunity to build a new, more effective health service designed with our communities to fit their needs.

We also arrive at the point with a growing belief in how we can use digital and technology much better than ever before. The rapid development and rollout of technology-based solutions to support remote care during the pandemic helped all of us to realise the rapid opportunities this presents. More and more people want to use apps and mobile devices to support their healthcare – and this doesn't have to be at the expense of face-to-face care, indeed as this stocktake shows, providing technology-based services for those who want them can free up more time for face-to-face care for those who need it.

Our biggest challenge is creating the conditions by which local change can happen – and that's going to require pivoting away from top-down directives and creating an environment that supports local change, not dictates it from the centre.

Ensuring local systems can access the right data to support the integrated neighbourhood teams to help primary care enhance the services it can provide is a good example. We also need to change step on how investment and financial support flows through the system. More new money is always welcome, but as a minimum every effort should be made to create as much local flexibility around discretionary funding as possible. That won't just support local teams to shape services in a way their communities want them to, it will help them create the right incentives to being GP practices of all shapes and sizes with us on this journey.

The glue that holds all of this together is leadership: investing in leadership at PCN, place and system level will be the difference between success and failure in integrating primary care. The talent pool that exists in primary care is vast: supporting and nurturing that talent to be innovative, brave and collaborative in leading the changes outlined in this stocktake will help to reignite appetite for change and improvement in neighbourhoods right across the NHS.

Very little of what is outlined in this stocktake is easy to deliver: I wouldn't have been asked to undertake this work if it were. But the prize of delivering the ideas outlined in this document is greater than just improving the experience, access and outcomes of primary care: I believe that working this way we can strengthen trust within the NHS and rebuild confidence in the services it provides.

Dr Claire Fuller

26 May 2022

Annex: Framework for shared action

1	**Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices.** This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face.	ICSs
2	**Assist systems with integration of primary and urgent care access,** specifically looking at the role of NHS 111, and considering the development of new metrics and standards on urgent and routine access, and introduce as planned, the new patient-reported experience measure for access to general practice.	NHS England
3	**Enable all PCNs to evolve into integrated neighbourhood teams**, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At place level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams. Focus on community engagement and outreach, across the life course. Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations. Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards.	ICSs
4	**Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams**, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multiprofessional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.	ICSs

5	**Develop a primary care forum or network at system level**, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place-based boards.	ICSs
6	**Embed primary care workforce as an integral part of system thinking, planning and delivery.** Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.	ICSs
7	**Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver this report (NHS England).** Recognising this is not currently funded, commit to future rollout of the NHS Staff Survey in primary care. Examine further flexibilities, and better communicate existing flexibilities, in the Additional Roles Reimbursement Scheme. Specifically consider, with DHSC and HEE, how the scheme should operate after March 2024, including the role of ICSs in working with national colleagues and PCNs in delivering it. Review the GPs Performers List to enable other appropriately qualified clinicians to contribute more easily as part of the primary care workforce.	DHSC with NHS England and HEE
8	**Pivot to system leadership as the primary driver of primary care improvement and development of neighbourhood teams in the years ahead.** Move to greater financial flexibility for systems on primary care. Bring together existing national primary care funding wherever practicable. Beyond 2023/24, maximise system decision-making on any future discretionary investment, beyond DDRB and pay uplifts.	NHS England
9	**Improve data flows** including by (i) solving the problem of data-sharing liability, issuing a revised national template; (ii) working with system suppliers on extract functionality; (iii) improving data to support access (actions 1 and 2 above), and (iv) helping to identify population cohorts to be targeted by neighbourhood teams.	NHS England
10	**Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care**, taking a 'one public estate' approach and maximising the use of community assets and spaces.	ICSs
11	**DHSC and NHSE should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues,** and practical support to work through them, as well as building ICS estates expertise. DHSC and NHSE should consider what flexibilities and permissions should be afforded to systems to allow shaping and influencing of the physical primary care estate, including through reviewing the Premises Cost Directions. DHSC	DHSC and NHS England

	should ensure that primary care estate is central in the next iteration of the Health Infrastructure Plan.	
12	**Create a clear development plan to support the sustainability of primary care and translate the framework provided by *Next steps for integrated primary care* into reality, across all neighbourhoods.** Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.	ICSs
13	**Work alongside local people and communities** in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.	ICSs
14	In support of systems, **set out how the actions highlighted for NHS England will be progressed.**	NHS England
15	DHSC and NHS England should rapidly undertake further work on the **legislative, contractual, commissioning, and funding framework** to enable and support new models of integrated primary care. This work should also consider how to improve equity in distribution of resource and ultimately improve health outcomes.	DHSC and NHS England

Workstream and task and finish group chairs

This stocktake has been informed by invaluable insights from nine workstreams and four task and finish groups, the Chairs of which endorse its findings

Professor Simon Gregory
Deputy Medical Director, Primary and Integrated Care, Health Education England
Chair, Workforce, people, leadership, education and training workstream

Dr Neil Modha
GP Partner and Chair of Greater Peterborough Network GP Federation
Chair, Data, pop health data, demand & capacity, risk stratification and health inequalities workstream

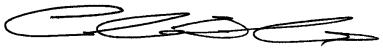
Fatima Khan Shah
Associate Director, Long Term Conditions and Personalisation, West Yorkshire and Harrogate Health and Care Partnership
Chair, Engagement with people and communities workstream

Thirza Sawtell
Managing Director/ Integrated Care, St George's, Epsom and St Helier Hospitals and Health Group
Chair, Governance & decision-making workstream

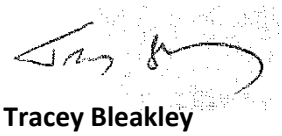
Dr Harpreet Sood
Non-Executive Director, Health Education England, and founding board member, Digital Health London
Chair, Non-physical access and digital workstream

Jan Thomas
Chief Executive Designate, Cambridge and Peterborough ICS
Chair, Physical access and estates workstream

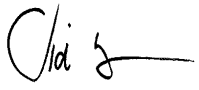
Joanna Killian
Chief Executive, Surrey County Council
Chair, Start well lifecourse workstream



Glen Burley
Chief Executive, South Warwickshire NHS FT, Wye Valley and George Eliot NHS Trusts
Chair, Live & work well lifecourse workstream



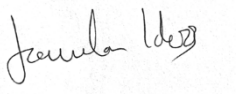
Tracey Bleakley
Chief Executive Designate, Norfolk and Waveney Integrated Care System
Chair, Ageing and dying well lifecourse workstream



Dr Nick Broughton
Chief Executive, Oxford Health NHS Foundation Trust
Chair, Mental health task and finish group

Daniel Elkeles
Chief Executive, London Ambulance Service
Chair, Urgent and episodic care task and finish group

Professor Kevin Fenton
Regional Director for the London Office of Health Improvement and Disparities
Co-Chair, prevention task and finish group



Dr Jaweeda Idoo
Clinical Champion for Personalised Care, Greater Manchester Health and Care Partnership
Co-Chair, prevention task and finish group

Rob Webster
Chief Executive, West Yorkshire Health and Care Partnership
Chair, Learning disability and autism task and finish group

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