Hertfordshire and West Essex Integrated Care System

DRAFT

Primary Care Outline Strategic Delivery Plan

2023-2026

Working together
for a healthier future

Primary Care Services – Herfordshire and West Essex

A snapshot of organisations in our Integrated Care System area – Who Are We?

1.6 million people

1 Integrated Care Board
1 Integrated Care Partnership
3 Health and Care Partnerships
1 Mental Health, Learning Disability and Autism Collaborative

1 Voluntary, Community, Faith & Social Enterprise (VCFSE) Alliance, representing thousands of local organisations

2 county councils and 13 district/borough councils

4 mental health and community providers

3 acute providers

8 GP federations - 3 in South & West Herts, 2 in West Essex and 3 in East & North Herts

130 GP practices; 35 Primary Care Networks (PCNs)

276 community pharmacies

225 opticians

243 dental practices

Hertfordshire and West Essex Integrated Care System

Hertfordshire & West Essex Strategic Framework- 2022-2027

To support the delivery of the NHS elements of the Integrated Care Strategy (ICP) and the Integrated Care Board (ICB) core purposes, the ICB has agreed a strategic framework that outlines its missions and aims for the next five years. An overview of this is below:

Our mission

- **Better, healthier and longer lives for all**

We will achieve this by

- **Improving physical and mental health across our population**
- **Tackling unequal access, experience and outcomes**
- **Enhancing productivity and value for money**
- **Ensuring the NHS supports broader social and economic development.**

In the first 3-5 years we will

- Increase healthy life expectancy, and reduce inequality
- Give every child the best start in life
- Improve access to health and care services
- Increase the numbers of citizens taking steps to improve their wellbeing
- Achieve a balanced financial position annually

The ICB will deliver this by:

- Setting direction for the NHS in Hertfordshire and West Essex
- Allocating NHS resources fairly and effectively
- Supporting, equipping, and empowering our people
- Working with and pooling resources with our partners
- Enabling improvement and driving change, with a focus on quality
- Using data and evidence to generate insight and assess impact

Hertfordshire and West Essex Integrated Care System

Key Achievements to date - Community Pharmacy is a key pillar of primary care system and partner in the system

A. Prevention – health and wellbeing; vaccination; lifestyle medicine; sign posting, smoking cessation, contraception
B. Proactive Management – new medicines use review, hypertension, discharge medicine services
C. Same day access – Community Pharmacy Consultation Service (positive impact rest on system – general practice; NHS 111 and other partners); support for urgent medication
D. Digital – procurement of pharma outcomes to support CPCS as an example
E. Workforce – Supportive of development of the Community pharmacy leadership at PCN
F. Patient empowerment and feedback – 90% love their community pharmacy; however 70% not aware of the range of services available to them from their community pharmacy other than prescription

National view - Fuller Stocktake Report

Aim of the Fuller Report was to provide a stocktake on integrated primary care, looking at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry) across systems.

The remit excluded the partnership model, the GP contract and the funding formula. Key areas of priorities included:

A person-centred, team-based approach to Chronic Disease Management and Complex Care - Integrated Neighbourhood Teams

- Development to enable Primary Care Networks (PCNs) to drive the creation of **integrated neighbourhood teams** through place in partnership with all system and local partners and stakeholders – providing more proactive, personalised care (medical/social/psychological) with support from a multidisciplinary team of professionals across health and care and wider community assets.
- **Secondary prevention**, driven by proactive management of chronic disease, to prevent deterioration in health and prolong healthy life expectancy, Enabling and supporting people to manage their own long-term conditions

A scaled and streamlined model to deliver Urgent and Episodic Care – Access

- Streamlining Urgent Primary Care Access using Population Health Management (PHM) approach at PCN/Locality level which may include streamlining/integrating Enhanced Access; integrated urgent primary care e.g NHS111 and same day access to all urgent care services including mental health, dental, community etc and more importantly an improved front of door in general practice with a combination of use of digital tools fully operationalised and embedded within the practice/network.
- Flexibility to offer **virtual or face to face options in line with patient preference and need**. Delivered at a **scale** that makes sense for local systems, as part of a wider integrated urgent and emergency care system, enabled by risk stratification of patients and shared care records.

A step-change in our ambitions on Preventative Care

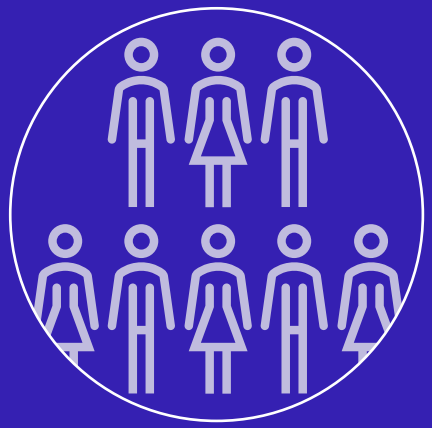
- Continued focus on prevention and helping people to stay well for longer
- **Supporting lifestyle change** via a combination of national and local programmes providing advice and support to improve diet, fitness and wellbeing, e.g health coaches and capitalising on evidence-based health apps, and the NHS app. This should involve the extended primary care team, harnessing the growing role of community pharmacy and dentistry in prevention, Voluntary, Community, Faith & Social Enterprise (VCFSE), and working at scale on prevention with Local Authority Public Health colleagues.
- A scaled approach **to delivering population-level interventions**, including screening and health checks, and adult vaccinations, building on the community engagement that characterised the Covid-19 vaccination programme.

NHS England delivery plan for recovering access to primary care – key messages

The NHSE Delivery Plan for Recovering Access to Primary Care was released on 9 May 2023 and has a focus on four key areas:

Empower patients to manage their own health including using the NHS App, self referral pathways and through more services offered from community pharmacy (investing up to £645 million over two years to expand services offered by community pharmacy

Implement 'Modern General Practice Access' to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment, so patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message.



Build capacity – develop primary care workforce.

Add flexibility to the types of staff recruited and how they are deployed.

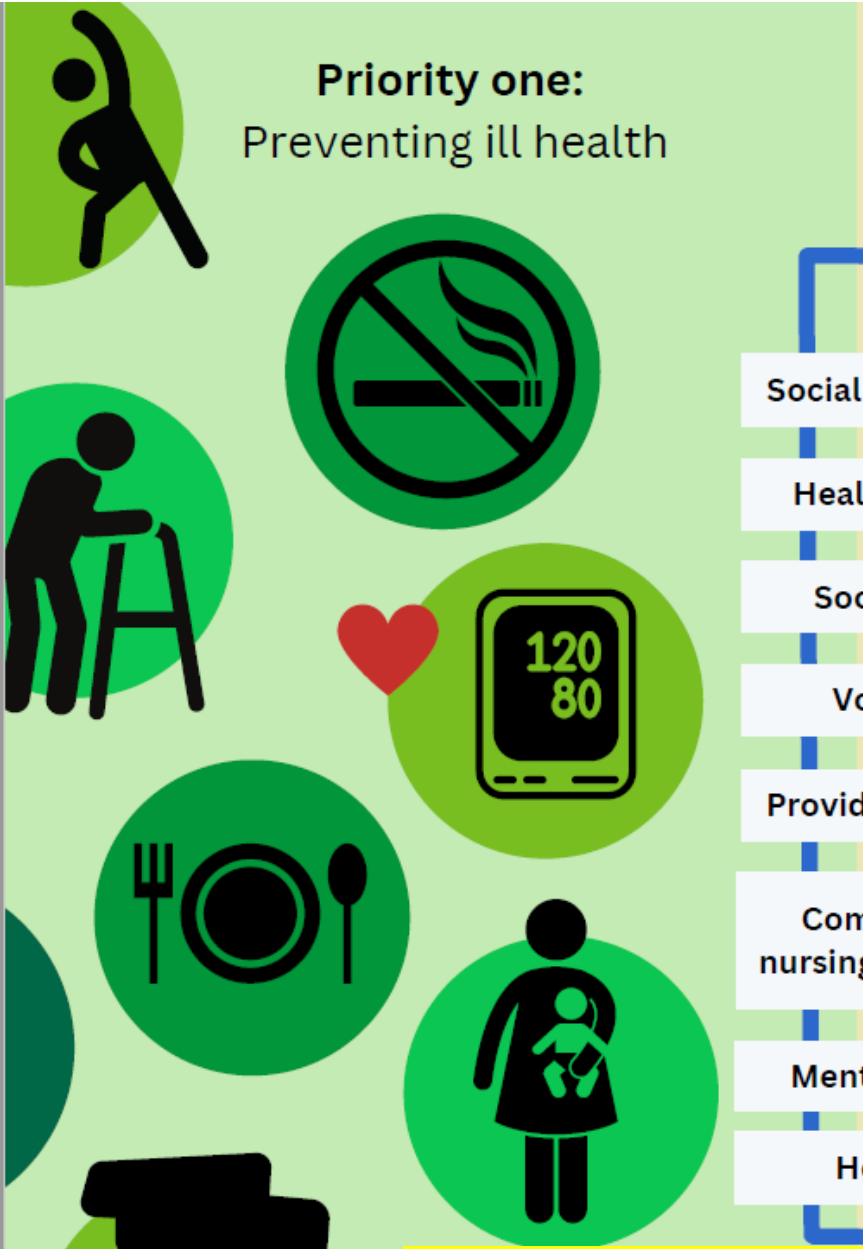
Changing to training, recruitment and retention and skill mix

National Long term Workforce Plan 2023

Cut bureaucracy Reducing the workload across the interface between primary and secondary care

Our primary care strategic delivery plan picks up the key requirements of the NHS England recovery plan

Priority one:
Preventing ill health



Priority two:
Integrated Neighbourhood Teams

Primary Care Network (PCN)

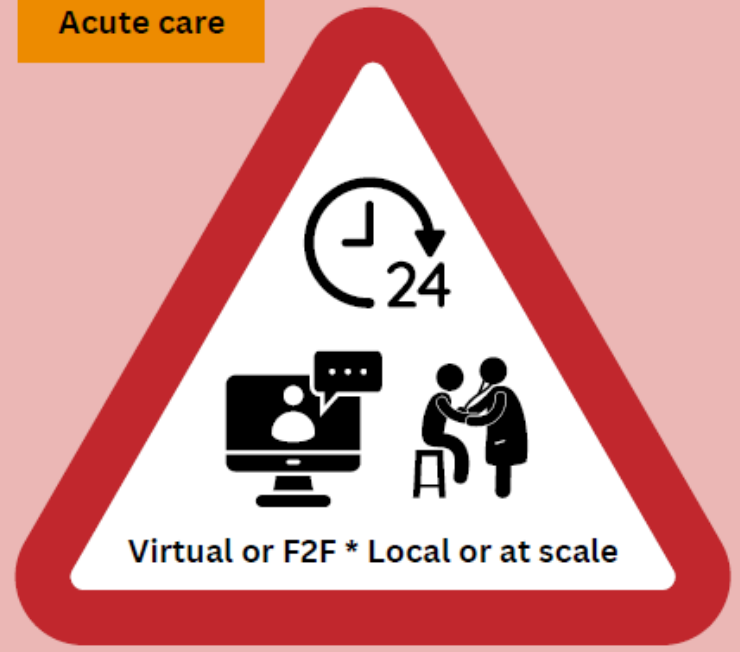
- Social Prescriber
- Healthy Hubs
- Social care
- Vol orgs
- Providers of care
- Community nursing & therapy
- Mental health
- Hospice

Patient supported by multi-disciplinary team delivering proactive case management

Working together as an Integrated Neighbourhood Team to improve people's outcomes and experience by meeting the health and social care needs of the local population

Priority three:
Same day / urgent access to care

- NHS 111
- GP out of hours
- SDEC
- Mental health crisis
- Community care
- Acute care



Timely access to: Dental, Pharmacy, Optometry

Underpinned with enabling workstreams – Patient empowerment, workforce recruitment retention, skills mix, leadership, digital – data, technology and insight, investment including contractual levers, estates

Next steps

- The ICB primary care team will continue to engage with both primary care and the wider system about the strategic delivery plan – seeking feedback to ensure the plan is deliverable and that we have buy in from across the board

- The place teams at the ICB will work with localities and PCNs to support the establishment of Integrated Neighbourhood Teams, same day access and projects to support prevention of ill health

- The ICB primary care team will work to establish template documentation and other resources that will help in the establishment of the key objectives, such as risk sharing agreements, data sharing agreements for INTs etc

- We will work with primary care place teams to ensure appropriate KPIs are set at local level, to ensure it is possible to measure impact of the changes being made to care provision.

- The document will be taken to the ICB Board at the end of July for sign off.