NHS
Nottingham and Nottinghamshire
Integrated Care Board

Developing a Primary Care Strategy for Nottingham and Nottinghamshire Integrated Care System

Briefing for Nottingham Health and Adult Social Care Scrutiny Committee

November 2022

1 Introduction

This briefing aims to provide an overview to the Health and Adult Social Care Scrutiny Committee on the emerging Primary Care Strategy for Nottingham and Nottinghamshire Integrated Care System (ICS). Specifically, this paper will inform the Committee of our vision, ambition, objectives and next steps.

2 Context

Patients are changing both in the complexity of their conditions and in their expectations of the health and care that they receive. If Primary Care is going to continue to provide an essential contribution to our local health and care system, it must innovate and evolve.

Our vision for a strong and effective ICS can only be achieved with strong and effective Primary Care, with clinicians providing first-contact, continuous, collaborative and co-ordinated care to citizens. This commitment over time saves lives, improves health outcomes and the experience of care and reduced inequalities.

The ICS Primary Care Strategy needs to be compliant with the NHS Long-Term Plan[1] and the Fuller Stocktake report[2], and needs to:

a) Establish a 5+ year strategic intent, against which every idea will be tested.
b) Create the motivation for system transformation.
c) Ensure a fairer distribution of resources which equitably reflects difference.
d) Outlines a credible plan for recruitment and retention.
e) Create mechanisms to engage and work with other independent contractor professional networks.

3 Our ambition

Our ambition is to deliver:

"A picture of transformed and sustainable primary care in Nottingham and Nottinghamshire."

Primary Care will remain the bedrock of the health and care system, central to transforming people's health and wellbeing outcomes and experience. Key attributes of future Primary Care in Nottingham and Nottinghamshire will include:

[1] https://www.longtermplan.nhs.uk/
[2] https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

a) Partnership working: practices will work with each other in an increasingly integrated and community-oriented way and also with other local health and care services.
b) Patients as partners: patients and carers are core members of the care team.
c) Strong health promotion and illness prevention: good joined up wellbeing policies and plans across sectors.
d) Excellent population and patient segmentation and stratification: tailoring equitable support to enable citizens to enjoy their best possible health and wellbeing.
e) Continuous personal, integrated health and care for our elderly, frail citizens and those with complex needs: provided seamlessly at or close to home and funded fairly.
f) Community-based mental health services: recognising the societal and personal importance of mental health, and interdependency with physical health and wellbeing.
g) Excellent evidenced-based care plans and pathways: developed by clinicians and patients, supported by improvement science.
h) Scaled primary care working: more resilient with the capacity and resources to deliver more services where this makes sense. Scaled up primary care will have access to diagnostics and treatments provided in fit for purpose facilities and supported by integrated neighbourhood teams.
i) Accountability: through the registered list and for outcomes not activity.
j) 'Hub and spoke' services: care in communities where possible but consolidated when necessary to improve outcomes and efficiency.
k) Workforce training development and motivation: delegation of skills from both the perspectives of patients and providers and achieving a positive workplace and workday experience for all

Further details can be found in Appendix 1.

4 Emerging strategic themes and objectives

The Primary Care Strategy will be built on the detailed insight obtained through co-creation and strong engagement with a broad range of existing stakeholder groups, including Primary Care Network (PCN) Clinical Directors, Place-based Partnership (PBP) Leaders, Locality Directors, the Local Medical Committee (LMC), GP Federations, Primary Care Commissioners, General Practice providers, Trust Clinical Directors and Patient Participation Groups (PPGs).

Deliberations have been structured around three overarching strategic themes:
a) Laying the foundations to recover primary care
b) Improving primary care quality
c) Making our system sustainable

Each strategic theme has a number of objectives. To achieve our ambition for high performing primary care, we will have a focus on at scale provision and integrated new models of care, delivering a person-centred approach.

The ten objectives of the strategy are distinct but are interdependent and mutually reinforcing, set out in Table 1.

Table 1 Ten objectives of the Primary Care Strategy

Theme 1: Laying the foundations to recover primary care
1. Establishing the clear culture, narrative and purpose
2. A focus on the person, patients and population; restoring the person - professional 'compact'
3. Enhancing access to primary care services

4. Improving communication, enabling information technology, sharing records and securing fit for purpose estate
Theme 2: Improving primary care quality
5. Supporting clinical transformation; the adoption of the population health management model
6. Supporting PCNs and establishing integrated care teams
7. Quality, data, and performance; research and innovation
Theme 3: Making our system sustainable
8. Workforce development and motivation; engaged and visible leadership
9. Evolving the finance and contractual model
10. Supporting provider and business model reform; green primary care

5 Enablers

To achieve our ambition for high performing Primary Care, we will have a focus on at scale provision and integrated new models of care, delivering a person- centred approach. Key enablers include:

a) Provider developments with particular attention to PCNs enabling service and workforce integration.
b) Local workforce priorities and actions which support development of an expanded workforce and Multi-Disciplinary Team (MDTs).
c) Maximising and improving our estate, use of digital technology, and analysis and information to increase access for patients.

6 Delivery of the Primary Care Strategy: next steps

The Primary Care Strategy will describe the health and care system we wish to create working with all local partners to deliver it. Implementation will require us to build transformational leadership capacity and capability, supported by building a change platform for innovation and improvement to spread progress in a more dynamic way than we have been able to do previously.

Implementation will be led and sustained by providers, not from a top-down managed process or hierarchical leadership model, requiring local planning and customisation.

Delivery of the Primary Care Strategy aims to overcome silo working and make connections between ICS programmes including the community, mental health and hospital transformation programmes, Place and PCNs. Delivery will be taken forward at both a local level by PCNs and Place, and as a system for sharing good practice and common solutions.

We propose the establishment of a Primary Care Transformation Board to provide strategic oversight and testing from across the ICS and ensure the strategy is ambitious enough to meet the needs of the people and professionals in the ICS. We will recruit both clinicians and caregivers to test rigour and practicality of the plan, and patients and public to provide insight and direction.

We will identify headline programme monitoring indicators e.g., patient and staff satisfaction, system impact, clinical outcomes, investment profile, change registered in the service offer.

Finally, we propose identifying an evaluation and learning partner e.g. a local university, and establishing development opportunities to improve quality improvement capability.

7 Recommendations to **Nottingham Health and Adult Social Care Scrutiny Committee**

Delivery of the Primary Care Strategy will see more efficient and effective services, improved financial stewardship and excellence in outcomes, and will enhance the trust, support and confidence of our population.

It is recommended that the Adult Social Care and Health Scrutiny Committee:

- Note the contents of this briefing.

Appendix 1: Benefits and risks

Benefits

Attribute		Details	Benefits
a)	**Partnership working**	Enhance integrated working within GP federations, with PCNs, place, secondary care and wider health and care services. Build from strong existing PCN base. Facilitate PCNs to evolve into Fuller "integrated neighbourhood teams*".* Develop and embed best N&N ICS primary care medical standards that recognise the whole practice team contribution of continuity to quality of care. Strong focus on MDT working, information sharing and care planning. Build a culture of collaboration and co-production across organisations and sense of belonging to and accountability for the system. Embed strong primary care leadership and influence in the ICS. Build more productive, less competitive relationships.	Ongoing PCN development will enable practices to: • meet complex needs, improve access, and reduce unwarranted variation through standardised care pathways and consistent delivery through an MDT approach • Empower communities to develop asset-based interventions to improve health and wellbeing (e.g., dementia networks, social prescribing initiatives) • Develop alternative access opportunities and care pathways utilising ARRS roles will create capacity for GPs to manage patients with complexity. Further developing a primary care model which is less dependent on GPs, sharing responsibility for patient care across lower cost professionals will increase value (as defined by quality/cost) Well recognised benefits of continuity of care including: • increased satisfaction, both for patients and staff • reduced costs: prescriptions, tests, ED attendance, and hospital admissions • reduced the 'collusion of anonymity', where a succession of clinicians deals only with what is most immediately pressing • increased trust within the clinician - patient relationship • increased willingness to accept medical advice, including adherence to long-term preventive regimens

Attribute		Details	Benefits
			• increased willingness to accept 'wait and see' management of non-specific symptoms that are often self-limiting • improved problem recognition and quality of management Cross-organisation collaboration and relationship building will: • facilitate development of standardised streamlined patient-centred pathways • accelerate system development and innovation • overcome system roadblocks
b)	**Patients as partners**	Ensure a strong patient voice, both as individuals receiving care and as stakeholders. Ensure patients and carers are core members of their care team. Shared decision making embedded as standard. *"No decision about me without me".* Co-production in design, delivery, and governance of primary care. Development and embedding of PROMS and PREMS to assess the quality and experience of healthcare, as reported by patients. Enhance the role of PPGs within practices to ensure patients voice is heard in the way services are delivered to best meet their needs, and the needs of the local community.	Building trust between patients and primary care will: • facilitate the restoration of the social contract • create opportunities to agree and enact reasonable and mutual expectations • facilitate ongoing calibration of patient experience and expectations with service delivery Evaluation of shared decision making has shown the potential to: • Improve communication and establish trust between patients and clinicians • Improve outcomes (including decreased anxiety, quicker recovery, and increased compliance with treatments) through engagement and empowerment of patients • Reduce costs as people who are fully informed about the risks and benefits of treatments tend to choose less-invasive, less-costly interventions and are happier with their decisions • Reduce unwanted clinical variation and enhance allocative efficiency

Attribute		Details	Benefits
			Use of PROMS and PREMS will enable primary care and the wider system to make informed changes to their services Enhancing the role of PPGs can: • help clinicians to develop an equal partnership with their patients and the wider community • help to improve services and resource utilisation by identifying changes that the practice may not have considered, which reflect what patients want and need • nurture mutually supportive networks for patients and the practice • play a role in encouraging healthier communities through the provision of information and support
c)	**Health promotion and illness prevention**	Ensure all members capitalise on the many opportunities in primary care to promote health and well-being, as the first point of contact for most patients. Embed as standard, a "*Making Every Contact Count*" approach. Adopt a person-centred approach to empower individuals to take actions for their own health, utilising appropriate support tools. Utilise our network of social prescribing link workers to effectively signpost and our PPGs to promote healthier communities through the provision of information and support. Ensure localised tailoring and delivery of system-wide strategies including our N&N ICS Health Inequalities Strategy.	Supporting individuals to make healthier choices will reduce the risk of developing ill health, disease, and premature death from preventable diseases caused by behavioural factors such as smoking, poor diet and excessive alcohol consumption. Adopting a person-centred approach improves patient engagement and activation. Tailoring strategies and resources to take account of local priorities will potentially increase impact on populations with greatest needs. Ongoing evaluation will help to shape further interventions.

Attribute		Details	Benefits
		Undertake evaluation and monitoring of approaches.	
d)	**Segmentation and stratification**	Use knowledge of the health and care needs of local populations to target interventions and resources to best effect. Provide the right amount of the right care, neither too much nor too little care, rather than meeting a minimum standard for all segments. Understanding which individuals and cohorts are at greatest risk of needing certain types of care and interventions.	Providers can take responsibility and create bespoke services for populations with heightened risks as determined by analysis of local population needs. Tailoring services to local population needs can improve health outcomes and experience for both groups of patients and individuals. Ensuring resource and capacity are better distributed to where most needed will promote equity of access to and quality of care. Developing specialist expertise can ensure the optimal response to the needs and preferences of a specific population segment.
e)	**Integrated care for frail elderly**	Coordinated responsive pathways which focus on holistic person-centred care and not just disease-specific interventions and treatments. Care will be underpinned by a strong evidence base around effective assessments and interventions for frailty. Strong focus on prevention (for example falls, UTIs) and early identification of frailty Development of registries and registry managers to identify and manage care gaps.	Evidence-based, person-centred care with a strong focus on prevention: • enables people to live better and more independently with frailty • supports a reduction in the number of unscheduled primary and secondary care contacts Potential costs savings can be realised through: • reducing avoidable hospital attendances and admissions, and reducing lengths of stay • reducing or delaying the need for home care and residential care

Attribute		Details	Benefits
		Patients will be listened to and treated with dignity and respect. *"What matters to me"* not *"What is the matter with me".*	Facilitating early medical assessment (within 2 hours) followed by appropriate care and treatments for unwell frail patients, is associated with lower mortality, greater independence, and reduced need for long-term care.
f)	**Enhanced mental health services**	Embed a cultural shift (as outlined in the ICS All-age integrated mental health and social care strategy), so that all staff see mental health as their business, understanding the issues people face, the support they need and the resources available to provide that support. Responsive holistic services which deliver care in an integrated way to ensure that a person's mental health, physical health and socioeconomic needs are addressed together. Deliver parity of esteem so that mental health is placed on a par with physical health. Ensure timely access to effective crisis management both within primary care and with the wider system. Ensure comprehensive access to talking therapies through Improving Access to Psychological Therapies (IAPT) Improve mental health awareness and understanding through delivery of mental health awareness training to all health care professionals in line with our ICS aim Ensure that there is high quality, comprehensive primary care mental health support for children and adolescents, and for older people, and that there is	A responsive holistic approach to mental health care can improve outcomes and experience, and reduce costs through: • encouraging the prompt uptake of treatment • promoting mental health awareness and faster diagnosis • identifying and addressing a person's needs more quickly and accurately • reducing a person's use of physical health services • improving relationships within teams and services • empowering people to manage their condition and access appropriate support Efficiencies can be realised through: • reducing the number of frequent attenders and repeat assessments • decreasing the likelihood of people not attending appointments • increasing the quality of referrals whilst reducing the demand for specialist services • effective management of transitions between services • supporting people to access/remain in employment, thereby increasing economic productivity Talking therapies help to improve self-management and health outcomes in people with long-term conditions, who also have with anxiety and depression. Successful therapy can help to reduce reliance on primary and emergency care. There is also strong evidence for the use of therapies to support people with medically unexplained symptoms.

Attribute		Details	Benefits
		timely and seamless access to specialist services when required.	Timely access to primary, community and specialist services reduces the need for crisis services.
g)	**Care plans and pathways**	Pathway development and implementation will be clinically led. There will be adequate funding for both development and implementation of pathways. Pathways will be standardised and based on best available clinical evidence. Pathways will be holistic and person-centred, and will include all stages of care including prevention, primary care, and specialist care, ensuring delivery of the right care at the right time in the right place. There will be a focus on managing transitions between different parts of the system. Pathways will be supported by patient and clinician information and education. Pathways will be digitally enabled to facilitate data sharing among providers. Pathway implementation will be supported an effective governance structure to ensure clear, pathway-wide accountability for outcomes and costs.	Widespread use of standardised evidence-based pathways has many benefits including: • Reducing unwanted clinical variation • Improving outcomes through clinical adherence • Increasing system delivery efficiencies through more appropriate use of specialised services and reducing duplication and waste • Facilitating close working between primary care clinicians, specialists, and other health and care professionals Clinical involvement in pathway development builds support and buy-in from clinicians for the changes to care delivery. Evidence based clinical pathways enable systems to determine the interventions' relative importance, prioritise how resources are allocated, and identify the outcome metrics that will help ensure optimal care delivery. Patient education is important, especially for chronic disease care pathways, because it strongly influences whether patients are willing to adopt healthier behaviours, comply with treatment, and engage in other forms of self-care. An effective governance structure ensures accountability as patients are transferred between providers.
h)	**Delivering primary care at scale**	Primary care 'at scale' brings groups of general practices together to provide care, working within	Delivering primary care at scale offers many benefits including increasing resilience in primary care and improving quality and clinical outcomes for patients.

Attribute	Details	Benefits
	multidisciplinary teams to support first-contact with patients. PCNs are the key delivery vehicle for primary care 'at scale'. Accountable clinical directors from each PCN are the link between primary care and the wider system. Primary care 'at scale' should be large enough to have impact and economies of scale, but not so large to lose the personal care ethos valued by both patients and primary care clinicians. Primary care 'at scale' will take a proactive approach to managing population health and assessing the needs of their local population.	Improved quality and clinical outcomes can be achieved through: • working at scale to meet agreed best practice standards for access and for continuity of care • releasing resources for front-line patient care by delivering efficiencies through economies of scale • realising opportunities to expand the range of services to patients and to easily integrate with the wider health and care system Greater resilience within primary care can be achieved through working at scale to: • managing financial and estates pressures and enabling better use of the primary care estate. • achieving efficiencies from shared admin/business support functions, facilitating growth in capacity and capability • streamlining fixed cost base (e.g., workforce, estates) • improving the ability of practices to recruit and retain staff • planning and mobilising rapid 'at scale' delivery of services in times of crisis • volume consolidation through specialist generalist role reduces specialist utilisation without a reduction in outcomes or experience Primary care 'at scale' supports the expectations and preferences of younger GPs, many of whom want to combine General Practice with other clinical work and prefer not to take on the administrative demands of partnership. It also offers opportunities to get involved in innovation and transformation that will improve patient care in the longer term.

Attribute		Details	Benefits
i)	**Accountability**	Embed a culture of accountability based on common values and motivations, as an integral part of primary care. This includes a culture of safety rather than blame. Ensure a culture of transparency and clear communication. Leaders will demonstrate honesty and integrity and the opinion of everyone will be valued. Clear channels for feedback and reporting will be developed. Develop and embed a formal code of conduct for the workforce as part of staff induction and ongoing rolling training programmes. Develop a set of standards which primary care is measured against (e.g., access, patient experience) to measure progress. Create incentives for clinicians to accept some fiscal responsibility for influenceable spend through continuous quality improvement.	A culture of accountability improves clinician-patient trust, reduces the misuse of resources, and helps organisations provide better quality care. Outcomes-based accountability to drive improvements and efficiencies. Accountable organisations can learn from mistakes and continuously improve. If primary care leaders model accountability, transparency, and ethical behaviours, they set an example for other staff and provide a strong trusted voice within the system. Staff are more likely to go above and beyond when they feel heard and empowered. A culture of accountability also provides greater professional satisfaction by improving the work environment.
j)	**Hub and spoke services**	Hub and spoke models facilitate delivery of care by the right person, in the right place, first time. Services may be: • centrally managed and centrally delivered • centrally managed but locally delivered • locally managed and locally delivered Hub and spoke models support the delivery of both primary care services and more specialist services being delivered in primary care settings.	Hub and spoke services can deliver integrated services working in partnership with primary care and with the wider system Benefits of the model include: • provision of patient-sensitive access offers, based on needs and preferences, including F2F and virtual (synchronous and asynchronous) • shared expertise, accountability and risk across providers • quality improvements through standardisation of care and greater continuity of team-based care

Attribute		Details	Benefits
		.	• increased efficiencies through minimising duplication of services and increasing economies of scale • increased treatment capacity • mitigation of unwarranted use of and pressure on other services (e.g., UEC)
k)	**Workforce plan**	The workforce plan for primary care is aligned to the wider N&N ICS People and Culture Strategy 2019-2029 Priorities include: • Growing a sustainable workforce with the right skills, knowledge and capacity, making effective use of people's skills and experience. • Developing robust recruitment and retention plans, promoting the ICS as a vibrant and progressive place to work. • Providing training and development opportunities, ensuring people are working at the top of their licence, and supporting new starters and newly qualified staff. • Providing career planning and development. • Building teams and leaders within primary care with the confidence and capability to work in partnership across the ICS. Developing general practice management capability. • Equipping the workforce with the skills to take forward digitalised care and work with new technologies and artificial intelligence	Primary care will benefit from a motivated, passionate and diverse workforce which supports service delivery and improvement. Benefits of an effective and comprehensive workforce plan which include: • ensuring adequate capacity, flexibility, skill mix, and capability within the workforce, to support delivery of clinical excellence, aid recruitment and retention and ensure a better workday experience for all • developing new roles and innovative ways of working • widening participation and ensuring equity of opportunity for all, through a comprehensive EDI strategy • providing career development opportunities including clinical leadership training and mentoring • embedding and supporting the specialist- generalist model to support career development opportunities and aid retention

Attribute		Details	Benefits
		• Demonstrating a commitment to strong EDI values, including opportunities for the diverse workforce to develop and to progress into senior roles. • Provision of quality health and wellbeing support for everyone. • Facilitating flexible and remote working to support work-life balance. • Ensuring the workforce feels valued and has a voice, through the development of the “immersion programme” • Reconnecting GPs with traditional values and increasing ‘caring’ Develop a set of performance metrics, including retention and vacancy rates, skill mix of teams, sickness levels, reasons for leaving.	
l)	**Improving primary care infrastructure**	Investment in primary care estates will provide modern, efficient buildings, equipped with the latest technologies. Investment in digital infrastructure will facilitate the expansion of virtual consultations including online consultation tools and provide patients and professionals access to electronic health and care records.	Investments in estates has been shown to have a significant, measurable impact on the quality of care and patient experience including reducing patient harm (especially falls). Improved estates can also improve workplace experience for staff and reduce staff sickness and turnover. New and improved estates can help the move towards being net zero by 2050.

Attribute		Details	Benefits
		Development of digital technologies and data analytics will support development, implementation and monitoring of services. Estate transformation will consider factors including: ▪ Inclusivity – ensuring everyone can use the building safely and with dignity, regardless of their age, gender, mobility, ethnicity, or circumstances ▪ Flexibility – ensuring different people can use the building in different ways Planning and designing a net zero estate will be a part of estate transformation plans in line with UK commitments to being net zero by 2050.	Developing primary care infrastructure can facilitate the expansion of services and MDT working. It can help to reduce siloed working and can support small practices with high rents and service charges and can also mitigate against the 'last man standing' scenario in GP owned premises. It can also provide opportunities to provide joined-up out of hospital care for patients. Investment in technology will support better consultation tools and workload management systems and support the development of record sharing technologies across organisations.

Risks

Overall risks to implementation of the primary care strategy	Enormous undertaking which will need to be implemented at pace Significant financial investments needed to develop and sustain new model Insufficient transformation and implementation capacity and capability Dependent on culture change within primary care, within our patients and public and across our ICS Requires building of trust between primary care and patients to develop a model which is less dependent on GPs and asks patients to take more personal responsibility for their health Tired and demoralised workforce post pandemic Serious recruitment and retention challenges within GP and nursing workforce Current significant socioeconomic challenges which may create barriers to behaviour change Potential for confusion about roles and responsibility between GP Federations and PCNs

	Whilst prevention can be cost effective, some interventions can also increase costs