Report to the NHS Somerset Integrated Care Board on 25 May 2023

Title: Primary Care Strategy	**Enclosure E**

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Summary and Purpose of Paper

In order to deliver the four aims of our ICS it is vital that we have a sustainable primary care provider sector. We now have local commissioning responsibility for community pharmacy, optometry and dental services as well as GP services. The primary care strategy sets out how we will 1) maintain the quality and sustainability of our primary care services and 2) develop a primary care sector that can fully deliver our five shared objectives already agreed as part of our Somerset Health and Care Strategy.

Recommendations and next steps

The Board is asked to approve the strategy, and to note that the delegation agreement between NHS England and NHS Somerset also requires the Primary Care Commissioning Committee to approve the strategy.

If the Board approves the strategy, the next steps will be to launch the strategy with stakeholders through a creative communications and engagement approach, and to focus on delivery. The early delivery priorities are:

- Supporting the primary care provider sector to organise itself effectively as an accountable system partner and to increase its own capacity to improve quality, resilience and innovation.
- Develop a new approach to primary care workforce to ensure that we have a sustainable workforce, noting challenges on GP numbers in particular
- Develop integrated neighbourhood teams anchored in their communities, of which primary care services will be an important element.
- Develop a new funding model to invest in population health, continuity of care and access, going beyond the PCN DES.

Impact Assessments – key issues identified	
Equality	The strategy will reduce health inequalities.
Quality	The strategy will improve quality of service delivery, patient safety, patient experience and clinical effectiveness. It will also have a positive impact on workforce and leadership development.
Safeguarding	The strategy will improve the capacity of the primary care provider sector to deliver its safeguarding responsibilities.

Privacy	The primary care strategy is consistent with our digital strategy which has a strong focus on privacy and information governance impacts.			
Engagement	There has been wide engagement with stakeholders, including patient representatives, elected members, primary care providers, the public health team and Somerset NHS Foundation Trust.			
Financial / Resource	Full delivery of the strategy will take place over a five year period, and additional investment will come from increased primary care allocations, national programme funding and agreed local contracts and programmes. All expenditure is within identified financial envelopes.			
Governance or Legal	There are no constitutional, legal impacts or conflicts of interest that are being addressed by the paper.			
Sustainability	The primary care strategy is fully consistent with the Somerset ICS Green Plan 2022-2025. This includes core work elements around sustainable healthcare, public health and wellbeing, estates and facilities, travel and transport, supply chain and procurement, adaptation and offsetting and digital transformation.			
Risk Description	Summary of risk description if applicable.			
Risk Rating	Consequence	Likelihood	RAG Rating	GBAF Ref
	5	4	Amber	Risks 222,387 and 565

Somerset Integrated Care System

NHS Somerset

ICS Primary Care Strategy
Summary of findings and recommendations

May 2023

Somerset Integrated Care System

NHS Somerset

Our shared vision

People using primary care services will experience a warm and caring environment.

Primary care teams will have the time and space to do a professional job and serve their patients well, responding to what matters most to them.

Primary care services will be local, well organised and comprehensive.

People will be able to access care when they need it.

Logic model

There is a long list of 17 perceived problems identified by stakeholders. Detailed analysis has identified the main and secondary problems.

The fundamental problem to resolve is the gross mismatch between demand and capacity and this is where our main effort must focus.

The other problems and challenges are aggravated by, and in turn are aggravating this fundamental problem.

Increasing capacity alone will not be enough- we will employ a whole system approach to resolve all the challenges.

Strategic fit

This strategy shows how primary services will deliver the five aims of our health and care strategy:

Aim 1 Improve the health and wellbeing of the population

Aim 2 Provide the best care and support to children and adults

Aim 3 Strengthen care and support in local communities

Aim 4 Reduce health inequalities

Aim 5 Respond to complex needs

Recommendations Part 1

GP Services

Priority actions

There is a wealth of detail in the analysis, evidence from stakeholders and review of literature. However all our findings and recommendations can be crystalised in 10 actions to sustain and develop GP services, within the overall context of our Health and Care Strategy.

Priority actions

Action 1: Enable and empower primary care to fix itself

Claire Fuller is correct; given time and space and the right infrastructure, the innovation and adaptiveness of primary care will generate creative local solutions. Enabling and empowering is a brave and demanding leadership choice, which will challenge us all. It isn't a soft option but an essential.

What will change?

Creating the right infrastructure will allow primary care to develop the same accountability, leadership, governance, service improvement and quality capabilities as other system partners. The first area of focus and the priority for 23/24 will be on practice resilience.

Priority actions

Action 2: Focus on delivery to patients

We must focus on the service patients receive and support any business model that can deliver good patient outcomes, reduced unwarranted variation, improved quality of care, leadership, patient experience, staff experience and value.

The business model is a political hot topic. But the fundamental problem is the capacity/demand mismatch. Changes to the business model will not solve that, although they may be required to support sustainability of General Practice. Our current diversity of models is a strength.

Priority actions

Action 2: Focus on delivery to patients

What will change?

We will agree a new funding and contract model that explicitly supports tangible improved population health outcomes and reduces unwarranted variation.

We will support every practice to review their business model and where necessary change their business model to ensure it offers a sustainable future.

Priority actions

Action 3: Organised primary care

General Practice is not currently optimally organised. Working with and through our primary care leaders, we will move quickly to a clear model that offers the right scale for different functions:

- Sustainability, efficiency and reduced variation at practice level
- Clarity about the future of Primary Care Networks within the context of our neighbourhood model, focusing on population level delivery
- A layer of infrastructure at county level that can do things once and do them well – in the form of a GP provider collaborative bringing together all the organisations that have capabilities to improve quality
- A strong system voice for GP providers

Priority actions

Action 3: Organised primary care

In particular, we will help the GP provider sector to help itself, through developing capacity and capability in:

- Practical interventions for challenged practices
- Innovations in multi-disciplinary team development
- Business and quality health checks for practices
- Quality improvement and spread of innovation
- Development of sophisticated data to drive service development

What will change?

We will agree the first step in a provider-led programme this summer.

Priority actions

Action 4: Clarity on what is most important

There are literally hundreds of different, often conflicting, targets. In the context of demand outstripping capacity we need to be absolutely clear about those activities which deliver the highest level of population health benefit, and then strip away activities which are of lower value:

1. Population health management, in particular reaching out into communities to find and treat undiagnosed non-infectious illness and reducing health inequalities
2. Continuity of care, ideally for every patient, but at least for those with complex long-term conditions
3. Appropriate access

Priority actions

Action 4: Clarity on what is most important

What will change?

We will create, during 23/24, a data-driven approach to population health management which will provide clear information to support practical action at PCN and practice level.

We will agree in 23/24, a new measure for continuity of care and give practical advice to practices on improving continuity.

An improvement programme will support delivery of the national recovery programme focusing on 1 day and 14 day access ambitions.

Creating the conditions for success

Having been clear that we will enable and empower primary care, and been clear about the absolute priorities, we will then ensure that the necessary conditions are in place. Specifically, this means comprehensive and decisive action on:

- Workforce
- Investment
- Digital
- Premises
- Population health management
- Continuity of care
- Access
- Organisation of General Practice
- Integration

It also means healing the decades old split between primary and secondary care, reintegrating services through collaborative provider leadership.

Priority actions

Action 5: Workforce

The fundamental solution to our challenges lies in significantly increasing the clinical and non-clinical workforce. In particular, meeting the medical, nursing and medicines needs of our ageing population, as well as locating those needs within their social context.

We have seen an increase in nurse numbers, and more than 200 new PCN roles posts. However GP numbers are forecast to decline over the next 5 years. In an optimistic scenario this will be small, but still further widen the gap between demand and capacity. A step-change in workforce initiatives will be implemented with a particular focus on developing nursing and pharmacist roles.

Priority actions

Action 5: Workforce

What will change?

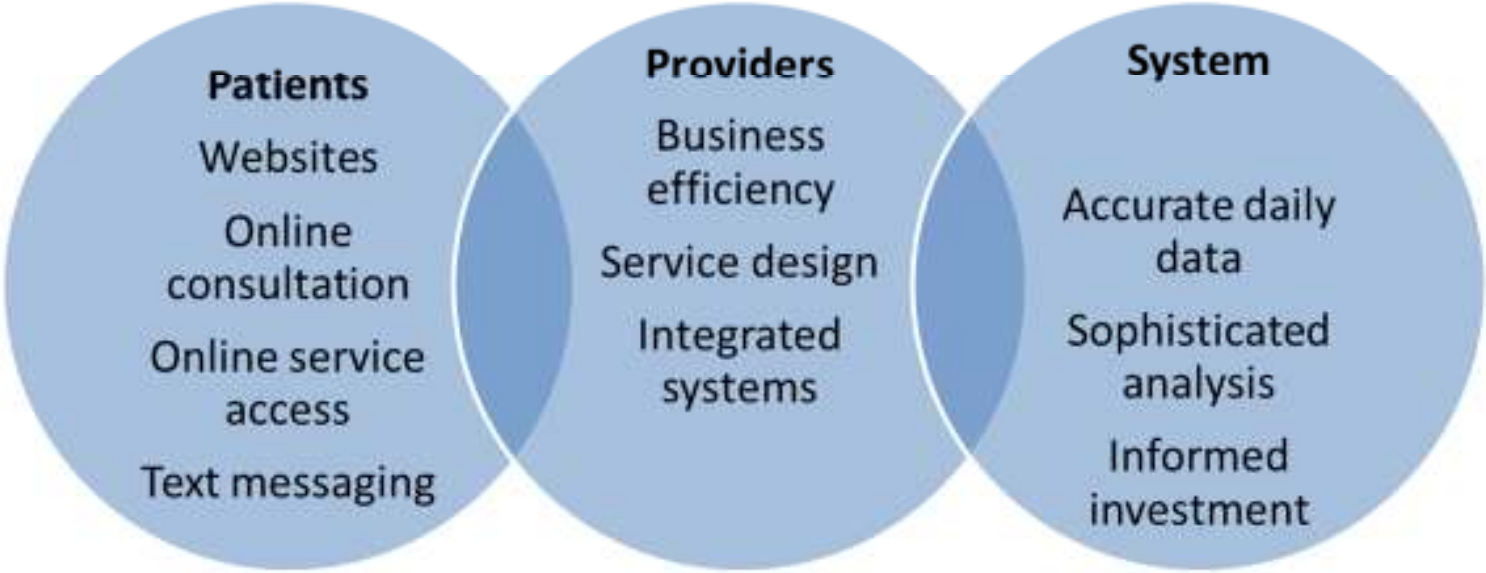
During 23/24 we will review all our primary care workforce initiatives and ensure that we have the right capacity to develop a sustainable workforce by:

- Attracting and retaining GPs, including trainees, with a particular focus on international medical graduates
- Increasing nurse numbers substantially, and developing greater leadership opportunities for nurses
- Increase the numbers of wider primary care teams, including a particular focus on moving from reception to care navigation.

Priority actions

Action 6: Digital

Our primary care and digital strategies fully align on the need to focus on these three priority areas for benefit realisation:



Priority actions

Action 6: Digital

What will change?

We will ensure that we have the right analytical capacity for data-driven service change, so that we develop the new services needed to allow General Practice to focus on continuity of care for those who need it most.

We will continue to support innovation in online access, supporting leading practices to test new products, and helping all practices to understand which systems will provide the safest, most efficient care, and for patients the most effective ways of getting their healthcare needs met.

Priority actions

Action 7: Population health management

GP services are well-placed to actively contribute to a PHM approach which reduces mortality, morbidity and cost arising from the biggest killers.

In order to do this, we need to rapidly create a short causal chain between PHM data and insight and operational delivery. That operational delivery has two main facets:

1. Reaching out into communities to support health and identify undiagnosed cases
2. Effective management of long term conditions, with hypertension being a priority

Priority actions

Action 7: Population health management

What will change?

We will positively impact on the health of the population by:

- Increasing the role of community pharmacy in identifying undiagnosed hypertension
- Providing detailed data at Neighbourhood, PCN and practice level that informs practical changes to identifying people at risk
- Making time and space for General Practice to focus on continuity of care for people with complex needs.

Priority actions

Action 8: Continuity of care

Policy experts agree that the main driver of population health benefit delivered by General Practice is continuity of care, in all three dimensions; relational, informational and management. Continuity reduces individual and population level mortality and reduces healthcare costs.

We should be clear that the most successful primary care systems offer near-total continuity. On the most frequently used measure, Somerset provides 46% relational continuity but with a range from 4% to 78%. There are a set of actions we can take to improve continuity and have asked the Nuffield Trust to help us in this work.

Priority actions

Action 8: Continuity of care

What will change?

- During 23/24 we will identify and implement a new reliable measure of continuity, so that we have clear information about performance and where we can improve
- We will use team-based continuity as a guiding principle as we develop integrated neighbourhood teams
- We will provide detailed information and practical help to practices to understand and improve continuity.

Priority actions

Action 9: Access

Access is not simple- the access needs of a care home resident are different from the access needs of a normally healthy person who has a minor but acute healthcare need. We need to work honestly and creatively with this complexity.

However we can be clear that same-day demand is overwhelming the current General Practice model. This is driven more by patient perception than clinical need. We will therefore work with primary care leaders to divert significant amounts of same-day demand from individual practices. This will look different for different patient groups and in different neighbourhoods but will mean substantial changes. Equality impact will be assessed.

Priority actions

Action 9: Access

What will change?

We will work across neighbourhoods to identify new ways of meeting same day demand for care. We will work with practices to make sure that people who have a clinical need to be seen the same day are seen, and that all patients who need an appointment within two weeks receive one.

We will continue to promote use of the NHS App as well as the suite of NHS approved apps which support people to manage their own health.

Priority actions

Action 10: Investment

It is clear that there are opportunities to improve the value proposition. Some require small or non-recurrent investment. But we need to be clear; the expert policy view is that investment in primary care in the NHS needs to double in order to provide an optimal level of investment to deliver population health improvements.

We therefore need to consider our overall appetite for investment over the longer-term, recognising that more than 80% of primary care funding is nationally defined and allocated.

Priority actions

Action 10: Investment

Recurrent investment in the core clinical and non-clinical workforce at practice, PCN and collaborative level to improve our capacity to respond to our three overarching priorities:

1. Population health
2. Continuity of care
3. Access

A new investment scheme is in development, which will incentivise these priorities, subject to ICB approval and negotiation with the LMC.

Priority actions

Action 10: Investment

What will change?

We will agree early investment in a resilience programme that will support practices at an early stage, before crisis point is reached.

We will develop an innovative new funding model which will prioritise population health management delivery, continuity of care and access.

Priority actions

Action 10: Investment

As well as the recurrent investment described on the previous slide, there are a number of funding implications from all of the ten priority actions described here.

The main headings for substantial further investment as it becomes available are:

- New workforce programme
- Primary care provider collaborative
- Digital
- Premises
- Access improvements

Pharmacy, Optometry and Dental services

We took commissioning responsibility for these services on 1 April.

We have made productive links with all three representative committees and have commenced work on our strategic intentions, which are summarised in the following slides.

Recommendations Part 2

Dental Services

Dental – summary

There is significant concern from stakeholders about access to NHS dental services as an increasing number of practices cease providing NHS services. Oral health is a significant driver of overall population health, going far beyond dental health and affecting our biggest mortality reduction opportunities including CVD. It is also an area where inequalities are increasing, and concerted action is needed now to make sure that the people of Somerset have equitable access to dental services. Given the scale of the challenge, we expect that the actions set out below will need to be delivered across the whole period of the strategy 2023-2027.

In discussion with patients, communities, dentists, stakeholders and NHS England as the current commissioner, six priority actions have been identified. They are all consistent with the three national priorities for General Dental Services: access, oral health, and inequalities.

Priority Action 1- Setting a clear ambition

Our ambition is that over the period 2023-2027 we achieve sufficient NHS dental capacity to provide access to all Somerset residents who wish to use NHS dental services. As not everyone wishes to use NHS dental services, the actual capacity to be commissioned should be sufficient to cover c70% of the population.

As this will be a step-change in access from our current c43%, we will need to come together as a healthcare system to deliver it. It will require a substantial programme of investment, development, procurement and contract management. However this level of population access has been achieved in the past, so we should have confidence in our ability to achieve this very stretching target.

Priority Action 2- Bringing dentists back into the NHS

In order to deliver our first priority, we need to change our relationship with the dental profession in Somerset, to communicate clearly the benefits of undertaking NHS work and to identify and remove the obstacles that stand in the way of more dentists undertaking NHS work and for those practices already providing NHS care to support them in expanding the service they offer. This will require flexibility, dialogue and creativity.

Priority Action 3- Maintain our local services

Given the size of Somerset and the dispersed rural population it is important to ensure we have a local delivery network. Such a local delivery network also encourages continuity of care which is important to both patients and dentists, although it is not explicitly incentivised in the current dental contract. There is some evidence that recruitment of dentists is more challenging in rural areas so a creative approach will be needed, recognising that each practice is in a different situation.

Priority Action 4- Creative commissioning

Although further reform of the national GDS contract is expected in due course, in the short term we will need to take a creative approach which while consistent with the national contract framework also allows us to take action to meet specific local needs. These would include sessional approaches to dental stabilisation, children-friendly practices and communities experiencing particular inequalities. This should also include careful consideration of children-only NHS contracts, which until now commissioners have avoided for good reasons. However all options should be considered to improve the oral health of the population.

Priority Action 5- Workforce

We will need to increase the NHS dental workforce considerably, and in order to do so will need to form creative partnership including with higher and further education providers who can help us to ‘grow our own’ local dental workforce, including oral health practitioner apprenticeships. We will also offer a wider range of opportunities to dentists to undertake more specialist roles including orthodontics. We will also review the ‘pull factors’ for Foundation Dentists for NHS work in Somerset.

Dental – what will change?

- Patients will be able to access urgent dental care when they need it
- Access to routine dental care will improve
- Information, help and support for people, including children, on looking after their teeth will be provided through an integrated population health approach
- Dentists will feel valued by the NHS in Somerset and will be enabled to increase the amount of NHS work they do.

Recommendations Part 3

Optometry Services

Optometry – overview

Optometry is an important service as c70% of the population wear some sort of corrective device. However like dental, the trend is away from NHS services and towards private provision.

Optometry offers significant integration opportunities and we need to develop the NHS service offer and ensure optometrists feel part of the NHS family. In particular to ensure financial viability contract funding needs to recognise provider costs.

We currently commission an urgent care service, ACES, but should also commission a long-term conditions management service which would reduce secondary care waiting times and improve outcomes.

Optometry – priority actions

Priority 1- Urgent Care

We currently commission an urgent care service, ACES, but we will review it with a view to expanding its scope and integration with the wider NHS system.

Priority 2- Long term conditions

We will work with system partners and optometrists to commission a long-term conditions management service which would reduce secondary care waiting times and improve outcomes.

Optometry – priority actions

Priority 3- Making best use of Independent Prescribers

An increasing number of Optometrists are independent prescribers and we will develop care pathways that allow Optometrists to work to the ‘top of their licence’ and reduce inefficiency and duplication in our healthcare system.

Optometry – what will change?

People with urgent eye problems will be helped to access the ACES service, which will be more closely integrated into the NHS.

People with long-term conditions will increasingly find that they are receiving NHS care at a high street optometrist rather than having to go to hospital.

Optometrists will feel valued by the NHS in Somerset and will find opportunities to use their professional skills to best effect.

Recommendations Part 4

Community Pharmacy

Pharmacy – summary

Community pharmacy offers significant opportunities and is keen to develop further as part of integrated neighbourhood teams. There are however challenges with workforce, capacity and business viability.

Our strategy will be to fully maximise the potential of community pharmacy. We have made an excellent start with CPCS, with the current focus on hypertension and new medicines. Making full use of pharmacies will also support business viability. Our goal is to maintain a local delivery network, delivering population health interventions, urgent care and long term condition management as well as medicines optimisation. The balance will move from dispensing towards clinical services.

Community Pharmacy – successes and opportunities

- Presence in local communities in 102 locations
- Ease of access
- High level of professional skill in pharmacists, not fully used
- Improves safety and quality of medicines through careful dispensing
- Resilient and innovative
- Independent prescribing becoming standard from 2026
- Team based continuity of care and integrated working with PCNs and GP surgeries, e.g. CPCS
- Integrated IT platforms to share data
- Operational efficiencies including robotic dispensing
- New national contract in development

Community Pharmacy – challenges

- Movement of pharmacists away from community pharmacy and into PCNs
- Business viability with a number of pharmacies closing
- Uncontrolled demand and flow of work
- Estate is constrained
- National contract incentivises dispensing items rather than clinical services
- Stock shortages taking up large amounts of pharmacist time unproductively, in both PCNs and pharmacies
- Despite some positive developments, still in competition for funds with other providers
- Limited public awareness of what pharmacies can offer

Community Pharmacy – 8 priority actions

Through listening to patients and clinical teams, data analysis and engagement with stakeholders, we have identified 8 priority actions which will form our strategy for community pharmacy over the next five years.

Priority 1 – Population Health

We will:

- Identify the PHM priorities and clearly communicate them to pharmacy teams
- Enhance health promotion including brief advice and recommendation of approved apps
- Develop and enhance case finding capabilities, starting with CVD, and including point of care testing
- Alignment of clinical IT systems for operational efficiency and outcome measurement
- Implement specific interventions to reduce health inequalities
- Expand vaccination services
- Get ready for genomic testing in pharmacy

Priority 2 – Urgent Care

We will:

- Further develop CPCS to improve data flow, increase the number of pharmacies and GP surgeries fully utilising the service and further increase patient satisfaction
- Develop an ED-CPCS to allow ED to book suitable patients in at a convenient pharmacy
- Develop a 'Pharmacy First' local service contract, incorporating MAS but going well beyond that
- Increase the range and availability of urgent medicines available, including through delivery

Priority 3 – Long Term Conditions

We will:

- Improve detection of conditions including AF, hypertension and diabetes
- Increase the management of conditions in pharmacy including asthma, hypertension, heart failure and diabetes with close integration with General Practice
- Further develop medicines monitoring, safety, concordance and waste reduction, through DOAC/DMARD monitoring, drugs teratogenic in pregnancy, new medicines service and post-discharge medicine reconciliation
- Get ready for genomic testing in community pharmacy

Priority 4 – Workforce

The ability for community pharmacy to deliver our shared objectives will depend upon having adequate workforce. We will:

- Continue to develop our pharmacy workforce strategy
- Create career progression opportunities
- Further develop apprenticeship opportunities
- Create a flexible pool for pharmacy roles
- Work closely with the new school of pharmacy at Plymouth University
- Improve job satisfaction and retention by widening portfolio opportunities
- Get ready for Independent Prescribers – defining the what, where and why of IP activity

Priority 5 - Data and Digital Innovation

We will:

- Improve efficiency through reduced number of different systems in use
- Develop full interoperability of clinical systems between providers
- Develop shared booking systems and rapid and automated post event notes
- Incorporate pharmacy data into predictive models and PHM tools
- Improve IT equipment in pharmacies, e.g. devices in all consultation rooms

Priority 6 – Team Based Care

Pharmacy lends itself particularly to team-based care, but many pharmacists are working in relative isolation. We will change this by:

- Developing a ‘team of teams’ approach which creates a MDT approach across the whole clinical system including hospitals
- Further integration of pharmacists into our new Integrated Neighbourhood Teams
- Closer links between PCNs and Community Pharmacy
- Further development of diagnostic services

Priority 7 – Estate

The community pharmacy estate is highly variable and not every site currently provides the optimal facilities to deliver our ambitions. We will:

- Ensure that the estate is taken into account in our PNA and JSNA processes
- Increase consultation capacity, including remote consulting options, with the ideal being multiple consulting rooms that can accommodate both booked and walk-in patients
- Targeted investment in pharmacy provision in areas of greatest health inequality (Core20 neighbourhoods)

Priority 8 – Public Awareness

Our engagement with the public shows that most people are unaware of the level of training pharmacists have and the wide range of healthcare services available at pharmacies. We will:

- Develop a communication campaign including print, broadcast and social media
- Work with specific groups to increase 'pull' to pharmacy particularly communities subject to health inequalities
- Improve signposting and referral to community pharmacy

Our commissioning approach

Our priorities will be to:

- Ensure consistent delivery of essential services at all pharmacies
- Promote delivery of advanced and national enhanced services
- Further develop a comprehensive set of locally commissioned services
- Use the same clinical model as for GP services to determine what services are delivered a) in every pharmacy b) one per neighbourhood c) one per locality d) county-wide as a single service
- Support innovation and creativity
- Celebrate the contribution of pharmacy to our community life in Somerset

Pharmacy- what will change?

People will be able to access a wider range of services at pharmacies.

Our pharmacy workforce will grow.

Pharmacies will be increasingly integrated into the wider NHS as important components of integrated neighbourhood teams.

Next steps

Following approval, the next steps will be to agree a clear plan to implement the strategy, and establish oversight and monitoring with an annual review of progress.

We also need to further develop our approach to localities, neighbourhoods and integrated neighbourhood teams, defining what we mean by these terms, agreeing definitions and specifying programme goals then implementing rapidly.

Somerset ICS Primary Care Strategy 2023-2028

Draft

11/05/2023

Contents

Foreword

In the development of this strategy, hundreds of people have contributed their hopes, fears, and potential solutions for primary care services in Somerset.

Hope has been a theme in many of these conversations. Patients hope for a warm, caring welcome, attention to their needs and an ability to access care in a timely way.

Primary care teams, whether working in GP, dental, pharmacy or optometry services, hope to be able to provide high quality care, with enough time and resources to meet patients' needs and go home with the satisfaction of a job well done.

System partners hope that our primary care services can be the foundation upon which our integrated care system can be built, a reliable and resilient foundation to deliver our four shared aims; population health, reduced inequality, greater efficiency, and increased social benefit from NHS activities.

Despite the difficulties and challenges- during the writing of this strategy GP services in Somerset had their busiest month ever, delivering an incredible 364,651 appointments in October 2022, against a long-term average of around 270,000- what was striking was how many patients reported receiving a good or even outstanding service, and how many primary care teams proudly showed their innovation and resilience in service delivery.

However, a second theme was the level of concern about primary care services. We heard upsetting stories from patients about being unable to access services effectively, and frustration from primary care teams at being unable to provide the comprehensive care to the population they wish to. It is anxiety provoking for patients to face an unreliable service. It is demoralising and distressing for clinical teams to face demand which they are unable to meet, however many extra hours they work.

The third and final theme was solutions. The challenges facing primary care in Somerset are explicable and resolvable if the right actions are taken locally, regionally and nationally. The evidence all points to a fundamental mismatch between capacity and demand. There are a number of ways to deal with this, but a successful response will require us to stay focused on this core problem and test all theories and ideas against it. People have been generous in their ideas, and creative in their suggestions. While there is no single easy solution, a well-designed and executed programme of clear and decisive actions that attend to the causes of our current challenges will improve the situation significantly.

This strategy starts to show those solutions. It is not however a detailed 'playbook' or implementation plan. That needs to be developed by all of us as our shared response to this strategy as we ask ourselves 'what does this mean for me?'

NHS Somerset has an important role in convening those conversations and we look forward to working with you all to move into the implementation phase.

Dr Bernie Marden BSc MBBS FRCPCH LLM
Chief Medical Officer

Introduction- why a new primary care strategy?

It has become commonplace to refer to a crisis in primary care services. These include GP services, dental, optometry and community pharmacy. People are experiencing a crisis in different ways:

- Patients are often having difficulty accessing services, increasing stress and anxiety and sometimes leading to avoidable suffering.
- Primary care teams are working harder than ever but cannot keep up with demand, making their working days long and stressful.
- Other parts of the healthcare system are finding it difficult to achieve what they need because of challenges related to primary care.

These problems have been developing for a long time and the Covid pandemic has exacerbated and exposed deep-seated problems. Policy experts across Europe, the UK and the US all agree that the fundamental problem is a shortage of clinical workforce relative to demand. The clinical workforce capacity in primary care has remained broadly static while demand has risen sharply over the last 15 years. This mismatch between supply and demand then causes various other problems, some of which become symptoms themselves.

We should be clear that, in aggregate, primary care services in Somerset still generally perform well compared to the national average. Many patients are continuing to receive an exemplary service and are sometimes surprised at how quickly and well they are treated. But the overall trend on all the most important measures- continuity of care, patient experience, access- is downward. There is significant unwarranted variation in the quality of care for patients.

This strategy therefore sets out how we will achieve two things:

1. Provide access to safe, high quality primary care services for the people of Somerset.

2. Develop a primary care sector that can deliver our shared ambitions as an ICS.

Our shared ambitions as an ICS are described in our Somerset Health and Care Strategy, with five aims:

1. Improve the health and wellbeing of the population
2. Provide the best care and support to children and adults
3. Strengthen care and support in local communities
4. Reduce inequalities
5. Respond well to complex needs.

Although there are many uncertainties and variable factors, we can be clear that our end point is a primary care provider sector that can deliver these five ambitions consistently.

Our primary care strategy is one part of our overall ICS strategy and its five-year delivery plan. To summarise the whole strategy in three points, we can say that we will:

1. **Develop a sustainable primary care workforce that can meet the needs of patients and provide a safe working day for our teams**

2. **Develop integrated teams anchored in their communities**

3. **Develop a new funding model to invest in population health, continuity of care and access, going beyond the PCN DES**

All three actions will be underpinned by a strong primary care provider collaborative, helping our providers to thrive

Executive summary

Points relevant to all four primary care services:

1. The key challenge is the mismatch between demand and capacity, which has been growing for many years, despite various attempts to mitigate it.
2. With an ageing population with higher healthcare needs there is high demand for clinical care. Supply has not kept up with demand. Public expectations of access are changing, and a preference for rapid access greatly contributes to the demand. Additionally, disease prevalence has significantly increased particularly in mental health, further contributing to the mismatch between demand and capacity.
3. We therefore need to grow the workforce significantly, integrate effectively around the needs of patients and innovate relentlessly to find new ways of delivering population health benefit.
4. We will enable and empower primary care teams to find creative solutions to the challenges facing us.
5. While all partners have relevant views on primary care services, our priority is to support the primary care provider to be a full and accountable partner in our integrated care system.

Points particularly relevant to GP services:

1. We need organisation at the right scale; a clinical and organisational model that provides care at practice, PCN and county level as appropriate, and supports practices and PCNs to be as efficient and effective as possible.
2. The business model is a secondary consideration, behind outcomes for patients. The key challenge is the mismatch between demand and capacity.
3. Continuity of care is the main driver of population health benefit; therefore continuity of care is an important metric for us to improve.
4. We will invest to build a GP sector that can deliver its full potential.
5. Workforce growth will be an essential factor in resolving the challenges facing us. We will significantly expand our primary care workforce programme.
6. Population health management and person-centred care will be at the heart of our approach to investment and development of GP services.
7. We will maintain a network of practices providing comprehensive services to their local communities.
8. Access will change, with patients being triaged to the most appropriate service for them, which will not necessarily be at the practice they are registered at. However care will always be provided as close to home as possible.

Our shared vison for primary care services in Somerset

This is our vision, which the strategy will support us to achieve.

People in Somerset will experience primary care services that give them a warm welcome and are caring.

People working in our primary care services will have the time and space to do a professional job, responding to what matters to patients.

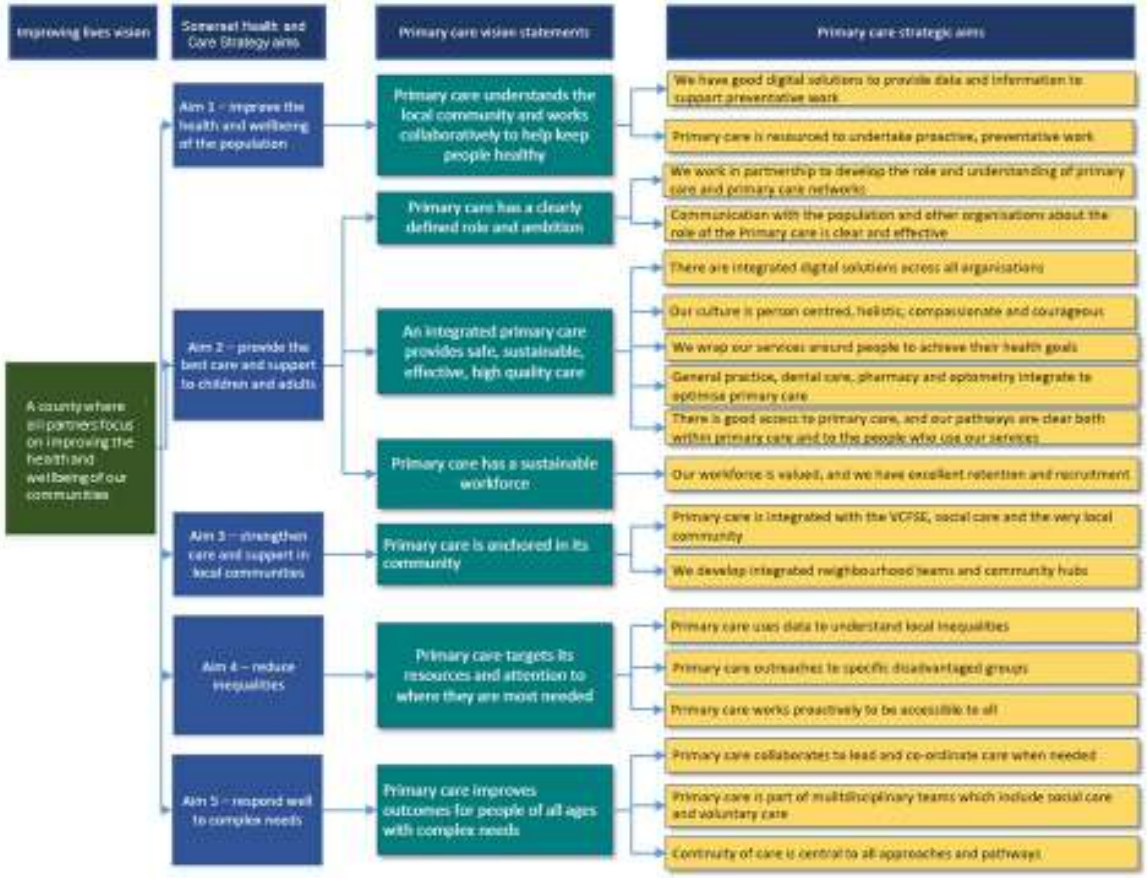
Primary care services will be local, effective, and comprehensive.

People will be able to access care when they need it.

Our strategic decision-making framework

The vision described above is drawn from a ‘strategic vision and decision-making framework’ developed with the help of hundreds of stakeholders through the Somerset Health and Care Strategy programme in three workshops. It explicitly shows how our primary care strategy is part of the overall Health and Care Strategy.

The vision and strategic decision-making framework are set out below:



Section 1 – General Practice

General Practice – Priority Actions

There are ten priority actions which will shape GP services in Somerset over the next five years. All our primary care development, commissioning and contracting activities will form the delivery programme of the ten priority actions.

The ten priority actions are set out in some detail here. Further detail will be included in the annual operational plan, and individual areas of development, such as a new collective approach to practice resilience, will have their own detailed plans.

The ten priority actions show how GP services will deliver the five aims of our health and care strategy:

Aim 1 Improve the health and wellbeing of the population

Aim 2 Provide the best care and support to children and adults

Aim 3 Strengthen care and support in local communities

Aim 4 Reduce health inequalities

Aim 5 Respond to complex needs.

1. **Enable and empower General Practice**

Claire Fuller was correct to say in 'Next Steps for Integrating Primary Care- the Report of the Fuller Stocktake' (2022) that if we can provide time and space for General Practice, it will develop its own creative solutions. General Practice has been in a constant process of innovation and change since it came into the NHS in 1948. The current challenges are primarily caused by the capacity/ demand mismatch. But that is creating an operating environment of such intensity that there is no time and space to step back. GP services will need to change radically over the next five years to adapt to increasing demand, workforce constraints, a rapidly ageing population and advances in clinical treatments, data and technology and organisation of care. That change will be made most successfully by a GP provider sector that is enabled and empowered to think carefully, build support for collaborative action, and can undertake the change management itself, with the support of the wider system. We recognise that is hard to arrive at a collective position in a diverse provider sector, but that does not mean we should discouraged from moving as far as possible in that direction.

We will help to create that time and space by taking the following actions:

- Support practices to close for half a day once a month for a structured programme of reflection, wellbeing and improvement.
- Develop a new programme of support and professional development for Practice Managers and PCN Managers
- Review the funding of PCN Clinical Directors, recognising that their current capacity is tied to delivery of the PCN DES. We will discuss with the Clinical Directors the potential for additional sessions, where they can undertake them. These sessions will provide time to actively involve the Clinical Directors in issues beyond PCN DES delivery.
- Support the development of effective governance and decision-making in PCNs, recognising the significant NHS resources committed.
- Help to develop the GP Provider Board to provide leadership, innovation and practical help to primary care teams.
- Ensure the Primary Care Partner member of the Integrated Care Board is able to put forward primary care developments that have been developed by the sector as part of our annual operational planning round.
- Develop, with representatives of General Practice, a new leadership programme that responds to the actual needs of the GP community.
- Improve the interface between primary and secondary care, bringing hospital doctors and GPs together to collaboratively develop and improve services.

2. Focus on delivery to patients

There has been much discussion in recent years about the business model of General Practice. There are now several different business models including commercial providers, independent partnerships, incorporated practices and NHS Trust-backed providers.

All practices, irrespective of their business model face the same challenge; a fundamental mismatch between capacity and demand. Until we make progress on that issue, all providers will continue to struggle to provide a safe, high-quality service with adequate staffing within the contract funding available.

However, it is true that partnership practices face particular challenges. There is a significant risk that as more GPs choose to take salaried or locum roles in which they have some control over their workload, and that as partner earnings reduce relative to salaried or locum GP earnings, that the partnership model becomes increasingly untenable for many, although there are a number of extremely strong partnership practices that are likely to thrive in any environment.

The diversity of our General Practice provider sector is a strength. GPs can choose to work in salaried, locum or partner roles, and have a choice of different business models. We need to support all practices, irrespective of their business model.

We will therefore:

- Support viable and successful GP partnerships to move away from unlimited liability through incorporation. Incorporation means that the GP partnership holding a contract may form themselves into a limited company whilst retaining their existing contract. This is a useful option for long-term stability of successful

practices that can demonstrate good governance and leadership. We will not support incorporation as an option for practices that are already in some difficulty.
- Continue to encourage GPs to become partners through a local incentive scheme
- Expand the incentive scheme to encourage more non-GP partners, particularly Nurse partners.
- Incentivise experienced partners to develop into or continue in senior leadership roles, with support to develop wider roles to benefit General Practice, including through the Careers Plus programme.
- Help practices that have become, or wish to move towards, employee-owned trusts to ensure their models are sustainable.
- Support Symphony Healthcare Services Ltd to develop and offer a wider range of services to the whole of General Practice.
- Review our contracts to ensure that the cost of delivering care is adequately reflected in our local contracts.
- Continue to provide specialist co-ordinated and bespoke help to practices that find themselves in difficulty, whether because of financial, quality, workforce or leadership challenges. Increasingly, this help will be provided by the GP provider sector itself.

All our attention to these business issues is to ensure patients receive a good service, measured by a minimum dataset jointly agreed by all partners including representatives of patients. We would expect this to focus on safety, outcomes, experience, continuity and access.

Our current risk-based surveillance and assurance approach, based on a suite of triangulated indicators, will continue to be used. This includes access, prescribing, workforce, finance, patient experience, clinical quality and premises.

3. General Practice at Scale

We need General Practice to be well organised at all levels. The right scale for delivery should be driven by logic and evidence considering effectiveness, cost effectiveness and optimal utilising of the available workforce.
The local practice model remains the bedrock of effective GP delivery and is what patients value. The smallness and localness are key ingredients in the successful model, not anachronisms to be abolished.

But there is much that can be organised more efficiently at a greater scale. It has been said that General Practice needs to ‘get big in order to stay small’. This means more than simply taking a conventional approach to scale and business efficiency. It is a radical orientation to supporting local delivery by effective organisation.

<u>GP Provider Collaborative</u>

Some aspects of this relate to PCNs and their role in providing place-based integrated care. However, our priority will be the rapid development of a primary care provider collaborative comprising all the organisations that currently or could contribute to the overall efficiency of General Practice. This includes the Local Medical Committee,

Somerset Training hub, GP Education Trust, Symphony Healthcare Services, Somerset Primary Healthcare, 100fold and individual practices. There is already a structure in place to convene and co-ordinate the provider collaborative; the GP Provider Board.

The primary care provider collaborative will deliver or significantly contribute to a range of services to practices and PCNs always drawing on the expertise of exemplar practices, including:

- Business intelligence
- Access redesign
- Continuity of care
- Workforce Planning
- Finance to PCNs to avoid cashflow issues related to ARRS payments
- Practice resilience
- Quality improvement including CQC preparation and follow up
- Payroll
- HR
- Remote care services including GP, nursing and prescribing
- Complaints management
- Business efficiency
- Leadership training and staff development
- Service improvement tools and techniques
- Service design, including business cases and participation in the annual planning round
- New service provision where services are commissioned once for the county
- Bringing the GP provider voice to system escalation calls and response to crises and challenges such as Covid vaccinations, asylum hotels, escalation beds, novel disease outbreaks etc
- Communications including social media
- Research participation, academic study generation and evidence implementation

The provider collaborative will be resourced in a variety of ways, including drawing on national and local funding, and contribution of time and skills from partner organisations.

It is important to be clear that the provider collaborative is an organic development of the good work that is already going on, rather than a new structure independent of existing work and relationships. We do not believe that such an approach, for example going out to procurement for a single organisation to provide all the services described above, would be most likely to succeed.

Resilience of General Practice

There are many positives to report. All our 62 practices are opening each day, providing the best service they can and coming back the next day to do it again. Practices are working together and collaborating to support each other and innovating new ways of working to cope with the demand.

However during the development of this strategy we have also seen one practice close (Springmead in Chard) and several others get into serious difficulty including one of our

largest practices, Burnham and Berrow Medical Centre, which is now improving. Practice teams are finding the operating environment more and more challenging.

It is important for us to improve the resilience of General Practice for two reasons:

1. Improved resilience and improved viability reduces stress and therefore will be key to retaining workforce, which will then help us to address the fundamental problem of the demand/ capacity mismatch.
2. When a practice gets into serious difficulty it diverts time, energy and money away from positive developments and into crisis response. That is time, energy and money that is then not available to help us to address the fundamental problem of the capacity/ demand mismatch.

We will take coordinated action at both practice and system level to improve resilience.

Practice-level interventions

The published literature and our own experience have identified the success factors in practice resilience:

- A strong leadership ethos which articulates the mission of the practice and is concerned with the experiences and needs of patients and staff
- Measurable culture of kind leadership throughout the organisation
- High morale
- An orientation towards innovation and quality improvement
- Clear succession planning for the longer-term future of the practice, whatever its ownership model
- Sufficient medical workforce to meet the needs of patients- the exact ratio will depend on the skill mix of the team and the demographic of the patients
- Sufficient nursing workforce
- Sufficient AHP, administrative and other healthcare roles
- High level of continuity of care
- High level of stability in the clinical team
- Retention of senior clinicians
- Appropriate capacity but also recognition of importance of Reception/ Patient Advisor teams and an orientation to meet patient needs early
- Robust clinical governance, including compliance with CQC domains
- Effective business processes
- Time and space built into working days to allow for wellbeing and reflective thinking
- Sufficient funding
- A positive outward orientation towards working with other practices, PCN and other agencies
- Good quality premises that are fit for purpose.

There is wide variation between practices in these areas. Without any sense of blame, we need to understand the situation of practices and work collaboratively to improve their resilience. While some of the improvements needed will be delivered by county-wide schemes, for example on workforce, the business model and premises, much of our focus does need to be at individual practice level.

It is vital that this work is led by individuals knowledgeable about General Practice. It needs to be ‘of, and for’ General Practice. We are therefore asking the GP provider community, through the GP Provider Board, to lead on this work on behalf of the whole system.

We will work with the GP Provider Board to agree a programme of work with individual practices, drawing on the expertise of the members of the GP Provider Board. We expect that the programme will include:

1. Data for improvement – helping practices to understand their own appointment, outcome, HR and finance information and data to inform actions to improve resilience.
2. An annual health check delivered free of charge to each practice, covering all the aspects described above.
3. An ability to provide intensive support where a practice is starting to experience difficulties, to stabilise the practice and resolve problems early before they develop into a crisis.
4. An ability to bring in a dedicated and experienced support team for a period of time where a practice is in crisis, to support the leadership team, stabilise the practice and return it to normal functioning.
5. An ability to deploy collective resource including short-term workforce.

As a system, we will support this work by drawing on the resources we already have that could form part of this approach to supporting practices, including funding, expertise, data and communications. This programme must be viewed by all providers as being entirely supportive, thus encouraging openness and transparency from the practices.

<u>System level interventions</u>

While much of our programme to improve resilience needs to be delivered at practice level, there are other actions that we will take at a system level. These include:

- Supporting the development of remote service hubs, including prescribing, nursing, GP and admin
- Allowing changes to the business model - see ‘Delivering for Patients’ above.
- Providing a dedicated communications officer function to support public understanding of primary care services.
- Concerted action on primary care workforce – see the chapter on workforce.
- Improvements in GP premises, ideally based on new national capital flows, but if not, based on revenue investment for priority schemes.
- Support with data and digital improvement initiatives.

4. Clear Priorities

There is a profusion of targets, ambitions, priorities and requirements which apply to GP services. At best these represent a cohesive response to a highly complex operating environment in which General Practice needs to deliver multiple outcomes. At worst they represent an environment in which the true drivers of value are obscured and therefore not optimised.

We therefore need to be clear about our priorities for General Practice in Somerset over the next 5 years. These are:

1- Population health: contributing to the overall health of the population
2- Continuity of care: focusing on long-term proactive care
3- Access: ensuring that patients' needs are met in the most effective and efficient way

All other targets, priorities and ambitions should be regarded as subsets of one of the over-arching priorities above.

5 Workforce

The fundamental solution to our challenge of capacity and demand mismatch lies in significantly increasing the clinical and non-clinical workforce. This will mean meeting the medical, nursing and medicines needs of our ageing population, as well as locating those needs within their social context and widening the workforce to do so. We need to avoid a false dichotomy between increasing the core clinical workforce 'the medical model' and the wider workforce e.g. health coaches ('the social model'). The future model of General Practice needs to be truly bio-psycho-social, integrating with healthcare resources such as acute hospital care, and simultaneously with community-based resources such as voluntary sector organisations.

We have seen an increase in nurse numbers, and more than 200 new PCN Additional Roles Reimbursement Scheme posts. However, GP numbers have started to decline and this trend is likely to continue over the next 5 years. In an optimistic scenario this reduction will be small, but still further widen the gap between demand and capacity. Even the more optimistic scenarios are unlikely to increase GP numbers relative to population need given our rapidly ageing demographic.

While there are a number of organisations involved in primary care workforce development, it is clear that we need a step change in our workforce development approach, particularly in light of our new responsibilities for pharmacy, optometry and dental services.

We need to agree a new system-wide approach, drawing on the capabilities and capacities of all system partners, which will deliver:

- Workforce development to achieve total integration at neighbourhood level around the needs of patients (as per Fuller), so including GP, district nurses, community rehabilitation teams, MIU/UCR, pharmacy, dental, optom, new roles , high skill mix, inter-disciplinary and inter-organisational working with a focus on proactive care.

- A particular focus on non-professionally qualified roles including health coaches, care co-ordinators and receptionists/ patient advisors.
- Improving the availability of clinical supervision for non-GP roles to free up GP time and to improve professional governance.
- A particular focus on the new disciplines in primary care e.g. Occupational Therapy in General Practice is a whole new professional discipline which needs to be celebrated, grown, evaluated etc.
- A particular focus on nursing and particularly nurse leadership, with senior nursing roles such as nurse partner, consultant nurse roles.
- Given the broad system implications for all partners, close working will be essential, for example on including primary care in overseas nurse recruitment.
- Maximising the opportunities on medical workforce especially IMG and SAS roles
- Increasing nurse and GP training places by brokering creative discussions to improve estates, IT, educator capacity etc to rapidly increase training place availability
- Working closely with system colleagues, increase retention through specific programmes e.g. for GPs over 50 but also wider workforce wellbeing initiatives
- Unashamedly championing the importance of leadership and culture in delivering successful healthcare organisations which attract and retain staff.
- Radical subsidiarity and decentralisation to create learning organisations in PCNs and neighbourhoods so that training and workforce initiatives can be shared between the organisations within the neighbourhood and key decisions including on funding made as locally as possible.

6 Digital and data

Our primary care and digital strategies fully align on the need to focus on these three priority areas for benefit realisation:

We will deploy the capabilities and capacity within the whole system to support rapid development in all three domains.

For patients, the programme will include practice website standardisation and improvements to phone systems to improve access. Online consultations have proved to be a significant disruptive innovation, with both successes and challenges for patients and practices. We will continue to support innovation in online consultation systems, recognising that it is a rapidly developing field.

For providers, the main focus will be service design and business efficiency, including automation and robotics as well as fully integrated clinical systems that allow team-based continuity of care across providers. Machine learning and AI will be particularly important, using predictive technology such as Brave to identify patients most at risk of adverse health outcomes.

For system partners, we will improve the quality, timeliness and usefulness of primary care data. This is particularly important in the context of significant changes in same-day access services, which will need to be fully integrated with service developments across the whole system.

Because we will need to move some activity away from General Practice in order to create time and space for continuity-based care for the people that need it most, data-driven service design will be crucial. We have a compelling example of this in North Sedgemoor, where the national CLEAR team have undertaken comprehensive and sophisticated data analysis based on 5 years of practice clinical and appointment data. We will enable service design to be enabled by high quality data and analytics.

7 Population Health Management

Hypertension, tobacco, alcohol misuse, high body mass index and low physical activity are the leading risk factors for illness and disability in Western Europe. Many of these risk factors are amenable to intervention by at national and local levels.

General practice, with its registered list of patients, has untapped and currently un-resourced potential to engage in a more proactive approach to improving the health and wellbeing of the local population. Such a focus is essential if the NHS is to meet the challenges of responding to rising rates of chronic illness at all ages of the population, during a time of financial austerity.

There are already examples of GPs engaging in work to improve access, outreach and management of both their chronically ill patients and those who are still healthy. Interviews with GPs, practice managers and other staff by the Nuffield Trust reveal both an appetite for further change and a multitude of ideas about how such visions might be realised.

Successful projects also depend on imaginative approaches to deploying staff, and better use of existing data in order to fully leverage the unique knowledge that staff in general practices have of their individual patients, their families and their local communities. Good-quality data and risk stratification tools will be essential to support this task. Routine data on smoking, body mass index and other lifestyle indicators for patients who do not normally come into contact with their GPs represent the biggest challenge. Policy-makers

will need to enable investment in data collection, alongside innovative approaches to payment systems and contracts, which will enable practices to take consistent action. Research shows wide variation in common procedures in general practice such as influenza vaccinations but also highlights the danger of using crude uptake as a performance measure. As is so often the case, a much more sophisticated approach to the use of evidence is called for.

GP services are well-placed to actively contribute to a PHM approach which reduces mortality, morbidity and cost arising from the biggest killers.

To do this, we need to rapidly create a short causal chain between PHM data and insight and operational delivery. That operational delivery has two main facets:

1. Reaching out into communities to support health and identify undiagnosed cases.
2. Effective management of long-term conditions, with hypertension being a priority.

This will be done by creating a clear logic model, in which the population health data overseen by the Population Health Transformation Board is provided to PCNs and practices in a way that stimulates practical action. It will be accompanied by clear guidance on optimum service models and brokerage of discussions with wider system partners including VCFSE organisations. The same population health data will be used to inform funding decisions, including local contracts between NHS Somerset and PCNs and practices.

We are proud to be part of a Marmot Region and expect to show how our local innovations in primary care can provide scalable examples of population health management in action.

8 Continuity of Care

It is clear from stakeholder discussions and some national policy that the importance of continuity in reducing mortality and healthcare system cost is still not widely understood. Continuity of care has gold-standard evidence of its importance as the primary value proposition in General Practice, and full references are given for this section.

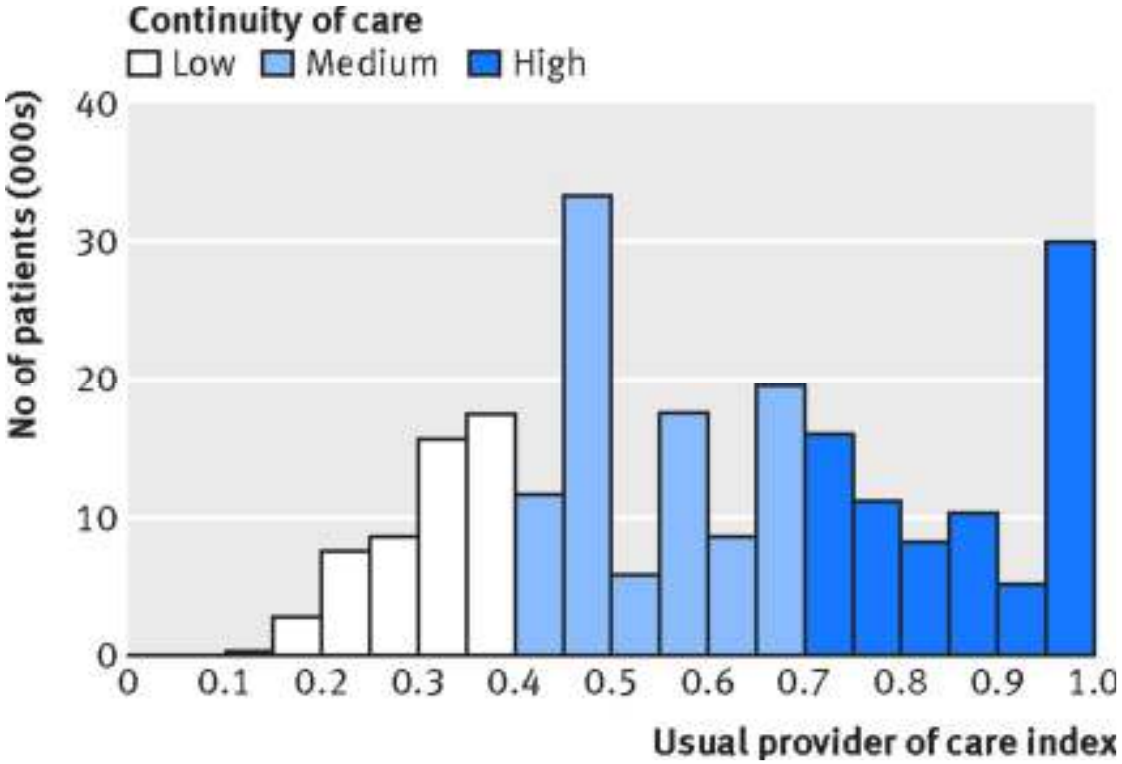
A significant body of evidence points to the benefits of continuity of care. For example, Hjortdahl et al (1991) found strong associations between accumulated knowledge of patients by the practitioner and use of healthcare resources. This included time saved in the GP consultation, laboratory tests (ten-fold difference), prescribing, sickness certification and referral.

Van Walraven et al (2010) conducted a systematic review of the relationship between continuity of care and outcomes in healthcare; they found that increased provider continuity is associated with improved patient outcomes.

Bankart et al (2011) studied the characteristics of General Practices associated with the emergency admission rates to hospital in a cross-sectional study. The conclusion of that study shows that there is a direct association between continuity and lower emergency admission rates.

Huntley et al (2014) conducted a systematic review on features of primary care affecting unscheduled care use. They found international evidence that continuity of care is associated with reduced emergency department attendance and emergency admissions.

Barker et al (2017) found that higher continuity of care was associated with fewer admissions for ambulatory care sensitive conditions. Specifically, a Usual Provider of Care index (UPC) was used to measure the proportion of patient contacts with the most regularly seen GP. The range was 0.10 to 1.00 Overall average UPC was 0.61, for patients at small practices 0.70, for large practices 0.59. The researchers found that 0.2 increase in UPC would reduce admissions by 6.2%. A figure showing the distribution of usual provider of care index from their paper (all patients with a minimum of two contacts with general practitioners (n= 230,472)



Although the researchers do not model the impact of any further increase in UPC, given that the current range is 0.90 point (0.10-1.00) it would not be unreasonable to suggest that with the appropriate intervention an improvement of 0.40 would be feasible. This could be expected to reduce admissions by 12.4%. Clearly this would have a significant positive impact for the acute hospital sector of our system.

Deeny et al (2017), giving an overview of the research and possible steps for frontline teams, found that patients who experienced higher continuity of care in general practice tended to experience fewer hospital admissions for ambulatory care sensitive conditions.

Imison et al (2017) in their comprehensive review of evidence to support shifting care out of hospitals highlight positive evidence of continuity of GP care in reducing whole system costs, and evidence of potential to increase system costs from urgent care centres not co-located with Emergency Departments.

Tammes et al (2017) found a relationship between discontinuity of care and unplanned admissions for older patients.

Rosen (2018) points out that medical generalism involves using deep contextual knowledge of patients and their family and social situation to understand and interpret symptoms and problems. It enables GPs to hold clinical risk in the community in partnership with patients without onward referral to other services. For around a quarter of patients, it can help to 'de-medicalise' problems for which medicine may be unable to find an answer. It can also help to relocate childhood trauma and addiction (the two major determinants of complex healthcare need) in a context of human experience rather than as a clinical problem to be solved.

Health systems like the NHS, which feature strong primary care with GP-registered lists and a gatekeeper function, generally have better health outcomes at lower cost. Evidence suggests that GPs contribute to this by requesting fewer tests and procedures and, where there is continuity with a lead GP, they refer to hospitals less. These approaches are characteristic of the medical generalist role. At a time when staff and money are in short supply, it is essential to clarify what we want from general practice and the role we want it to play in the wider NHS. There are opportunity costs associated with the current emphasis on timely and convenient access because fewer resources are left to deliver medical generalist and multi-disciplinary care. It is also true that the traditional continuity-based model can be bolstered by well designed specialist interventions. For example the South Somerset Complex Care Team, which is a national exemplar of multi-disciplinary practice, person-centred care and de-prescribing for better patient and system outcomes.

Pereira Gray et al (2018) performed a systematic review of continuity in all medical settings. Of the 726 articles identified in searches, 22 fulfilled the eligibility criteria. The studies were all cohort or cross-sectional and most adjusted for multiple potential confounding factors. These studies came from nine countries with very different cultures and health systems. The authors found such heterogeneity of continuity and mortality measurement methods and time frames that it was not possible to combine the results of studies. However, 18 (81.8%) high-quality studies reported statistically significant reductions in mortality, with increased continuity of care. 16 of these were with all-cause mortality. Three others showed no association and one demonstrated mixed results. These significant protective effects occurred with both generalist and specialist doctors. The researchers concluded that increased continuity of care by doctors is associated with lower mortality rates. Although all the evidence is observational, patients across cultural boundaries appear to benefit from continuity of care with both generalist and specialist doctors. Many of these articles called for continuity to be given a higher priority in healthcare planning. Despite substantial, successive, technical advances in medicine, interpersonal factors remain vital in healthcare.

It is clear from the evidence that valuing, preserving and developing continuity of care will save lives and save costs. We will therefore take the necessary actions to:

- Incorporate a standardised measure of continuity in our local primary care dataset (SLICC or UPC are the most frequently used measures, but there are others)
- Promote the importance of continuity in all discussions about General Practice
- Take a keener interest in variation between practices , given that on the current, imperfect measure our practices range from 4% to 78% on patient-reported continuity with an aggregate measure of 46%.

- Recognise that the three domains of continuity (interpersonal, informational and management of care) are all equally important and that continuity of care does not mean a 'Same GP only' model of care.
- Recognise that access and continuity do not have to be in tension with each other, although they often are, particularly in poorly designed healthcare systems.

9 Access

The two issues that have dominated the debate throughout the development of this strategy 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 fact, 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. When we talk about 'primary care same day demand' we therefore need to be clear that we mean first contact from patients, rather than type of provider or contract. Primary care same day demand is therefore an issue for everyone in our system. This includes General Practice, Dental, Optometry, Community Pharmacy, Minor Injuries Units, Urgent Community Response teams, Integrated Urgent Care, Ambulance services, Emergency Departments, Adult Social Care and other services. VCFSE partners including Citizens Advice and Food Banks are also seeing more people with pressing problems that need to be addressed on the same day.

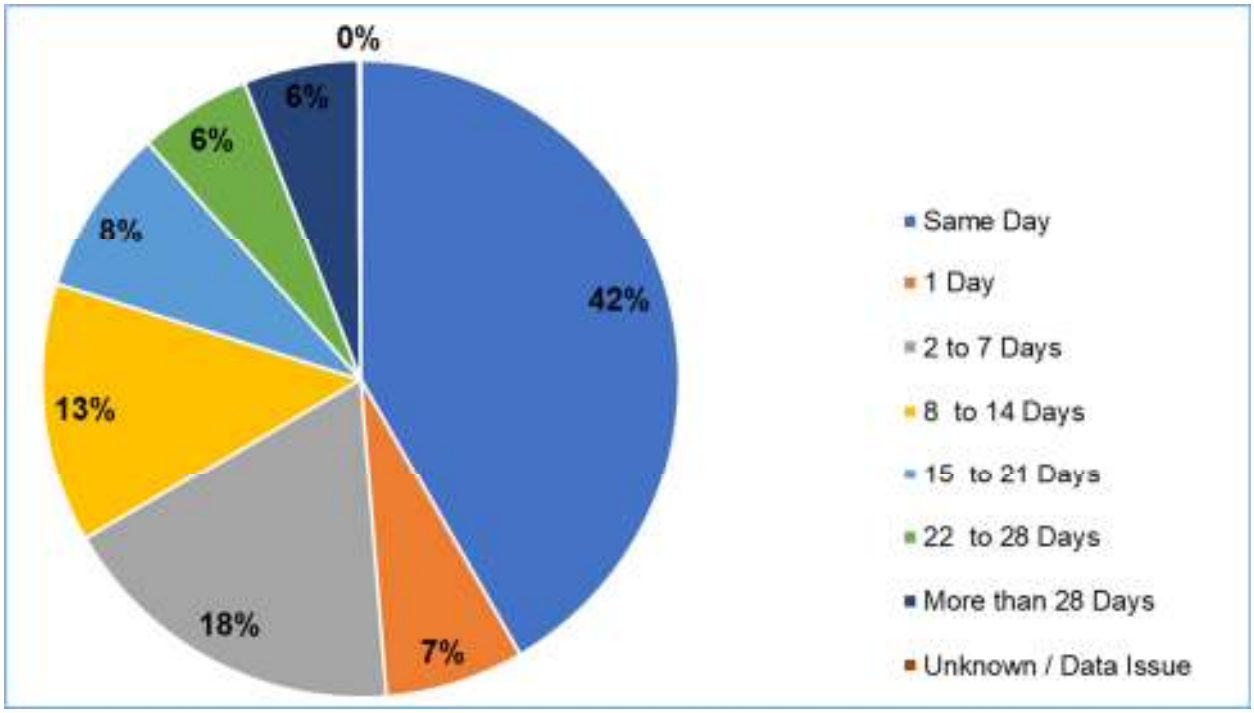
The international evidence on access to primary care is strong and demonstrates significant reductions in population mortality where primary care services are available.

We need to take a new approach to access for three compelling reasons:

- Patients are reporting difficulty accessing GP services in a timely manner, particularly in 3 of our 13 PCNs.
- Same day demand is overwhelming practices, meaning that they cannot focus on continuity of care, and are unable to provide safe care at times.
- Same day demand is a critical issue for our whole system, and a national priority fro the NHS.

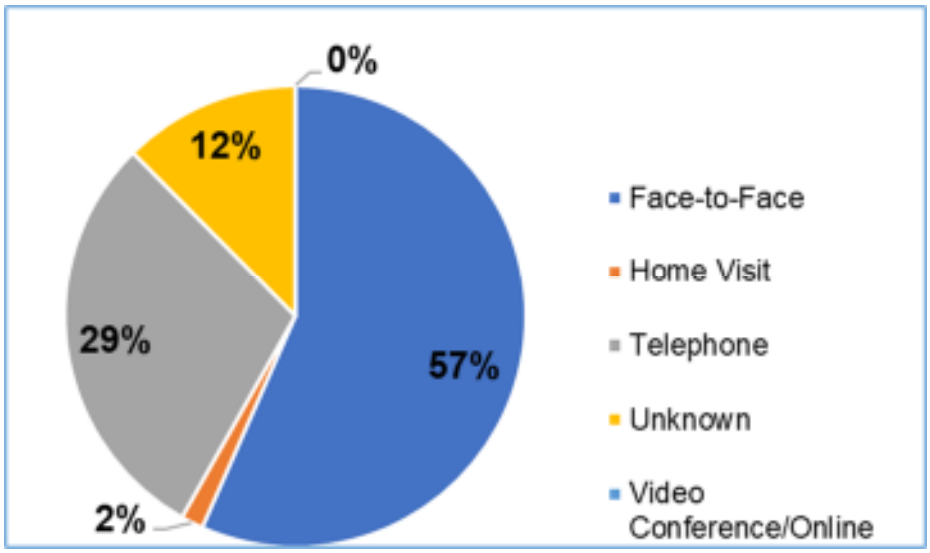
<u>Current access in General Practice</u>

We have been working hard to create an accurate dataset of GP appointment activity and although the data still has substantial caveats and areas for data quality improvement, we now have a dataset that includes all Somerset practices which forms the basis for our monthly overview of patient access. The latest figures relate to March 2023:

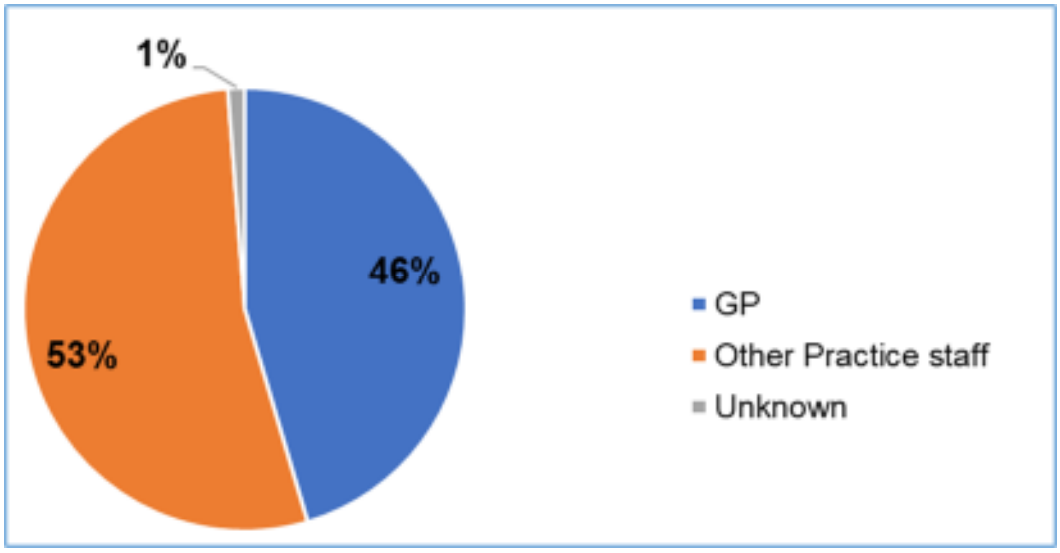


The chart above shows that 42% of appointments are delivered on the day of booking with 80% within two weeks. The threshold for two week achievement is that all patients who need an appointment within two weeks should receive one. There will be some patients for whom a good service means waiting longer than two weeks, for example to see their usual clinician for a complex but not urgent problem. Therefore two week achievement will never be 100%.

Appointment modes are shown below – note that 'unknown' is likely to include video and some online consultations.



Appointment by clinical role is shown below:



The professional consensus and published literature would suggest that about 25% of presentations in General Practice are clinically urgent and need a same-day response to prevent adverse health outcomes. However, this figure has not been adjusted to reflect the long tail of increased healthcare demand arising from the pandemic. It is a recognised phenomenon that increased ill health following population-level trauma persists for some years.

Discussion with practice teams and analysis of the data shows that in order to allow practice teams to focus on the activity that gives the greatest impact, which is continuity-based care for people with long-term conditions, there needs to be a new approach to same-day demand, based on accurate data, that diverts activity away from practice teams, but with strong links to provide team-based continuity. We already have a good example of this approach in the Community Pharmacy Consultation Service (CPCS) that we have already implemented.

As Claire Fuller says, “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”.

We will rise to this challenge by developing a local model of urgent care in each of our neighbourhoods which is fully integrated around the needs of patients. Patients will be assisted to get their needs met by whichever service is most appropriate for these needs, without having to contact multiple different services. Integration of clinical systems will mean that team-based continuity applies, and the GP patient record will continue to be the core continuous clinical record for that patient, wherever and whoever they see.

Service change and organisational delivery is likely to be stimulated by the new neighbourhood models, but the clinical model will have primacy, and changes to funding, contracts and organisational responsibilities will be agreed once the clinical model is developed and agreed.

Our new Integrated Neighbourhood leadership teams will be asked to lead on the development of local models of same day care, considering population need, current

services, geography and available workforce. This work will run in parallel to the programme to establish co-located and locality based Urgent Treatment Centres.

Our priority for development will be our three most challenged Neighbourhoods initially (South Somerset West, North Sedgemoor and Yeovil), with progress in all Neighbourhoods during 2023/24, starting with West Somerset, given challenges in Minehead. These Neighbourhoods will be supported with data and analytical capacity, service improvement support, and communications and engagement to help the population understand the new service model.

Concurrently, we will support all our practices to review their access approaches, drawing on local best practice, innovation and professional consensus. We will draw on the resources provided by the national Delivery Plan for Recovering Access to Primary Care to help practices take a quality improvement approach to their access arrangements. In this we will work closely with our patient representatives and Healthwatch.

10 Investment

It is clear that there are opportunities to improve the value proposition. Some require small or non-recurrent investment. But we need to be clear; the expert policy view is that investment in primary care in the NHS needs to double over a period of time in order to provide an optimal level of investment to deliver population health improvements.

We therefore need to consider our overall appetite for investment over the longer-term, recognising that more than 80% of primary care funding is nationally defined and allocated.

Recurrent investment is essential in the core clinical and non-clinical workforce at practice, PCN and collaborative level to improve our capacity to respond to our three overarching priorities:

1. Population health
2. Continuity of care
3. Access

A new investment scheme is in development, which will incentivise these priorities, subject to ICB approval and negotiation with the LMC.

Section 2 – Dental

2.1 Dental Priority Actions

There is significant concern from stakeholders about access to NHS dental services as an increasing number of practices cease providing NHS services. Oral health is a significant driver of overall population health, going far beyond dental health and affecting our biggest mortality reduction opportunities including CVD. It is also an area where inequalities are increasing, and concerted action is needed now to make sure that the people of Somerset have equitable access to dental services. Given the scale of the challenge, we expect that the actions set out below will need to be delivered across the whole period of the strategy 2023-2027.

In discussion with patients, communities, dentists, stakeholders and NHS England as the current commissioner, six priority actions have been identified. They are all consistent with the three national priorities for General Dental Services: access, oral health, and inequalities.

The six priority actions show how dental services will deliver the five aims of our health and care strategy:

Aim 1 Improve the health and wellbeing of the population

Aim 2 Provide the best care and support to children and adults

Aim 3 Strengthen care and support in local communities

Aim 4 Reduce health inequalities

Aim 5 Respond to complex needs

Priority Action 1- Setting a clear ambition

Our ambition is that over the period 2023-2027 we achieve sufficient NHS dental capacity to provide access to all Somerset residents who wish to use NHS dental services. As not everyone wishes to use NHS dental services, the actual capacity to be commissioned should be sufficient to cover c70% of the population.

As this will be a step-change in access, we will need to come together as a healthcare system to deliver it. It will require a substantial programme of investment, development, procurement and contract management. However this level of population access has been achieved in the past, so we should have confidence in our ability to achieve this very stretching target. The first priority will be to secure an urgent dental access service that is fit for purpose and able to meet the current demand for urgent dental services in the county.

Priority Action 2- Bringing dentists back into the NHS

In order to deliver our first priority, we need to change our relationship with the dental profession in Somerset, to communicate clearly the benefits of undertaking NHS work and to identify and remove the obstacles that stand in the way of more dentists undertaking NHS work and for those practices already providing NHS care to support them in expanding the service they offer. This will require flexibility, dialogue and creativity.

Priority Action 3 – Maintaining a local delivery network

Given the size of Somerset and the dispersed rural population it is important to ensure we have a local delivery network. Such a local delivery network also encourages continuity of care which is important to both patients and dentists, although it is not explicitly incentivised in the current dental contract. There is some evidence that recruitment of dentists is more challenging in rural areas so a creative approach will be needed, recognising that each practice is in a different situation.

Priority Action 4 – Creative commissioning

Although further reform of the national GDS contract is expected in due course, in the short term we will need to take a creative approach which while consistent with the national contract framework also allows us to take action to meet specific local needs. These would include sessional approaches to dental stabilisation, children-friendly practices and communities experiencing particular inequalities. This should also include careful consideration of children-only NHS contracts, which until now commissioners have avoided for good reasons. However, all options should be considered to improve the oral health of the population.

Priority action 5- Workforce

We will need to increase the NHS dental workforce considerably, and in order to do so will need to form creative partnership including with higher and further education providers who can help us to ‘grow our own’ local dental workforce, including oral health practitioner apprenticeships. We will also offer a wider range of opportunities to dentists to undertake more specialist roles including orthodontics. We will also review the ‘pull factors’ for Foundation Dentists for NHS work in Somerset.

Section 3 – Optometry

Optometry is an important service as c70% of the population wear some sort of corrective device. However, like dental, the trend is away from NHS services and towards private provision.

Optometry offers significant integration opportunities and we need to develop the NHS service offer and ensure optometrists feel part of the NHS family. In particular, to ensure financial viability, contract funding needs to recognise provider costs. In consultation with stakeholders we have identified three priority actions for Optometry in Somerset.

The three priority actions show how optometric services will deliver the five aims of our health and care strategy:

Aim 1 Improve the health and wellbeing of the population

Aim 2 Provide the best care and support to children and adults

Aim 3 Strengthen care and support in local communities

Aim 4 Reduce health inequalities

Aim 5 Respond to complex needs

Priority 1- Urgent Care
We currently commission an urgent care service, ACES, which is effective and highly valued by patients and other NHS providers. We will review it with a view to expanding its scope and integration with the wider NHS system.

Priority 2- Long term conditions
We will work with system partners and optometrists to commission a long-term conditions management service which would reduce secondary care waiting times and improve outcomes particularly for our priority conditions including diabetes.

Priority 3- Making best use of Independent Prescribers
An increasing number of Optometrists are independent prescribers and we will develop care pathways that allow Optometrists to work to the ‘top of their licence’ and reduce inefficiency and duplication in our healthcare system.

Section 4 – Community Pharmacy

Community pharmacy offers significant opportunities and as a sector is keen to develop further as part of integrated neighbourhood teams. There are however challenges with workforce, capacity and business viability.

Our strategy will be to fully maximise the potential of community pharmacy. We have made an excellent start with CPCS, in addition to the current focus on hypertension and new medicines. Making full use of pharmacies will also support business viability. Our goal is to maintain a local delivery network, delivering population health interventions, urgent care and long term condition management as well as medicines optimisation. The balance of commissioned activity and funding will move from dispensing towards clinical services.

There are many positives to celebrate:

- Presence in local communities in 102 locations
- Ease of access
- High level of professional skill in pharmacists, not fully used
- Improved safety and quality of medicines through careful dispensing
- Resilient and innovative
- Independent prescribing becoming standard from 2026
- Team based continuity of care and integrated working with PCNs and GP surgeries, e.g. CPCS
- Integrated IT platforms to share data
- Operational efficiencies including robotic dispensing
- New national contract in development
- Expansion of the pharmacist workforce into new areas, particularly PCNs

There are also a number of challenges being faced by the sector:

- Constrained workforce
- Business viability with a number of pharmacies closing
- Uncontrolled demand and flow of work
- Estate is constrained
- National contract incentivises dispensing items rather than clinical services
- Stock shortages taking up large amounts of pharmacist time unproductively, in both PCNs and pharmacies
- Despite some positive developments, still in competition for funds with other providers
- Limited public awareness of what pharmacies can offer

Through listening to patients and clinical teams, data analysis and engagement with stakeholders, we have identified 8 priority actions which will form our strategy for community pharmacy over the next five years.

Priority Action 1- Population Health Management

We will:

- Support pharmacies to identify the PHM priorities and develop effective strategies to manage.
- Enhance health promotion including brief advice and recommendation of approved apps
- Develop and enhance case finding capabilities, starting with CVD, and including point of care testing
- Align clinical IT systems for patient safety, operational efficiency and outcome measurement
- Implement specific interventions to reduce health inequalities
- Expand vaccination services

Priority action 2- Urgent care

- Further develop CPCS to improve data flow, increase the number of pharmacies and GP surgeries fully utilising the service and further increase patient satisfaction
- Implement and optimise the NHS UEC CPCS pathway to enable the safe referral of patients from EDs and UTCs to community pharmacyDevelop the ‘Somerset Pharmacy First’ locally commissioned service to augment the national Pharmacy First advanced service
- Increase the range and availability of defined urgent medicines available, including through delivery

Priority action 3- Long term conditions

- Develop the role of community pharmacy in the detection of chronic health conditions, including AF, hypertension and diabetes
- Increase the management of conditions in community pharmacy including asthma, hypertension, heart failure and diabetes, with close integration with General Practice
- Expand the role of community pharmacy in medicines monitoring, safety, adherence, waste reduction and post-discharge medicine reconciliation
- Develop the role of community pharmacy in pharmacogenomics and personalised prescribing to improve patient outcomes

Priority action 4- Workforce

The ability for community pharmacy to deliver our shared objectives will depend upon having adequate workforce. We will:

- Continue to develop our pharmacy workforce strategy
- Create career progression opportunities
- Further develop apprenticeship opportunities
- Create a flexible pool for pharmacy roles
- Work closely with the new school of pharmacy at Plymouth University
- Improve job satisfaction and retention by widening portfolio opportunities
- Get ready for Independent Prescribers – defining the what, where and why of IP activity

Priority action 5- Data and digital innovation

We will:

- Develop full interoperability of clinical systems between providers
- Develop shared booking systems and rapid and automated post event notes
- Campaign for improved timely data collection from community pharmacy
- Incorporate pharmacy data into predictive models and PHM tools
- Improve IT equipment in pharmacies, e.g. devices in all consultation rooms

Priority action 6- Team based care

Pharmacy lends itself particularly to team-based care, but many pharmacists are working in relative isolation. We will change this by:

- Developing a ‘team of teams’ approach which creates a MDT approach across the whole clinical system including hospitals
- Further integration of pharmacists into our new Integrated Neighbourhood Teams
- Closer links between PCNs and Community Pharmacy
- Further development of diagnostic services

Priority action 7- Estate

The community pharmacy estate is highly variable and not every site currently provides the optimal facilities to deliver our ambitions. We will:

- Ensure that the estate is taken into account in our PNA and JSNA processes

- Increase consultation capacity, including remote consulting options, with the ideal being multiple consulting rooms that can accommodate both booked and walk-in patients
- Targeted investment in pharmacy provision in areas of greatest health inequality (Core20 neighbourhoods)

Priority action 8- Public awareness

Our engagement with the public shows that most people are unaware of the level of training pharmacists have and the wide range of healthcare services available at pharmacies. We will:

- Develop a multichannel communication campaign to promote the role of community pharmacy in an integrated care system
- Work with specific groups to increase the attraction to and use of community pharmacy, focusing on communities subject to health inequalities
- Improve signposting and referral to community pharmacy

Our commissioning approach

Our priorities will be to:

- Ensure consistent delivery of essential services at all pharmacies
- Promote delivery of advanced and national enhanced services
- Further develop a comprehensive set of locally commissioned services
- Use the same clinical model as for GP services to determine what services are delivered a) in every pharmacy b) one per neighbourhood c) one per locality d) county-wide as a single service
- Support innovation and creativity
- Celebrate the contribution of pharmacy to our community life in Somerset

Section 5 – Wider implications and next steps

Wider Implications

There are a number of implications of this primary care strategy that go beyond primary care itself. They are summarised briefly below.

Integrated Neighbourhood Teams

The Fuller Stocktake sets out a detailed vision for Integrated Neighbourhood Teams which should include NHS community services, VCSE partners, urgent care providers and all four primary care services. We need to provide integrated urgent care and integrated long term conditions care/ complex care, as well as population health management in each neighbourhood. This is a huge change and will require substantial inputs of leadership, organisational development, logic models and data, service improvement, digital innovation and estates development.

It is important that we are clear about the scale of the change, and do not assume that PCNs are, or will easily become, Integrated Neighbourhood Teams.

Place, locality and neighbourhood

In order to support the development of fully integrated neighbourhood care, we need to be clear as a system what activities we wish to take place at system, place, locality and neighbourhood level. Within primary care, we will use a clinical model which uses logic to define the scale at which primary care services are provided:

- Individual practice level
- PCN/ Neighbourhood level
- Locality
- County-wide or remote

Agreement on the defined neighbourhood footprints will be a precursor to effective integration. Although we have 12 nominal NHS neighbourhoods which are coterminous with the 13 PCNs (East Mendip neighbourhood contains 2 PCNs), in practice there is insufficient resource to spread NHS community services across 12 neighbourhoods and the footprints for community services remain 8, which are broadly consistent with PCNs but not coterminous. A neighbourhood could contain more than one PCN as there is no national definition of ‘neighbourhood, whereas PCNs are constrained by the terms of the PCN DES.

We are also actively engaging with the development of Local Community Networks (LCNs) as a further part of the picture of integrated, community based health and wellbeing.

Urgent care

It is important to note that the ambition to develop fully integrated care at neighbourhood level will have implications for urgent care services including MIUs. Any changes to services will be subject to engagement and consultation as necessary. We also need to recognise the importance of out of hours primary care. We will continue to develop an integrated urgent Care Service with the local NHS111 at its core, and explore how this will link to the locality based “same day care” services we plan to develop.

Next Steps

Once approved, the strategy will be launched using a range of communications channels, and the focus will then move to implementation.

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