Under pressure: an analysis of primary care pressures facing Integrated Care Systems at launch

FUTURE HEALTH

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> WAITING LISTS AND PRESSURES IN PRIMARY CARE WERE RISING BEFORE THE PANDEMIC, BUT THE RESTRICTIONS ON ACCESS TO SERVICES AND THE IMPACTS ON POPULATION HEALTH FROM COVID-19 MAKE THE ROAD TO SERVICE RECOVERY EXTREMELY DIFFICULT.

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ABOUT FUTURE HEALTH

Founded by former UK Government Special Adviser, Richard Sloggett, Future Health is a policy research centre with a mission to advance public policy thinking that improves the health and wealth of people, communities and nations.

Healthcare systems around the world are facing significant challenges of demographic, societal and technological change. The importance of prevention and the development of new technologies have long been seen as ways to transform health systems to improve patient outcomes and performance, but progress has often been slow. COVID-19 is an inflection point, demonstrating the need and opportunity of investing in and delivering more effective and efficient healthcare services in the future. In undertaking cutting edge public policy research across key areas such as prevention, technology and links between healthcare and the wider economy, Future Health is working to support such positive changes and deliver policy that improves health outcomes and tackles health inequalities.

This work, funded by Acumentice, is part of a new programme of work from Future Health focusing on system pressures and operations.

To find more about Future Health's work please do contact Richard Sloggett at richard@futurehealth-research.com

About the Author

Richard Sloggett is the Founder and Programme Director of Future Health. He was previously a Senior Fellow at Westminster's leading think tank Policy Exchange and from 2018-19 was Special Advisor to the Secretary of State for Health and Social Care. Richard is a regular commentator in the national media on health and social care including in The Times, Telegraph, Financial Times, Economist and on Times Radio and LBC. He has been named as one of the top 100 people in UK healthcare policy by the Health Service Journal.

During his time with the Secretary of State, Richard worked across Whitehall, the NHS and local government on major policy decisions including the NHS Long Term Plan, the Secretary of State's Technology Vision and the Prevention Green Paper. He has fifteen years' experience in public policy and healthcare, starting his career in Parliament before a successful career in public affairs where he led a team of 20 to the prestigious Communique Public Affairs Team of the Year Award.

Richard is undertaking his doctoral thesis in preventative healthcare systems at Liverpool University.

About Acumentice

As a specialist healthcare management consultancy uniquely led by ex NHS frontline experts, Acumentice are on a mission to create a healthier NHS. They achieve this by helping to deliver positive, sustainable improvement and intelligence to the NHS, enabling it to reach its full potential both now and in the future. Founded in 2014, Acumentice's deep understanding of the NHS and all its sectors from the inside and out, allows it to work in genuine partnership with the NHS to deliver successful outcomes at pace for healthier patients and staff.

Acumentice's expertise focuses on four core pillars of healthcare management that are fundamental in optimising NHS services:

- Strategic and Operational Improvement
- Digital Transformation
- Data Strategy, Analytics and Modelling
- Data Quality Improvement & Assurance

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Working across NHS organisations, Acumentice works at all levels including integrated care systems and individual provider organisations. Their unique methodologies and partnership with the NHS, have consistently delivered positive, sustainable results which are highly regarded in the industry.

Executive Summary

The NHS is facing perhaps its greatest ever set of challenges. Waiting lists and pressures in primary care were rising before the pandemic, but the restrictions on access to services and the impacts on population health from COVID-19 make the road to service recovery extremely difficult.

The creation of new Integrated Care Systems (ICSs) is an opportunity for the various different parts of the healthcare system to work closely together to get patients the care and treatment they need. The move to a more integrated system has been a journey over recent years, and the benefits of such partnership working were clearly evidenced through the pandemic.

There have though been long standing challenges to joining up healthcare across the NHS, particularly between primary care services and the hospital and secondary care sector. The creation of Primary Care Networks (PCNs) provides an approach for general practices to work together at scale and tackle a wider set of population health challenges with ICSs.

However each new ICS is different and whilst many face similar challenges (such as workforce pressures and a lack of capital investment), the scale of their primary challenges varies. This research reveals:

- The number of primary care appointments per head of population is 58% greater in Cornwall ICS than in North Central London ICS
- A nearly threefold variation in the number of patients unable to get a GP appointment so attending A&E. Black Country ICS in the Midlands with 16% has the highest rate, Herefordshire and Worcestershire with just 6% has the lowest rate
- Herefordshire and Worcestershire has the lowest GP to patient ratio, below 1500. Kent and Medway has the highest, which is 50% higher (over 2000)
- Birmingham and Solihull and Black Country ICS both have 20% of patients noting a fairly or very poor experience of primary care. This is more than double Gloucestershire ICS with just 8% of patients

When looking at these pressures, and the challenges in secondary care in A&E, electives and clearance times, the research finds:

- A set of 16 ICSs are under both relatively high levels of primary and secondary care pressure – these include Bedfordshire, Luton and Milton Keynes, Kent and Medway, Leicester, Leicestershire and Rutland, South Yorkshire and Sussex
- A similar number of systems who are under low relative levels of primary and secondary care pressure including Bristol, North Somerset and Gloucestershire, Buckinghamshire, Oxfordshire and Berkshire West, Coventry and Warwickshire, Hertfordshire and West Essex, Staffordshire and Stoke on Trent, Suffolk and North East Essex

For Government and NHS England understanding these relative pressures, the different challenges systems face and how to alleviate them will be central to delivering on plans for elective and primary care recovery.

The report highlights a number of systems with relatively high levels of deprivation who are also experiencing relatively high primary and secondary care pressures. For new ICS leaders understanding these differences in population health need, through detailed and co-ordinated data analysis and working closely with local places to develop tailored approaches will be critical.

The report seeks to provide ideas for positive action in two forms.

Firstly a set of system case studies and learnings, based on interviews and desk research. These case studies – from areas identified as experiencing relatively low primary care pressure – are designed to highlight not only the action taken and the positive benefits, but to understand how action to deliver change can be best undertaken.

Secondly a set of recommendations aimed at national policymakers that would help underpin the recent Dr Claire Fuller stocktake report[1]. The report set out a vision for future primary care/ICS working but acknowledged that other nationally led actions were needed. These include critical actions for how to ensure effective primary care participation in ICSs, the deployment of capital to support community-based care, improving data flows, fixing funding flows to encourage integration, providing flexibility on local workforce requirements and reforming NHS pensions.

Taking forward these proposals will be critical to ensuring the NHS overcomes the challenges it faces.

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

Recommendations

“This report (Fuller stocktake) sets out a limited number of recommendations for NHS England, the Department of Health and Social Care (DHSC), and other national bodies that will enable local systems to drive change in their communities and neighbourhoods. This includes ensuring future national policy is designed to support and enable local systems to do what they need to do rather than apply a one-size-fits-all approach.”

Fuller stocktake

The Fuller stocktake saw widespread and extensive engagement across the primary and secondary care system on how the new NHS structures should work effectively together.

But Dr Fuller’s report was also open that without national Government and NHS leadership the reports ambitions would struggle to be delivered. This report argues that the introduction of the following would all support the ambitions within the Fuller report to be realised:

- **Accountability** – Ministers must put tackling service variation as a central objective of their winter and long term service plan. To deliver this NHS England should ensure that Ministers and the Department of Health and Social Care have access to the most up to date and granular data on pressures in the system. A small team of data analysts should be employed in Ministerial private office with full access to the data and use it to brief Ministers weekly on current trends and challenges relating to health service pressures. NHS England should include measures within the new national oversight frameworks for ICSs, such as the NHS Oversight Framework, that properly assess the role of primary care in ICS decision making. It will be important that system oversight is both proportionate and takes into account the different healthcare needs of ICS populations and the impact of the pandemic
- **Funding** – A new funding formula for primary care that properly takes into account levels of deprivation and a review of primary and secondary care financial flows to ensure that payment mechanisms are flexible and support integrated care for patients
- **Workforce** – Providing greater flexibility to local teams regarding recruitment through the Additional Roles Reimbursement Scheme (ARRS) and putting such roles on a more long term and certain footing
- **Capital** – Re-prioritising healthcare capital spending to ensure capital funding is available for primary and community care and to support more integrated service transformation. This could include a proposed Community Health Infrastructure Fund[2]
- **Data** – Utilise the Digital Health and Care Plan[3] and the efforts during the pandemic to reduce bureaucracy in data sharing and enforce action on suppliers who do not conform to minimum standards. Streamline national health technology funding into a health data infrastructure accelerator that enables systems to join up health data more quickly and easily
- **Regulation** – Ensuring that new system level service regulation through the CQC Single Assessment Framework clearly engages with primary care leaders, particularly Primary Care Networks (PCNs)

These actions from national bodies will provide an enabling environment for regional and local systems to deliver the changes and improvements in care needed.

2 https://policyexchange.org.uk/publication/health-and-social-care-what-do-we-want-from-the-next-prime-minister/
3 https://www.gov.uk/government/publications/a-plan-for-digital-health-and-social-care/a-plan-for-digital-health-and-social-care#appendix-a-our-action-plan-for-delivering-a-digital-future

CHAPTER 1: NHS PRESSURES AND THE ROLE OF INTEGRATED CARE SYSTEMS

As the NHS looks to recover from the worst of the pandemic, it faces perhaps its greatest set of combined challenges in its history:

- Widespread workforce pressures and staff vacancies
- An elective wait list over 6.7 million and rising
- Record numbers of appointments in primary care
- Longer response times for ambulances and waits in A&E departments
- A lack of adequate social care funding and provision
- A long running deficit in capital spending impacting the ability to deliver service change
- Having to continue to manage and plan services with COVID-19 still in circulation; alongside a growing understanding of the health impact of long COVID
- Wider deteriorations in public and population health as a result of the pandemic
- Ongoing demographic shifts in the population, and in particular treating an older population with multiple co-morbidities
- Growing levels of public and patient dissatisfaction[4]

The role of Integrated Care Systems

Against this backdrop the healthcare system is undergoing its latest re-organisation to plan and deliver care. The creation of ICSs through the Health and Social Care Act 2022 seeks to join-up health and care services on a regional level.

The 42 ICSs have four over-arching objectives set out in Box 1 below.

Box 1: Integrated Care System objectives

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development[5]

4 https://www.kingsfund.org.uk/blog/2022/03/public-satisfaction-nhs-falls-25-year-low
5 https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

NHS England believes this model will help the health system tackle more complex challenges such as:

- Improving the health of children and young people
- Supporting people to stay well and independent
- Acting sooner to help those with preventable conditions
- Supporting those with long-term conditions or mental health issues
- Caring for those with multiple needs as populations age
- Getting the best from collective resources so people get care as quickly as possible[6]

Integrated Care Systems and tackling service pressures – the winter plan

In August 2022 NHS England published its winter plan. 'Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter' states that the NHS is under 'significant pressure' and that 'there have been too many occasions when staff have not been able to provide timely access for our patients in the way they would have wanted[7].'

The plan included a number of objectives summarised in Box 2.

Box 2: NHS winter plan objectives

- Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme
- Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter
- Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999
- Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts

6 https://www.england.nhs.uk/integratedcare/what-is-integrated-care/
7 https://www.england.nhs.uk/next-steps-in-increasing-capacity-and-operational-resilience-in-urgent-and-emergency-care-ahead-of-winter/

- Reduce crowding in A&E departments and target the longest waits in Emergency Departments, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services
- Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway
- Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'
- Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

The document is the first service plan to be published following the formal establishment of ICSs. The plan notes that the Integrated Care Board (ICB) for each ICS will be responsible for:

- Ensuring that their system providers and other partners deliver their agreed role in their local plans
- Work together effectively for the benefit of the populations they serve
- Initial problem solving and intervention should providers fail, or be unable, to deliver their agreed role
- Monitoring performance against agreed standards[8]

In September 2022, the Government published 'Our Plan for Patients' which included new commitments for patients who need a GP appointment to be able to access one in two weeks, a greater role for pharmacy, some changes to NHS pension rules and some additional funding for social care to support hospital discharge[9].

8 https://www.england.nhs.uk/next-steps-in-increasing-capacity-and-operational-resilience-in-urgent-and-emergency-care-ahead-of-winter/
9 https://www.gov.uk/government/publications/our-plan-for-patients/our-plan-for-patients

The role of primary care in Integrated Care Systems

Primary care is seeing record or near record levels of demand each month[10]. But with difficulties retaining staff, and the Government well off track with its ambitions to recruit 6,000 more GPs, the system is struggling.

The NHS Long Term Plan and the five year framework for the GP contract established Primary Care Networks (PCNs) to get GP practices to work together at scale and provide a wider range of staff and services to patients.

The establishment and rolling out of PCNs has been slowed as a result of the pandemic and the vaccination programme. The ambitions for PCNs are to deliver a set of seven national service specifications and for PCNs to be the link between primary care and the ICSs[11].

In November 2021 NHS Chief Executive Amanda Pritchard tasked Dr Claire Fuller from Surrey Heartlands ICS with a review of how primary care can work effectively with the new ICSs. This was with a view to:

- Building from the successful collaboration seen across systems in the vaccine programme
- Ensuring a strong voice for primary care within the new system structures
- Delivering the prevention ambitions within the NHS Long Term Plan[12]

Dr Fuller's stocktake report was published in May 2022 and included a future vision for primary care that included:

- Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention[13]

The report made a set of 15 recommendations, with nearly half of the recommendations specifically aimed at ICSs. These ICS recommendations are summarised in Box 3 opposite.

10 https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice
11 https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/supporting_documents/Draft%20PCN%20Service%20Specifications%20December%202019.pdf
12 https://www.england.nhs.uk/2021/11/nhs-chief-announces-next-steps-for-local-health-systems/
13 https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

CHAPTER 1 NHS pressures and the role of Integrated Care systems

Box 3: Recommendations for ICSs in Fuller Stocktake report

Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices. This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face.

Enable all PCNs to evolve into integrated neighbourhood teams, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At place level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams. Focus on community engagement and outreach, across the life course. Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations. Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards.

Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multi-professional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.

Develop a primary care forum or network at system level, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place based boards.

Embed primary care workforce as an integral part of system thinking, planning and delivery. Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.

Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care, taking a 'one public estate' approach and maximising the use of community assets and spaces.

Create a clear development plan to support the sustainability of primary care and translate the framework provided by *Next steps for integrated primary care into reality*, across all neighbourhoods. Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.

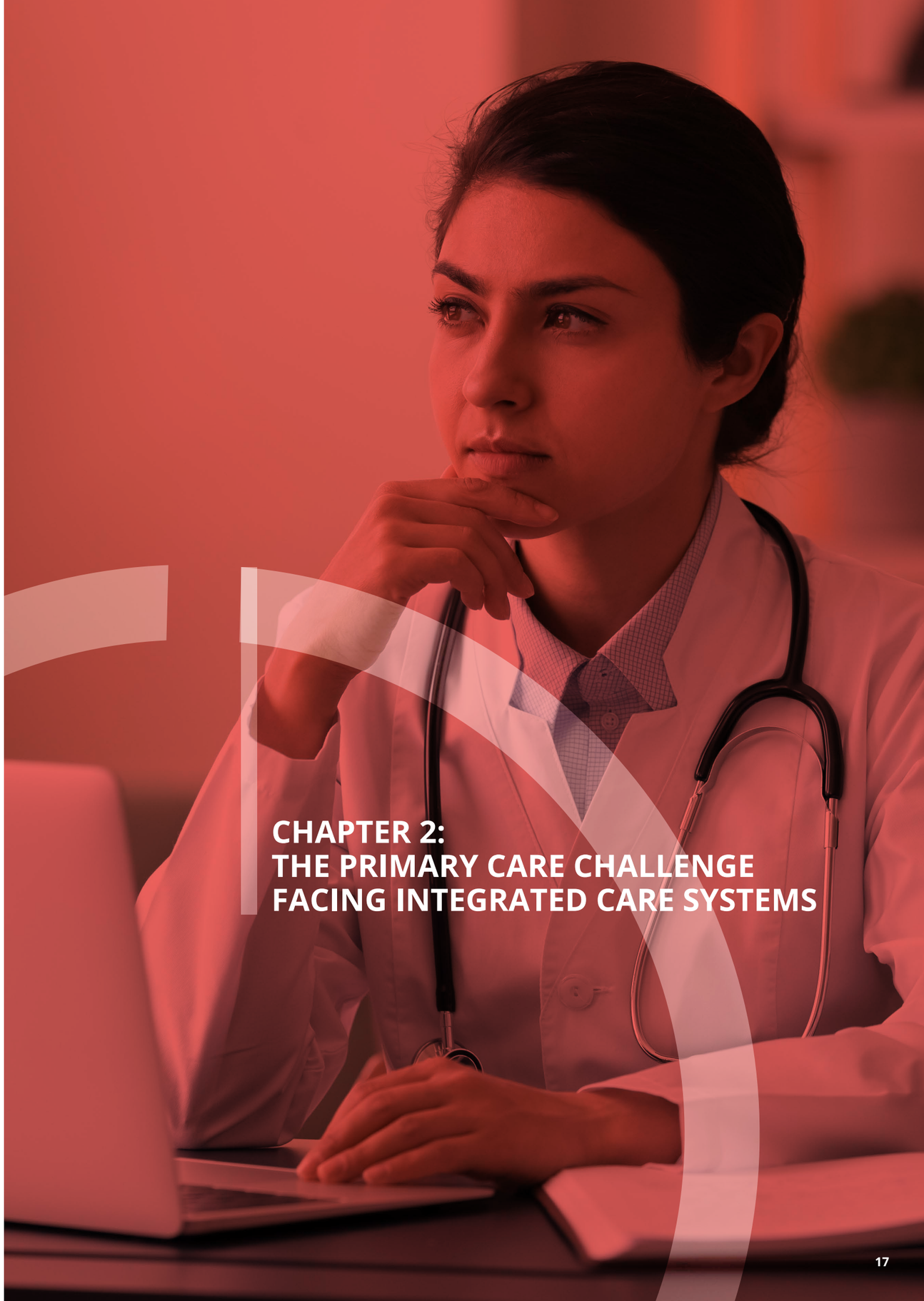
Work alongside local people and communities in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.

All 42 ICS CEOs signed the Fuller stocktake and committed to its implementation.

As they begin their formal role in the health system, against a backdrop of significant pressures and with these commitments to working with primary care established, now is a good time to explore the challenges facing ICSs in relation to primary care in their geographic areas, along with ideas and proposals for tackling them.

This research analyses:

- The primary care challenge facing ICSs
- Links between primary care and secondary care service pressures
- An assessment of deprivation and service pressures



CHAPTER 2: THE PRIMARY CARE CHALLENGE FACING INTEGRATED CARE SYSTEMS

When assessing the pressures and challenges facing ICSs in relation to primary care, there are a number of areas to consider including[14]:

- Demand for services and workforce to support delivery
- Patient access
- Patient experience

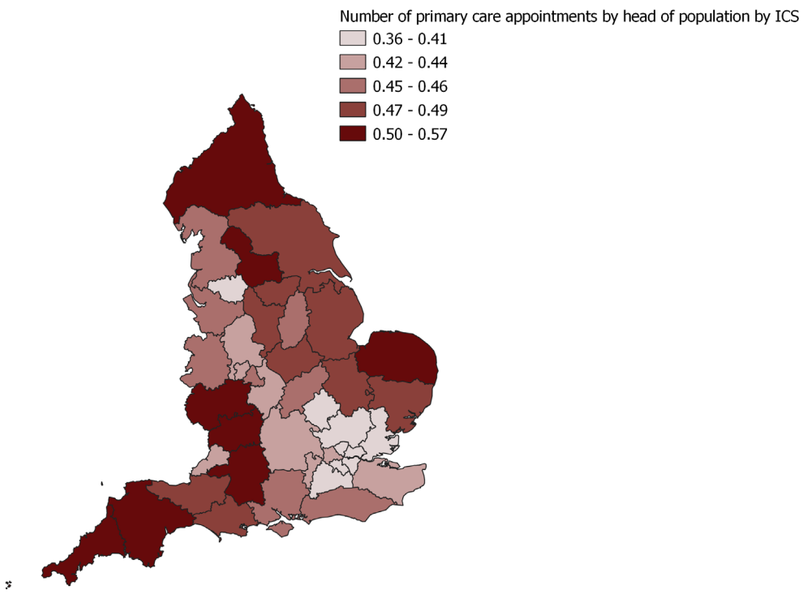
Demand for primary care services

ICSs have different scales and populations to serve. The largest such as North East and Cumbria ICS has a population over 3 million. In comparison Shropshire, Telford and Wrekin ICS serves just over half a million people.

Such differences in scale make comparing demand in a fair way across systems challenging. Different populations also have different healthcare needs.

One mechanism to assess demand between systems is the healthcare usage per head of population. For primary care this can be done by looking at the number of primary care appointments per head of population.

Figure 1: Number of primary care appointments per head of population by ICS



14 Full methodology and sources for analysis is included at the end of the report

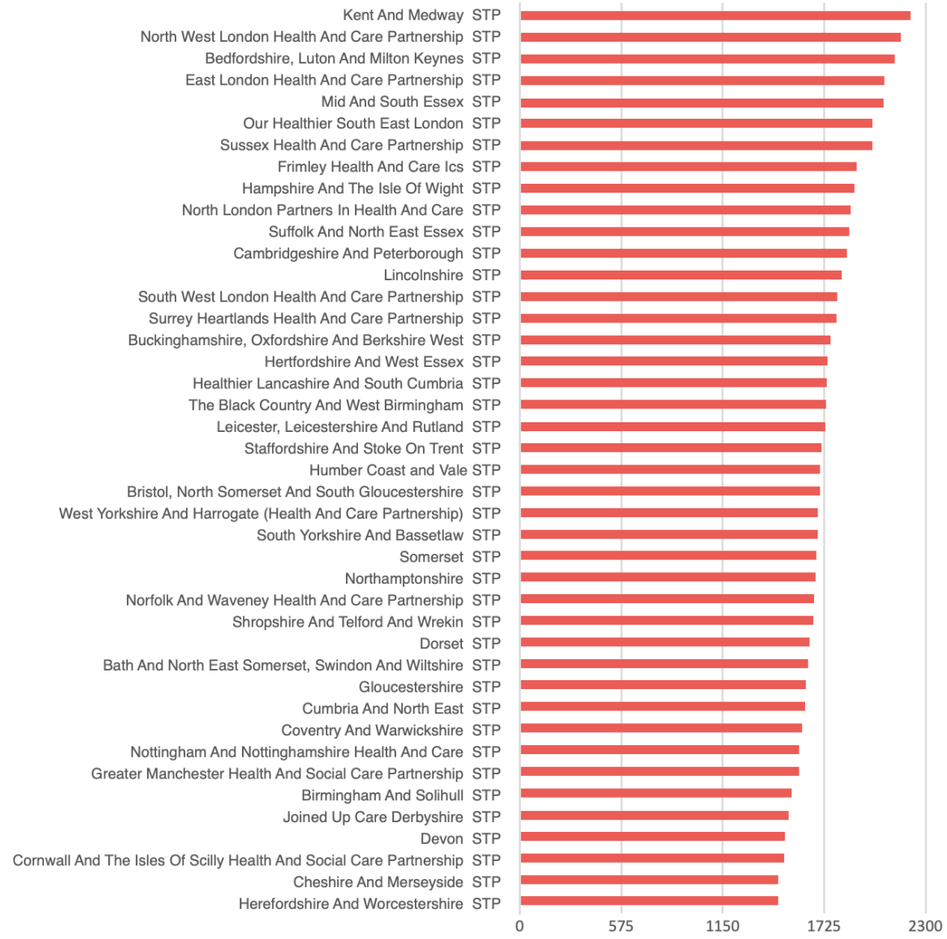
The highest number of appointments per head is in Cornwall – 58% greater than in North Central London which has the lowest. The average number of appointments per head is 0.46.

4 of the 5 London systems have the lowest number of primary care appointments per head of population – all below 0.4 appointments per person. By contrast a number of systems in the West and South West such as Cornwall, Devon, Herefordshire and Worcestershire and Gloucestershire all record over 0.5 appointments per head of population.

Demand vs workforce

When looking at system pressures, it is important to look at how the demand for healthcare maps to the workforce available to deliver it. There are large variations across ICSs /STPs in the size of population to GPs as set out in figure 2 below.

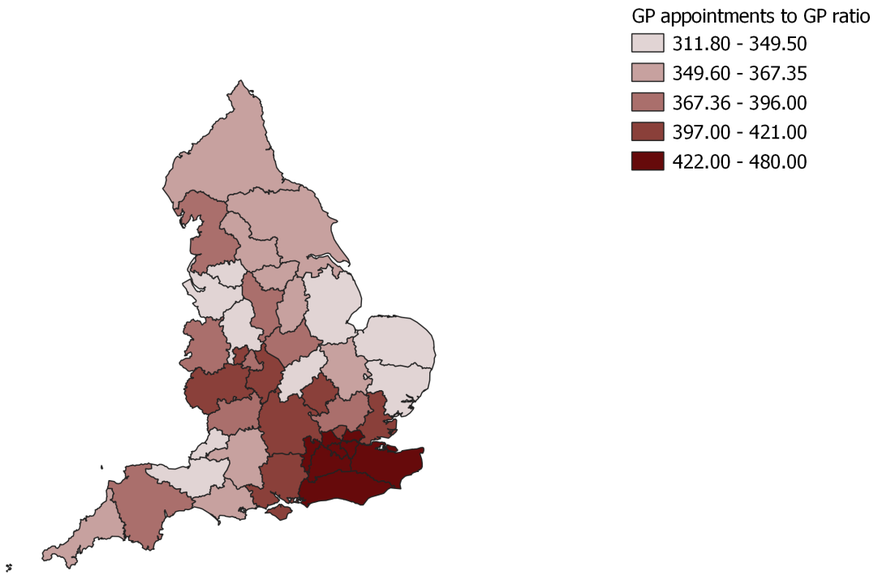
Figure 2: Population to GP ratio



Some systems such as Kent, North West London and Bedfordshire all have population to GP ratios of over 2000. By contrast Herefordshire and Worcestershire, Cheshire and Merseyside, Cornwall and Devon all have population to GP ratios of below 1500. The average number of people to a GP by system is 1,752 and there is a 51% difference in the ratio between Herefordshire and Worcestershire, with the lowest ratio and Kent and Medway with the highest.

Using the monthly GP appointment data it is possible to then map the number of GP appointments to GPs within the new systems, as set out in Figure 3 below.

Figure 3: Number of GP appointments per GP by ICS



Whilst a number of systems in the South East such as Frimley, Kent and Medway and Sussex all recorded over or near 450 GP appointments per GP, others such as Somerset and Lincolnshire were closer to 300 appointments. All London systems recorded over 400 GP appointments per GP. The average number of GP appointments to GPs was 384.

The difference between the system with the highest number of appointments to GPs (Frimley) and the lowest (Somerset) was 54%.

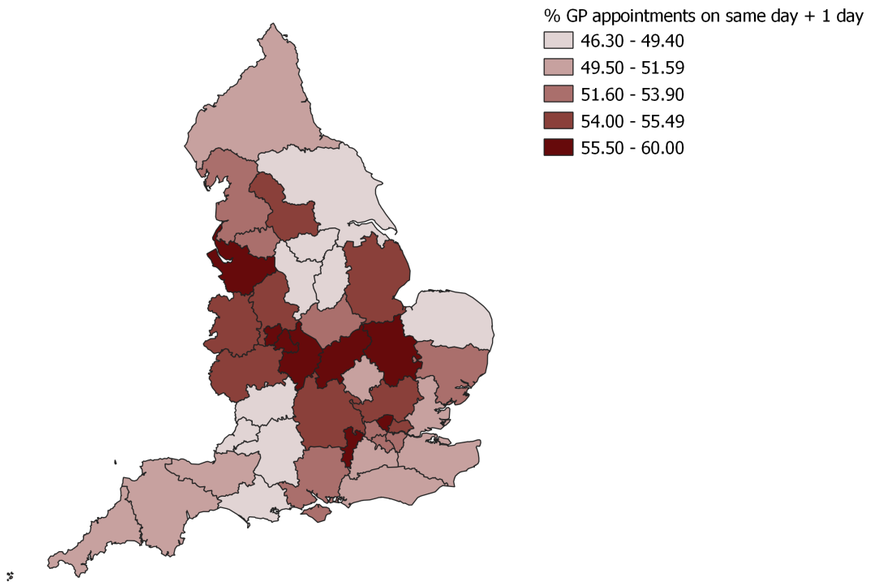
Across all three of the areas analysed above there is a similar level of variation in demand recorded, with just over 50% difference between areas with the highest and lowest recorded levels.

Access to primary care services

Another important element for assessing pressures on primary care services is how quickly patients are seen for assessment. Recent polling by YouGov for the Sunday Times found that over half of patients had found it harder to get a GP appointment and 41% thought their local GP service had worsened[15].

The following analysis looks at the proportion of primary care appointments delivered by ICS/STPs on the same day or within 1 day (figure 4) and those delivered in over 22 days or more (figure 5).

Figure 4: Percentage of GP appointments on same day or +1 day of booking



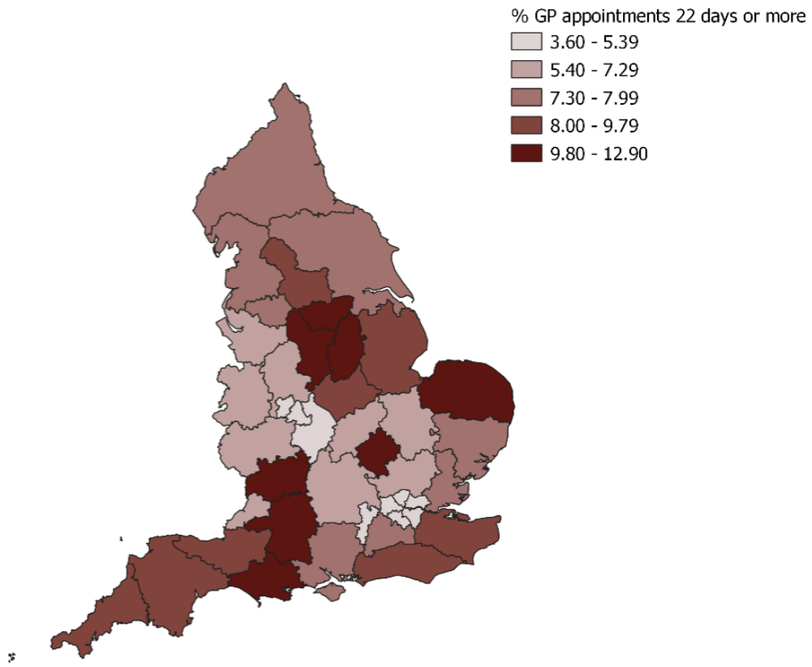
Systems are delivering on average 53% of appointments on the same day or within 1 day. Nine systems are delivering less than 50% of appointments. A number of systems in the Midlands are delivering over 55% with some such as Coventry and Warwickshire and North London nearly reaching 60%.

There is a more widespread difference in the number of appointments delivered over 22 days or more. Five of the six systems recording the lowest figures were in London (alongside Coventry and Warwickshire which also recorded the highest number of appointments on the same day and within one day). All these systems recorded 5% or fewer appointments over 22 days or more.

15 https://www.thetimes.co.uk/article/britain-falls-out-of-love-with-the-nhs-poll-reveals-three-in-five-now-expect-delays-v8mnz0tx3

By contrast six systems Bedfordshire, Luton And Milton Keynes, Bath And North East Somerset, Swindon And Wiltshire, Nottingham And Nottinghamshire Health And Care, Dorset, Derbyshire and Gloucestershire, all recorded over 10% of their appointments over 22 days or more. The average was 7.4% appointments.

Figure 5: Percentage of GP appointments over 22 days or more



Within primary care comparing speed of access is not always straightforward as patients do not necessarily want or require an appointment rapidly, and certain groups – for example those requiring more planned care - may well have appointments scheduled weeks ahead.

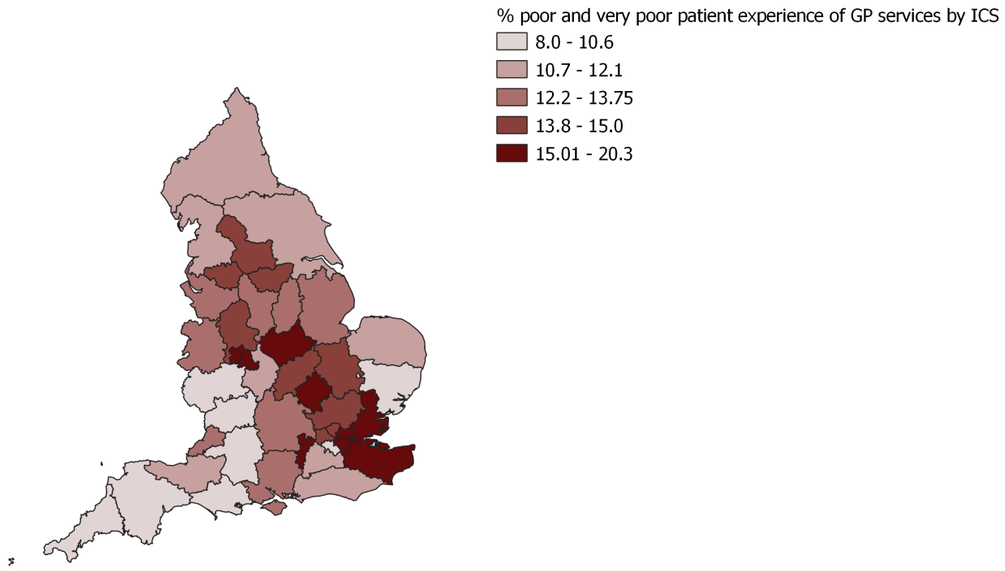
What these access data do show is that systems are offering quite different levels of access to appointments. There is a 3.5 fold variation between North London and Gloucestershire in the number of appointments offered over 22 days or more. The variation on same day and 1 day access is much smaller. Coventry and Warwickshire offers 14% more appointments on the same day or within 1 day than Dorset at the bottom of the table. But this variation is much smaller (0.3) than the 3.5 fold variation for appointments over 22 days or more.

This variation could be accounted for due to population mix, pressures on the system or some combination of the two. Further investigation would be needed to determine this.

Patient experience of primary care

The third area for assessing primary care pressures is to examine the experience of patients. The recent GP survey provides data comparing patient experience across different systems (see figure 6 below).

Figure 6: Percentage of patients recording poor or very poor experience of GP services BY ICS



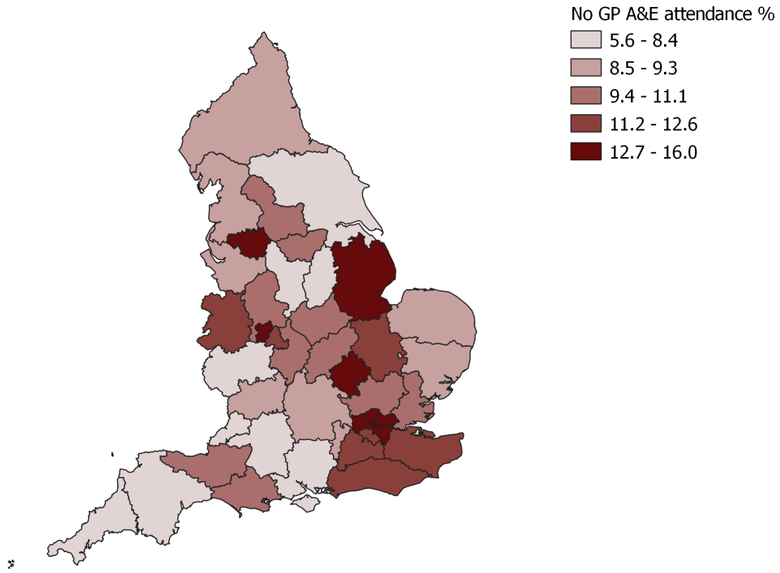
Two systems in the Midlands (Birmingham and Solihull and Black Country) recorded 20% of patients noting a fairly and very poor experience. By contrast four systems Herefordshire and Worcestershire, Devon, Dorset and Gloucestershire recorded less than 10%. The average of people reporting a fairly or very poor experience was 13%.

Devon, Dorset and Gloucestershire all recorded over 4 in 5 patients with a very or fairly good experience. The average across systems was 73%.

Another metric captured through the patient experience survey is whether people could access a GP appointment at all, and if not whether they had to seek healthcare support from elsewhere. The GP Survey captures the proportion of patients who say that they could not get a primary care appointment so they went to A&E (see figure 7 on the next page)[16].

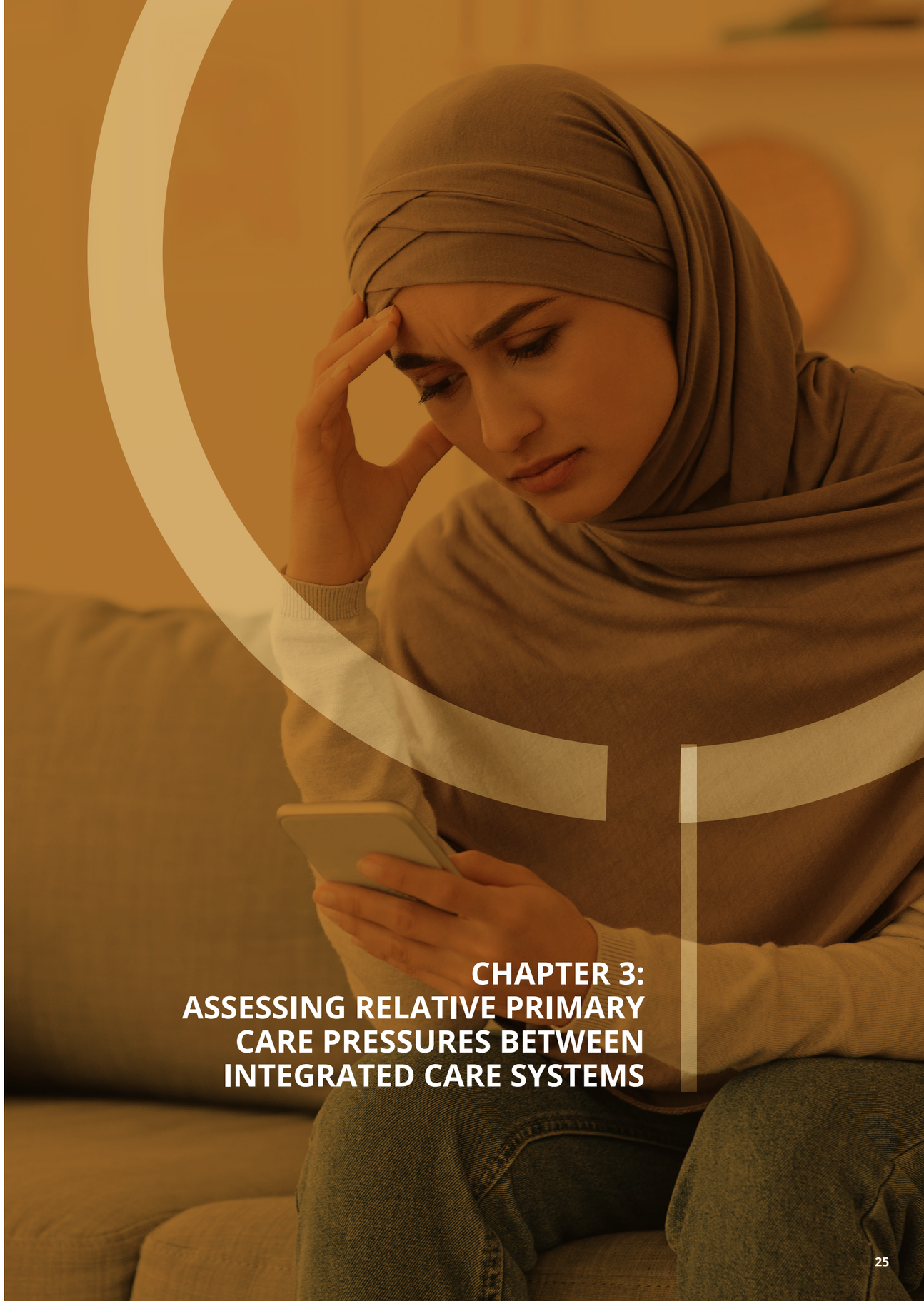
16 https://www.gp-patient.co.uk/surveysandreports

Figure 7: Percentage of patients recording that they were unable to get a GP appointment so went to A&E by ICS



4 of the 5 London systems recorded a score of 15%. The only other system to record a rate higher than this was Black Country ICS with 16%.

By contrast Herefordshire and Worcestershire and Bath and North East Somerset, Swindon and Wiltshire both recorded rates of just 6%, resulting in an almost three-fold difference between the highest and lowest performers. The average recorded rate was 10%.



CHAPTER 3: ASSESSING RELATIVE PRIMARY CARE PRESSURES BETWEEN INTEGRATED CARE SYSTEMS

When looking to compare the challenges ICSs face in relation to primary care, it is clear that each is starting from a different place with varying levels of pressures.

By using the data from the previous chapter it is possible to build a picture to identify which systems might be under greater relative primary care pressure.

Future Health ranked each system (1- highest pressure; 42 – lowest pressure) against the following variables:[17]

- Appointments per population head
- GP appointments to GP ratio
- % same day + 1 day appointments
- % of appointments of 22 days or more
- GP patient experience
- No GP appointment but went to A&E

These rankings were then accumulated to deliver a 'rank of ranks', with a lower rank of ranks indicating systems under greater pressure. It is important to note that this model is designed to assess relative pressures rather than performance.

The following table provides a snapshot of the results with systems grouped on each metric by quintile (quintile 1 – highest pressure, quintile 5 – lowest pressure).

Table 1: Relative pressures of primary care by ICS

	Appts head of pop	Appts to GP	% same day + 1 day appts	% of appts of 22 days or more	Pat exp fairly very poor	No GP A&E attendance	Rank of Ranks quintile
Kent and Medway	4	1	2	2	1	2	1
Leicester, Leicestershire and Rutland	1	2	3	2	1	2	1
Bedfordshire, Luton and Milton Keynes	5	2	2	1	1	1	1
Sussex	3	1	2	1	3	2	1
South Yorkshire	2	4	1	1	2	3	1
Gloucestershire	1	3	1	1	5	3	1
Derbyshire	2	3	1	1	3	4	1
Mid and South Essex	5	2	2	3	1	2	1
Dorset	2	4	1	1	5	3	1
West Yorkshire	1	4	4	2	1	3	2
Norfolk and Waveney	1	5	1	1	4	4	2
East London	5	1	4	5	1	1	2
Lincolnshire	2	5	4	2	2	1	2
Nottingham and Nottinghamshire	3	4	1	1	3	5	2
The Black Country	4	2	5	5	1	1	2
North West London	4	1	3	5	2	1	2
Somerset	2	5	2	2	4	2	2
South East London	5	1	3	5	1	1	2
Cumbria and North East	1	3	2	3	3	4	3
Bath and North East Somerset, Swindon and Wiltshire	1	4	1	1	5	5	3
Surrey Heartlands	4	1	2	3	4	2	3
Birmingham and Solihull	3	3	5	4	1	2	3
Devon	1	3	2	2	5	5	3
Cambridgeshire and Peterborough	2	2	5	4	2	2	3
Cornwall and Isles of Scilly	1	4	2	2	5	5	3
Shropshire, Telford and Wrekin	2	2	4	4	3	2	3
Hampshire and Isle of Wight	3	2	3	3	3	5	4
Humber and North Yorkshire	2	4	1	2	4	5	4
Frimley	3	1	5	5	2	4	4
Greater Manchester	5	5	3	3	2	1	4
Lancashire and South Cumbria	3	3	3	3	4	4	4
South West London	5	1	3	5	4	1	4
Buckinghamshire, Oxfordshire and Berkshire West	4	2	4	3	4	4	4
North Central London	5	1	5	5	2	1	4
Hertfordshire and West Essex	5	2	4	4	2	3	5
Northamptonshire	3	5	5	4	2	3	5
Bristol, North Somerset and Gloucestershire	4	4	1	3	4	5	5
Herefordshire and Worcestershire	1	2	4	4	5	5	5
Suffolk and North East Essex	2	5	3	2	5	4	5
Staffordshire and Stoke on Trent	4	5	4	4	3	3	5
Cheshire and Merseyside	3	5	5	4	3	4	5
Coventry and Warwickshire	4	2	5	5	5	3	5

Systems identified as under greater relative primary care pressure on this modelling are:

- Kent and Medway
- Leicester, Leicestershire and Rutland
- Bedfordshire, Luton and Milton Keynes
- Sussex
- South Yorkshire
- Gloucestershire
- Derbyshire
- Mid and South Essex
- Dorset

17 Methodology at Annex A

Kent and Medway is identified as the system under greatest relative pressure. Against four of the six metrics it is in the top 10 for each. It has the second highest appointments to GP ratio, the fifth highest number of patients recording a fairly or very poor experience and is tenth for the number of patients unable to see a GP and going to A&E.

The model also helps identify systems that may be adopting innovative models that work for their populations. One example is Gloucestershire, which has the fifth highest number of appointments per head of population and provides the second lowest number of same day and 1 day appointments. The system recorded the lowest rates of dissatisfaction from patients and had a below average number of patients saying they were unable to get an appointment so went to A&E.

Such insight is important as it challenges assumptions that long primary care waits equal a bad experience and poor access. Gloucestershire's relative pressure highlighted in the model may well come from serving a population with relatively high regular health needs, but it would also appear to be a system putting in place processes that support patient care and overall system sustainability.

Systems identified as under less relative primary care pressure on this model are:

- Hertfordshire and West Essex
- Northamptonshire
- Bristol, North Somerset and Gloucestershire
- Herefordshire and Worcestershire
- Suffolk and North East Essex
- Staffordshire and Stoke on Trent
- Cheshire and Merseyside
- Coventry and Warwickshire

The two systems identified as under least relative pressure, Coventry and Cheshire and Merseyside had above average relative pressure on only one metric (Coventry, appointments to GP ratio; Cheshire and Merseyside, patient experience). Coventry had the highest percentage of appointments on the same day and within one day and recorded the fourth lowest percentage of appointments booked over 21 days.

Again a closer look at the data reveals some notable examples. North Central London in the fourth quintile has the lowest appointments to population ratio, the second highest percentage of appointments on the same day and within one day and lowest percentage of appointments over 21 days. But on patient experience it scores relatively poorly. It has the eighth highest number of patients recording their service as very or fairly poor and the third highest number of patients being unable to get an appointment and then going to A&E.

Herefordshire and Worcestershire by comparison has relatively high demand measured by appointments per head of population and the appointment to GP ratio. However, it provides an above average number of same day appointments, a below average number of appointments over 21 days and records very high patient satisfaction and low numbers of people accessing A&E as a result of not getting a GP appointment.

Such differences show the challenges when comparing systems on a set of established metrics. Understanding the demographic and geographic differences between systems will be critical to interpreting the outcomes they are delivering for their populations and their relative success or failure in doing so.

Summary

The above analysis provides a snapshot of relative primary care system pressures for ICSs against a set of metrics covering demand, access and patient experience.

In adopting a 'relativist' approach, the model seeks to highlight and compare the different pressures systems are facing as they start their formal operation. Against the parameters set, it is possible to identify a number of systems who may be facing relatively higher levels of pressure in primary care.

A closer examination of the data however reveals the inherent challenge in seeking to compare systems against a set of national metrics. For example the model highlights Gloucestershire as a system under relatively high pressure, but recording high levels of patient satisfaction. In comparison North Central London appears to be under relatively less pressure but patients it would appear are struggling to get appointments, attending A&E as a result and recording high rates of dissatisfaction.

The key learning for Government and NHS England as they explore how to hold ICSs to account on their primary care responsibilities, is for a need to develop a balanced scorecard of measures that provide a realistic and intelligence led snapshot that takes into account the differences between systems. It is also important to understand what patients want and are experiencing. Just because a system is providing faster access for example does not mean it is providing a higher quality service.

CHAPTER 4: EXPLORING RELATIONSHIPS BETWEEN PRIMARY CARE AND SECONDARY CARE PRESSURES

The Government and NHS through the 'Build Back Better Health and Care document'[18] and 'Elective Recovery Plan' has set out an approach to reduce waits for elective care[19]. The key targets in the plan are set out in Box 4 below.

Box 4: Elective Recovery Plan

- Waits of longer than a year for elective care are eliminated by March 2025
- By July 2022, no one will wait longer than two years[20]
- Eliminating waits of over 18 months by April 2023, and of over 65 weeks by March 2024
- 95% of patients needing a diagnostic test receive it within six weeks by March 2025
- By March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.
- Local systems to return the number of people waiting more than 62 days from an urgent referral back to pre-pandemic levels by March 2023[21]

What impact might pressures in primary care have on the Government and NHS meeting these targets?

First we sought to establish an assessment of secondary pressures in each system. This was calculated through an analysis of three core metrics:

- 4 hour A&E performance
- 18 week elective treatment
- Percentage of patients waiting over 52 weeks from referral to treatment

In addition, clearance activity times were calculated at system level by dividing the waiting list size by weekly activity numbers[22]. These clearance times were a fourth metric included in the analysis.

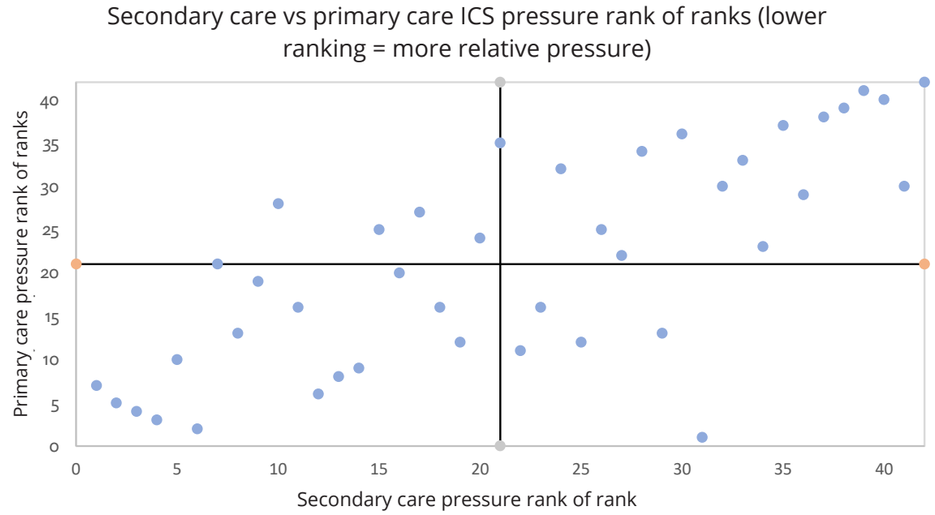
18 https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care/build-back-better-our-plan-for-health-and-social-care
19 https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-COVID-19-backlog-of-elective-care/
20 This has been broadly met: https://www.england.nhs.uk/2022/08/nhs-marks-milestone-in-recovery-plan-as-longest-waits-virtually-eliminated/
21 https://www.england.nhs.uk/2022/08/nhs-marks-milestone-in-recovery-plan-as-longest-waits-virtually-eliminated/
22 https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/Recording-and-Reporting-guidance-April_2021.pdf, p33 To note in the national dataset, the clearance times are only available at provider level so estimates were then calculated at ICS/STP level, as some providers cross multiple systems.

Adopting a rank of ranks approach, similar to the primary care analysis in the previous chapter, was then undertaken using all four metrics. Systems were grouped by quintile, with those in quintile 1 seen to be under the most relative pressure and those in quintile 5 under the least pressure with the results set out below.

Figure 8: Secondary care relative ICS pressures, grouped by quintiles

This assessment of relative pressure was then mapped to the relative pressures in primary care from the previous chapter.

Figure 9: Mapping relative secondary care pressures to relative primary care pressures



The quadrants on the graph help divide ICSs into four types of system:

- Systems with both relatively high primary care and secondary care pressure
- Systems with high primary care pressure but relatively low secondary care pressure
- Systems with low primary care pressure but high secondary care pressure
- Systems with relatively low primary care and secondary care pressure

The following provides a breakdown of which systems sit where on the map.

Table 2: Relative ICS pressure matrix

High primary and secondary care pressures	Low primary and low secondary care pressures	High primary low secondary care pressures	Low primary high secondary care pressures
Bath and North East Somerset, Swindon and Wiltshire	Birmingham and Solihull	East London	Cambridgeshire and Peterborough
Bedfordshire, Luton and Milton Keynes	Bristol, North Somerset and Gloucestershire	Lancashire and South Cumbria	Cornwall and Isles of Scilly
Cumbria and North East	Buckinghamshire, Oxfordshire and Berkshire West	Lincolnshire	Hampshire and Isle of Wight
Dorset	Cheshire and Merseyside	Norfolk and Waveney	Humber and North Yorkshire
Gloucestershire	Coventry and Warwickshire	Shropshire, Telford and Wrekin	Derbyshire
Kent and Medway	Devon		
Leicester, Leicestershire and Rutland	Frimley		
Mid and South Essex	Greater Manchester		
North West London	Herefordshire and Worcestershire		
Nottingham and Nottinghamshire	Hertfordshire and West Essex		
South East London	North Central London		
South Yorkshire	Northamptonshire		
Surrey Heartlands	Somerset		
Sussex	South West London		
The Black Country	Staffordshire and Stoke on Trent		
West Yorkshire	Suffolk and North East Essex		

The analysis identifies a set of 16 systems under relatively high primary and secondary care pressure; and a similar number of systems under relatively low pressure. Five systems have relatively high primary care pressure but relatively low secondary pressure. For another five the reverse is true with lower relative primary care pressures and higher secondary care pressures.

There are five health systems that find themselves in the top 10 'rank of ranks' for both primary and secondary care pressure:

- Bedfordshire, Luton and Milton Keynes
- Kent and Medway
- Leicester, Leicestershire and Rutland
- South Yorkshire
- Sussex

There are six systems that find themselves in the bottom 10 'rank of ranks' with both primary and secondary care pressures:

- Bristol, North Somerset and Gloucestershire
- Buckinghamshire, Oxfordshire and Berkshire West
- Coventry and Warwickshire
- Hertfordshire and West Essex
- Staffordshire and Stoke on Trent
- Suffolk and North East Essex

Relationships between primary care and secondary pressures

What impact might primary care pressures be having on performance against core secondary care targets?

To explore this three pieces of analysis were conducted:

- Population health needs and performance against the elective waiting time standard
- Primary care access challenges and performance against the A&E 4 hour standard
- Long waits in primary care and over 52 week waits in secondary care

In each case there was no correlation or direct relationship. However the analysis did highlight some issues that may be having an impact in particular systems.

Population health needs and performance against the elective waiting time standard

There were three systems which have high numbers of primary care appointments per head of population and below average performance in treating patients within 18 weeks of a referral. These were:

- Norfolk and Waveney
- Herefordshire and Worcestershire
- Devon

All these systems have primary care appointments per head of above 0.5 and referral to treatment performance against the 18 week standard of below 60%. In these areas it would be worth investigating whether higher population health (and perhaps greater need for elective care) could be part of the difficulties in delivering on the referral to treatment standard.

Primary care access challenges and performance against the A&E 4 hour standard

This analysis does highlight certain systems where access to primary care may be having a knock-on impact on A&E. North Central London and North East London Health and Care Partnership both recorded 15% of patients saying they were unable to get a GP appointment and recording less than 70% of patients being seen within the 4 hour standard in A&E.

It also highlights systems where primary care access would appear more than adequate but where A&E pressure is relatively higher. Herefordshire and Worcestershire for example recorded less than 6% of patients going to A&E as a result of not getting access to a GP appointment; but reported only 64% of patients being seen in A&E within the four-hour standard.

Long waits in primary care and over 52 week waits in secondary care

When looking at long waits in primary care and the relationship to long waits for treatment in secondary care once again there was no correlation across England.

Indeed Gloucestershire which has the highest percentage of 22 days or more GP appointments has only just over 2% of patients waiting longer than 52 weeks for elective treatment.

The analysis does highlight systems with low waiting times on both measures. Three systems in London: East London, North London and North West London all have percentages of GP appointments 22 days or more below 4% and a similar number of 52 week waits for elective treatment.

The system with the highest number of 52 week waits, Birmingham and Solihull, has a below average number of GP appointments 22 days or more. However Leicester, Leicestershire and Rutland which has the second highest proportion of 52 week waiters does have an above average number of patients waiting 22 days or more for an appointment. Norfolk and Waveney and Devon similarly are above average on both measures.

The importance of 'place' – deprivation and primary and secondary care system pressures

Whilst there is no correlation on the above selection of individual variables covering primary and secondary care, the analysis does highlight certain systems that may be experiencing difficulties in meeting population health demands and providing timely access to care across primary and secondary care.

One particular focus area for ICS leaders in improving the health of their population is in tackling health inequalities. The Core20PLUS5' framework provides the model for tackling this, see Box 5 below.

Box 5: NHS Core20PLUS5 Framework[23]

Core20

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

PLUS

PLUS population groups we would expect to see identified are ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others.

Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

5

The final part sets out five clinical areas of focus (maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, hypertension). Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve national aims.

23 https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

An analysis by the Health Foundation highlighted the different levels of deprivation facing ICSs. The Health Foundation analysis compared ICSs on their levels of deprivation. The following table ranks ICSs by the percentage of their areas with neighbourhoods classified as the most deprived[24]:

Integrated Care System

Rank (1- greatest % of neighbourhoods classified as most deprived)

Birmingham and Solihull	1	North West London	23
Black Country	2	Bedfordshire, Luton and Milton Keynes	24
Greater Manchester	3	Devon	25
South Yorkshire	4	Suffolk and North East Essex	26
West Yorkshire	5	Cambridgeshire and Peterborough	27
Cheshire and Merseyside	6	Shropshire, Telford and Wrekin	28
North East and Cumbria	7	Leicester, Leicestershire and Rutland	29
Lancashire and South Cumbria	8	Herefordshire and Worcestershire	30
Nottingham and Nottinghamshire	9	Hampshire and Isle of Wight	31
North East London	10	Mid and South Essex	32
North Central London	11	Sussex	33
Staffordshire and Stoke on Trent	12	Somerset	34
Humber and North Yorkshire	13	Gloucestershire	35
Derby and Derbyshire	14	Dorset	36
South East London	15	South West London	37
Bristol, North Somerset and Gloucestershire	16	Bath and North East Somerset, Swindon and Wiltshire	38
Kent and Medway	17		
Norfolk and Waveney	18	Buckinghamshire, Oxfordshire and Berkshire West	39
Lincolnshire	19		
Northamptonshire	20	Frimley	40
Coventry and Warwickshire	21	Hertfordshire and West Essex	41
Cornwall and Isles of Scilly	22	Surrey Heartlands	42

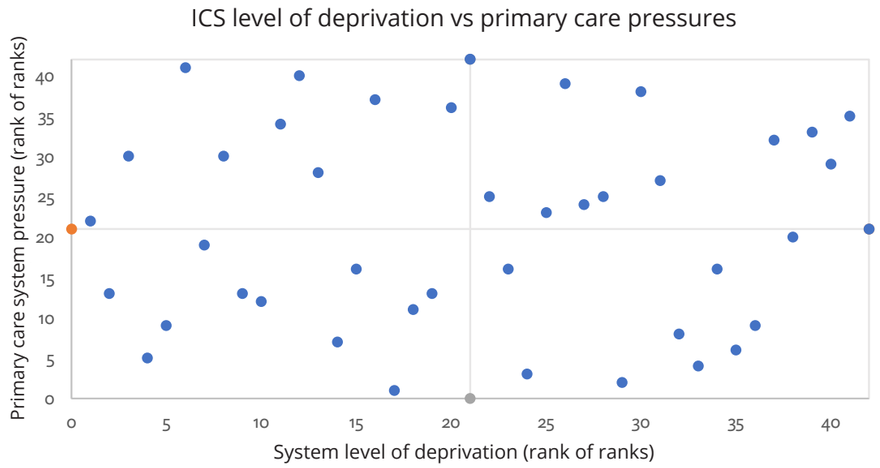
Birmingham and Solihull ICS has the highest percentage of neighbourhoods in the most deprived category, 49%. The only other ICS with similar levels of deprivation is also in the West Midlands, Black Country ICS has 46% of neighbourhoods in the most deprived category.

By contrast NHS Surrey Heartlands has only 1% of its neighbourhoods in the most deprived category. Such variation demonstrates the importance of the place level to understanding the different pressures systems are facing.

An analysis of levels of deprivation and system pressures in primary and secondary care, reveals no correlation but a set of systems that have higher levels of deprivation and higher relative pressures.

24 https://www.health.org.uk/publications/long-reads/integrated-care-systems-what-do-they-look-like

Figure 10: ICS level of deprivation compared with relative primary care pressures

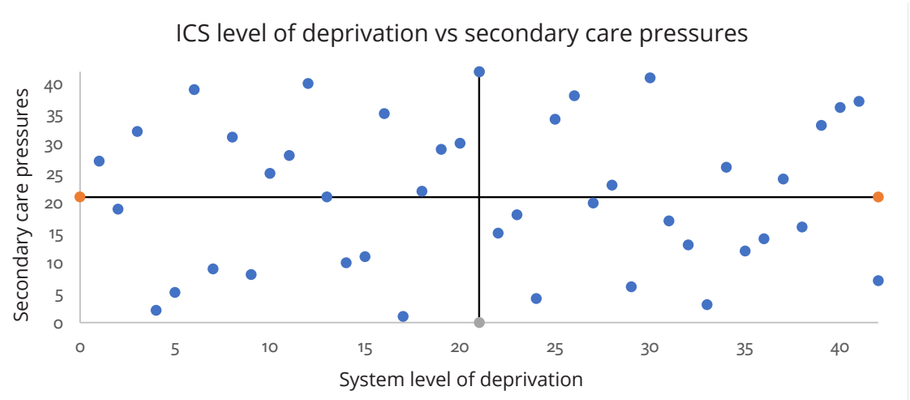


The above chart maps the level of ICS deprivation (classified as the % of neighbourhoods recorded as most deprived) against primary care system pressures.

On this comparison there are a set of systems with higher levels of deprivation who also face higher relative primary care pressures. These are:

- Cumbria and North East
- East London
- Derbyshire
- Kent and Medway
- Lincolnshire
- Norfolk
- Nottingham
- South East London
- South Yorkshire and Bassetlaw
- The Black Country
- West Yorkshire

Figure 11: ICS level of deprivation compared with relative secondary care pressures



Looking at levels of deprivation and relative secondary care pressures there are a number of systems with higher levels of deprivation that face higher relative secondary care pressure, these are:

- Cumbria and North East
- Humber, Coast and Vale
- Derbyshire
- Kent and Medway
- Nottingham
- South East London
- South Yorkshire and Bassetlaw
- Black Country
- West Yorkshire

There are seven systems that appear in both lists – recording higher relative levels of deprivation alongside relatively high levels of primary and secondary care system pressures.

Given the likely higher population health needs of these systems, consideration from national bodies should be given to whether they will require additional resource and support to meet the pressure they face.

Within ICSs the level of variation in deprivation and population health need, will need to be both acknowledged and understood. A one size fits all approach to system planning and delivery will not work effectively, and a detailed place-level analysis that understands the different needs of populations is essential. Critical

to this will be a thorough analysis of population health data across primary, secondary and social care. Alongside developing this insight, ICSs will need to build engagement models that empower places and neighbourhoods to lead on localised approaches that will be best suited to improving health outcomes.

Summary

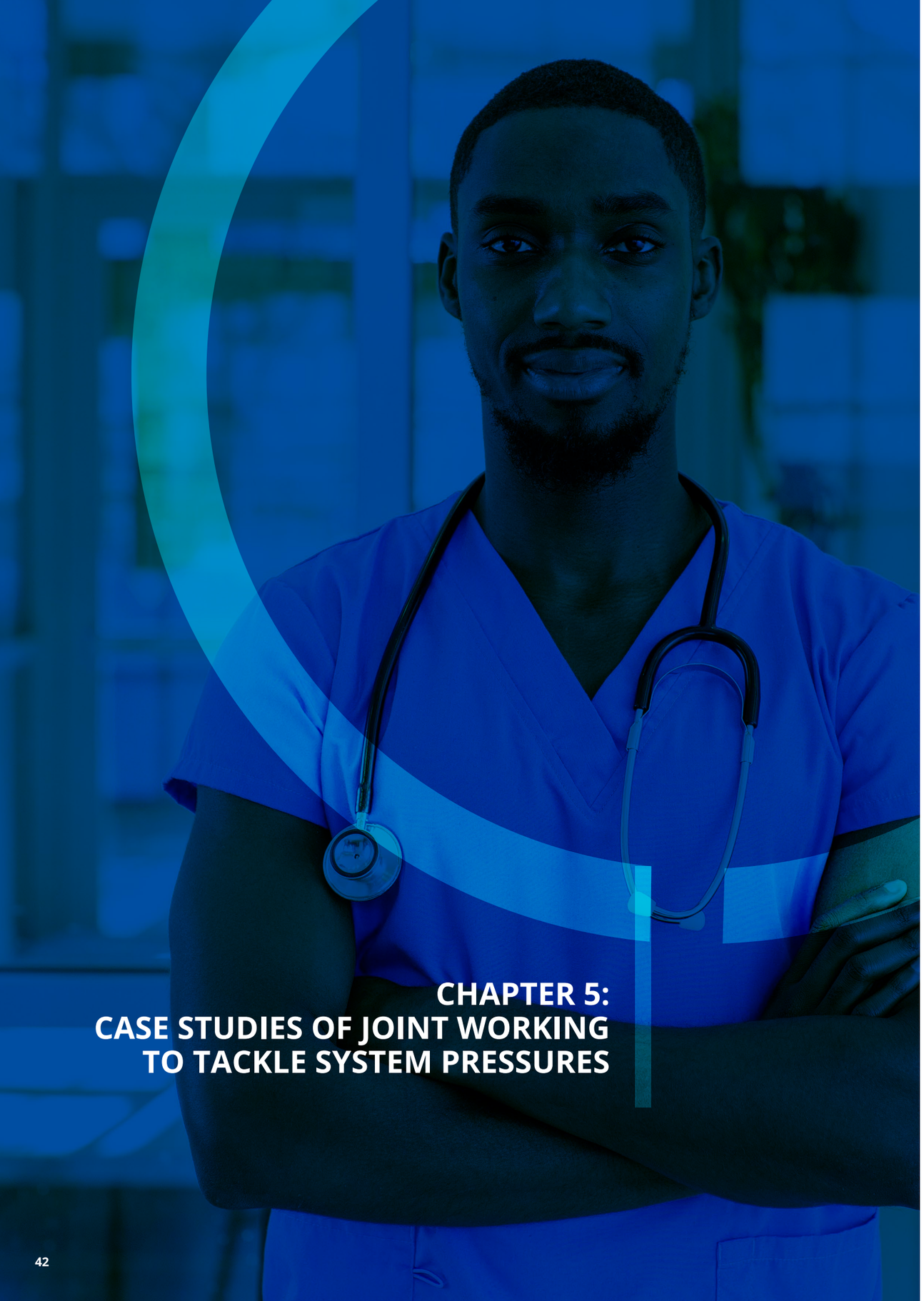
The analysis indicates that at a system level there may well be links between pressures in primary and secondary care in the new ICSs.

Across the 42 systems, 32 (76%) find themselves either categorised as having either high primary and secondary care relative pressure or low primary and secondary care pressures. Only a small number of systems find themselves in a more mixed set of circumstances.

A closer look at specific variables across primary and secondary care however is inconclusive. There is little evidence of higher population health need affecting waiting times for treatment, pressures in primary care forcing up A&E waits and long primary waits being replicated in secondary care. This challenges narratives that an inability to see a GP affects A&E performance and highlights that the situation is more complex.

Some systems under high relative pressure are also serving populations with relatively higher rates of deprivation. Whilst it is not possible in this analysis to determine the impact of this, it does raise questions about whether certain systems will require greater investment to take into account their population health needs.

The level of variation at neighbourhood level in deprivation and population health re-iterates the need for ICSs to develop place level insights and to work with and to empower local health leaders to improve population health outcomes.



CHAPTER 5: CASE STUDIES OF JOINT WORKING TO TACKLE SYSTEM PRESSURES

As part of the project research Future Health interviewed a small number of health system project leaders and managers about their work and experience of delivering more integrated primary and secondary care in the new health structures.

Case study sites were selected based on:

- The classification of the system within the data analysis – geographic areas with lower primary care pressure were selected as it was felt important to see what learnings or actions these areas had taken that may have contributed to deliver these results
- A literature search of current case study examples in these geographic areas
- A representative geographic sample of systems
- Coverage of a selection of important issues for collaboration:
    - Waiting list management
    - Workforce deployment
    - New models of care
    - Utilisation of data to support improved population health

Primary and secondary care waiting list management – University Hospitals of Coventry and Warwickshire NHS Trust[25]

The University Hospitals of Coventry and Warwickshire NHS Trust has built a shared patient tracking list. The idea was given new momentum following the experience of collaboration during the pandemic.

The approach is not only about sharing capacity but about effective prioritisation. Patients are still treated in order of clinical priority but within the waiting list categories there are opportunities to look at the potential outcomes for patients rather than prioritising simply by when they were referred.

The Trust is working with primary care to identify those with wider health needs, such as those with comorbidities or whose employment might be affected by waiting for treatment. An ethics board is used to take decisions on treatment priority based on this data and information.

Data is also being used to identify people who may need treatment but have not come forward. Vaccination sessions are also being used to spot early signs of cancers or cardiovascular disease by adopting a prevention and healthy lifestyle tool the trust has developed.

25 https://www.nhsconfed.org/case-studies/tackling-long-waiting-lists-and-health-inequalities-coventry-and-warwickshire

Workforce deployment – Primary care dieticians supporting older people in North Yorkshire[26]

Within the Vale of York there was the recognition that community services and primary care could work closer together to benefit patients and improve the offer of care closer to home. The head of community services at York and Scarborough Teaching Hospitals NHS Foundation Trust and the clinical director of Selby Town PCN worked together to jointly host a dietician role within the PCN, taking the service closer to the patient.

Historically, if a resident in a care home was beginning to lose weight, the care home would arrange an appointment with the GP, who would then refer to the dietetic service. Due to the referral process and the availability of clinics, it could take as long as three to four weeks to get the intervention, during which time the patient could potentially be deteriorating.

The Trust utilised funding from the Ageing Well programme to offer a dietician on a six-month secondment to the PCN. This was felt to be both long enough to deliver positive change, whilst also enabling a focused timeframe in which to deliver tangible results.

The dietician was based in the local medical practice at Selby, but made efforts to build wider relationships within and across the PCN using visits and posts on message boards to raise awareness of the role.

The dietician provided regular catch-up opportunities where staff could bring patients to review their nutrition. They also worked closely with other staff such as frailty coordinators, who have regular contact with vulnerable patients and who may be subject to malnutrition.

There were challenges particularly in the restrictions imposed by the pandemic, and in collecting data on outcomes as the project moved beyond its original care home remit and into the wider community.

Through the project the PCN has learnt how to successfully integrate secondary care staff into primary care and for the dietician the programme has provided helpful insights into the primary care model and ways of working.

The project has improved patient outcomes due to the dietetics service being much more aligned to the needs of residents, saved £30,000 through stopping/reducing nutritional supplements in care homes and reduced administration time.

The programme has resulted in the PCN hiring a full-time permanent dietician and a neighbouring PCN has hired part time roles on the back of the results. Selby PCN is using the experience to evaluate more widely how it can successfully utilise other Allied Health Professional (AHP) roles in its delivery of care.

26 https://www.nhsconfed.org/case-studies/collaboration-between-primary-care-and-community-services-support-care-older-people

New models of care – Frimley NHS Foundation Trust Virtual Frailty Community Ward[27]

Frimley's project lead, Dr Lucy Abbott, heard about the Hospital at Home models that had been set up in Scotland and Oxford at industry conferences. During the winter of 2020 all the directorates in the Trust were given a challenge to see how they could reduce emergency admission and boost out of hospital care. Winter pressures funding was available for this.

The bid was successful as it came from a credible team in the Trust focused on frailty supported by good data on delayed transfers of care.

The project was delayed due to COVID but a three-month funding pilot delivered strong outcomes. These were helpful in then aligning the work to the rollout of NHS England's Ageing Well Strategy linked to the NHS Long Term Plan.

Frimley added intermediate care therapists to its hospital at home team to provide the urgent and community response element of the NHS England programme. The team take referrals from GPs, specialist community nurses, NHS 111, 999, and for patients being stepped down from acute hospital care. Instead of being sent an ambulance or being asked to attend hospital or a GP surgery, patients can be seen in their own homes by the Urgent Community Response (UCR) team within two hours of referral.

Frimley is perhaps fortunate as its acute and community services are well integrated and it had an existing Hospital at Home model to build from. Implementing a model such as this from scratch would not be as straightforward for other systems.

Frimley's consultant geriatrician is the medical lead for patients and can refer patients for scans and help co-ordinate their care. The availability of point of care testing also helps improve the diagnosis and flow of patients through the system. A pharmacist in the community frailty team can support medication dispensing and reviews.

The move into the new system structures does pose some challenges, particularly in co-ordinating actions across PCNs and social care. This is still a work in progress as the new structures bed in and against a backdrop of rising pressures.

27 https://www.fhft.nhs.uk/news/hospital-home-expands-its-service/

New models of care – Mental health – Hampshire, Southampton and Isle of Wight Integrated Care Board[28]

Hampshire and the Isle of Wight recognised the challenge of people accessing mental health support during a crisis. Local data was analysed which showed that a third of ambulance call outs were due to mental health issues.

National policy documents had also been important for setting out the issues – such as the Mental Health Five Year Forward View and NHS Long Term Plan.

A business case was submitted that set out how improving mental health could help tackle problems in urgent care.

The Senior Programme Manager for Crisis Care, Sonya Mclean had relationships in urgent and emergency care and was able to bring the right people together to try and co-ordinate a more patient-centred service with a focus on using embedding mental health practitioners in NHS 111

There were challenges to breaking down organisational silos. Training parademics in mental health support and awareness was an important part of the programme and building relationships between different teams took time.

Data challenges, particularly on data sharing between organisations was another issue; particularly ensuring that nurses responding to incidents had access to care plans. Signing up each of the mental health systems in the area individually on an agreed set of parameters and governance enabled such sharing to take place. There were clear timelines and accountability structures set up and new updated job descriptions had to be written and agreed.

The programme operated a development, deploy and review model which saw services regularly reviewed and adapted based on feedback from staff and users.

It has reduced the number of people needing to be attend and/or transferred to A&E and reduced pressures on ambulance services. In 2020/21 there were 21,697 contacts, 87% of which were supported with home management/self-care; 1.9% needed an emergency ambulance response, 10% were asked to see their GP; 0.3% were recommended to attend A&E.

When the service first started, 69% of patients were referred to primary care, compared to 10% now. 999 mental health contacts have been reduced by 26% by embedding mental health nurses into NHS 111, seeing a movement in how people access mental health services across urgent and emergency care.

28 https://www.nhsconfed.org/case-studies/nhs-111-mental-health-triage-service

Utilisation of data to deliver improved population health – Bristol, North Somerset and Gloucestershire Integrated Health system – Heart Failure[29]

The heart failure project was developed as part of a national 22-week Population Health Management (PHM) Development Programme to help find and support groups at higher risk of developing heart failure and significant health inequalities.

The region has a long standing culture and practice of sharing data between health partner organisations as part of efforts to improve clinical outcomes and this was helpful in providing a platform for the project and bringing together different groups.

A linked data set was interrogated using a PHM approach to produce a report specifically identifying drivers of emergency admissions by clinical risk, multimorbidity and matrix segmentation for the PCNs.

The data used linked from general practice, acute, community, wider determinant and mental health services. It showed that the key attributes of people to focus on were:

- People within the highest deprivation quintile
- Obese with BMI =/>35
- Hypertensive
- Coded with depression and anxiety
- Aged between 40-69

A cohort of 102 people with these combined attributes that the data showed as being at higher risk of developing heart failure were selected. Patients were offered an appointment with a social prescriber to discuss their personal needs and onward referral to other services including weight management and exercise programmes, medication reviews and annual health checks, links to peer support and a Healthy Heart Group consultation.

The project has also helped build strong relationships between the ICS, PCN, social prescribers and the voluntary sector. It has also started to embed health inequalities within the actions of the system.

The ICS role in the programme was as a facilitator and supporter of delivering on shared objectives and harnessing resources effectively. The ICS utilises PHM to solve particular problems that are raised by those within the system – this 'bottom-up' led approach helps build effective partnership working across the ICS and PCNs.

29 https://www.england.nhs.uk/wp-content/uploads/2022/07/B1779-Actionable-Insights-Tackling-inequalities-in-healthcare-access-experience-and-outcomes-guidance-July-202.pdf

The team noted that it is important that PHM programmes do not become 'top-down' and about pushing problems out into primary care – even if that is the best place to solve them. Instead PHM should be used to support PCNs with their challenges and the solutions and approaches developed be co-produced and co-owned.

Two of the other important project learnings were to take an iterative approach and continue to mould and update the programme as it develops; and the need next time to undertake proper co-production for the development of the project. This co-production with communities is being built into the next phase of the work.

Summary of case study learnings

The following sets out the main learnings from the case study sites about what works effectively:

- The programmes were put in place to focus on a clear problem or issue
- Past collaboration or joint working helped provide a platform for change
- A strong team or project manager led the work and was empowered to do so
- Iterative approaches and project builds that gathered regular feedback
- Work scopes were enabled to be changed as projects developed
- National policy was helpful in providing direction and objectives. It also provided funding for pilot schemes
- Data sharing challenges are a persistent problem, but are not insurmountable
- Co-production with patients and the public should not be overlooked

CHAPTER 6: LOOKING AHEAD: ACTION TO TACKLE SYSTEM PRESSURES

ICSs face a series of pressures as they begin operations. This winter looks particularly challenging and the medium-term recovery from the pandemic will be very difficult.

As this analysis shows however pressures are not uniform. A set of 16 systems appear to be under relatively higher levels of both primary and secondary care pressure. Tackling such pressure will involve a range of actions:

- Understanding demand and co-ordinating responses across both primary care and secondary care
- Developing an integrated data strategy that can support system wide responses to the challenges
- Supporting the workforce and retaining staff
- Sharing resource and expertise across different organisations
- Ensuring funding is aligned to health needs and that it supports ambitions for more integrated and patient centred care
- Using capital investment to transform services and deliver more preventative and community care
- An updated regulatory approach that supports the new working arrangements and ensures effective accountability

The establishment of new systems does provide an opportunity to bring together different parts of the healthcare system to work together in new ways and in particular building on some of the learnings and partnership seen during the response to COVID-19. To be successful and overcome the pressures they face, system leaders will need to create a strong role and voice for primary care in their operation - and it was encouraging that all ICS leaders signed up to the Fuller Stocktake recommendations[30].

The following sets out opportunities and recommendations to support closer primary care and ICS working.

New working relationships and practices – A new working relationship between Government and NHS England needs to be established and tackling service variation should be a central objective of joint efforts both this winter and longer term. To deliver this NHS England should ensure that Ministers and the Department of Health and Social Care have access to the most up to date and granular data on pressures in the system. A small team of data analysts should be employed in Ministerial private office with full access to the data and use it to brief Ministers weekly on current trends and challenges relating to health service pressures.

The move away from clinical commissioning groups (CCGs) presents new opportunities for primary and secondary care working and collaboration to support improvements in population health. It will be important, with the disbanding of CCGs, that such discussions ensure there is strong clinical input. The new way of working should encourage a more strategic conversation to take hold about how resources can be best deployed to serve local communities.

30 https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

But for this to work effectively there will need to be strong and consistent input from primary care into ICBs. A recent survey by the NHS Confederation found that just 12% of primary care leaders and managers surveyed felt they were always involved in discussions at a system level[31].

ICSs will need to put in place measures to ensure primary care has the necessary representation and influence to properly contribute. Alongside this there will need to be a focus on place-based partnerships with local leaders in their communities. This will vary across geographies, but will be best built with a 'bottom-up' approach and from what exists already (for example Health and Wellbeing Boards).

Nationally NHS England will also need a mechanism to hold systems to account on working relationships and proper primary care/ICS participation. Currently the oversight mechanism for NHS England with ICSs is the NHS Oversight Framework (OF).

This includes two metrics on system leadership based on the Staff Survey and the CQC Well Led Framework. But these are heavily leant towards secondary care. The next version of the OF should ensure that feedback from primary care is properly included in this assessment element of the ICS. Part of this could be addressed by properly extending the NHS staff survey into primary care or ensuring that primary care leader feedback is included within the next OF metrics refresh in 2023/24.

Tackling health inequalities through a new funding formula – Before the pandemic a series of reports highlighted the differences and widening gaps in health outcomes and life expectancy across the country[32].

The Government's 2019 manifesto included a welcome commitment to increase healthy life expectancy by five years by 2035. However progress against this target is well off track[33].

As this report shows there are a set of ICSs with higher levels of recorded deprivation that face pressures in both primary and secondary care.

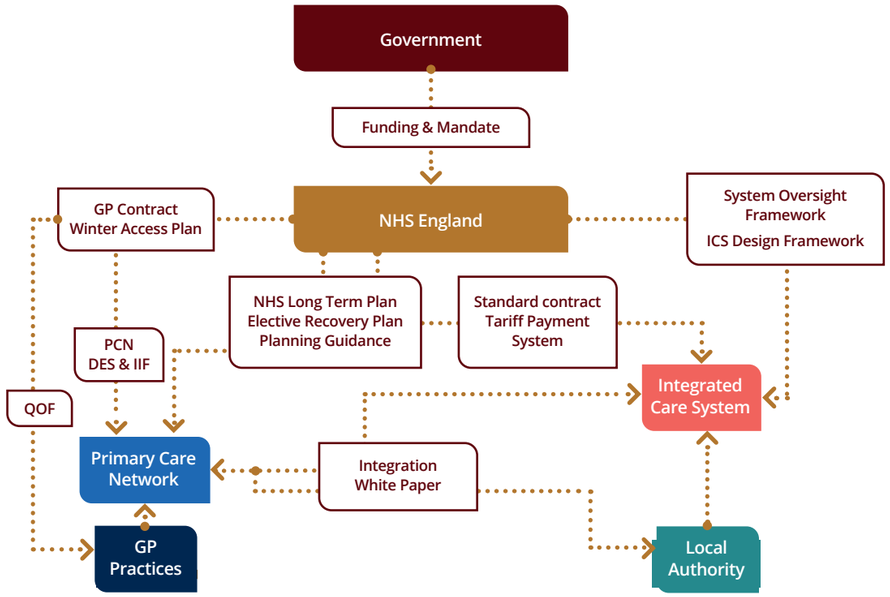
Currently the funding formula for general practice, known as Carr-Hill, does not take in account levels of deprivation. Given the differences in health outcomes between systems and as part of the next GP contract negotiations the formula should be reviewed. With the 2019 NHS Long Term Plan setting out a path for increasing levels of overall NHS investment in primary care, a change to the formula would manage the political difficulty of some areas potentially seeing reduced expenditure at the expense of others[34]. This change to the funding formula could also be informed by the Office for Health Improvement and Disparities Chime tool which maps the impact of COVID-19 on different communities[35].

31 https://www.nhsconfed.org/sites/default/files/2021-05/The-role-of-primary-care-in-integrated-care-systems_FNL.pdf
32 https://alumni.health.org.uk/publications/reports/the-marmot-review-10-years-on
33 https://www.health.org.uk/news-and-comment/charts-and-infographics/healthy-life-expectancy-target-the-scale-of-the-challenge#:~:text=Previously%20published%20Health%20Foundation%20analysis,%E2%80%9311%20and%202015%E2%80%9317.
34 https://www.longtermplan.nhs.uk/
35 https://analytics.phe.gov.uk/apps/chime/

Against the backdrop of a refreshed Long-Term Plan and informed by data on health inequalities investment in primary care would rise in all areas, but at faster rates in areas with higher levels of deprivation.

Fixing financial flows to deliver more integrated working – One of the main long standing barriers to integrating care is that the different contracts and funding flows across the NHS encourage single organisational and silo-ed behaviour. The below seeks to summarise some of the different financial flows, major policies and organisational working arrangements across primary and secondary care in the new system.

Figure 12: Mapping key policy levers around PCNs and ICSs



The emergence of PCNs has seen the landscape become more complex with the Primary Care Network Direct Enhanced Service aimed at supporting PCN development and associated funding, including the Investment and Impact Fund[36].

Many of these frameworks and contracts are designed for a different era of care – one that is more episodic and transactional. The Government and NHS England should conduct a review of primary and secondary care funding flows with an objective of supporting more integrated care and resource sharing. This could be aligned with changes to the funding formula proposal (see above) and could be expanded to include joint funding for health and social care (such as the Better Care Fund).

36 https://www.england.nhs.uk/primary-care/primary-care-networks/network-contract-des/

Supporting and expanding the primary care workforce – The Government will not meet its target of increasing the number of GPs by 6,000 by the next election. The RCGP has warned that 19,000 GPs may quit in the next five years[37] and experts have projected shortfalls based on current policy of close to 1 in 4 GPs and general practice nurse posts by 2030/31[38].

One of the reasons for GPs retiring or leaving the service is due to punitive pension tax rules that see them exceeding their annual and lifetime allowances and then receiving large tax bills[39]. This is disincentivising additional work and reducing length of service. The Government should urgently bring forward a pension reform package to address this, and support improvements in GP retention.

The Additional Roles Reimbursement Scheme (ARRS) has been created to support PCNs with 26,000 additional roles to create multi-disciplinary teams. These roles include pharmacists, social prescribers and care co-ordinators. However, recruitment for some roles and in some regions has been difficult and progress against the target slower than hoped[40].

Some of the feedback has been that the system is too inflexible on the types of roles that local systems can bring in. There has also been research showing that integrating ARRS roles requires leadership, organisational and cultural skills which are not easily accessible to PCNs[41]. In addition many ARRS staff are on fixed term contracts and certainty is needed beyond 2024 to retain them.

NHS England should continue efforts to make the ARRS as flexible as possible so that local areas can fill the roles they need. Government and NHS England should as soon as possible set out longer term support for these roles which can play an important part in co-ordinating and joining up care across the system. For ICSs there should be opportunities to work with primary care to share resource and learnings that can support the effective training and integration of ARRS roles in primary care in their areas. The creation of a dedicated management allowance for PCNs, as was the case for CCGs could also be helpful in supporting the development of networks.

Capital investment and service re-design – The major focus for the Government's capital spending set out in the Health Infrastructure Plan and the New Hospital Building programme has been on secondary care[42]. The Spending Review confirmed a three-year capital spending settlement for the Department of Health and Social Care, split between:

- Nationally allocated funds – for strategic projects such as new hospitals and hospital upgrades
- Other national allocations – for national programmes such as elective recovery, diagnostics and technology funding
- System level allocations – £4.1bn for integrated care systems, including from 2022/23 £0.1bn of capital for investment in primary care estates and IT

37 https://www.gponline.com/rcgp-warns-19000-gps-quit-mass-exodus-next-five-years/article/1790632
38 https://www.health.org.uk/publications/reports/projections-general-practice-workforce-in-england
39 https://www.gponline.com/gps-face-pension-tax-penalties-worth-half-post-tax-income/article/1791333
40 https://www.gponline.com/multi-billion-pound-pcn-recruitment-scheme-fails-meet-halfway-target/article/1740916
41 https://www.kingsfund.org.uk/publications/integrating-additional-roles-into-primary-care-networks
42 https://www.gov.uk/government/publications/health-infrastructure-plan

However the scale of investment comes against a rising backlog maintenance bill of £9.2bn[43].

NHS England's capital guidance to 2025 does include £100m in 2022/23 for primary care estates and IT capital within ICS capital spending. A floor has been placed on primary capital spending from this year through to 2024/25. This is welcome particularly given the pressures on the NHS budget and concern that the NHS pay uplift will be paid for with reductions in diagnostics and capital spend. However even if protected, rising inflation means that the value of this spending is diminished. A survey this summer for the NHS Confederation found that:

- 9 in 10 NHS leaders say their efforts to reduce the size of the waiting list are being hindered by a decade long lack of investment in buildings and estate
- Two thirds say they do not have enough capital funding to meet 'digital ambitions' including rolling out electronic patient records
- 9 in 10 say they cannot transform patient services to meet current NHS England Long Term Plan targets without further capital[44]

The NHS Long Term Plan set out a trajectory for service change and transformation over ten years. But without a proper capital investment plan to support it many of the changes will not be realised. Policy Exchange has put forward a proposal for a Community Health Infrastructure Fund, with budgets unlocked from the unused cash reserves of specialised services to support the transformation of the primary care estate.

With funding under pressure, such a re-allocation of funds may be necessary to ensure that primary care can support the patient centred approach set out in the Fuller stocktake and work with ICSs on new community-based pathways of care[45]. As ICSs mature Government should build a new model and approach to NHS capital investment that seeks to devolve more power and responsibilities to the system level.

Improving data flows – One of the recurring themes in the case studies and in delivering more integrated services is the challenge of data sharing and data flows across systems. Updated guidance and support from the NHS Transformation Unit would be helpful, particularly learning from the experience, governance and ways of working during the pandemic. There also needs to be greater enforcement of compliance with standards of data sharing and action against suppliers who do not fulfil their obligations.

43 https://www.ft.com/content/cf0e5a70-d2e2-4e3c-a1cd-04817eeb1e3f
44 https://www.nhsconfed.org/news/lack-capital-funding-risking-patient-safety-and-impeding-waiting-list-recovery-new-poll-nhs
45 https://policyexchange.org.uk/publication/health-and-social-care-what-do-we-want-from-the-next-prime-minister/

Government and NHS England should be focusing data and technology resource on supporting systems in sharing information easily and quickly and making processes easier for doing so. A Health Data Infrastructure Accelerator that ICSs can draw on to adopt the best technologies and processes quickly and easily would be a helpful mechanism for doing this. Existing health technology funding as set out in the Unified Tech Fund should be rationalised and focused to deliver this[46].

ICSs will all be starting from different points on their data and digital journey. National organisations should support ICSs in them each developing a single data strategy that incorporates primary, secondary and social care data which will be critical to delivering integrated and preventative care. This will require clear data governance and security alongside accountability for sharing data in a timely manner.

Smarter regulation and oversight – Traditionally the Care Quality Commission (CQC) has regulated the healthcare system on an organisation by organisation basis.

With the move to system working and following an amendment to the Health and Social Care Act work is underway to effectively regulate ICSs[47]. The CQC's new single assessment framework is based around the organisation's established five quality statements (safe, effective, caring, responsive, well-led) and six evidence categories (people's experience, feedback from staff and leaders, feedback from partners, observation, processes, outcomes)[48].

As the new assessment process is applied it will be important that it supports cross system working and learning. For their part ICSs will need to acknowledge that individual organisational performance is affected by the wider system and vice-versa; and they will need to bring different organisations together to collaborate around the needs of patients.

For the CQC rolling out its new framework effectively will require transparent and wide-ranging engagement with patients, staff and system leaders. A set of recent pilots focused on Urgent and Emergency Care included an encouraging level of primary care representation in the evidence gathering which should be the model approach for the process moving ahead[49]. PCN leaders need to be properly engaged in the future operating model.

46 https://transform.england.nhs.uk/digitise-connect-transform/unified-tech-fund/unified-tech-fund-prospectus/
47 https://www.cqc.org.uk/news/stories/statement-dr-rosie-benneyworth-government%E2%80%99s-amendment-health-care-bill
48 https://www.cqc.org.uk/about-us/how-we-will-regulate/evidence-categories
49 https://www.cqc.org.uk/what-we-do/services-we-regulate/urgent-emergency-care-system-wide-inspections

Conclusion

ICSs begin their formal operation at a time of immense challenge. But these new systems are not all starting from the same place. Whilst undoubtedly a lot of the issues they face are similar (e.g. workforce shortages, a lack of capital investment), this research indicates that the pressures they face are not.

The Fuller Stocktake set out a vision for how primary care can work in collaboration with ICSs to deliver more joined up and integrated care that supports efforts at NHS recovery. The case studies in this report show systems that are putting in place new models of care, population health management systems and collaborative working models to improve the way healthcare is delivered and tackle the primary and secondary care pressures they face.

The King's Fund in its literature review alongside the publication of the Fuller Stocktake identified a set of principles for change in primary care. These were:

- Changes work best when they are driven bottom up
- Financial incentives can distort priorities
- Culture is critical
- People need capacity and capability to make change happen[50]

The recommendations in this report seek to get Government and national NHS leaders to deliver on these principles, providing the enablers for change, whether they are workforce actions, targeted capital investment, better oversight metrics or fixing system funding flows and investing more in deprived communities.

During the COVID-19 vaccination programme and in the response to long waits in the early 2000s the NHS has demonstrated that with the right focus, collaboration and resource it can deliver.

Now is the time for Government and NHS England to support ICSs and PCNs in their efforts to deliver the pandemic healthcare recovery that is needed.

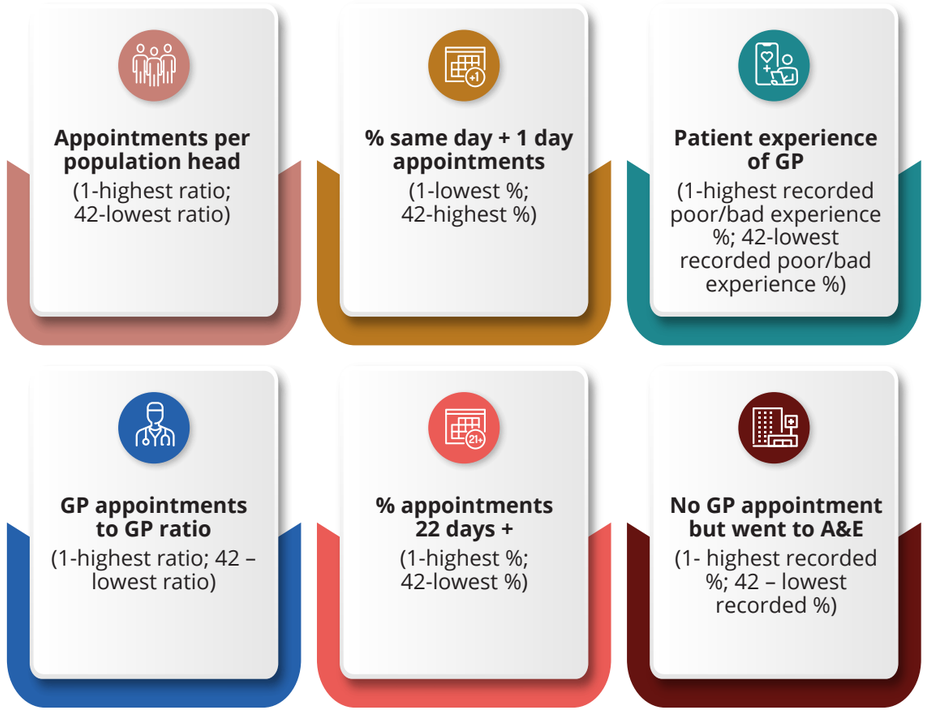
50 https://healthcareleadernews.com/insight-and-analysis/how-will-icss-steer-change-in-general-practice/?utm_content=bufferba314&utm_medium=social&utm_source=twitter&utm_campaign=hcl%2520social

Annex A: Methodology and data sources

Future Health analysed core NHS data on primary care pressures. This was undertaken in July 2022 and included the following:

- NHS primary care workforce data: https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/31-march-2022
- NHS primary care appointments data: https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/may-2022
- GP patient survey data: https://www.gp-patient.co.uk/

Future Health then built an assessment of relative primary care pressures between systems by ranking each ICS 1-42 (1- most pressure, 42- least pressure) on a set of six metrics set out below:



This led each system to be given a 'rank of ranks' score.

For secondary care three established metrics were selected to assess relative pressures:

- Patients waiting 4 hours or less in A&E
- Percentage of patients waiting 18 weeks or less from RTT
- Percentage of patients waiting 52 weeks or more from RTT

Sourced from: A&E waiting times data: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

RTT data: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

In addition, clearance activity times were calculated at system level by dividing the waiting list size by weekly activity numbers. Systems were again ranked 1-42 (1- most pressure, 42- least pressure) to create a 'rank of ranks' for secondary care and to compare that with the 'rank of ranks' for primary care and to look for patterns and connections between the two.

To assess deprivation levels Future Health used the neighbourhood deprivation index created by the Health Foundation: https://www.health.org.uk/publications/long-reads/integrated-care-systems-what-do-they-look-like

> NOW IS THE TIME FOR GOVERNMENT AND NHS ENGLAND TO SUPPORT ICSs AND PCNs IN THEIR EFFORTS TO DELIVER THE PANDEMIC HEALTHCARE RECOVERY THAT IS NEEDED.

METHODOLOGY AND DATA SOURCES Looking ahead: Tackling system pressures

Methodological points to note:

- The creation of a 'rank of ranks' for both primary and secondary care pressures is aimed at ascertaining the 'relative pressures between systems' and to help identify systems with greater/lesser pressures
- We are not passing judgement on the performance of systems in the research, but rather saying that each system has slightly different challenges (albeit some of the underlying problems are the same; see chapter 6 for the recommendations for action) and start their life from different places
- Given this and the nature of the method employed it was deemed more appropriate to group systems into quintiles for presentation in the final report rather than list them in a 'rank of ranks' table; which could be mis-interpreted as a 'league table'
- Some of the data points selected are open to interpretation. For example is an area delivering more GP appointments within one day under less pressure? On our model the ability to see patients within this time frame is a sign of less pressure as more appointments are able to be scheduled. By comparison those with fewer appointments are classified as under more pressure due to being able to provide less appointments. However the situation is not straightforward and as highlighted in the report not all patients need same day or one day appointments and some patients with more planned care will be satisfied with appointments of 22 days or more. Population health needs differ making such comparison not straightforward
- The overarching purpose of the research is to highlight:
    - Systems that may have demand, access and experience challenges across primary and secondary care
    - The relationships between primary and secondary care pressures
    - The complexities and challenges of assessing systems on a set of oversight metrics
- We hope that our research approach provides useful insights on these elements, as well as enabling constructive debate on the best route forward
- It is of course possible to select a different set of metrics and different timeframe and uncover different results. It is worth also noting that some of the data-sets whilst all recent cover different timeframes which may also impact on the results

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