Hertfordshire and
West Essex Integrated
Care System

Hertfordshire and west Essex Integrated Care Board

Primary Care Strategic Delivery Plan

2023-2026

Working together
for a healthier future

Introduction

Primary Care includes general practice, community pharmacy, dental and optometry (eye health) services. These services provide the first point of contact in the healthcare system, acting as the front door of the NHS. General Practice has historically fulfilled a unique role, with patients (and often several generations of their families) developing close, trusting relationships, solidified over many years. We are now contending with spiralling demand on all healthcare services and regrettably many GP practices often feel unable to provide the responsive, personalised care that has been valued so highly over several decades.

At a time when everyone is working harder, under more pressure and often longer hours than ever before, it perhaps feels unreasonable to set out a strategy for transformation and change - yet more work. However there is good reason to do so - evidence suggests that attempting to simply expand the current model of primary care will not bridge the widening void between the needs of patients and service capacity. We firmly believe that it is possible to narrow this gap and to do so in a way that re-establishes fulfilling careers and enhances staff wellbeing.

Transformation change requires some upfront funding which is recognised nationally with the allocation of some service development fund for primary care. What the delivery signals is areas of priority for which we are seeking to align the primary care service development funds which will aim to deliver the ICB set strategic objectives and continuous improved experience and outcomes for our population. The delivery plan with the strategic priority areas are proposed to be the guiding principle for investment over the next 3 years.

Our Strategic Primary Care Delivery Plan supports a number of other key strategies across Hertfordshire and West Essex including the 10 year Integrated Care, Urgent and Emergency Care (UEC), People Plan, Quality Strategy and the ICS and Primary Care Digital Roadmap. The plan also encompasses the recommendations from the Fuller Stocktake Report and key requirements of the NHSE Recovering Access to General Practice plan. We have set out 3 key transformation objectives:

- Increase our focus on prevention: we must reduce people developing lifestyle diseases and experiencing exacerbations from long-term conditions
- Establish Integrated Neighbourhood Teams (INTs) across all of Hertfordshire and West Essex
- Simplify how patients with urgent health problems receive the right help

By focusing on these areas, we can better meet the needs of *all* service users for example by managing urgent health problems differently we can devote more capacity for people suffering with chronic long-term conditions or to ensure that carers' health and support needs are fully understood.

We are not starting from a blank page, there are many examples where exciting innovation has improved access and services for patients. We will continue to celebrate and share these important successes.

All local partners and stakeholders, including patients have been engaged in the development of this plan and we would like to express our sincerest thanks to everyone that contributed.

The ability to turn strategic objectives within the plan, into tangible changes of course hinges on the health and social care system moving forward in a new, truly integrated way of working. This plan supports primary care integrated further with our four Health Care Partnerships with primary care providers an equal partner in system planning and operational delivery through each place or across places.

As primary care leaders on the ICB Board, we will be doing everything we can to make these plans come to fruition and we ask the same of all our colleagues across Hertfordshire and West Essex – to play your part in creating a better health and care system for everyone.

Dr Prag Moodley - ICB Primary Medical Partner Lead for Primary Care Transformation
Dr Nicolas Small - ICB Primary Medical Partner Lead Primary Care Workforce
Dr Ian Perry - ICB Primary Medical Partner Lead for Primary Care Digital and Estates

Stakeholder engagement

We have sought views from local stakeholders, including patients as part of developing our strategy. These include the following:

General practice colleagues across Hertfordshire and west Essex	Patient/Public feedback via ICB website and engagement events across HWE	East and North Hertfordshire NHS Trust
West Herts Teaching Hospitals NHS Trust	Royal Free London NHS Foundation Trust	The Princess Alexandra Hospital NHS Trust
East of England Ambulance Service NHS Trust	Healthwatch – Essex & Hertfordshire	Essex Local Medical Committee
Bedfordshire and Hertfordshire Local Medical Committee	Public Health (Herts County Council and Essex County Council)	Essex Partnership University Hospital NHS Trust
Hertfordshire Community NHS Trust	Community Pharmacy Essex, Community Pharmacy Hertfordshire - and contractors	Hertfordshire County Council, Essex County Council
Hertfordshire Partnership University NHS Foundation Trust	HUC	Central London Community Healthcare NHS Trust
Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations	Hertfordshire Local Optical Committee, Essex Local Optical Committee	Local Dental Committees and contractors

Primary Care Services – Hertfordshire and West Essex

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

1.6 million people

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

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

2 county councils and 13 district/borough councils

4 mental health and community providers

3 acute providers

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

130 GP practices; 35 Primary Care Networks (PCNs)

276 community pharmacies

225 opticians

243 dental practices

Our integrated care board (ICB) is one of two key components of the Hertfordshire and West Essex Integrated Care System (ICS).

- The ICB is the local NHS organisation that plans and oversees how NHS money is spent and makes sure health services work well and are of high quality.
- The second is the integrated care partnership (ICP). They work closely together. Overall it is designed to improve the general health and wellbeing of residents, tackle the inequalities which affect people's physical and mental health, get the most out of local health and care services and make sure that they are good value for money and help the NHS to support social and economic development in west Essex and Hertfordshire.

Hertfordshire and West Essex Integrated Care System

Alignment with local strategies / key priorities

The Primary Care Strategic Delivery Plan aligns with local strategies including:

Delivery of the six strategic priorities from **the 10 year Herts and west Essex Integrated Care Strategy,** these are:

- Give every child the best start in life
- Support our communities and places to be healthy and sustainable
- Support our residents to maintain healthy lifestyles
- Enable our residents to age well and support people living with dementia
- Improve support to people living with life-long conditions, long term health conditions, physical disabilities, and their families
- Improve our residents' mental health and outcomes for those with learning disabilities and autism

The **Hertfordshire & West Essex Integrated Care Board (HWEICB) Primary Care Digital strategy** noting the importance that digital and technology plays in supporting the key objectives outlined in the primary care strategic plan, such as the establishment of a single fully joined up, interoperable landscape of local platforms, remote monitoring of patients where appropriate, use of the NHS App, supporting digitally excluded patients by utilising Voluntary, Community, Faith & Social Enterprise (VCFSE) and advance telephony.

The Urgent & Emergency Care (UEC) strategy (supporting the key stated objectives such as reducing demand for UEC, reducing ED attendances, reducing emergency admissions and supporting safe and effective discharge through taking a Population Health Management approach in INTs and improving same day access in primary care, and developing the role of social prescribing link workers)

The **Hertfordshire & west Essex Strategic Framework- 2022-2027 -** this strategy aligns to the Framework mission of '*Better, healthier and longer lives for all'*

Some of the key outcomes that will be delivered from the strategy include improved staff morale, improved recruitment and retention of staff – all of these align with the **Hertfordshire and west Essex Integrated Care Systems (HWEICS) People Strategy 2023-2025.**

Supporting the key **mental health priorities** such as new model development, access, integration with primary care, and early intervention with children and young people.

The strategy supports the **HWEICS Quality Strategy** – planning and delivering the best possible joined-up and high-quality and safe services which promote equal access, positive experiences and good clinical outcomes.

This strategy also aligns and **supports delivery of key children and young people (CYP) priorities** including areas of focus such as community paediatrics and neurodiversity, diabetes & epilepsy, asthma transformation and co-production and engagement.

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

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

Empower patients to manage their own health including using the NHS App, self referral pathways and through more services offered from community pharmacy – launch of the pharmacy first scheme via national contract; create options to enhance access to digital tool but also reducing digital exclusion through integrating with the community and VCFSE.

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

Build capacity – develop primary care workforce.

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

Changing to training, recruitment, retention and opportunities of skill mix

National Long term Workforce Plan 2023.

Cut bureaucracy

Reducing the workload across the interface between primary and secondary care such as how we can use digital technology for prescriptions, increase self referrals for a range of services; onward referral from specialists and maximising the use of shared care records to obtain the relevant information to support triage.

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

HWEICB Primary Care Transformation objectives

The Delivery Plan has 3 key transformation objectives; **proactive management to support routine and complex care through establishment of Integrated Neighbourhood Teams (INTs), simplifying and enhancing access for urgent primary health needs** and **continued focus on prevention and health inequalities - helping people to stay well for longer. At all times the patient/citizen is at the centre of care**.

Prevention and Health Inequalities

Proactive Care – A person-centred, team-based approach to Chronic Disease Management and Complex care through Establishment of Integrated Neighbourhood Teams

Simplifying & Enhancing Access For Urgent Primary Health Needs

Key enabling workstreams

Patient empowerment and education and communications

Workforce – clinical and non-clinical

Premises - one estate

Data, information and digital technology

Investment and Contractual levers

Improving outcomes, better care, integration of services, improving referral pathways and efficiency and cutting bureaucracy, reduce unwanted variation apply throughout the strategy

Prevention and Health Inequalities

Prevention and Health Inequalities

"Primary care has an essential role to play in preventing ill health and tackling health inequalities, working in partnership with all health and care including VCFSE partners to prevent ill health and manage long-term conditions" – Fuller Stocktake report (May 2022)

Primary Care providers have been pivotal to delivery of key aspects on prevention and inequality agenda. In collaboration with a range of health and care partners examples below are to be built to continue focus on delivery of primary/secondary and tertiary prevention

Population Health Management (PHM) – using data and intelligence to identify need at system/place/locality and network level with a view to reducing variation and reducing inequalities examples include work on migrants, veterans, traveller communities, diabetes in BAME communities, outreach support LD/SMI for healthchecks including vaccination

Enhanced Commissioning Framework (ECF) for General Practice – Commissioning consistent approach across all practices including case finding; Secondary prevention in CHD; disease staging and enhanced proactive management – carers register and carers health checks and also where appropriate to prevent tertiary conditions – e.g. Referring eligible patients to weight management

Continue to grow the personalised care approach – Through social prescriber/health & wellbeing coach, and care-coordinators. E.g. Prevention from an early age in Children and Young People – including working with local authority partners to promote access to healthy lifestyle and physical activity programmes, such as via Healthy Hubs. Opportunity through personal health budgets

Community pharmacy and Optometry - Supporting self-care, health promotion; role in prevention including smoking cessation; identifying conditions such as hypertension;

Secondary prevention - Cholesterol and blood pressure monitoring.

Access for minor eye conditions, secondary prevention through screening

Voluntary, Community, Faith and Social Enterprise (VCFSE) - Strengthen the role of the VCFSE sector in:

- prevention
- community resilience
- co-design and
- identify pockets of inequalities

e.g. investment in VCFSE to support delivery of blood pressure monitoring; reduce digital exclusions

Dental - Addressing the impact of social inequality for not only dental decay, but also tooth loss, oral cancer, oral health and on people's quality of life particularly in early years under 5. Joint work with both Public Health leads across HWE.

Given the ageing population, high quality oral health care and attention for all those living in care homes or requiring care in other domiciliary settings is a key priority to build on

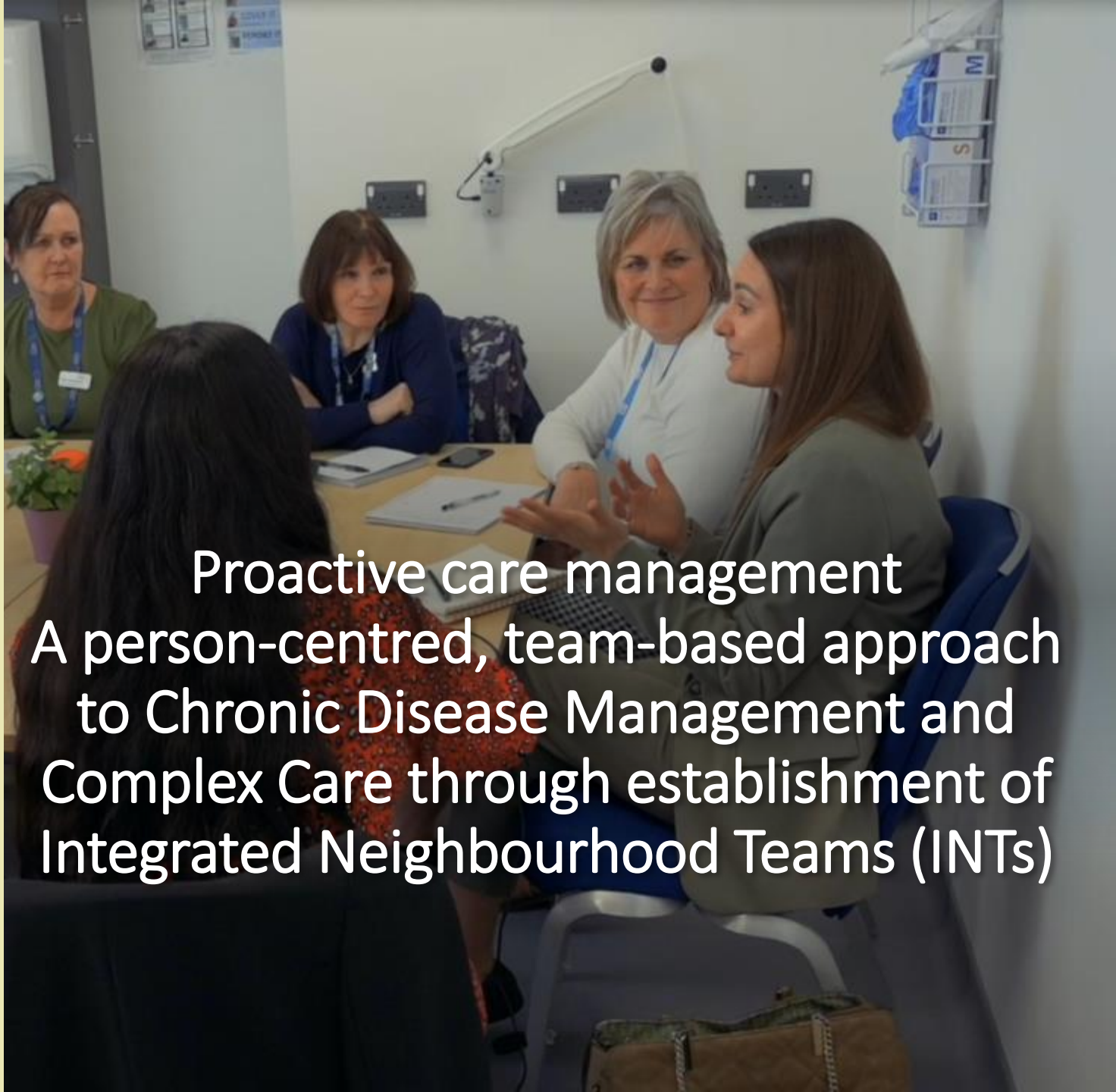
Priority two:
Integrated Neighbourhood Teams

Primary Care Network (PCN)

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

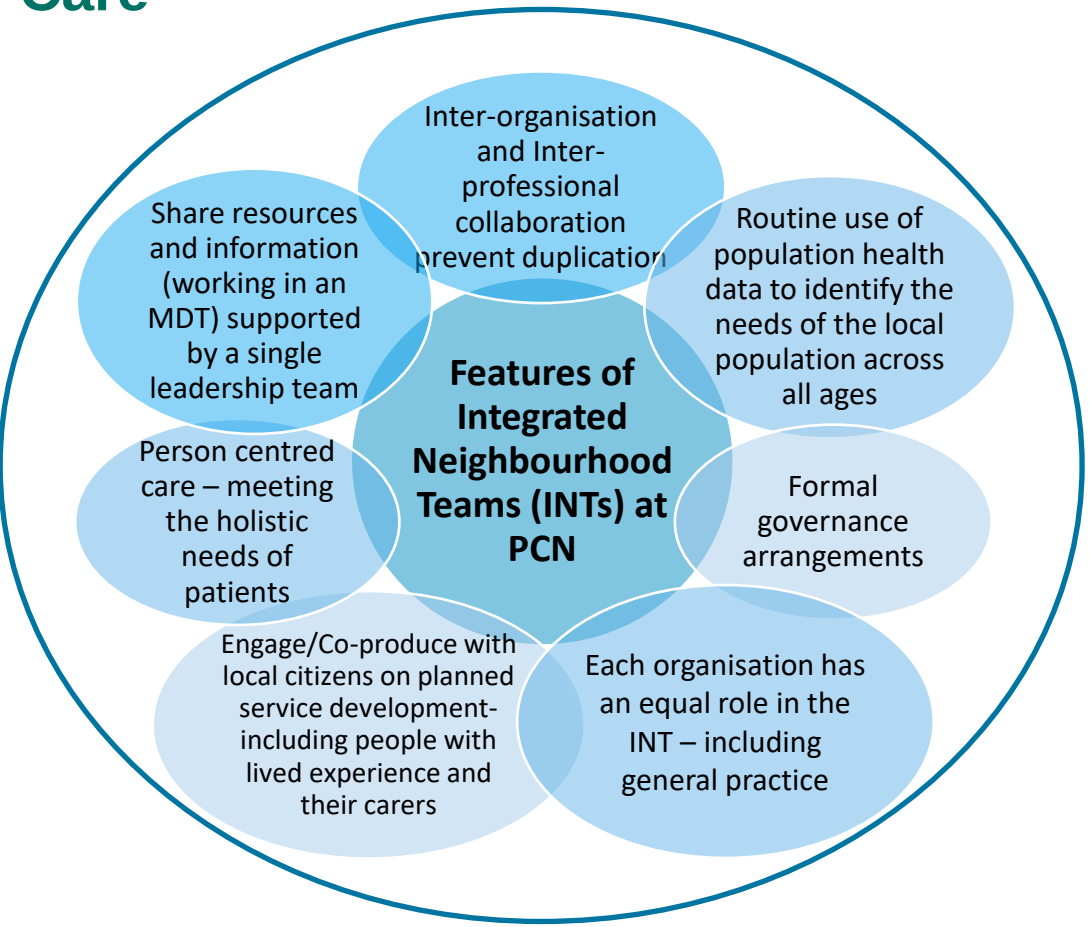
Patient supported by multi-disciplinary team delivering proactive case management

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



Proactive care management
A person-centred, team-based approach to Chronic Disease Management and Complex Care through establishment of Integrated Neighbourhood Teams (INTs)

Proactive Care Management - Establishment of Integrated Neighbourhood Teams (INTs) - a person-centred, team-based approach to Chronic Disease Management and Complex Care



Locality Leadership with PCN delivery of INT through collaboration in the Health and Care Partnerships

INTs core characteristics:

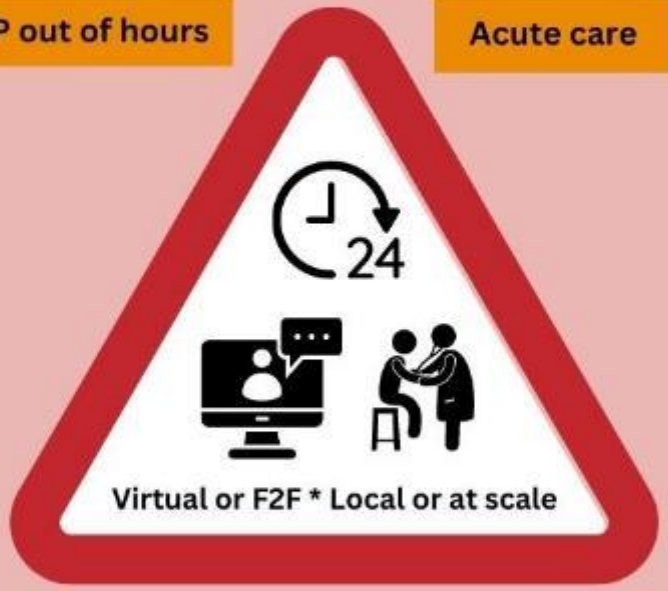
- INTs are the delivery vehicles at PCN level to have multidisciplinary approach for case management
- Supported through locality senior leadership from a range of partners who are able to create conditions to enable professionals to be released to develop the INT at PCN level with a common purpose/vision/goal
- Each INT will bring together a skilled workforce of professionals from across the health and care sector supported by a single leadership team to promote multi-disciplinary problem solving and utilisation of all available community assets to improve the outcomes and experience of the local population
- Clinical leadership – both GP and Community pharmacy key feature
- Priorities informed by Population Health Management (PHM) - start small and identify how the team will work best to create a shared vision for the identified cohort
- INT/Multi Disciplinary Team (MDT) to have a lead care – coordinator (Connector roles) (example using ARRS role flexibly where possible or additional resources through transformation) and deliver proactive care through MDT approach with a named lead professional
- The teams enable collaborative, flexible working with simple care pathways that prevent duplication
- Build from existing structures - not creating new
- INTs will record and monitor outcomes with oversight via the senior leadership through locality
- Membership from all local stakeholders
- Clear governance including Terms of reference; Memorandum of Understanding and Risk sharing agreements would enhance decision making and cross organisational working.

Integrated Neighbourhood Teams Vision Statement:

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

Priority three:
Simplifying and enhancing access for urgent primary health needs

- NHS 111
- Same Day Emergency Care
- Mental health crisis
- Community care
- GP out of hours
- Acute care



Timely access to:

Dental
Pharmacy
Optometry

Simplifying & Enhancing Access For Urgent Primary Health Needs

Simplifying & Enhancing Access For Urgent Primary Health Needs

The establishment of new access models for those (of all ages) who have an urgent primary healthcare need, led by a multidisciplinary team of colleagues will be key to ensuring the national direction of travel is implemented across Hertfordshire and West Essex (HWE). Enhancing and changing the model of access for urgent healthcare needs applies to all providers including; general practice, dental, pharmacy, optometry, community, acute, UTC, Integrated Urgent Care, mental health, community care – e.g rapid response/ virtual ward, social care, VCFSE and self referral.

Improving the pathway for those with urgent healthcare needs will free up capacity and time to see those who have routine healthcare needs.

Address variation through building on our existing **General Practices and Primary Care Network based service models** evolving across HWE

Facilitative support using QI methodology to support operational change at practice/PCN – national and local support

Test new models including telephony/e-consultation hubs; possible integration with NHS111/Community Care-coordination/enhanced care navigation/testing of AI in navigation and referral direction. Expansion of 111 service to include a greater range of clinical advice.

One of the key aspirations for the future of community pharmacy in HWE is that **Community Pharmacy is integrated into primary and community care, often being the first point of contact for patients, supporting better access** and improved outcomes for patients and the population for a range of minor conditions.

The ICB will capitalise on the skills within community pharmacy and how community pharmacy also develop and work in collaboration with others in the same area.

Dental in hours – analysis of urgent/same day demands versus provision to commission the appropriate capacity. Key is to ensure urgent access not at the detriment of routine/proactive dental care to create a balanced service provision

Dental out-of-hours – review dental out-of-hours services underway including data from NHS111 and A&E. Data not robust; however need to ensure a service is in place for winter to support ongoing future model of care across urgent care services.

The ICB will be reviewing urgent and emergency eye services over the coming 12 months, taking into account the pilot results from the Minor Eye Conditions Service (MECS) service to form new commissioning plans

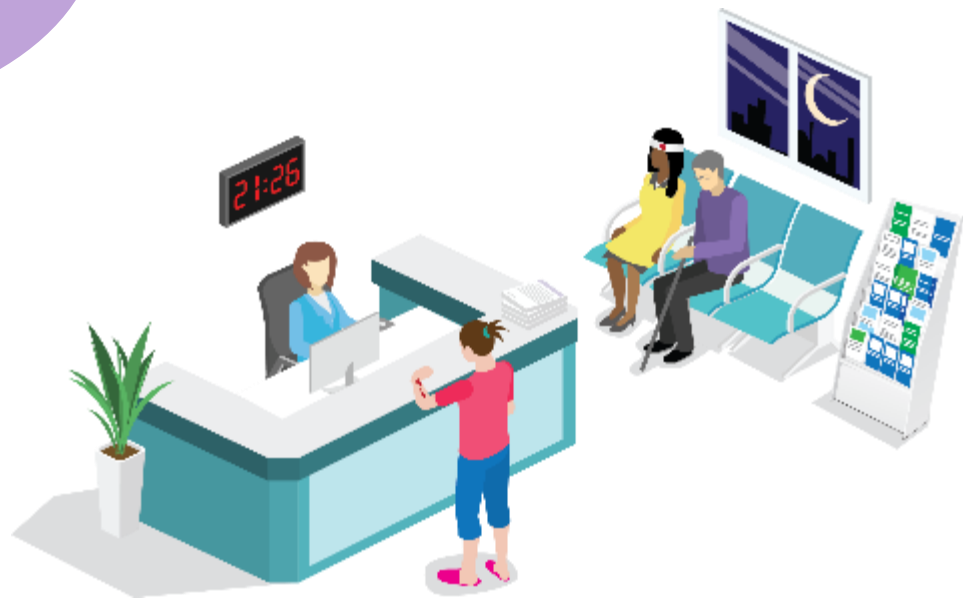
We will continue to work towards the implementation of Eyes-eRS to facilitate a direct referral pathway from **Community Optometrists** to Ophthalmology services to support on the day eye management.

Simplifying & Enhancing Access for Urgent Primary Health Needs: Defining Features

Features of Simplifying & Enhancing Access For Urgent Primary Health Needs

- Increased use of non-medical healthcare professionals, non-registered workers and voluntary sector
- Patient empowerment / education and coproduction (Self care/self referrals)
- Access is needs-led and the assessment of need is holistic
- Access is non-discriminatory and takes into account the needs of all service users
- System is easy to navigate for patients; *consolidate points of access; safe redirection from Emergency Department (ED); enhance use of digital and automation (AI)*

Case study: The following video showcases the urgent on the day service that Stort Valley and Villages PCN have implemented and how this is supporting both patients and staff:
Click here to see the Stort Valley and Villages Urgent on the Day Service video



Key transformation objectives – timelines

Key transformation objectives – timelines – 2023-2026

Prevention and Health Inequalities

Year 1 – 2023/24	Year 2 – 2024/25	Year 3 – 2025/26
2023/24 - Enhanced Commissioning Framework for GP practices as lever to commission general practice in prevention – primary/secondary as build on the work to date Dental – commission enhanced oral support; scope plan with education and public health (health visitors) Scope and commission outreach to care homes across HWE Scope future opportunities through prevention programme including lifestyle interventions and opportunities with districts to reach pockets of hard to reach communities and patient groups	**2024 – 25** - Development of a digital solution to capture outcomes and impact of personalised care on population health outcomes and work with ARRS and VCFSE to support digital solutions.	
2023 -2025 - Development of personalised care and social prescribing for children and young people - the ambition is that each PCN across HWE will have a Children and Young People's Social Prescriber / personalised care practitioner by end of 2024/25.		
2023-2026 - ongoing training and development of the 3 personalised care roles (social prescribing link worker, health and wellbeing coach and care coordinators) and investment in the VCSFE sector in prevention and reducing inequalities, including digital and how VCSFE are embedded in INT.		
2024-2026 - The ICB will commission healthy conversations training via Public Health to enable both clinical and non-clinical staff to develop their skills in behaviour change in order to support the prevention agenda.		

Key transformation objectives – timelines – 2023-2026

Proactive Care, Chronic Disease Management and Complex Care through Integrated Neighbourhood Teams (INTs)

Phased implementation from Year 1– 2023/24 to Year 3 2025/26

By March 2024 – Implementation of the Asthma Hubs at PCN/locality level
April –June 2024 – Scope test other chronic disease at scale

September 2023 to July 2024 – Hertfordshire and West Essex will have INT coverage at PCN level through;

- Establishment of locality leadership board
- Recruitment of overall lead
- Documents to support establishment of INTs (such as: Terms of reference, Memorandum of Understanding and risk sharing agreements) will be drafted by the ICB for INTs to use
- Commencement of Organisational Development (OD) programme to support leadership of the INT.

May 2024 onwards in a phased way - All INTs will have identified a population cohort that would benefit from a joined-up approach

- PHM data will continue to be shared by the ICB with INTs
- Each INT through collaborative approach identify the interventions and deliver with the Health and Care Partnership

September 2024 onwards - completion of OD programme.

Ongoing evaluation to understand impact and using quality improvement methodology to continuously show improvement.

Key transformation objectives – timelines – 2023-2026

Simplifying & Enhancing Access for Urgent Primary Health Needs

Improving the pathway for those with urgent healthcare needs will free up capacity and time to see those who have routine healthcare needs

Year 1 – 2023/24	Year 2 – 2024/25	Year 3 – 2025/26
September 2023 - ICB working with PCNs with their core practices and non-core members will have mapped all access points and reviewed relevant data to determine where access is most challenged – *through Support level Framework/GP Intensive support national programme* **October 2023 onwards** - Plans implemented for one or more initiatives that are expected to improve access in a key area where there is the greatest potential to have a positive impact on access. **December 2023 -** implementation of national community pharmacy first across HWE from December 2023	**From November 2023** – Test new integrated, multi-provider service models where there is highest need with deprivation (UEC priority areas). **April 2024-June 2024** Review of MECs Service and develop options working with Planned Care **January 2025** – evaluation, write up of pilots and explore opportunities to make new models business as usual.	**2025 -2026 -** Continue to embed new models as business as usual. **July 2025** – improved patient experience reporting, improved patient reported outcomes; impact on urgent care outcomes including A&E, increase in self care.

August 2023/24 – Extend current urgent in and out hours dental services contracts whilst preparing the commissioning model of care aligned to the UEC strategic outcomes and ICB and Primary care objectives of same day access or urgent primary care (dental needs)
April 2024/25 – Commission an urgent dental care providing equality access across HWE whilst addressing the health inequalities identified in deprived areas

Impact on Planned Routine Access
General Practice – through improvement in patient access for routine care
Dental – through improvement in planned dental activity and proactive care reducing need for urgent on the day
Community Pharmacy – Increased use of Electronic Prescription Service, integrated chronic disease management pathways with community pharmacy with New medicines review, monitoring of conditions – Hypertension etc.

Enabling Workstreams – key achievements to date

Key achievements to date

A number of key achievements have already taken place in our enabling workstreams – some of these are outlined below:

Patient empowerment and education and communications

A workshop took place, led by the Patients Association, in June 2023 to support practices and patient groups in the use of social media, particularly Facebook. Another workshop was also run in early July 2023 about how patient groups can support the reduction of health inequalities.

Three patient representatives were appointed to the ICB primary care board in May 2023.

The first Patient Engagement Forum meeting took place in June 2023 – this forum provides assurance to the ICB Board on levels of patient and community involvement and participation. Patient representatives were appointed from a range of committees, groups and local areas to ensure a broad representation. These patients also link into other community networks.

Toolkits on the role of receptionists for practices to use now developed, next stage to share with reader panel for views.

Five practice websites created and in operation in the area end of May 2023, template content to be shared wider. User testing and feedback being used for improvements.

The ICB has been working with the Patient Association (PA) since Autumn 2022. The focus on this work has been to support the development of GP practice patient groups across Hertfordshire and west Essex. This involves offering one to one support, developing a patient led 'buddy' scheme, sharing resources including a number of workshop videos, including one on social media and health inequalities. As part of this work the ICB has developed their patient network which now numbers approximately 500 people.

Workforce

Primary Care Networks Training Team implementation across all 35 PCNs – supported with detailed workforce data pack including headcount/full time equivalent; number equivalent per registered population; potential number of future retirements; number of training placements and how population needs data through PCN data pack reflects the number and type of range of professional to be recruited.

Shortlisted for HSJ Patient Safety Awards 2023 – category Primary Care Initiative of the year (PCN Training Teams implementation).

Recruitment and implementation of the 33 out of 35 PCN Community Pharmacy Liaison Leads across all PCNs.

2 year New to Practice Programme – 6 GPs in year 1 and 16 GPs in year 2. The programme supports newly qualified GPs and General Practice Nurses (GPNs). The programme supports portfolio working and learning and development opportunities.

18 GPNs undertaken the Professional Nurse Appraisal Pilot Project. The project focus is to train nurse appraisers to support the GPN appraisal process.

Apprenticeships – 16 Nursing Associates currently on programme. 2 qualified in February 2023.

Monthly lunch time and evening virtual Educational webinars – over 100 primary care staff join with numbers increasing each month.

Monthly PCN Protected Time to Learn Events – Learning opportunity for all practice staff and platform to interact with providers/partners and learn together. All PCN/Practices engaged.

Increased recruitment to multidisciplinary roles in PCNs/Practices through range of ARRS roles projected to ensure budgets are maximised.

Key achievements to date continued

Data and Information

We have Primary Care data flowing into the ICB data environments to support Population Health Management (PHM) models and workstreams (including transformation).

We are piloting Machine Learning on the ICB Population Health Management (PHM) model to create bespoke practice searches to identify patient at risk on an A&E admission – currently being tested in Uttlesford and Hertsmere.

The use of the Ardens manager dashboard is in place for all practices in the ICB for Quality and Outcomes Framework (QOF), national and local Enhanced Services - improved performance on LD/SMI healthchecks, 8 care processes for Diabetes, Enhanced management of Frailty/EOLC etc.

We have access to high level Dentistry, Optometry and Community Pharmacy activity data. Further scoping to be done on how this data flows into the future ICB data warehouse and how we triangulate information.

We are ensuring General Practice appointment data is pulled into the Patient Access dashboard and triangulating this with other data sources including workforce to provide better support to practices.

We have created an internal resilience Index dashboard to support the Primary Care team in order for them to support Practices accordingly (this includes appointment capacity, estates, workforce, CQC visits etc).

Digital technology

Procured a number of SystmOne Hubs to enable at scale delivery of a variety of clinical services by PCNs; provided extensive ongoing support for this technology.

Roll out of Virtual Desktop Infrastructure (VDI) which enables clinicians to access clinical systems from any device, any time anywhere. We have c. 400 regular users and will extend this over the coming year – impact on need of clinical space/eventual cost of hardware.

In September 2022, all GP practices were offered an online consultation solutions to support digital front door. In this time, we have had approaching 80,000 digital consultations in total across our patch.

Under recent nationally led telephony programmes, *Surgery Connect* advanced telephony system has been deployed in 36 practices. Across HWE 101 practices now have a cloud-based telephony system. We continue to support remaining practices to move to a cloud-based solution. Whilst enhancing and integrating the cloud-base into the practice clinical system.

A Virtual Chronic Kidney Disease (vCKD) review service has been implemented between general practice and the East & North Herts Hospitals Trust. This has increased the number of patients being reviewed and reduced the potential for patients to develop chronic disease. The service is currently being extended to GP EMIS practices.

Premises and sustainability

Concluding the projects where the capital funding was sourced by NHS England under the Estates and Technology Transformation Fund (ETTF) programme, which had originally launched in 2016 - many projects that have benefitted thousands of patients and staff to receive and deliver healthcare from improved premises.

Lloyd George Digitalisation of patient notes - over 280,000 patient records were digitised and to date has created 56 desk spaces and 3 new consulting rooms, providing additional services/support.

Improved engagement with the 13 Local Planning Authorities (LPAs) covering Hertfordshire and West Essex and a better understanding of housing trajectories from the LPAs who have advanced their Local Plans; emerging work with others.

Successful development of 35 PCN Clinical Strategies – National programme to identify estates change requirements in order to be able to deliver care to address their local population's health needs and priorities; support the development of the workforce; and plan for future service needs.

Enabling Workstreams - areas of focus over the next 3 years

Patient empowerment and education - key areas of focus over the next 3 years

Year 1 to year 3 – 2023 - 2026

May 2023 onwards - ICB communications team to support development of local patient survey questions that GP practices/PCNs can use to survey their patients to measure improvement in patient experience

Proactive ICB wide series of patient feedback working with Healthwatch Hertfordshire and Essex.

April 2023 onwards - GP Practice Website Support - Develop a model GP practice website to best practice standards defined by NHSE. Clear content and task-based navigation that enhances patients' experience of services by highlighting online access and new ways of delivering services including additional roles and different types of appointment.
Phase 1 was to pilot model website with 5 practices in ENH – this took place end of May 2023.

September 2023 onwards -Phase 2 roll out model website content across HWE practices in a phased way to support practices.

Promotion of range of roles in Primary Care
Working with practices to promote the importance and value of additional roles that are available within general practice. Develop a toolkit of materials that practices can use to help promote these roles. Work with practices to develop case studies for use, in video form as well as non-digital channels.

- July/August 2023 - Promote the role of the reception staff in directing people to appropriate services
- August/September 2023 - Focus on key roles within practices with case studies and toolkits

Promote different ways that patients can contact their general practice with a particular emphasis on promoting and increasing the take-up of online services.

- October 2023 - National online access campaign promoted locally
- November 2023 - Day in the life of a practice – full range of work. Help with understanding of pressures on practice and routes in to support

Promotion of preventative and self care options – linking in with the ICS 'Lifestyle medicine' workstream for improving overall wellbeing as well as promoting screening, vaccination-take up etc, particularly amongst those who experience health inequalities. Linking with work below to involve PPGs and VCSFE in this work to boost self-care and wellbeing.

Continue to support development of GP practice patient groups at practice/PCN and Place through Health and Care Partnerships delivered alongside the National Patient Association - the ambition is that patient groups will be able to link in with their local communities and support patient empowerment and education by running sessions such as Cancel out Cancer talks, patient led webinars and condition specific support groups (e.g diabetes). Resources to support PPGs will be developed building on the content to date who are producing 'how to' guides and training materials on engagement - It will be important to ensure that pharmacists, dentists and optometrists are linked into patient groups to support community primary care engagement.

Workforce - key areas of focus over the next 3 years

Year 1 - 2023/ 24

Emerging Leaders Programme – establish links between primary care and the system's leadership programme
Implementation and Evaluation with a view to evolve the Community Pharmacy PCN Liaison Leadership Role across 35 PCNs

- June 2023 – Leadership Training event for appointed Community Pharmacy Leads
- April – March 2024 – Project Evaluation

Enhanced workforce data collection and reporting across PCNs and General Practice and evaluation of training programmes

- June 2023 – Develop a schedule of evaluations of training and development initiatives reporting
- July 2023 onwards – Production of monthly workforce data reports using National Workforce Reporting Service (NWRS) data and intelligence from quarterly PCN education team reporting
- August 2023 onwards – quarterly reporting on training and development initiatives, projection to operating plan workforce for primary care for General Practice/PCN

Clinical placements and work experience

- Increase undergraduate pharmacy clinical placements capacity & quality of placements across all pharmacy sectors, other roles such as paramedic, podiatry, physician associate, nurses. HWE ICB (in conjunction with University of Herts) ran a successful training event for potential placement providers in March 2023, this work continues with the development of 'champion roles'.
- Increase school work experience opportunities in primary care through the education sector working via County Council

Develop system-wide pharmacy/dental and optometry recruitment & retention plan including skill mix

- October 2023-January 2024: Map the gaps against the operation programme of work for each sector (including intra-professional collaboration & safe staffing levels), & develop a process at regular time periods to update, particularly at the point that supports winter planning – this will be with Health Education England (HEE)
- January 2024 - Develop a system-wide recruitment and retention programme across all sectors (Primary/community and where appropriate acute) for this group of professionals

Retention Pathfinder – engagement with system's pathfinder programme exploring areas of support such as flexible working, onboarding and career development pathways.

Apprenticeships – April 2024 - review opportunities to establish the new health and wellbeing level 3 apprenticeship to support community wellbeing

Equality, Diversity and Inclusion – align activity in primary care with the wider ICS to support and achieve the high-impact actions identified as part of the national EDI improvement plan, and supporting the region's commitment in delivering the anti-racism strategy.

Workforce continued - key areas of focus over the next 3 years

Year 1 to year 3 – 2023 - 2026

PCN Training teams continue to support the recruitment and retention of the Primary Care workforce and the protected time to learn events

- 6 Monthly feedback reports to reflect on events that have taken place and to support making future improvements and the sharing of learning opportunities that may be beneficial to PCNs
- Encourage PCN to be become learning organisation
- Jan 2024 - March 2024 - Evaluation of the PCN Training Team with a view to expand the role and remit and embed them for a longer term contract.

Training Hub to have a comprehensive array of multi disciplinary programmes for all primary care disciplines and at all career stages

- July 2023 – March 2024 – exploring roadmaps and training and development opportunities for the new roles in Primary care
- Ongoing career clinics for all staff to discuss training and development opportunities

Supporting the upskilling of existing community based Optometrists to become independent prescribers

- Engagement and promotion
- Course intake January and September

2023 – 2024 – plan / 2024– 2025 implement: Staff wellbeing & experience

- Implement strategies to promote job satisfaction, work-life balance, & a positive work environment.

September 2023-March 2024 – Develop skills mix and scope the development of dental workforce, including upskilling dental nurses and therapists and integrated roles between primary/community and acute.

Cross sector working /Career pathways development

- Increase number of rotational & hybrid roles working across secondary care, community pharmacy and PCNs. Workstream to include facilitation, e.g. governance, access to IT hardware & systems.

Pharmacy: Independent prescribing

- Maximise the value of independent prescribers (including through commissioning) in all pharmacy sectors in preparation for 2025/26, when all new pharmacist graduates will be Independent Prescribers. The aim is to facilitate the implementation of innovative clinical practice and service delivery models.

Premises and sustainability - key areas of focus over the next 3 years

Year 1 – 2023/24

Deliver the HWE ICB/ICS Infrastructure Strategy

- Working as a system to make best use of estates to support delivery of care – ensuring optimum use of all existing public sector estates
- NHS England seek completion by December 2023, all system partners engaged. Primary Medical Care key partner to this development across the system.

Year 1 to year 3 – 2023 - 2026

2023 – 2025 - Continued work is taking place to digitise the Lloyd George Patient Records of EMIS practices and to store the records of Systm1 practices off site in order to repurpose the space where it can usefully be repurposed into clinical or administration space for primary care. Resource identified from the Primary Care Team to support the premises team and aim to conclude this in 24/25.

2023- 2026 - ICB continue to work to reduce void costs on NHS Property Service assets by using the voids for occupation by primary care – especially to assist in accommodating ARRS staff and where possible to create additional clinical/consultation rooms. On-going and already achieved a reduction from £1.1m - £370k.

2023 -2026 - The ICB Premises Team continue to work with many practices and PCNs across the ICB on a variable range of premises projects. This is developed through the priority list which will be reviewed as year on year with changing circumstances and opportunities developing through evolving model of care, thinking differently for education and training opportunities.
Ongoing although the market conditions high inflation, increased borrowing costs, increased cost on labour and materials are causing viability issues on projects across the country.

2023 -2026 - From 1 April 2023 the ICB Premises Team have taken on the reimbursement scheme from NHSE and have already had positive feedback.

All system partners are working towards the 2040 - 2045 Net Carbon Zero Agenda. To ensure we meet this nationally set timeline, we will continue to focus and plan to deliver on this agenda - supporting the development of sustainable, resilient, energy and cost efficient buildings (whether it be new builds or by the upgrading of existing estate - including the Boiler Upgrade Scheme where practices, dentists, optometrists and pharmacists could qualify).

Data, information and digital technology- key areas of focus over next 3 years

Year 1 to year 3 – 2023 - 2026

Advanced Telephony - work to be undertaken as part of the Primary Care Recovery plan initiative will identify, validate, and prioritise (against an agreed ICB priority list) those practices that still have an analogue system. This list will be submitted to NHSE Region for funding to be considered. Once confirmation and approvals are received, work will be undertaken to deploy Cloud-based Telephony to those practices. We will support the process and will ensure that practices have support in maximising the benefit of these systems by putting in place a resource within the ICB who will work with practices on optimising system functionality to suit their business model.

- April – June 2023 – Assessment of systems
- July 2023 – March 2024 – deploy new systems
- October 2023 – March 2024 – **Optimisation and integration of resource to maximise benefits**
- July 2024 – March 2026 – ongoing monitoring and support
- January 2023 – September 2025 - Performance data and patient feedback show access improvement

NHS App The NHS App, with its full functionality, is now viewed as the future gateway to all NHS services and we need to work with practices and patients to make that the expectation. The NHS App can be used to make/amend/cancel appointments at a patients GP practice, view GP records (where enabled), order and manage repeat prescriptions, use the NHS symptom checker, manage and make secondary care appointments from a referral, manage donation preferences and data sharing preferences. We will develop a communications campaign, in line with any national programme, to ensure practices can inform patients of the benefits of the NHS App and that we use all avenues (other appointments with providers etc.) to inform patients of the NHS App and its uses. **We will work with practices and system partners to optimise their interfaces with the NHS App so that any options for automation/integration are applied.**

- July – September 2023 - Develop public facing communications campaign
- October 2023 onwards – run campaign ongoing to support cultural change across population through all networks
- January 2024 – December 2024 - Monitoring of uptake of NHS App and impact on online services, ERS usage and access to record
- January 2024 – December 2024 - Use Digital Leads and delivery partners to work with practices where uptake and benefits not seen
- January 2024 – June 2025 - Patients use NHS App and practices able to reinvest time saved back into face to face on need and patient experience and patient reported outcomes

Automation - Working with Herts Beds Luton ICT (HBLICT) and practices, and taking learning from other areas, we will look to develop a suite of automation tools that tackle both back-office tasks but also some of the administrative components of clinical tasks around Long Term Conditions. Part of this should be making sure Primary Care Electronic Patient Records (EPRs) are configured to automate as many tasks and processes as possible.

- July – September 2023 - Understand processes most suitable for automation
- October – December 2023 - Develop suite of automated tasks for practices to use
- April 2024 – September 2024 - **Use evidence from other areas to develop automated tasks around clinical pathways such as follow ups and bid to fund to test where AI may be able to support end to end clinical pathways tasks but also support in front end direct care. This is to be tested in conjunction with appropriate system partners**
- April 2025 – September 2025 - Expand usage if pilot successful
- January 2024 – March 2026 - Practices able to reinvest time saved back into face to face interaction with those who require it
- April 2025 onwards -Scope the learning from automation to other primary care contractors – community pharmacy, dental and optometry

Data, information and digital technology- key areas of focus over next 3 years continued

Year 1 to year 3 – 2023 - 2026

Digital Workforce - We will identify and work with PCN Digital Leads to bring together best practice ideas and ensure that they understand how to work within the GP IT Operating Framework. Establish opportunities for learning from each other through user forums. Share resources via MS Teams, workshops and other mediums. Create easy access to ICB Digital Leads to help with ability to work together across all partners. In addition, we need to consider staff training and support of digital skills to optimise the use of the digital tools available. This might be with support from the Herts and west Essex Training Hub or 3rd party providers.

- July – September 2023 - Understand current PCN Digital workforce
- October – December 2023 - Map local PCN digital projects
- October 2023 – June 2024 - Create User Groups/resource sharing space
- January 2024 – September 2025 - Local network of informed Digital Leaders in Primary Care working within and understanding broader ICB Primary Care Digital Strategy

Digital Inclusion - Work with partner organisations, such as local authorities and VCSFE organisations, who have programmes specifically aimed at either helping people become digitally skilled or can help with equipment or access to the internet. We will look to create a resource hub for primary care that will allow them to signpost patients to appropriate services.

- July 2023 – December 2023 - Map current local projects available to support digital inclusion
- October 2023 – March 2024 - Create centralised resource hub of links to various schemes
- January 2024 - June 2024 - Communications to practices and information on resource hub
- April 2024 – March 2026 - Maintain relationships to keep hub information current
- January 2024 – March 2026 - Practices able to signpost patients to local resources that support their needs

Community Pharmacy - Look to understand where the current challenges are in terms of pharmacy and digital position. Through appropriate channels look to deploy any systems that can facilitate flow of information and support general practice to pharmacy work flows. Make sure we have resource to support utilisation and uptake of systems. Scope current/future advances that will impact pharmacy over the next 5 years, to permit pharmacy teams to be part of a digitally connected, wider multidisciplinary team providing opportunities for targeted interventions to improve individual patient and population health.

- July 2023 – December 2023 - Baseline of current digital position in Pharmacy in view of new initiatives underway including pharmacy first and pathfinder of independent prescriber
- January 2024 – June 2024 - Develop digital roadmap for pharmacy including how systems can be streamlined for community pharmacies and integrated with practices and acute partners in first instance
- April 2024 – February 2025 - Deploy any systems, record sharing mechanism, protocols possible
- January 2024 – March 2026 - Community Pharmacy and General Practice workflows as integrated as possible, patients receive equitable services.

Data, information and digital technology- key areas of focus over next 3 years continued

Year 1 to year 3 – 2023 - 2026

Infrastructure Working with our GP IT delivery partner, HBL ICT, we will do a thorough review of all the laptops currently deployed and those in use. We will develop a standard policy for how laptops are managed and allocated. This must all be managed with the budget available to us so may require a bidding type process. We will continue to look to develop the Virtual Desktop Infrastructure (VDI) option which allows access to clinical systems securely on personal devices so that general practice staff are supported to work in an agile way that doesn't need them to be 'in the office':

- April 2023 – September 2023 - Continue VDI pilot
- July 2023 – September 2023 - Establish baseline of current laptops and usage
- October 2023 – December 2023 - Develop Standard Operating Procedure for allocation of laptops
- October 2023 - March 2024 - Establish VDI as business as usual function
- January 2024 – June 2024 - If needed procure and deploy any new laptops
- January 2024 – March 2026 - Practices able to have hardware to support ways of working with robust allocation process and support arrangements

Access to GP records – this is a national programme that is now part of the GP contract, and practices must enable this functionality by end of October 2023. This will allow patients to have prospective access to their records - only data from the date the practice goes live and moving forward will be visible. 19 GP practices across HWE ICB are live so far and we will work with practices to support them to enable this function over the coming months.

2023 – 2026 - a new data platform system will provide clinicians with a range of tools to manage patients and improve outcomes, significantly strengthening our Population Health Management approach. The platform links data from Primary Care, Acute, Mental Health, Community and social care for every person registered to a local practice and staff will be able to identify patients, where clinically appropriate. This data will be available at practice and PCN level along with a wide range of reports and dashboards to help providers understand more about the local population. In addition, PHM tools such as population segmentation and risk stratification will enable teams to identify people who are most likely to benefit from care. The system will also allow the ICB to provide Population Health Management support to clinical teams to design and manage care according to local health needs.

Dental and optometry -
September 2023 onwards – ensure digital is key enabler as we progress with the dental workplan on procurement/commissioning of a number of areas including, in and out of hours urgent on the day, community dental services, domiciliary dental and optometry care.
October 2024 – March 2025 - work to understand the challenges being faced, look to see if any 'quick wins' are possible and develop a longer term strategy to digitally support these areas

Additional broader primary care programmes of work including reviewing digital solutions between primary and secondary care interface, NHS app interface with patient portals, onward referrals within secondary care and remote monitoring, and resident-owned devices will also be looked into over the coming 3 years.

Investment and Contracting

Contracting Options from Year 1

- Strategically where possible, we will seek alternative contracting mechanisms to APMS contracts for primary medical services, with a view to commission longer term contracts, increasing sustainability and allows the flex in partnership working
- We will explore different contracting models with the objective of increasing resilience, capacity and value for money - such as contracts held by incorporated PCNs, Federations and Partnership models such as Primary/community etc.
- Through our contracting approach we will aim to ensure consistency of service offer and access across HWE and not create inequality
- A commitment to work with a wide range of providers to explore innovative solutions to service delivery that support our strategic plan for delivery of services, in an integrated way tailored to the local population
- We will ensure ongoing quality assurance of all primary care contracts through a standardised approach
- We will encourage providers to offer the full range of additional services within the national contracts and enhanced where commissioned beyond core contracts across all primary care providers as appropriate
- We will look at opportunities of how these new local contracts aim to address the inequality in health and care outcomes across pockets and how by integrating primary care, creates opportunities to develop commissioning and contracting options through a population health lens.

High level Areas of Priority in Primary Care where Funding is already committed

Areas of work – brief summary	Proposed £	ICB Objective/Outcomes
Primary Medical Care Service Workforce – Recruitment/retention and all initiatives such as PCN Training team, Continuous Professional Development (CPD), Enhanced Fellowships, Nurse development, Apprenticeships, ARRS development, practice resilience	£1.3M (additional to ongoing Training Hub costs)	We will improve out recruitment and retention objectives together improved well being of the workforce
Data, Information and Digital Technology – core GPIT, data quality and intelligence support through Ardens, EMIS enterprise, Online consultations – Accurx and E consultations; VDI. Practice supporting tools – Team net	£7.2M	We will continue to improve our data quality which support future commissioning, understanding our needs, reduce workload through ways of streamlining, integration of tools and systems and scope and test and use of AI
Enhanced Commissioning From Primary Medical Care Service Providers including ECF, enhanced services such as shared care, anticoagulation, care homes, asthma hubs, Migrant support (ARAP, Afghan etc), Additional winter support through PCNs NOTE - excludes national enhanced services as part of the core delegated national contract. **Dental Transformation Ring Fenced to Dental -**	£20M £2M (TBC)	We will continue to improve on our outcomes for management of patients with long term conditions; improve access; support unprecedented demands during winter, enhance the case finding/prevention and personalised care
Premises– Committed on agreed areas of priority to be developed; follow through with digitalisation of notes or off site storage	£2.6M (TBC)	Key enabler to deliver strategic objectives including housing appropriate workforce.

Proposed new investment – Primary Care Service Development Funds (uncommitted)

Areas of work – brief summary	Proposed £ FYE	Proposed Outcomes
Development of INT including • Primary Care Clinical Leadership (GP and Community pharmacy) • Co-Ordinator/convenor (across partners) at locality level • Organisation development – PCN/locality/Place • PCN Leadership and Management directly to PCN via PCSE	£2M £1M	• Improved quality of life of patients in receipt of INT services: Self-reported confidence, wellbeing, and independence • Improved clinical outcomes, for example: Reduction in exacerbations of Long-Term Conditions • Reduction in locally identified health inequalities, for example: Improved detection of specific conditions • Improved workforce health, wellbeing, and satisfaction, reduction in work-related stress • Reduction in utilisation of health and care services; Including all partners' services
On the day access – as outlined in UEC Opportunity of primary/community in collaboration with partners where most needed • Harlow • Stevenage • Hertsmere PCN innovative testing models Dental access (existing ringfenced dental funding)	£1.2M	• Easily accessible, when clinically required – improved experience and patient reported outcomes • Services will collaborate to optimise capacity within the system - ensuring all pathways are effectively utilised • Use of total triage systems will provide consistent messaging and will result in better patient awareness of services available, and ensure people are seen in the right place at the right time • Dental access – equity of access across whole ICB footprint for both in and out of hours
Primary Care Digital (beyond GPIT) includes project management, utilisation resources for fixed term 12 months; opportunity including Piloting automation; Enhanced VDI, Support the gap in national advance cloud based telephony, support digital infrastructure through Hubs	£1m	• Better patient access to services through different options, primary care workforce able to work in more agile way through infrastructure that supports them, automation of admin tasks to free capacity for staff to do other things, support with utilisation of new telephone systems to maximise benefits for patients and practice staff.
Prevention and Health inequalities – Support the work being undertaken in the VCFSE sector helping to reduce health inequalities, including reducing digital exclusion and development of personalised care roles.	£200k	• Improved data sharing between personalised care healthcare workers and wider system • Improve outcomes measurement of personalised care interventions • More patients able to confidently use digital interfaces with healthcare services and therefore be able to benefit from the widest range of access options offered by health services.
Communications/Engagement – including Healthwatch/ongoing work with Patients Association and communications development	£40k	• High quality clear and consistent practice websites • High levels of public confidence in new healthcare worker roles • Well functioning and impactful PPGs • Patients better able to find their own solutions where appropriate for their own minor health queries

Next steps / close

Every day I continue to be struck by the incredible professionalism, commitment and resilience demonstrated by colleagues working across all our primary care providers in collaboration with health and care partners, striving to deliver the best possible care in an enduring, testing environment. I'm also acutely aware of the toll this is taking on all our clinical and non-clinical staff and also of the frustration experienced by our citizens when services are not as easy to access as we would all wish. As a system we have made great strides to improve the quality and experience of care across all our sectors and I feel strongly that the areas of focus outlined in this plan provides a step change over the next few years to continuously improve the outcomes for our population whilst also creating a positive impact on our workforce across all our partners but also the wider community.

Within this document we have attempted to set out what we believe good looks like and also a firm commitment to change via the annotation of clear milestones, however we are mindful not to be prescriptive on the "how" as they need to be co-produced and implemented at network/locality/place level with the population we serve.

The idea of this plan is to ensure we don't duplicate/triplicate - where it is possible to provide the support once strategically we will do so, whether that is through commissioning of the enhanced framework across all practices, designing the MOU/risk sharing for INT and governance of locality leadership to be adopted through each PCN/Locality and Health and Care Partnership. Aim of this is to be open and transparent on how primary care funds including non-recurrent service development funds for primary care are aligned to the national and local system priorities. The plan highlights priority areas agreed for pump-priming for 2023/24 such as funding for a co-ordinator/connector to support the running of the INT, clinical leadership at PCN and locality level, funding of organisational development/cultural shift programme across all partners, or areas of primary care digital priorities including testing automation and how we support new initiatives on recruitment and retention of the whole primary care workforce.

Each area will have its key requirement of how we measure benefits and see the impact both in terms of hard and soft lived experience, hence continued active focus on the community/engagement investment. Next steps will be to build on the outline plan and develop detailed proposals with partners involved and provide progress via various forums with a view to embed the learning and show improvement in key areas through quantitative data but more importantly through lived experiences across our representative patient groups.

I would like to take this opportunity to thank everyone who has been involved in the development of this plan and your ongoing support in implementation and driving the change.

Avni Shah
Director of Primary Care Transformation
Hertfordshire and West Essex Integrated Care Board