Next steps for integrating primary care:

Building on the Fuller Stocktake

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Introduction: The Fuller Stocktake report

This pack is a free and independent resource developed to support discussions at a System, Place, Primary Care Network and Neighbourhood level in responding to the findings of the Fuller Stocktake report.

The Fuller Stocktake report, commissioned by NHS England & Improvement from Dr Claire Fuller (GP and Chief Executive of Surrey Heartlands ICS) was published in May 2022. It sets out a vision for integrating primary care and improving access, experience and outcomes for communities, centred around:

- **streamlining access to care and advice to meet the needs of infrequent users of healthcare services**
- **providing more proactive, personalised and multi-disciplinary care for people with more complex needs**
- **helping people to stay well for longer, through a joined-up approach to prevention**

In many ways, the report articulates the very best of what primary care has always provided in England, and highlights a number of specific case studies where elements of the vision are being taken forward already. However, it also challenges areas to be bold and innovative in creating "*both the conditions to enable locally led change and the supporting infrastructure to implement it*".

"Despite the current challenges, there is real optimism that the new reforms to health and social care – if properly supported to embed and succeed – can provide the backdrop for transforming how primary care is delivered in every community in the country."

Dr Claire Fuller

PPL is a social enterprise and B Corp that exists to promote better health, wellbeing and economic outcomes across the UK working with individuals, communities and the organisations that support them. PPL has been involved in the development of better integrated, person and community-centred care for the last 15 years, working in partnership with systems including Surrey Heartlands, Greater Manchester, and the London ICSs.

Context: Tomorrow coming to the aid of today

Our healthcare systems are under intense pressure. The daily issues facing patients, carers, the frontline clinicians and professionals who support them have led to increasing recognition that the "status quo" in primary care is un-sustainable.

The challenge is moving to new ways of working whilst continuing to manage existing pressures: on primary care, communities, and on all other parts of our health and care systems. This means finding solutions which improve access, quality and outcomes of local care, whilst demonstrating clearly how "tomorrow is coming to the aid of today".

There are a number of elements of the Stocktake that require change at a national level. This includes action on GP numbers and workforce challenges, funding, contractual and commissioning arrangements within General Practice.

This pack is specifically designed to support next step discussions locally around what we can do, now, as systems and as partnerships: building on positive examples and progress to-date. It is about ensuring that long-standing and new inequalities are being addressed, and that primary care is supported to continue to play its core role in the health and wellbeing of individuals and communities across England.

Two suggested questions for systems and partnerships at the end of each discussion are:

1. **What capacity is being added through our proposed actions** and how will this help to address the feelings and experience of patients, carers, clinicians and other frontline professionals of being overwhelmed?
2. **How do we ensure next steps are agreed, communicated and delivered** including with appropriate representation from primary care, partners, and local communities themselves?

Building integrated neighbourhood teams

In most consultations GPs identify areas for non-medical help and support in patients' lives. These needs, if un-met, often drive further inequalities and requirements for support. There is an opportunity to mobilise additional resources to address these needs.

Working with people and communities

Developing an understanding of local assets and resources, and the role these could play in supporting improved health and wellbeing.

Improving same day access to urgent care

Co-ordinating resources across primary, acute and other health and care services to better respond to demand, in the way most appropriate to individuals.

Personalised care for people who need it the most

Enabling improved self-management and support for patients and carers, enabling people to achieve their ambitions as active participants in their own care.

Prevention

Reducing demand pressures on the health and care system by joining-up support to people at each stage of their lives.

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Refers to corresponding entry in the framework for shared action

Discussion map (1/2):
Linking to the Fuller Stocktake Framework for shared actions (ICSs)

In developing a roadmap for implementation within systems, one suggested approach is to consider the required at different spatial levels (e.g. Home, Neighbourhood, Place and System) and the three critical areas highlighted in the report (Prevention, Complex Personalised Care and Integrated Urgent Care):

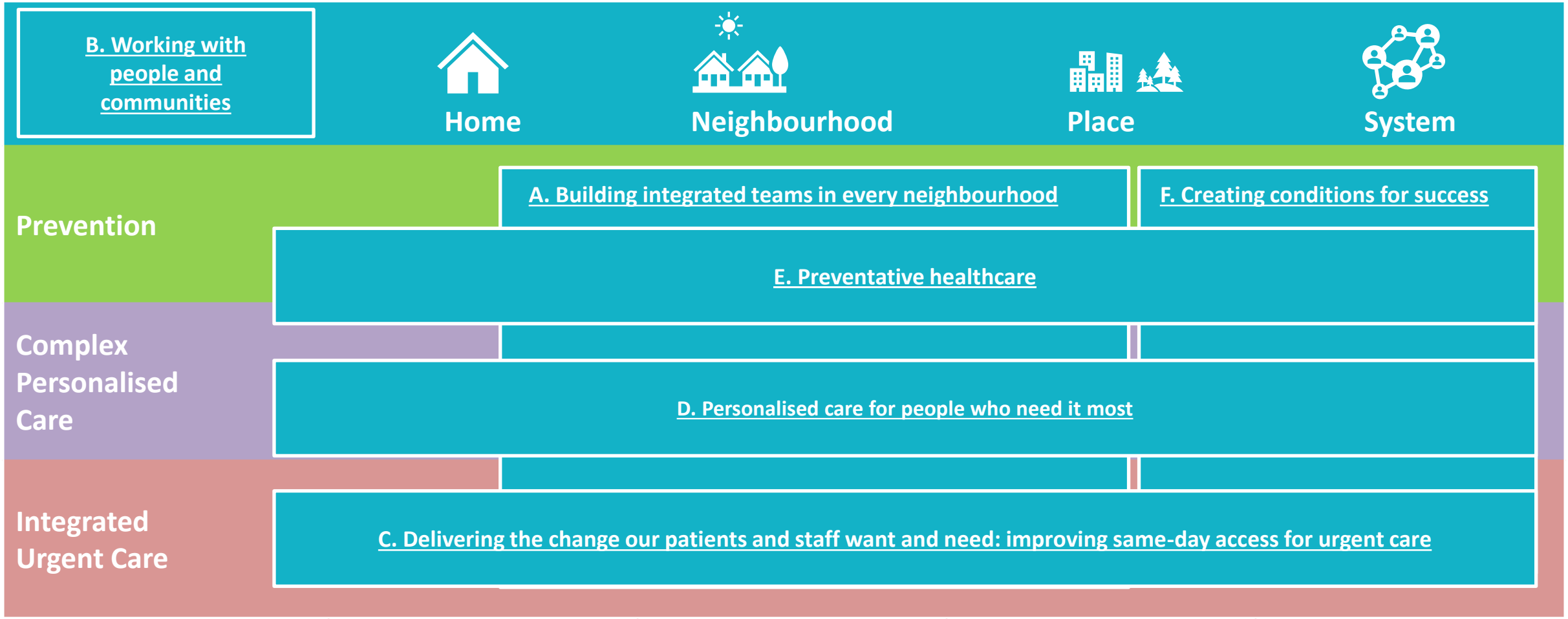
	Home	Neighbourhood	Place	System
Prevention				
Complex Personalised Care				
Integrated Urgent Care				

Key objectives

- **Understanding existing assets, progress and plans across each area and at each "spatial level" within our systems**
- **Prioritising short – medium – long term opportunities for bringing resources together to improve capacity and improve outcomes**
- **Developing the trust and relationships needed to enable successful delivery**

Discussion map (2/2):
Linking to the Fuller Stocktake Framework for shared actions (ICSs)

In each system, delivering on these commitments and achieving the associated benefits will involve joint-working in each priority area and across all to build the holistic plans, trust and relationships to deliver and sustain change:



A. Building integrated teams in every neighbourhood

Success in this area will increase resources available to support individual needs, whilst addressing underlying causes of inequality, poor mental and physical heath. Integrated neighbourhood care teams will be different from current Primary Care Networks. What does this look like in practice?

"At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations." (Fuller Stocktake Report, p6)

Identified stakeholders:

- **Primary Care Networks (PCNs)**
- **Wider primary care providers**
- **Secondary care teams**
- **Social care and wider local council services**
- **Domiciliary and care staff**
- **Voluntary and community sector partners**

*"together to share resources and information and form multi-disciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities… **'teams of teams' need to evolve from Primary Care Networks (PCNs)**, and be rooted in a sense of shared ownership for improving the health and wellbeing of the population"*

Identified enablers:

- A more **psychosocial model of care**
- A more **holistic approach to health and wellbeing** of a community
- Realignment to a population-based approach, e.g. **aligning community health services and secondary care specialists** to neighbourhood teams
- An **improvement culture** and a safe environment to learn and experiment
- Availability of **back-office and transformation functions** for PCNs
- A shared, system-wide approach to **estates**

*"We heard consistently throughout our engagement that a **'top-down' approach of driving change and improvements risks alienating the workforce and communities** and hinders development of trusting relationships"*

Suggested discussion theme:

No system or place is starting from scratch. Where is this already working well locally, and what are the opportunities and barriers to us scaling up?

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Some key questions to consider:

a) **How can we build on and link to existing local infrastructure e.g. local authority hubs? Who else will need to be involved e.g. VCS partners?**

b) **How will we align across different footprints, recognising PCNs are not necessarily co-terminus with either neighbourhoods or communities?**

c) **How does this add to the resources available, and how will we start to bring these together e.g. through the Better Care Fund?**

B. Working with people and communities

The pandemic has highlighted the key role individuals and communities play in delivering improved health and wellbeing. How will we work differently to ensure these relationships and lessons are not lost?

"Throughout the stocktake, we heard that the PCNs that were most effective in improving population health and tackling health inequalities, were those that worked in partnership with their people and communities and local authority colleagues." (Fuller Stocktake Report, p7)

Identified stakeholders:

- **Health and care organisations as "anchor institutions"**
- **Local Government including elected members**
- **Voluntary, Community & Social Enterprises (VCSEs)**
- **Schools and Higher & Further Education Providers**
- **Health inclusion Groups**
- **People with Learning Disabilities and Autism**

*"creating the space and opportunity to do far more on the most pressing challenge for health and social care systems: **tackling the determinants of ill health and helping people to live happier and healthier lifestyles**."*

Identified enablers:

- **Building on the outreach model** that characterised COVID-19 vaccinations, including by partnering with community organisations and public health
- Developing **meaningful and sustained relationships** within communities including through building on the expertise, resources and relationships held by the **NHS and local government, VCSEs, community groups and community leaders**
- Understanding **local social, demographic and cultural factors**

*"Outreach **should not be considered a bolt-on to the day job** – it's central to people's roles and should be reflected in protected time and job plans, for both current and upcoming roles."*

Suggested discussion theme:

How do we genuinely put local people at the heart of planning, delivering and assuring our local health and care services and systems?

Some key questions to consider:

a) **What do we need to do now to sustain the networks and relationships developed during the pandemic response?**

b) **How do we ensure we are not just hearing from the "usual voices"?**

c) **What opportunities exist to bring together local resources and infrastructure to the work of primary care teams and local partnerships to produce better outcomes?**

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C. Delivering the change our patients and staff want and need: Improving same-day access for urgent care

Access to the right care when and where needed affects everyone. How can we work jointly to overcome barriers to same-day access for all, whilst creating space and capacity to support those with more complex, ongoing needs?

"The two issues that have dominated the debate throughout this stocktake are the need for people to access same-day urgent care and the need for GPs to be able to provide continuity of care to those patients who need it most. In reality, they are two sides of the same coin." (Fuller Stocktake Report, p10)

Identified stakeholders:

- **GP practices and PCNs**
- **Community pharmacy**
- **Urgent Treatment Centres**
- **111 Out-Of-Hours Services**
- **Emergency Care Teams**

*"We need to enable primary care **in every neighbourhood to create single urgent care teams** and to offer their patients the care appropriate to them when they pop into their practice, contact the team or book an online appointment."*

Identified enablers:

- **Same-day access** to urgent care (through a range of services)
- **Streamlined referral into emergency care**
- **Telephone-based and digital care** (where appropriate)
- **Face-to-face services** (where not)
- **Improvement support, data and leadership**

*"Critically, **we need to create the conditions by which [we] can connect up the wider urgent care system**… for example, general practice in-hours and extended hours, urgent treatment centres, out-of-hours, urgent community response services, home visiting, community pharmacy, 111 call handling, 111 clinical assessment – and organise them as a single integrated urgent care pathway in the community that is reliable, streamlined and easier for patients to navigate."*

Suggested discussion theme:

How are people experiencing same-day urgent care now and how will deliver the biggest impact on the quality and accessibility of urgent care across different communities?

Some key questions to consider:

a) **What does our data tell us around how healthcare services are being accessed currently, across different parts of our population?**
b) **What are the different offers do we need to develop to improve the way in which patients and professionals are supported?**
c) **What are the barriers to bringing resources together in response and how can we work together to overcome those barriers?**

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D. Personalised care for people who need it most

Bringing together people's lived experience and what matters to them, in responding to complex care needs and in enabling better shared management of conditions. How do we use the opportunity of integrated care systems and partnerships to support more equal relationships and to co-develop better long-term outcomes?

"A personalised care approach means 'what matters to me, not what's the matter with me'. We heard a strong message via the stocktake that we must start with people's abilities and work with them to support self-care and self-management of complex and long-term conditions." (Fuller Stocktake Report, p12)

Identified stakeholders:

- **Patients and Carers**
- **Primary care**
- **Secondary care**
- **Social care providers**
- **VCSEs**
- **Adults and Children's Services**

"…excellent examples of good practice from outreach work and joint MDTs for child health, to population-based approaches to management of chronic disease, and partnership working on end-of-life care. All these were ***characterised by strong relationships, trust and mutual understanding****…"*

Identified enablers:

- **Shared decision-making with patients and carers**
- **Improving availability and usability of patient-held records**
- **Reasonable adjustments for people with a disability**
- **Personal Budgets**
- **Social Prescribing**
- **Capacity and Organisational Development**

*"****This should consolidate the multitude of existing models and teams*** *focused on discharge to assess, virtual wards, mental health crisis response, enhanced health in care homes and urgent community response to support people who are unwell to be cared for safely at home, and for those requiring hospital treatment, to ensure safe and effective transfers into and back from hospital."*

Suggested discussion theme:

How do we ensure that everyone in our area who needs it is supported by high-quality, co-ordinated care, built around them?

Some key questions to consider:

a) **How can we ensure secure access to the information and data people need, including the informed consent of individuals themselves?**

b) **What do we have in place already, and how can we start to co-ordinate resources around the needs of individuals and carers at scale?**

c) **What practical steps do we need to take to foster greater shared trust and understanding between patients, carers and professionals?**

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E. Preventative healthcare

Being clear on the factors which are responsible for poor health and inequalities in our communities; and what our priorities are as systems and partnerships in supporting people to stay healthy, independent and well at each stage of their lives.

"Primary care has an essential role to play in preventing ill health and tackling health inequalities, working in partnership with other system players to prevent ill health and manage long-term conditions." (Fuller Stocktake Report, p14)

Identified stakeholders:

- **Individuals and communities**
- **Local authorities including Public Health, Housing and Social Care**
- **Primary care including Community Pharmacy and Dentistry**
- **Secondary care**
- **VCSEs, Schools, Businesses**
- **Health coaches and social prescribing link workers**

*"At a system level, ICSs, particularly through their local authority members, have the opportunity to **shape and co-ordinate cross-sector efforts** to support people to stay well by working with the voluntary sector, local business and education providers to provide a more consistent offer for socially excluded and most disadvantaged groups, for homeless and inclusion health services."*

Identified enablers:

- **The Core20PLUS5 approach for reducing healthcare inequalities**
  - identifying a target population comprising the **most deprived 20%** of the population of England (the Core20)
  - **other groups** identified by data (plus groups)
  - and the **five clinical priorities** for action: Maternity, Severe Mental Illness (SMI), Chronic respiratory disease, Early cancer diagnosis, Hypertension
- **Availability of data and infrastructure to neighbourhood teams**

*"there is often insufficient attention and resources directed toward providing effective support for children and young people, and to people with a learning disability and autistic people... A real measure of success for this and other ICS strategies will be **whether ICSs have meaningfully improved outcomes and experience for these groups**..."*

Suggested discussion theme:

What are the broader determinants of inequalities in our communities and what are we going to do about them?

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Some key questions to consider:

a) **To what extent are our existing priorities and plans positively addressing the major causes of inequality locally? Where do we need to focus?**

b) **Do we have all the right partners around the table, including children's services and wider local partners, to achieve this?**

F. Creating the conditions for success (1/4): People

"…most of the recommendations contained in this report are by systems for systems, as well as requiring more national action on workforce, estates and data; and not all the recommendations require additional funding. It is just as important that we create an environment that supports local change not dictates it: we need to energise local ambition if the new vision for integrating primary care is to succeed." (Fuller Stocktake Report, p18)

Workforce enablers:

- **Improving the supervision, development and career progression of individuals in Additional Roles Reimbursement Scheme** (ARRS) roles.
- **Working with system partners** to promote education, apprenticeships and new local employment opportunities.
- **Innovative employment models** such as joint appointments and rotational models to promote collaboration rather than competition
- **Electronic staff records or a similar integrated workforce solutions** in primary care to inform demand and capacity planning and enable improved rostering
- **Support to local recruitment and training of key community healthcare teams** to enable integrated neighbourhood teams.
- **Ensuring flexible working and developing support to retain staff and reflect the diversity** of the communities being served.
- **Developing clinical and professional leadership**, including "consultant in general practice" models.

Some key questions to consider:

a) **How well do we understand capacity and demand challenges facing primary care** across our local communities?

b) **What can we do as a system / partnership to address gaps in resourcing locally,** and ensure that everyone in primary care is enabled to operate to the top of their clinical and professional abilities?

c) **What mechanisms do we have for engaging with people working in primary care** and how do we ensure that we are responding effectively to what they are saying?

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F. Creating the conditions for success (2/4): Estates

"Next steps for integrating primary care sets out a vision of integrated neighbourhood teams, providing joined up accessible care. But much of the general practice and wider primary care estate is frankly not up to scratch." (Fuller Stocktake Report, p23)

Estates enablers:

- **Understanding estates as "much more than buildings"** - focusing on patient needs, creating a positive working environment for staff, and providing space for key activities like training and team development.
- **Establishing a "one public estate" approach** including around access, population health and addressing health inequalities, making use of local authority, third sector and community assets, void and vacant space in the NHS Property Services and Community Health Partnerships portfolios.
- **Co-location of primary care** with other services including secondary care.
- **Re-purposing existing space**, looking at high-street opportunities and the ability to engage local authorities in raising capital.

Some key questions to consider:

a) **Each place is different.** Where are our local needs and our existing assets, and how can we work differently to bring these together?

F. Creating the conditions for success (3/4): Data and digital infrastructure

"Integrated neighbourhood teams can only flourish if we ensure information about patient care can be properly shared – for use in providing and improving the co-ordination of care at an individual level, and for wider planning and research." (Fuller Stocktake Report, p24)

Data and digital infrastructure enablers:

- **Baseline assessments of the current state of digital infrastructure** in their area to understand current needs and gaps and explore more streamlined systems for accessing general practice.
- **A clear system plan for data sharing across the system to support the development of population health management approaches at neighbourhood and place level** enabled by a clear information governance framework and work with providers and patients to co-produce data sharing agreements where appropriate.
- **Ability to read and write seamlessly into a shared patient record** that provides a single version of events for each patient with appropriate information and governance in place.
- **Real-time data on demand, activity and capacity** to improve services, identify gaps and take action to redistribute resources and plan workforce accordingly.
- **A digital training offer** for clinical and non-clinical primary care staff.
- **Ensuring that potential barriers to using digital tools, such as digital exclusion, are understood and addressed** in the establishment of digitally enabled primary care hubs.

Some key questions to consider:

a) **What are people telling us** around the current state of information sharing and digital tools in primary care?

b) **Where do we have existing exemplars** of practices successfully working with patients and communities to use new technologies to improve access to and outcomes of care?

c) **If we cannot address everything today, what are our priorities** for developing improved information sharing and digitally-based services (ensuring that "the best does not become the enemy of the good")?

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F. Creating the conditions for success (4/4): Locally-led investment and support

"successful delivery of the new model can only be optimised if systems ensure they bring GP practices of all different shapes and sizes with them. We need to recognise that maintaining stability in general practice will be central to being able to deliver the new model of integrated care." (Fuller Stocktake Report, p29)

Locally-led investment and support enablers:

- **Establish a firm understanding of current spending distribution across primary care** weighted by deprivation and other elements of the Core20PLUS5 approach.
- **Review discretionary investment in primary care** working with clinical colleagues to understand the data and make the case for alternate approaches.
- **Developing an ICS primary care support offer for all providers**, including quality improvement; digital, data and analytics; understanding local communities and user experiences; physical infrastructure; workforce planning and transformation; service design; and development of the primary care provider landscape.
- **Where there are gaps in provision, or individual providers are rated 'inadequate' by CQC** provide tailored support to practices to improve and, where appropriate, actively commission new providers of integrated list-based primary care, in particular for the least well served communities.
- **Responsibilities for development of integrated primary care are explicit in the ICS accountability framework**, including the respective roles of ICS and place-based leaders.
- **Embedding primary care leadership throughout system** building relationships with existing local committees and groups.

Some key questions to consider:

a) **How will we work with primary care and other partners** to identify opportunities to allocate existing resources to where they are needed most?

b) **What are the priorities for supporting development of practices and networks**, building on existing local assets and opportunities to link with other partners?

c) **Are we clear on how primary care is being engaged** in decision-making throughout the system and what supported will be needed to ensure that clinical and professional groups are effectively represented at each stage of development and delivery?

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Summary of the Fuller Stocktake: framework for shared action

1. ***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 (ICSs)***
2. *Assist systems with integration of primary and urgent care access (NHSE)*
3. ***Enable all PCNs to evolve into integrated neighbourhood teams (ICSs)***
4. ***Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams (ICSs)***
5. ***Develop a primary care forum or network at system level (ICSs)***
6. ***Embed primary care workforce as an integral part of system thinking, planning and delivery (ICSs)***
7. *Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver this report (DHSC, NHSE, HEE)*
8. *Pivot to system leadership as the primary driver of primary care improvement and development of neighbourhood teams in the years ahead (NHSE)*
9. *Improve data flows (NHSE)*
10. ***Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care (ICSs)***
11. *DHSC and NHSE should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues (DHSC, NHSE)*
12. ***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 (ICSs)***
13. ***Work alongside local people and communities (ICSs)***
14. *In support of systems, set out how the actions highlighted for NHS England will be progressed (NHSE)*
15. *DHSC and NHS England should rapidly undertake further work on the legislative, contractual, commissioning, and funding (DHSC, NHSE)*

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With sincere thanks to
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All errors or omissions are our own.

We welcome feedback on this resource.
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