Mid and South Essex
Health and Care
Partnership

Primary Care Strategy

Working together for better lives

Contents

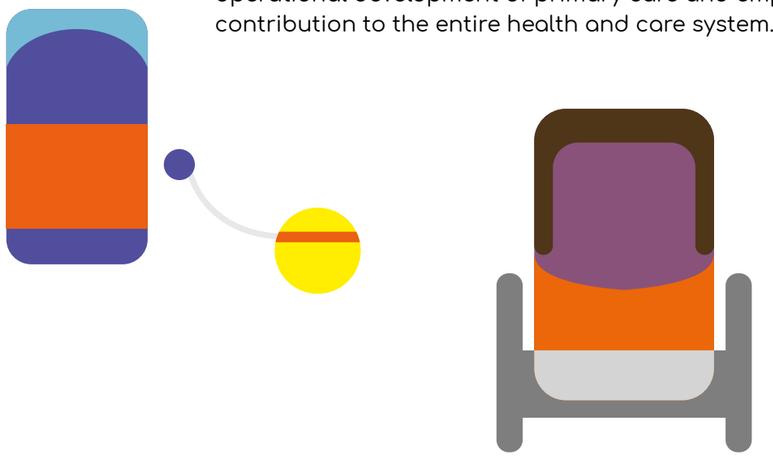
Primary Care Networks (PCNs) will support collaboration amongst organisations, groups and individuals who positively impact on their population's health and wellbeing. As well as primary medical services and general practice, this includes other significant incumbent providers of health and care, education providers, major employers, the third sector and community groups. PCNs are seen as a vehicle to bring together the wider network of primary care providers including community pharmacists, optometrists and dentists.

1 Executive Summary

The Mid and South Essex Health and Care Partnership comprises all key NHS, local authority, community and voluntary sector organisations that collectively serve our 1.2m population.

Our 5-year strategy, published in December 2019, set out our key ambition to work in partnership to reduce health inequalities. We now know that the COVID-19 pandemic has widened those existing health inequalities and sadly affected many of our residents. Throughout the pandemic response, all partners worked closely together, putting the needs of the population above organisational requirements and boundaries. We have demonstrated that joint working is key to supporting our residents. Nowhere is this more important than in primary care – the gateway for our population to access help, support, advice and treatment. This paper describes how we will support primary care, through Primary Care Networks (PCNs) to become more resilient, to take a key role in integrating care at a local level, and to improve the health and wellbeing of our residents.

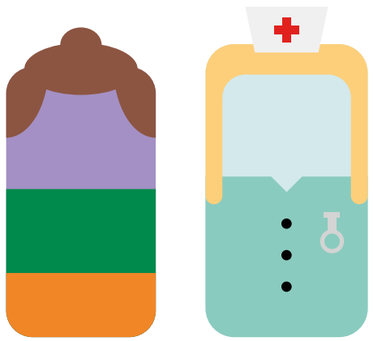
This paper describes a review of the Primary Care Strategy agreed in 2018 and addresses the key changes to health and healthcare since that date as they relate to this sector, and primary care's enhanced role within mid and south Essex. It is intended as a blueprint that will both guide the strategic and operational development of primary care and emphasise its importance and contribution to the entire health and care system.



Key strategic areas and expected changes within the next two years

Refining and Strengthening Primary Care Networks (PCNs) and their role in service integration

Strategic Priority	Expected Progress by 2023/24
Clarify and implement NHS England's core ambitions for PCNs, namely improved sustainability in general practice, and enhanced capacity across primary care.	Practices are confident about PCN service delivery and its effect on their patients.
PCNs will lead the integration of services, working with Community Providers covering both physical and mental health and local authorities.	Practices routinely use population health data to guide their work and support integration with community partners to improve patient care.
Local delivery models, led by individual or groupings of PCNs, will allow closer collaboration between primary care and both secondary care and mental health providers.	Networks are able to fund community level improvements and the development of care pathways.
Through PCNs and the national service specifications PCNs will deliver services in partnership that contribute to the improvement of care within local priority areas including cancer care and ageing well.	Networks are delivering services that are in in line with requirements, and where appropriate exceed to meet local priorities.



Addressing the legacy of the pandemic by improving collaboration with acute care

Strategic Priority	Expected Progress by 2023/24
Explore the development of a "Guardian" service which will address the issues arising from the patient group who have been referred but will have prolonged waits for definitive treatment.	Patients will have mostly virtual access to their diagnostic tests and ready access to their care plans and timescales.
Utilise the administrative capacity of the Guardian service to identify and address unnecessary delays and problems affecting patient care, and producing increased workload.	Communication between Primary care and Acute services will where necessary be channelled through the Guardian service.
Encourage and develop joint working between primary and secondary care and the production of agreed care pathways with a focus on prevention, personalisation and self-care through all partner organisations involved in PCNs.	Pathway development will be a trigger for joint clinical training and education across the system.

Developing leadership and innovation within the primary care workforce

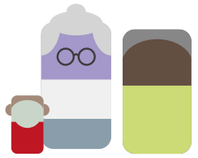
Strategic Priority	Expected Progress by 2023/24
Increase management capacity within PCNs in order to drive integration.	Within twelve months create an infrastructure which can independently innovate and solve local problems.
Promote specialist roles and portfolio careers for clinicians from both primary and secondary care.	Demonstrate clinical collaboration is driving meaningful bottom up integration through adoption of a framework similar to the Integrated Workforce I-Statements Framework.
Continue to develop Accelerator PCNs and invest in success.	Support for all Networks through their wider development and also freeing and supporting lead and accelerator PCNs to make progress.

2 Commitments

To support delivery, we commit to building the infrastructure that enables new, collaborative, ways of working.

The Mid and South Health and Care Partnership commit to:

- Supporting PCNs to understand the information available to them, and making operational and planning decisions based on understanding. We will give PCNs the tools and competencies to adopt an operational health management approach
- Support the identification and implementation of digital solutions that support the aims of managing demand, creating capacity and improving collaboration across partners (This will be included in the Digital First Primary Care Strategy)
- Through the Workforce Training Hub, and wider workforce strategy, support the retention of the existing workforce and maximise the uptake of the Additional Roles Reimbursement Scheme that is available to PCNs to see the workforce in General Practice increase
- As we move to a system operating budget, and service line budgets, ensure PCNs are part of this development, and identify a target investment level for General Practice that builds upon the current baseline
- As we further develop our Integrated Care System we will ensure governance arrangements are fit for purpose enabling collaboration and transformation to happen at PCN level and remove unnecessary bureaucracy
- Over the next 18 months we are committed to supporting PCNs to engage with a wider range of stakeholders to co-design how best to maximise health and wellbeing at the local level.



Throughout this strategy, we will seek to address the challenges of unaligned purpose and incentives amongst partners. We will look to align purpose amongst stakeholders at PCN level, working to address local needs and inequalities whilst contributing to agreed system priorities. This will enable PCN success to be measured across three domains:

1. Improvements in population health outcomes as determined through the national contract and local outcomes framework
2. Use of system resources, and;
3. PCN and Relationship Maturity.

3 Introduction

The current Primary Care Strategy (PCS) was approved by the five Clinical Commissioning Groups (CCGs) in June 2018 and covers the period to 2020/21. Its focus was:

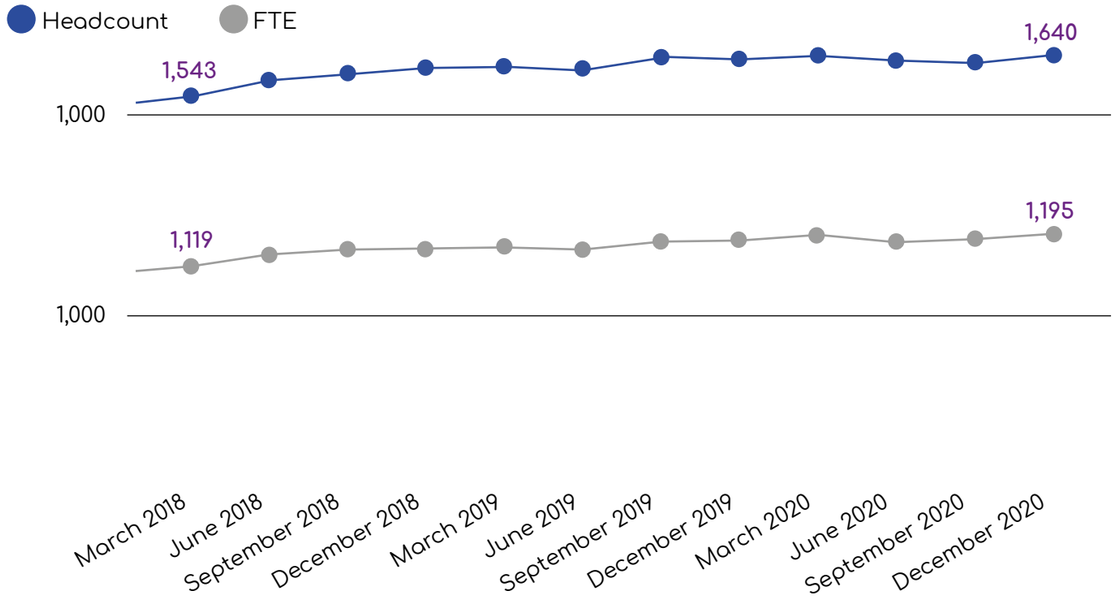
// Quantifying and addressing the existing and projected capacity gap in primary care within general practice

// Improving the sustainability of general practice and increasing its attractiveness as a place to work in Essex

// Building on a relatively new locality structure in order to improve standards and mutual support across primary care.

The three years since the approval of the strategy have seen continued increase in staff, particularly clinical staff, involved in the provision of primary care and an apparent stabilisation of the GP workforce.

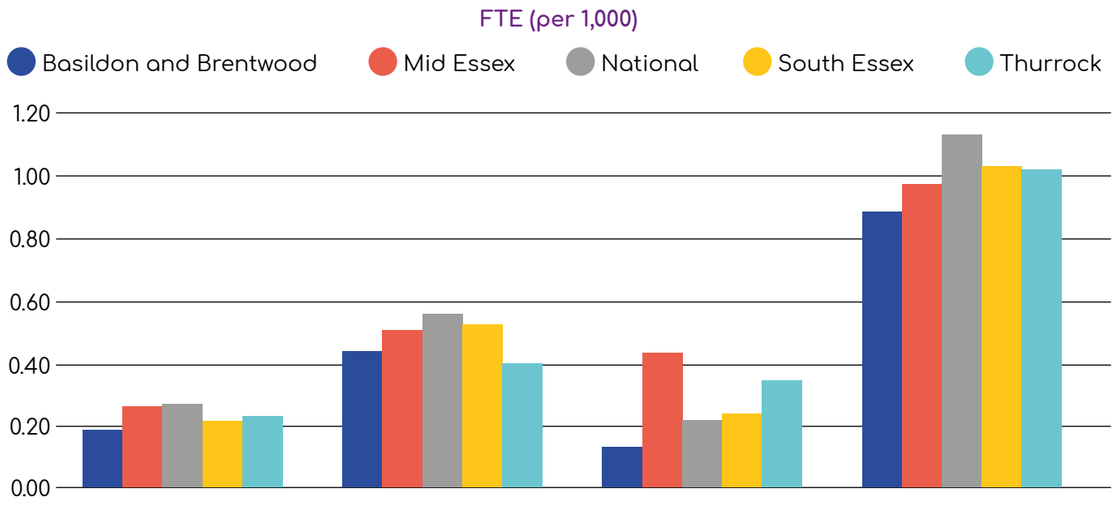
Headcount and FTE by reporting period



General Practice Workforce, GP, Nurses and Direct Patient Care (exc ARRS) March 2018-December 2020. Headcount and Full-Time Equivalent (FTE) Time Series – NHS Digital

Whilst the headcount and FTE has increased across the footprint, we still remain low when compared to national benchmarks for FTE per 1,000 registered patients across most reported staff groups.

National Comparison (per 1,000 registered patients)



General Practice Workforce by staff group. FTE per 1,000 registered patients, by CCG and National Average December 2020 - NHS Digital

Whilst the rate of decline in GP numbers appears to have slowed, it would be wrong to claim that the GP capacity issue has been solved and the numbers and time frame involved are insufficient to allow firm conclusions. There are particular concerns over the falling number of GP partners, with Thurrock being among the lowest CCGs nationally for partner/patient ratios.

The changes to the environment in primary care since June 2018, both anticipated, planned and globally unplanned, have been profound and a realignment of the strategy with this new world is now necessary.

The purpose of the strategy refresh is to revisit the principles agreed in 2018 in the context of recent changes, and to ensure primary care transformation is fit for purpose in the evolving landscape of our Integrated Care System, and the ambitions of the Mid and South Essex Health and Care Partnership.

4 Guiding principles to the strategic review

The strategy refresh has been undertaken with the following principles at its heart:

// The views of our residents and patients will be routinely sought and will guide the development of our system

// Primary care will play a key role in improving the health and wellbeing of the local population

// The review of the strategy must be informed by reliable and up to date information on primary care capacity and the needs of the population

// The economic status of primary care as a network of independent entities should be maintained and used to best effect where these contribute to the improved health and wellbeing of the population we serve

// System integration and transformation will recognise the challenges for and potential of primary care

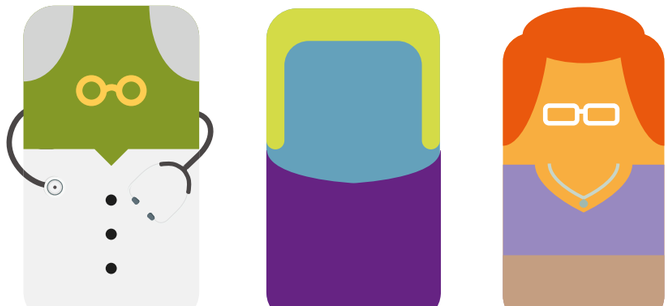
// System integration and collaboration will to a large extent proceed on the basis that the importance of primary care is recognised and primary care colleagues are able to engage in system development

// Increased provision of care in community and primary care sectors will be planned, agreed and resourced with due consideration given to the impact on other services, and recognising the impact of General Practice operating under a nationally negotiated contract

// The growing primary care workforce will be supported and valued both within General Practice and by system partners.

To this extent, the Mid and South Essex Health and Care Partnership will see the involvement of, and leadership from, general practice in PCNs as fundamental to the long-term success for the system.

The Partnership commits to supporting those that are willing to drive this agenda forward through the targeting of development funding, supplemented by supportive resource, to increase competencies available within PCNs. In delivering against this commitment, the Partnership will seek to identify and support lead and accelerator PCNs.



5 Key strategic areas for primary care in an Integrated Care System

The Mid and South Essex Health & Care Partnership 5-year Strategy identified an overarching ambition to reduce health inequalities experienced within the population. This would be achieved through:

// Creating opportunities – through education, employment and supporting socio-economic growth

// Supporting health and wellbeing – with a focus on prevention and self-care

// Bringing care closer to home – where safe and possible

// Transforming and improving our services with and for the population.

Progress made since 2018, in both general practice and the wider system, suggest that there are four key strategic areas this refresh needs to focus on to deliver the greatest effect on both primary care and the wider system:

1 The changing scope of primary care as a consequence of the pressures faced by other parts of the system

2 The requirement of a strategic presence of primary care within a future integrated care system and its role in supporting the delivery of the ambitions described above

3 The operationalising of the ambition to drive improved health and wellbeing through the collaboration of partners at a PCN footprint, with general practice fulfilling its role within this, and;

4 The requirement to transform the workforce and embed cultural change at all levels of the system.

5.1. Refocusing on primary care/ the scope of primary care

One of the main concerns expressed by practices since the Covid crisis has been the impact of work transferred from secondary to primary care due to changes in the format of out-patients, and the workload involved in managing patients who have been referred but are awaiting secondary care appointments. This latter group are now spending considerable time "between" service providers and therefore at risk of unplanned changes to their clinical status and of unmonitored deterioration.

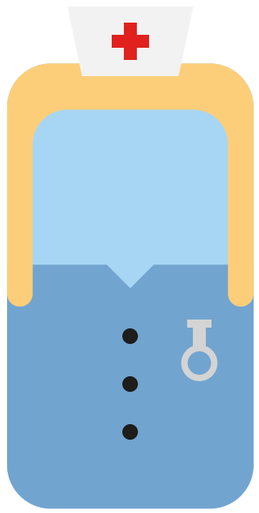
It is some years since the NHS had widespread prolonged waiting lists for secondary care and the population has grown accustomed to ready access across most specialities. This increases patient expectation and therefore their impact on services. In essence, this is a growing cohort with genuine identified need who are not currently under the direct care of any provider for that need. They have been referred from primary care but are unable to access the secondary care they require.

As a system we need to understand and address the growing unmet need of our population that have been "referred but not seen". Where possible we will adopt a Population Health Management (PHM) approach to understand and address this challenge.

The question of how the care of patients is managed by which part(s) of the health sector and where accountability and responsibility lie might be better answered by a consideration of the advice and support, and potential new services that should be put in place to ensure patient safety.

In a perfect tax funded, list-based system, care of the patient lies with the registered practice and referrals merely transfer, usually temporarily, part of this responsibility to the secondary care (or other) sector. This is not the current situation and a "care gap" is emerging which in time risks causing harm to patients, particularly those who are inexperienced at accessing services or who are disadvantaged in other ways.

Patients routinely expect their general practice to support them in owning and managing their condition(s) holistically - but as the number of patients in this group increases it is becoming increasingly clear that their needs are not being met and this is beginning to add an additional strain on primary care that will naturally affect other provision. Primary care clinicians are currently carrying the responsibility for conditions which they know require specialist intervention and patients are at risk of deterioration whilst waiting to be seen in secondary care.



5.1.1. A Guardian Service?

This "care gap" will impact on the health and wellbeing of those people who will be living with an unmanaged care need. It is considered the impact on service providers of increasing waits post-referral but pre-first appointment and the increasing time between first appointments and commencement of treatment will mainly fall on general practice in its role as the gateway to health and care services. It is proposed that the system explores the practicalities of primary care being resourced to support referred patients by the establishment of a new "Guardian Service" that would be owned by and accountable to primary care, through PCNs, to manage at scale the increase in patient queries and support required falling to general practice. As well as providing oversight and clarity on patient journeys such a service would be in a strong position, if operated at a scale no lower than place level, to identify challenges in the system and encourage resolution by developing improved local care pathways, and relationships between PCNs and the local acute provider.

This is one of the most difficult choices for both primary care and the system as a whole, as while it could move resources into primary and community care and support patients who are struggling with the current lack of capacity, it could also increase the workload of hard-pressed practices and further accelerate the decline in GP partners.

As this challenge cannot be ignored, alternative approaches might be to:

// Move resources into community trusts, or another provider, to provide a link between the other parts of the service, or;

// Increase resources for the acute trust to allow it to improve monitoring and care to those awaiting formal assessment or procedures or to accelerate delivery of their specialist services.

Neither of these two solutions will adequately take account of the fact that accountability remains with general practice, and as such would still require their input. This is the key reason why any guardian service should be accountable to primary care. However, this will require careful handling to ensure the service improves care pathways and does not over-extend the responsibility of PCNs. Similarly, this change will require improved discipline within primary care to complete agreed referral workup for patients and provides an opportunity to explore the development of non-acute based diagnostic solutions.

A guardian service must be seen as a supporter and protector of patients and it must at all times work towards solving problems and developing improved, agreed care pathways. It will not solve all the current problems within the NHS, but it will aim to improve communication and the effective delivery of guidance and care to patients.

The PCNs are responsible for the delivery of the Designated Enhanced Service (DES) on behalf of their practices. This is the first example of a service within general practice's General Medical Services (GMS) which requires practices to work together across an identified population linked by a network. Part of the specification requires PCNs to work with community trusts on the care of patients being discharged from hospital back into the community. The proposal above would widen this to cover those patients transitioning between primary and secondary care and proposes that a new service, answerable to primary care, be explored.

Potential key functions of a guardian service:

// Provide a first point of contact for referred patients

// Organise and report required diagnostic investigations and ensure agreed workup has been completed before referral continues

// Improve communication between clinicians

// Improve secondary care prioritisation of waiting lists – making use of intermediate services (tier II) and other community provision, including lifestyle support (e.g. smoking cessation, weight management)

// Maximise the opportunity that technology offers in managing the patient journey

// Control and reduce unnecessary, and duplication of, workload across the system.

We will rapidly explore the feasibility of delivering a guardian service within mid and south Essex that covers the full registered population.

5.2. Primary care's strategic presence within the Integrated Care System (ICS)

It is essential that we clarify the role of General Practice within the integrated care system – strategically and operationally - and for General Practice to be able to take up that role effectively.

The planned legislative changes being discussed by NHS England will almost certainly result in a new statutory framework during the life of this strategy.

There is little detail available on the relative power and accountability of these new structures, and in particular a lack of specifics on how this new system relates to Local Authorities and other partners. It is possible therefore to only cover the principles and generalities of how primary care may be able to influence within the ICS environment.

Local change already focuses on improved collaboration across the Health and Care Partnership and the creation of a simpler NHS commissioning and strategic planning infrastructure. Irrespective of future form it is essential that General Practice is supported to mature to a position whereby it can, across all parts of the emerging system - PCN, Place and System:

// In the interests of patients, and the population as a whole, speak with one voice, and

// Acquire an appropriate influence, and make meaningful contribution, to decision making at all levels

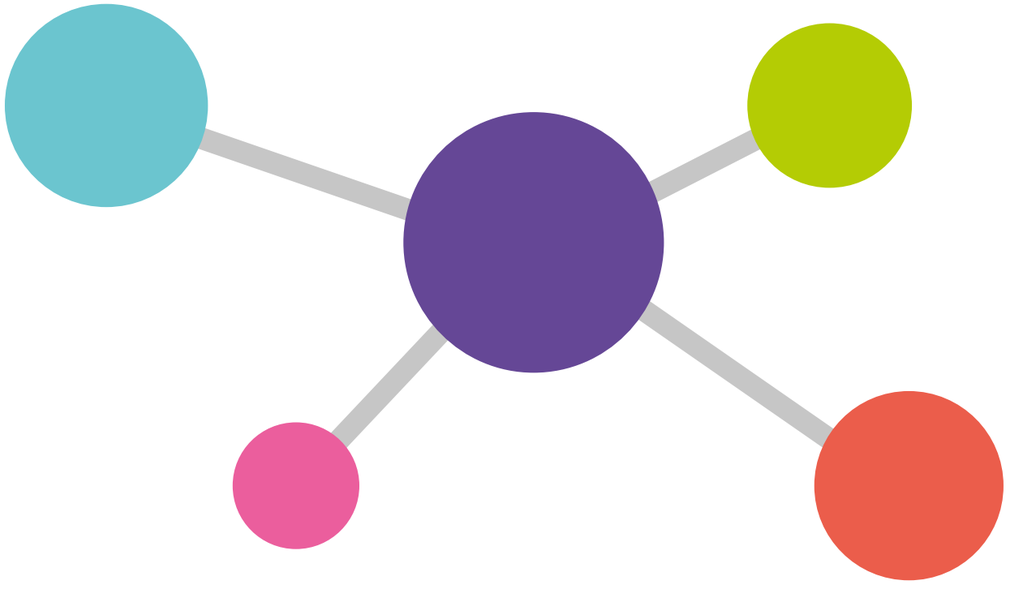
5.2.1. Networks

Primary care within Essex has always supported bottom up change and the PCNs are an obvious structural embodiment of this attitude. These relatively new collaborations are far from a position of maturity and will be growing and recruiting staff, both clinical and managerial, for several years to come whilst also coping with the uncertainty and pressures of the current pandemic response.

A crucial function of the networks, and recognised by General Practice, is their integration with community providers, Local Authorities and wider stakeholders. A network which fulfils its role as a community-based health and care provider grouping will need to be accountable for improvements in outcomes to both the NHS and the local authority.

Such divided accountability does not need to be over complicated and should dovetail with the co-operative nature of networks being groupings of local general practices. It is probably unnecessary to attempt to be prescriptive about decision making and influence at this level as individuals ought to be able to undertake this in a way which best suits their community and circumstances. To truly succeed there will need to be decisions made at PCN level amongst all partners, these include:

// Leadership and decision-making arrangements in a growing network
// Formal relationships with community providers and local authorities
// Interaction with other networks and the local Place/Alliance
// Individual PCNs ambitions for presence or influence at place-based Alliance and system levels.



5.3. PCNs - general practices operational presence in the Integrated Care System

We will enhance local care teams, led by multidisciplinary teams, that optimise the skills of a diverse workforce

// Partners adopt a system-wide view and approach to delivering high quality, integrated services that are multidisciplinary team led. We will adopt best practice across the system, supporting all professionals to work at the top of their skillset.
// Local teams will have ownership for helping deliver clinically, operationally and financially sustainable services.
// We will support GP practices to work more closely together and to work with other care providers, sharing skills and resources.

NHS England's operational model, and investment route, for General Practice is the PCN. This was made clear in the Long-Term Plan and continues to be reinforced by subsequent spending commitments, particularly in additional staffing across networks. Mid and south Essex's localities for the most part adapted well to this change.

5.3.1. PCNs must be more than a collaboration amongst practices

Over recent years significant work has gone into improving collaboration amongst system partners. To date this has tended to focus on two related but separate areas of work, that over the life of this strategy need to become aligned, and expanded to include other partners, to create 'delivery units' focused on the health and wellbeing of the population which they serve.

Experience through the pandemic, and in particular in relation to delivery of the Covid vaccination programme, has provided a valuable learning experience in relation to practical approaches to collaboration, focused around collective delivery. As we progress, we will take the learning from these experiences, share them, and build upon them.

5.3.2. Collaboration amongst practices

Collaboration between practices was a key focus of the 2018 Strategy, and a significant contributor to closing the previously modelled demand and capacity gap particularly through utilisation of a diversified workforce. Prior to development of the PCN Network DES this was progressed in varying ways across the Partnership. The release of the DES, and its position in the GP Contract for the coming years, makes it the key vehicle for enabling intra-practice collaboration, in particular through the Additional Roles Reimbursement Scheme (ARRS).

The ARRS, which forms part of the nationally negotiated GP Contract, provides funding for defined roles to be recruited to at a PCN level. Recent announcements expanded these roles to include joint funded mental health workers working for the PCN, but funded through both PCN and community mental health providers. Criteria and restrictions are nationally decided which can create supply shortages and drive costs for difficult to recruit staff groups and there are emerging problems with training, mentoring and induction for this growing workforce. The increased demands placed on PCN Clinical Directors has not been addressed despite the national expansion in the workforce and the increased expectation placed on networks.

It is considered that the previous demand and capacity gap identified in 2018 should close by 2024 through full take up of the additional roles across PCNs by 2023/24. This enables a refocus of discussions from insufficient resource, to one around best use of resource. Uptake to date has not been in line with plans, leaving unutilised resource for 2020/21.

We will work with PCN Clinical Directors to ensure maximum uptake, and best use, of this resource in future years. We will also explore alternative employment models, such as through local community providers, as a way of making best use of this contractual entitlement.

Where it is considered appropriate there is nothing to stop the system from further increasing investment into PCNs, as envisaged by the original Strategy, and enabling a more rapid growth in and out of hospital capacity both in terms of its quantity and also in the range of services provided where it is considered this will deliver improvements in health and wellbeing outcomes, collaboration amongst partners and a reduction in health inequalities. This investment could be financial, or in-kind, through the alignment of existing resources and expertise already working within the system within partner organisations. This would enable PCNs to increase their competencies and expand their boundaries beyond General Practice.

Using PCNs to develop GP Practices

PCNs will be supported by Alliance or Place Directors and their teams, and possibly also by resources at MSE Partnership level. It is important to remember that the PCNs currently have no legal status and as such cannot directly employ staff or hold contracts to provide services – these functions are generally undertaken through a lead practice. Similarly, groups of PCNs at Place level will function only by utilising lead practice or other contractual measures or organisational forms.

Any change to the current status of PCNs would require careful preparation as a hasty move to create legal entities, particularly if they could hold GMS or PMS contracts, could destabilise general practice with practices and Networks becoming competitors for finite resource. PCNs are immature but growing in strength and should be allowed to grow organically.

PCNs exist as collaborative structures encompassing local practices in order to deliver care across wider populations. The registered patient list lies with individual practices and patients identify with practices and not PCNs. The current Covid vaccination programme may begin to alter this relationship but it is unlikely that the population's fundamental link to the NHS will move away from "their" general practice and its staff.

This refresh has highlighted and worked around the national policy of diverting general practice funds through PCNs and as such it is easy to overlook the individual practices and their assets and challenges. It would however be a mistake to overlook the very real diversity among our practices in terms of workforce, organisation and ambition. If all innovation, and funding, is focused on PCNs there is a danger practices stagnate, fail to recruit and become vulnerable to contract failure and ultimately termination. This has happened in the recent past and the effect on patient care has been immensely negative.

The system needs to recognise the risk associated with development and leadership training solely focusing on PCN Clinical Directors. There is a clear need to promote wider leadership across primary care and to assist succession planning in practices.

5.3.3.Collaboration beyond practices

In parallel integration programmes have been progressed across all four places within mid and south Essex, with many examples of closer working – some include General Practice, some do not – and there are already excellent examples at Alliance level of wider Network development which includes the community providers and local authorities. This is evident in patches across the Mid & South Essex footprint.

As a system we will build on good practice and through alignment of key staff make such innovation normal in mid and south Essex. The alignment of staff could give primary care the infrastructure necessary to accelerate real and pragmatic integration at Network level.

Examples of current collaboration include

Thurrock began their transformation journey in 2012 with a focus on the better integration of services at place, the built environment and stronger communities. This has evolved and grown over recent years and in 2017 moved to a more whole system approach for phase 2 and the Better Care Together programme bringing together commissioners of services with adult and child social care, community and acute providers of physical and mental health services, the third sector through their local Association of Voluntary Services and others. This journey has seen material improvements including the relationships with local communities through the implementation local area co-ordinators who help vulnerable people find ways to make a better life and improve strategic relationships between key stakeholders within the area through the development of their integrated care partnership, and the development of Enhanced Primary Care Teams, hosted by the local community services provider, covering two of the four PCN footprints. One of the next steps, currently underway, is the alignment of General Practice in both strategic and operational conversations across partners through engagement with the Clinical Directors.

Essex County Council (ECC) have explored multiple approaches to collaboration with other partners, showing a flexible approach based on local context. As well as aligning social workers with practices and PCNs to improve relationships – ECC have, in partnership with Provide CiC who deliver NHS community services within mid Essex, formally undertaken a programme of integration focused on collaboration among front-line care providers. This has seen progress made in the approach to collaboration, and within the Dengie they are about to launch a 18 month pilot working across organisations to coordinate activities such as planned visits. At present this excludes General Practice, although the ambition exists to bring them into the working arrangements.

Within south east Essex they are progressing a transformation programme of current services into an integrated model of care, on a locality footprint. The ambition being to create a family of professionals who are well networked and deliver in concert to meet health and care needs at both population and individual level.

Across the footprint there are examples of improvements in collaboration between the acute provider and General Practice through models such as the employment of First Contact Physiotherapists on behalf of, and managed by, PCNs, and a joint consultant paediatrician and GP clinic in the community, targeting low risk cases with common presentations and conditions for those under 5. The aim being to increase skills, experience and confidence of GPs enabling them to manage similar cases in the future in primary care. Each session ends with a teaching/development session for colleagues across the PCN with the ultimate aim to align a paediatrician to each PCN.

MSE will seek to provide resources to widen the range of staff within PCNs and facilitate a more flexible approach to care provision which best suits each community.

5.3.4. Embedding Collaboration

The ambition to truly integrate, or collaborate, with General Practice from other partners has been a reality for a number of years. To date universal coverage has failed to materialise.

In order to achieve the ambitions of the Long-Term Plan, the Mid and South Essex Health and Care Partnership 5-Year Strategy and the original Primary Care Strategy these aligned but separate arrangements for collaboration will need to be 'aligned' and 'expanded'.

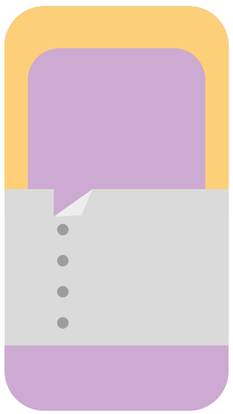
Through the NHS Alliance Directors, and their local teams, we will facilitate the coming together of all partners that are working with common populations. Whilst the focus has been on health and adult social care we need to work towards models that are all age, all need, with collaboration being the norm. We should enable the collaboration around both operational pressures as well as longer-term planning at a PCN footprint.

The changes outlined in this review will require a fundamental change in the relationship between PCNs and NHS statutory bodies (in the short-term CCGs, and longer-term the ICS NHS Body), whilst defining the relationship between PCNs and place. In some areas this is still the traditional "parent/child" attachment which gives comfort to both sides but has a tendency towards self-preservation therefore slowing down the maturation of the provider, in this case the Network.

We will endeavour to create the environment that enables effective collaboration, including supporting the development of shared purpose, identification of time to enable development, and where possible the removal of unnecessary bureaucracy

We will drive collaboration at PCN level through the alignment of incentives to locally set outcome measures that contribute to the ambitions of the Health and Care Partnership

We will look to share good practice, and support maximum impact of innovation by working to improve our approach to 'spreading' adoption, including the development of lead and accelerator PCNs to drive this agenda forward



5.3.5.Micro Commissioning

The Mid and South Essex Health and Care Partnership believes in 'building from the bottom up'. We want to plan and deliver care in the heart of our communities with PCN's providing the building block around which integration best occurs. The ambition is to devolve planning and delivery down to the lowest possible level where it makes sense to do so. The starting point for service delivery, transformation and integration will be Primary Care Network level and we will only plan, commission and deliver services over wider geographical footprints where a clear case can be made that this is necessary.

As such PCNs need to have the capacity and competencies to fulfil that role alongside those at place and system – engaging closely with their local populations in the context of the wider system.

Changes in one part of the system, or one sector, have an impact elsewhere. Closer integration should have the result of increasing agreed and planned change, which allows maturing PCNs to obtain the capacity to deal with additional work.

The Health and Care Partnership Board has committed to targeting the "Partnership Pound" on appropriate care needs for our patients and residents, and the system has committed to managing resources on the basis of a system operating budget, through the use of service line reporting, linked to the performance framework for the system.

To achieve the commitments in managing resources in a meaningful way we need to ensure that we co-ordinate the financial management roles of System, Place, PCNs and Partners to maximise the potential for our population.

To optimize the benefit of working as a system we have agreed that we can only spend/ financially manage the partnership pound once. Therefore, aside from the System role of resource allocator, there are two types of roles that will operate in the system; Resource Consumer or Resource Manager.

The distinction between the two roles has been made as follows:

Resource consumer will be measured on the level of resources consumed of services provided by others. Management reporting for resource consumption will provide a view of the level of resource that has been used – it is not the transfer of cash and the aim of reporting will be to understand the variation of resources use to improve population health.

Resource manager is the direct manager of a budget for resources, incurring the costs for the delivery of care and is linked with cash transactions. Management reporting will provide insight into the performance against budget and is a hard measure for the financial success of the ICS against the System financial envelope.

Primary Care Networks hold a unique position within the system by having a role as both consumer and as a provider of primary care.

This framework could enable the introduction of a 'Micro Commissioning' role influenced by PCNs to meet specific needs for their populations, including impacting on local health inequalities, and supporting the personalisation agenda

Micro Commissioning, alongside PCN development, will be supported by the new NHS Alliance Directors and their local teams, who have transformation and managerial responsibility for the four "Places" in mid and south Essex.

In line with the movement to service line reporting, lead PCNs will need to emerge where one network can drive change in a specific clinical area in conjunction with partners from other sectors (e.g. secondary care, community and mental health services, local authorities, community and voluntary sector organisations) with, and on behalf of the whole population.

Through the movement to system operating budgets we will look to develop a local planning role for PCNs aligned to enhancing local service provision to meet the needs of the local population.

Integration will not be effective unless the management capacity or infrastructure across the system is re-balanced to support PCNs, and explicitly General Practice to take its place within them. To date investment in PCNs has been through clinical capacity, without corresponding investment in managerial, estate or digital infrastructure.

NHS Alliance Directors and their teams are currently engaged in wrapping support and services around PCNs. As this process matures, the system will need to address the transition from PCNs being the recipients of CCG management support to one where Networks have access to, and influence over, the necessary skills and competencies to deliver the outcomes expected of them.

Emerging PCNs and CCGs work closely together but are often significantly different in terms of their organisational culture and interaction with the wider health and social care environment. This refresh proposes formal recognition of PCNs as the future vehicle for the provision of primary care and a commitment to supporting them to develop the skills and competencies required to succeed. This commitment enables a genuine focus on:

// Clear strategic aims and objectives

// The precise operational functions required by the out of hospital system

// Matching the needs and skills of the available staff to the required functions contained within new primary care management roles

// Integration at Network level which is meaningful to local authorities, community providers and other key stakeholders

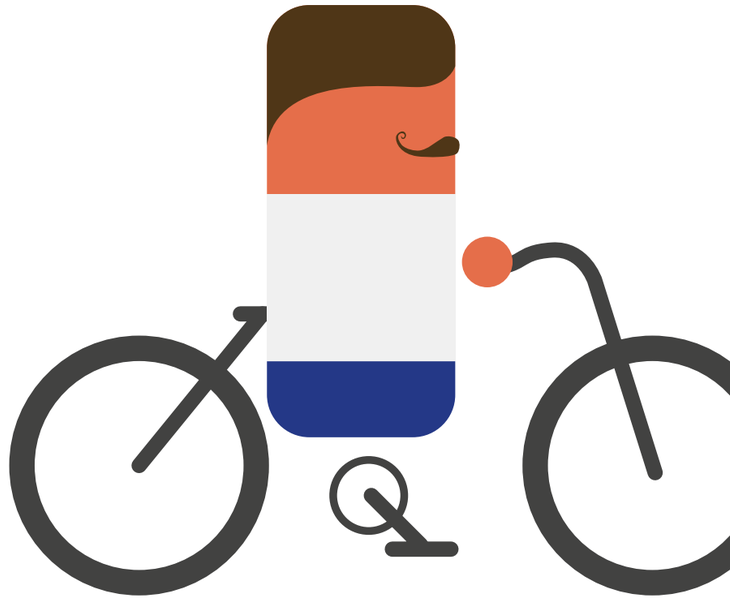
The environment allows a genuine focus on function rather than form although the designation of Mid and South Essex as an ICS, and the establishment of an ICS management team will provide overall stability.

There is a clear need for the workforce plans of the ICS to address these issues and to promote the organisational development of PCNs which may make progress at differing speeds and with varying ambitions. The key to success will be to create a system which encourages growth to the next level without losing sight of their primary functions nor of stifling these new "organisations" through over ambitious plans and expectations.

The Mid and South Essex Health and Care Partnership recognise PCNs as a fundamental building block of the future system and will actively support

Development of Leadership and the culture of the system to enable primary care driven change.

General Practice to develop the capacity and capability to lead and accomplish primary care driven change in an integrated system.



5.3.6. Closer working with Dental, Pharmaceutical and Ophthalmic services

We will enhance local care teams, led by multidisciplinary teams, that optimise the skills of a diverse workforce

// Partners adopt a system-wide view and approach to delivering high quality, integrated services that are multidisciplinary team led. We will adopt best practice across the system, supporting all professionals to work at the top of their skillset.

// Local teams will have ownership for helping deliver clinically, operationally and financially sustainable services.

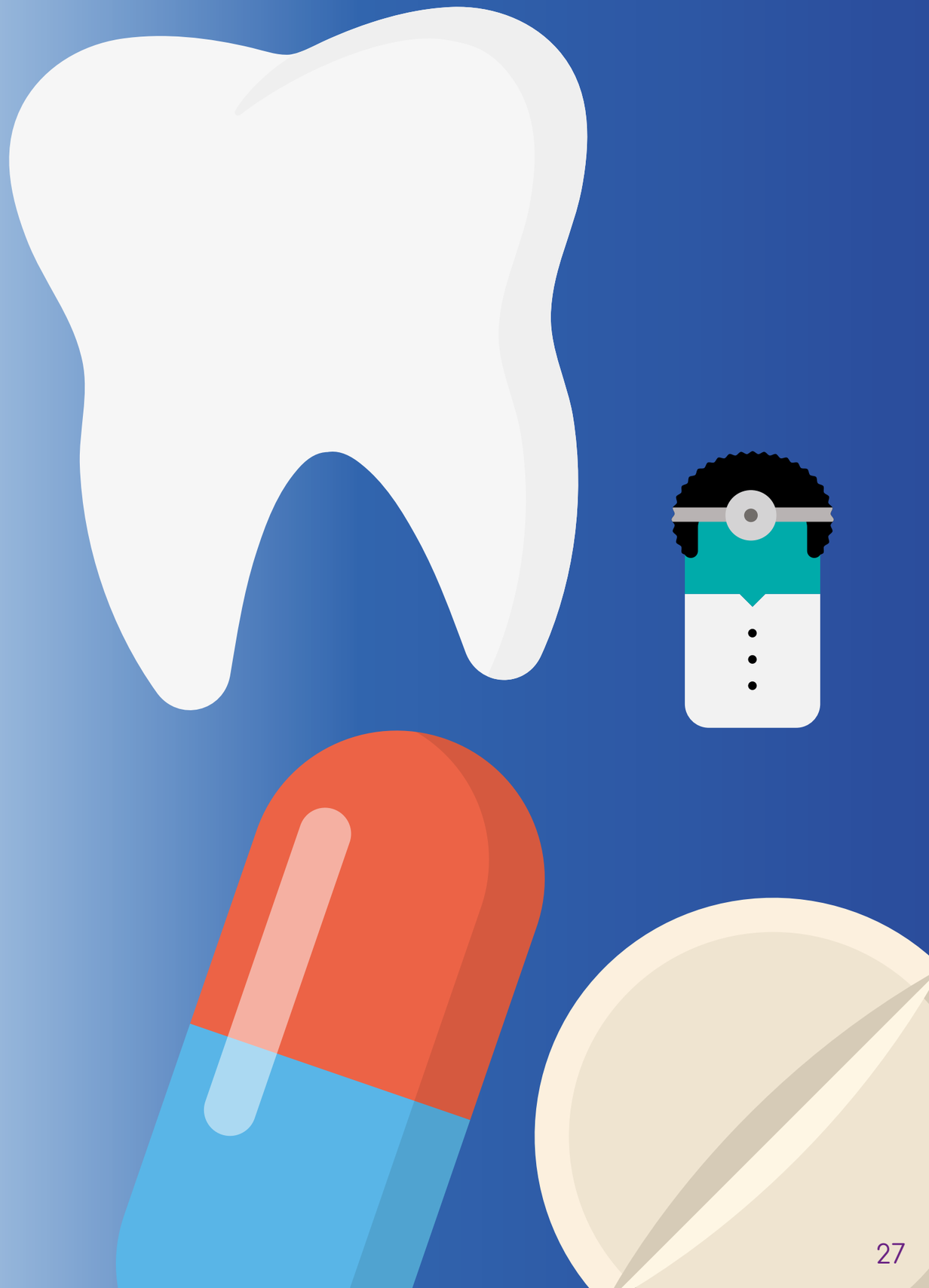
// We will support GP practices to work more closely together and to work with other care providers, sharing skills and resources.

The complexity of the commissioner and provider landscape for the other three elements of primary care has traditionally made this one of the more difficult areas to address in enabling local collaboration, with all three holding slightly different contractual relationships with the NHS.

It is considered however that for PCNs to fully achieve the ambition of improving population health and wellbeing, better collaboration across the whole of primary care is required.

In addition to the opportunity to develop the concept of Making Every Contact Count all three sectors provide excellent opportunities for early identification of deterioration in people's health, the prevention agenda and in some elements, on-going care and support. It is important that we begin to bring their expertise into the conversation and work through how we enable collaboration across the whole of primary care.

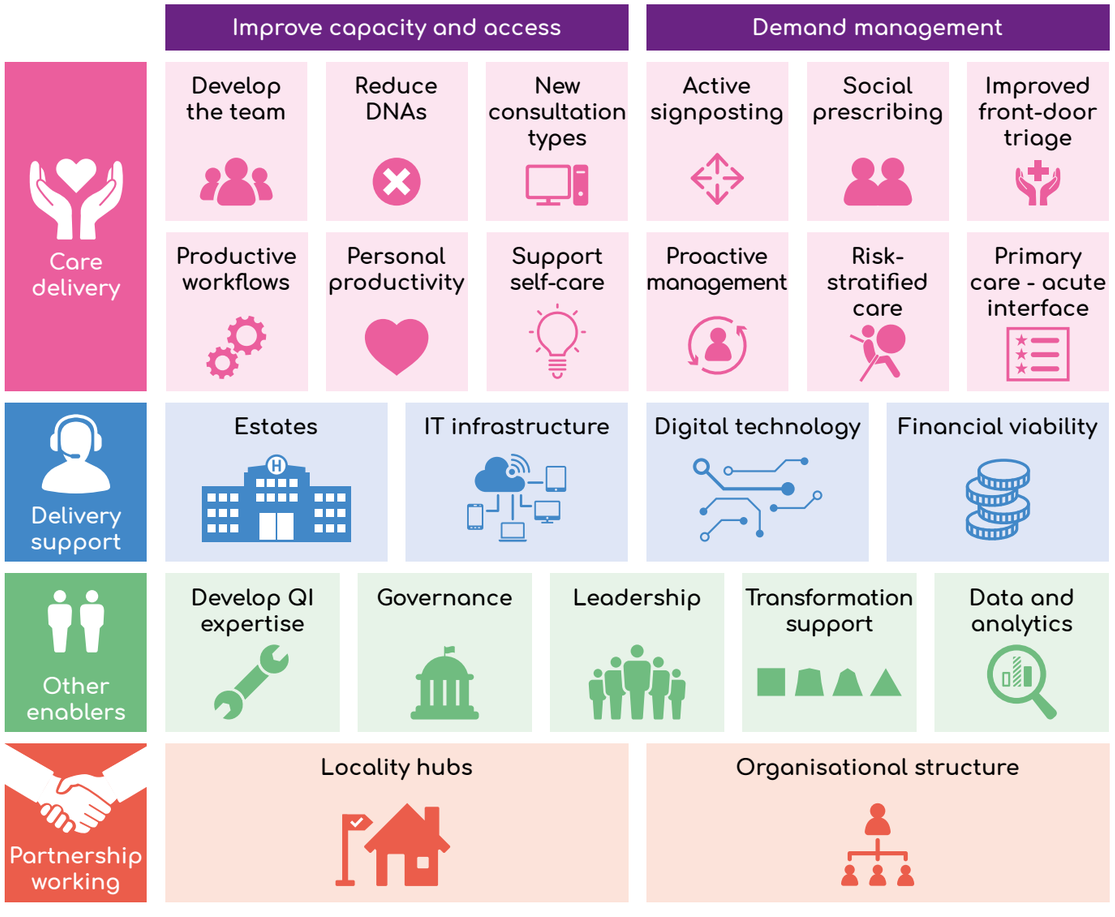
We have to date been unsuccessful in this arena, and we will look to improve relationships and collaborative working as we build on the competencies within PCNs. The proposed legislation, as described in the Government's White Paper 'Integration and Innovation: working together to improve health and social care for all' will give stronger responsibilities for commissioning all primary care services to the NHS ICS statutory body, and we intend to take these opportunities to integrate where possible.



6 Model of Care and the MSE Target Operating Model

In 2018 the Primary Care Strategy focused on the sustainability of General Practice. At the time it was considered that there were risks to the system associated with the resilience of individual practices. The majority of interventions were built on principles in the GP Forward View, with the focus of support aligned to individual practices and the collaboration between practices.

The priority at the time was addressing an identified and projected demand and capacity gap through implementing a range of interventions as illustrated in the diagram below. The ambition being to manage demand and improve capacity and access.



As part of this Strategy Refresh support was identified to model a range of demand and capacity scenarios for General Practice over the life of the current GP contract reforms (2023/24). This was undertaken in partnership with place based primary care leads – both clinical and managerial. Scenarios were developed that covered assumptions with a high likelihood of occurrence and some more speculative scenarios. In summary the key conclusions of the work were:

// Current Q4 2020/21 workforce levels will not provide sufficient capacity to meet forecast demand in 2024.

// Planned increases to core GMS resources by 2024 will not provide sufficient capacity to meet 2024 demand.

// Planned recruitment through the Primary Care Network (PCN) DES under the Additional Roles Reimbursement Scheme will provide sustainable Primary Care capacity by 2024 and can meet forecast demand levels (for scenarios with a high likelihood of occurrence).

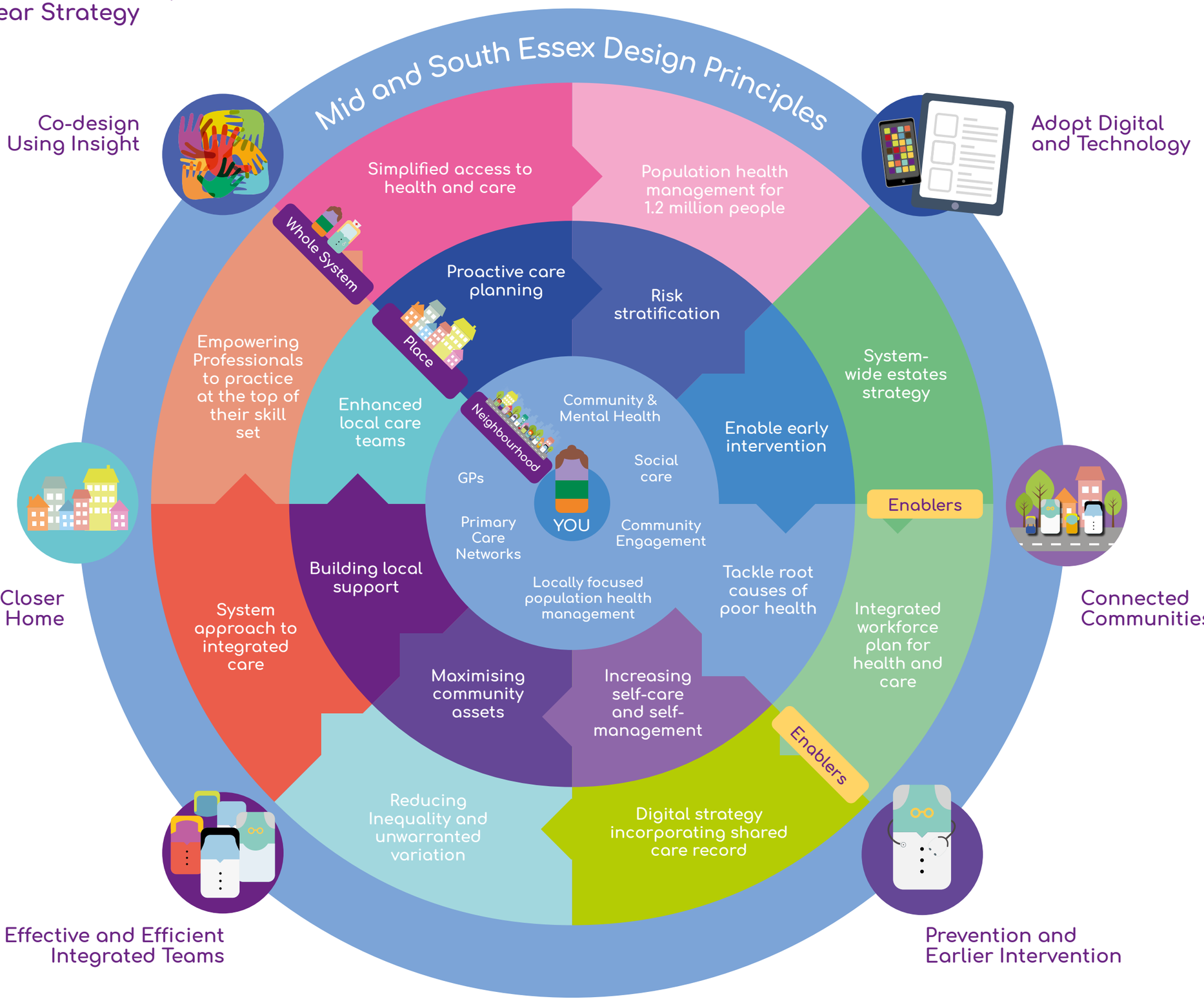
// PCN DES resources can provide sufficient capacity to meet increased 2024 demand resulting from a range of 'external factors' if a number workload reduction and prioritisation schemes are implemented effectively and consistently and achieve maximum levels of forecast benefits across the Mid and South Essex Health and Care Partnership in tandem with recruitment

It is clear from the analysis that recruitment to the 'ARRS' roles is essential in achieving a resilient and sustainable model for General Practice across the Partnership and creating the foundation upon which enhanced collaboration can take place.

Significant investment – money and time - has gone into areas that increase capacity within, and across, practices since the original strategy was improved. However, whilst partnership working beyond General Practice was identified as a requirement this has in most areas occurred around General Practice (e.g. between other partners) and not with General Practice.

The ambition for collaboration was enhanced within the Mid and South Essex Health and Care Partnership 5 Year Strategy which included a Target Operating Model for the system that saw this as a fundamental building block to improving health and care outcomes. The principle of subsidiarity and collaboration looks beyond individual organisational responsibilities and at the collective delivery of improved outcomes for the population.

Target Operating Model: Mid & South Essex Health & Care Partnership 5 Year Strategy



This Target Operating Model was underpinned by six design principles that will shape on-going transformation across mid and south Essex, and form a key part of this strategy refresh and its implementation.

This strategy refresh does not propose an alternative model of care, but further commits to the principles of managing demand, increasing capacity and the development of collaboration to improve the wellbeing of our population. General Practice must take its place alongside partner organisations, with the PCN DES providing the opportunity, and vehicle, for those who are willing and able to take a leadership role in the future model of care. Through our accelerator programme we will work with those with ambition to lead the way and develop models of good practice for adoption and spread.

Design Principle	Description

We will co-design with insights and intelligence, putting residents at the centre 	// We will work with our residents and staff to shape services that are focused on better outcomes, long-term sustainability and continuous improvement, driven by a feedback culture.
	// We will use data that is connected and evidence to ensure we understand fully the challenge and opportunity.
	// We will ensure we have the right resources to enable us to get an accurate view from shared and collective knowledge, insight and data, which will inform our plans and actions.

We will connect people together, delivering integrated care in the community 	// Services are designed to put residents in control – providing high quality information that is accessible online at any time and supporting them to make informed decisions. // We will ensure different organisations work together, meaning people get the right care more quickly and easily.
We will support people to stay well through prevention, self-care and independence thus building resilient communities 	// We will shift from the reactive transactional model currently in place, to a responsive, proactive and sustainable system that focuses on keeping residents well and supports them through all stages of their life. // We will reduce inequalities by acknowledging and investing in the wider determinants of health and ensuring pathway design begins with prevention.

We will adopt digital and technology by default 	// Services will seek to optimise the use of technology consistently e.g. digital channels will be adopted as the primary and preferred method for communication and patient interactions.
	// Other channels will remain available but used only when most appropriate.
	// Staff and residents are supported to adapt to new ways of working and champion innovation.

We will enhance local care teams, led by multidisciplinary teams, that optimise the skills of a diverse workforce 	// Partners adopt a system-wide view and approach to delivering high quality, integrated services that are multidisciplinary team led. We will adopt best practice across the system, supporting all professionals to work at the top of their skillset.
	// Local teams will have ownership for helping to deliver clinically, operationally and financially sustainable services.
	// We will support GP practices to work more closely together and to work with other care providers, sharing skills and resources.

 We will deliver services as close to home as possible	// Community based provision of services is the default position, unless necessitated by clinical need. This ensures residents are able to access health, care and wellbeing services in the most appropriate setting for their needs, including online.

7 Measuring success

In 2018 it was recognised that we did not systematically track outcomes in primary care at either individual practice or 'locality' level. This meant that the priorities and targets being aimed for were not always clear, and it was difficult to track and understand levels of progress.

There has been limited progress with this over the past three years, although recent decisions at both a Partnership and national level, through the Mid and South Essex Health and Care Partnership Outcomes Framework and the Impact & Investment Scheme respectively, will begin to move the dial on the ambition.

Moving forward success of PCNs needs to be measured within the context of the system in which they are operating, and the expectations placed upon them. As such success will be measured across three domains

1 Improvements in population health outcomes
2 Use of system resources, and
3 PCN Maturity/Relational Development

7.1. Improvements in population health outcomes

It is important that we don't create an environment that measures something that drives perverse behaviours, be it from a care or administrative burden perspective.

The PCNs contribution towards improvements in health outcomes will be against two set of measures.

7.1.1. Impact and Investment Fund

The IIF is an incentive scheme built into the GP contract reform. It focuses on resourcing high quality care in areas where PCNs can contribute significantly towards the 'triple aim':

// improving health and saving lives (e.g. through improvements in medicines safety)

// improving the quality of care for people with multiple morbidities (e.g. through increasing referrals to social prescribing services)

// helping to make the NHS more sustainable.

The metrics are set nationally, and achievement funded through Primary Care Allocations. The table below identifies the metrics for the IIF in 2020/21.

Domain	Area	Indicators
Prevention an tackling health inequalities	Prevention	PR01: Percentage of patients aged 65 and over who received a seasonal flu vaccination.
	Tackling health inequalities	HI01: Percentage of patients on the learning disability register aged 14 and over who receive an annual learning disability health check.
Providing high quality care	Personalised care	MS01: Percentage of patients aged 65 and over currently prescribed a non-steroidal anti-inflammatory drug (NSAID) without a gastro-protective medicine.
	Medicines safety	MS02: Percentage of patients aged 18 and over currently prescribed an oral anticoagulant (warfarin or a direct oral ainticoagulant) and an antiplatelet without a gastro-protective medicine. MS03: Percentage of patients aged 18 and over currently prescribed aspirin and another antiplatelet without a gastro-protective medicine.

It is important to recognise that payments achieved through this are likely to form part of individual practice income. Achievement will be monitorable through the NHSE PCN Dashboard due for release during 2021.

7.1.2. Mid and South Essex Health and Care Partnership Outcomes Framework

The Mid and South Essex Health and Care Partnership have collectively agreed a set of outcome measures, and priorities as noted at the top of the document, that they want to achieve for the population. Achieving improvement in many aspects will sit at place and PCN level.

It is the expectation that PCNs become the owners of their information, and the needs of their population. Through this knowledge PCNs will identify local priorities – utilising information such as Joint Strategic Needs Assessments, population health analysis and patient engagement - to address local need and health inequalities that contribute towards system ambition.

Reducing Inequalities

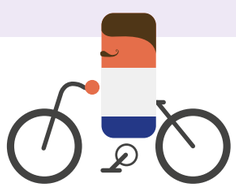
// Slope of Inequality
// Health Life Expectancy measures

Creating Opportunity

// School Readiness
// Percentage of people in employment
// Educational attainment
// Statutory homelessness
// Number of non-decent dwellings
// Air quality

Health & Wellbeing

// % of adults classified as overweight or obese
// Reception and year 6 prevalence of overweight children
// % of adults physically active
// Smoking prevalence
// Admissions for alcohol related conditions
// QOF prevalence for diabetes, AD, CHD, hypertension, cholesterol
// % of people self-caring after reablement
// Patient Activation Measures



Moving care closer to home

// Patients reporting good overall experience with practice appointment times and good experience of making an appointment
// Patients reporting a positive experience of their GP practice
// Delayed transfer of care
// A&E attendances conveyed by ambulance

Transforming our services

// Breast and bowel screening uptake
// Cancer waiting times
// Elective waiting times
// % of residents with high self-reported happiness
// Reduction in depression cases
// Reduction in suicide
// Treatment and recovery rates for IAPT services
// Physical health checks for patients with serious mental illness
// Mental health admissions to hospital

7.2. Use of system resources

PCNs operate in a system of finite resources, and decisions made impact on these. It is important that PCNs understand their wider use and impact on these resources. To date we have not collated or shared this information.

During 2021/22 we will work to develop regular information for PCNs to understand how their population is utilising system resources. This is supported by the movement to service line budgets.

7.3. Maturity/relational

PCN success will be determined by the maturity of the relationships between individuals and partner organisations.

We are yet to define how we will measure this, but it is proposed that during 2021/22 we develop a way to understand this across the system, enabling areas of good practice to be identified and shared across the wider footprint. The 'Integrated Workforce 'I' Statements (IWIS) Framework" provides a structure that the system could look to adapt to measure improvements in this area.

[1] https://learning.wm.hee.nhs.uk/sites/default/files/2017-03-27_final_21453_-_integrated_toolkit_booklet_v157927.pdf

8 Developments since 2018 and the case for strategic refresh

8.1. NHS Long-Term Plan

The NHS Long Term Plan was launched in January 2019 in an effort to provide a strategic plan for services which would be "fit for the future" and which would provide "the most value for patients".

The plan had a clear emphasis on the prevention of ill health and on improving outcomes for patients, and signalled an increase in funding for primary and community care.

The LTP encouraged "doing things differently" to give people more control over their own health and also encourage more collaboration between GPs and community services. The latter signalled the creation of "Primary Care Networks" (PCNs) and this initiative was bolstered by the GMS Five Year Contract Agreement of 2019 which put PCNs at the centre of new investment into General Practice. NHSE stated ambition at the time was that by 2023/24 PCNs will have accomplished five things

- First, **stabilised general practice**, including the GP partnership model
- Second, **helped solve the capacity gap** and improved skill-mix by growing the wider workforce by over 20,000 wholly additional staff as well as serving to help increase GP and nurse numbers
- Third, become a proven **platform for further local NHS investment**
- Fourth, **dissolved the divide between primary and community care**, with PCNs looking out to community partners not just in to fellow practices
- And fifth, systematically delivered new services to implement the Long-Term Plan, including the seven new service specifications, and **achieved clear, positive and quantified impacts** for people, patients and the wider NHS.

This was a natural progression on the local 2018 commitment to address an existing and projected demand and capacity gap within General Practice through the provision of a wider workforce, the movement to a GP Led as opposed to GP Delivered model of care and the progression of improved collaboration between General Practice and other local partners. In response the Mid & South Essex Health and Care Partnership (MSEHCP) developed its 5 Year Strategy that made clear its ambition for PCNs.

This stated "Primary Care Networks (PCNs) will form the vehicle for delivering collaborative working amongst front-line staff. Through PCNs we will deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. We will move to a GP-led model of care focused on improving population health and wellbeing, and supporting provider sustainability. PCNs will be the foundation stone on which local places will thrive and the key provider vehicle for delivering local services."

As part of the 5 Year Strategy the Partnership have agreed on the priority areas of ageing well and cancer.

The National Ageing Well agenda, with a focus on anticipatory care and enhanced health in care homes, as well as urgent community response, will only deliver the ambitions where PCNs take a leading role in the care of older people in the community – irrespective of where they live. We envisage, through both nationally negotiated contracts, and local enhancement, that PCNs will deliver more than just the medical requirements of two of these three programmes of work.

As part of this programme, anticipatory care is beginning to move from a reactive, hospital-centric, health and care offer to one of prevention, empowerment and community and personal resilience. The principles of anticipatory care underpin the future models and focus on maintaining wellbeing. This will be underpinned by our Population Health Management work stream.

Anticipatory care will also encompass supporting maximum coverage of screening opportunities – including supporting early cancer diagnosis, annual health checks for those who would benefit from it, ensuring that there is sufficient support for carers, on whom the system relies so much, and contributing to the challenge presented by health inequalities.

As a Partnership we continue to commit to the improvements included within the 5-Year Strategy for improvements in Cancer care, with PCNs playing a key role in emerging models of care.

// PCNs will be focused on prevention and ensuring we meet standards for screening programmes for breast, cervical and bowel cancers

// By working together, practices will be able to offer faster access to appointments ensuring fast onward referral, where required, for tests and treatments

// Patients diagnosed with cancer will receive personalised support throughout their treatment and afterwards

// Close work with community and voluntary sector organisations will support patients and their families to access a wider range of services – for example, on welfare advice and support groups.

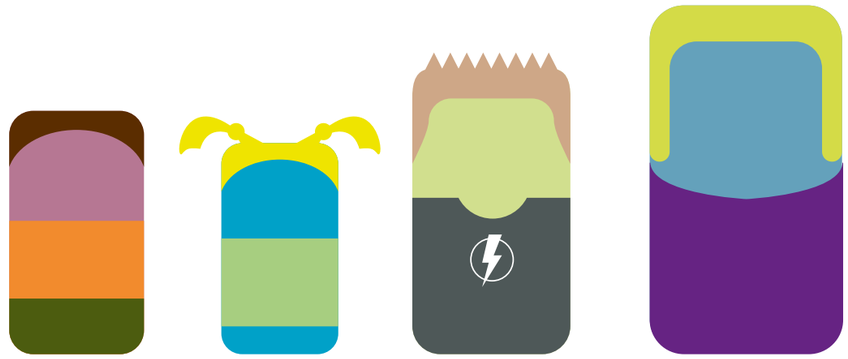
8.2. Primary Care Networks and investment

PCNs now cover all patients and virtually all practices in England are members. In mid and south Essex the PCNs, which cover the full population, have been a natural progression of previous locality structures, and this was a major advantage for the area in rapidly adapting to the new national environment.

National direction is that PCNs will be the unit at which investment is targeted, through a range of initiatives including investment through the Additional Roles Reimbursement Scheme (ARRS), which will fund a significant increase (circa 620 WTE against pre- ARRS baselines) in numbers working across PCNs, and the PCN Impact and Investment Fund that will reward achievement of nationally set population outcome measures.

Other ambitions within the Long-Term Plan included tackling health inequalities, supporting an increasing workforce, and making better use of digital technology.

The early result of this, and the on-going implementation of the mid and south Essex strategy, has been an increase in funding for primary care from £149m as noted in the 2018 Strategy to £163min 2019/20 – or 9.29% of total spend. Whilst the investment figure needs caveating due to the complexity of primary care funding sitting across six commissioning organisations, and multiple investment streams, the increase supports the local commitment to ensure seeing investment into primary care increasing at a rate that will meet the GPFV commitment (i.e. to increase the proportion of investment going into general practice services to be over 10 percent by 2020/21).



8.3. COVID-19

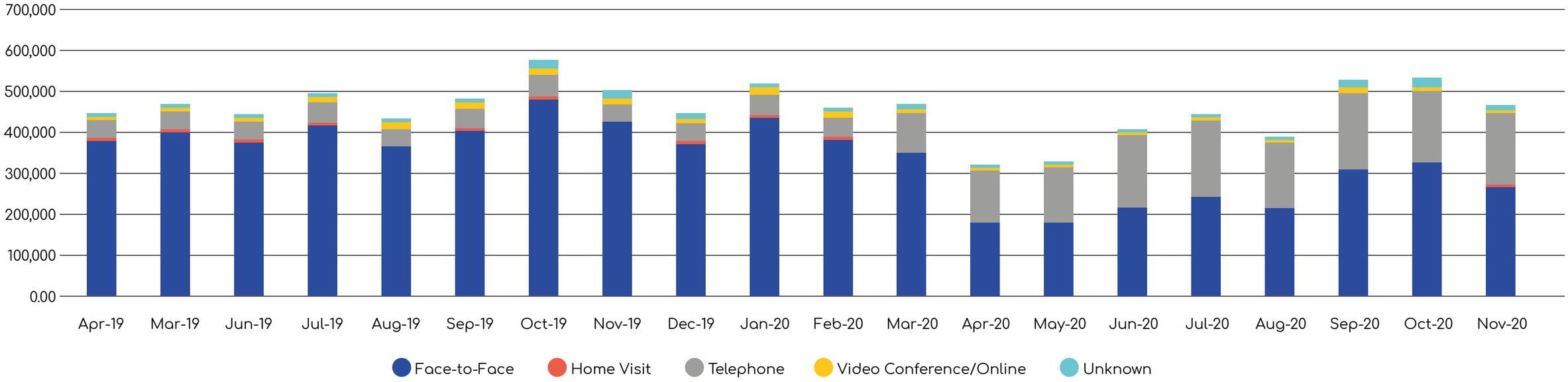
The Covid-19 pandemic, which arrived in the UK in the early months of 2020, presented the most strategic, and operational, challenge to the health and care system in its lifetime.

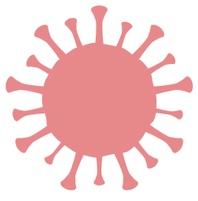
Across the system operational changes were enacted rapidly which will have a long-term strategic effect on delivery of and access to services. There has been an initiation of a strategic change, but one imposed by factors external to the system itself.

Many of the changes were originally within NHS and its partners plans but the assault on the care system forced these to be implemented more rapidly and more comprehensively than was ever anticipated.

General Practice transformed within a two-week period into a system based almost entirely on remote universal triage and telephone/video consultation. Face to face consultations did not disappear but did fall to an absolute minimum.

Consultation Method - Mid & South Essex General Practice





Whilst the method of consultation has begun to recalibrate it is unlikely there will a return to the traditional model of General Practice in the lifetime of this strategy but instead an appraisal of which of the enforced changes should be further developed and expanded, and a new balance between triage and access which is more grounded in the opportunities presented by digital innovation (ensuring that patients without access to digital platforms are not excluded).

8.4. Covid and post-Covid impact on services

There are clear operational challenges for the whole system due to the persistent effect of Covid in the community and the challenge arising from the cessation of normal activity during periods of the pandemic.

Primary Care in an ongoing pandemic environment will require more distinction of patient cohorts and the days of undifferentiated surgeries are probably at an end, at least for the foreseeable future. Care navigation and total triage have transformed the patient experience and are likely to remain as significant public facing elements of the service. Normal GMS, crudely defined as caring for people who are ill or feel themselves to be ill, will in future be more clearly segmented and ordered by triage and care navigation using both clinicians and trained administrative staff.

This inevitably leads to categories of service such as:

a GMS services requiring additional infection control measures
b Preventative care
c Long-term conditions
d Enhanced care home provision
e Integrated, all ages all needs, primary/community care
f Care for Post-Covid patients and care for “shielded“ patients
g Covid Vaccination programme
h Urgent/unplanned care
i Demand management measures to improve access to secondary care
j Support for patients awaiting secondary care.

Whilst the first category is solely related to General Practice, the others fully align to the integration agenda, with best outcomes likely to be achieved through collaboration between General Practice and other partners. Categories i. and j. maybe represent the greatest challenge but also provide a real opportunity to drive “integration“ in more innovative ways.

Patients have rapidly learned to adapt to the changes in access, but the service clearly needs to better explain how care will be delivered in the future. There may be a need to agree what patients should expect from primary care in the new post-Covid world. Access to primary care will be different, but there is no reason why it should be difficult.

In relation to care delivery the impact of the pandemic goes far beyond the boundaries of General Practice. The impact on services, and those working within partner organisations has been just as significant. All of those working across the system – in hospitals, community services, physical and mental health services, social care, care homes and domiciliary providers, education and beyond - have had to adapt to new ways of working, experiencing situations that could not have been imagined before 2020.

As we plan to move forward these experiences and the likely fatigue felt by the wider workforce must be acknowledged.

8.5. Digital

The contribution of Information Technology – hardware and software including new digital solutions - to the transformation of patient access, and ways of working, has been remarkable and has allowed general practice to remain open despite an initial dramatic reduction in face to face consultations and overall footfall within practices. Necessity has driven change across every practice, with mirrored responses in all other parts of the service, and such changes are now accepted across the system where previously there was opposition or scepticism.

The NHS Long Term Plan target of every patient having access to a "Digital first offer" by 2023/24 has been achieved in a matter of months. This provides an opportunity to continue to modernise access and perhaps to increase the contribution of the existing workforce, although patient acceptance of remote consultation in the medium to long term will require careful planning, and it is important that we understand the risks associated with this strategic opportunity in relation to those who may be considered digitally disadvantaged, or even digitally excluded. Meaningful engagement with patient groups and communities will be required to ensure this.

8.6. The effect of the pandemic on waiting lists and patient waiting times

The need to focus on the care of Covid patients during the pandemic forced immediate changes to the delivery and access of primary care but had an entirely different consequence in secondary care, where staff and resources were re-directed to treat infected patients and planned, routine or normal footfall and activity was reduced significantly.

A large number of patients have not been seen as planned and this is likely to become an increasing problem as patients return to primary care for clinical problems which they have lived with during the crisis.

Primary care has similar issues with the care of long-term conditions, and preventative medicine, but the new reality of significantly longer waiting times for hospital care will need to be addressed through increased joint working between primary and secondary care, and with wider partners who have influence on addressing the wider determinants of health and supporting people to keep well.

8.7. Integration and innovation: working together to improve health and social care for all

In February 2021 the Department of Health and Social Care published its White Paper describing its legislative proposals for a Health and Care Bill. At its heart the Bill is about backing the health and care system and everyone who works in it. The proposals build on the NHS's own – those in the Long Term Plan, and to which local plans are aligned.

This review has taken account of the strategic direction as described within that paper.

9 Making it happen

9.1. Engagement

a. Engagement: looking forwards

In December 2020, we met with Healthwatch Southend, Healthwatch Essex and Healthwatch Thurrock to gather their views on the Primary Care Strategy refresh.

The development of the public voice in the growth of PCNs formed a key part of discussions, recognising the need for sustained and continuous community engagement.

Risks around ensuring plans have due consideration of the digitally disadvantaged were also discussed. Note: considerations of these risks and further analysis will form part of the system's Digital Strategy.

We will connect people together, delivering integrated care in the community

// Services are designed to put residents in control – providing high quality information that is accessible online at any time and supporting them to make informed decisions.

// We will ensure different organisations work together, meaning people get the right care more quickly and easily.

Existing engagement structures do not support progression in line with our expectations. Discussion with the Director of Communications & Engagement for the Mid and South Essex Health and Care Partnership has identified that whilst the newly developing Citizens' Panel provides one source for engagement, there is benefit from developing an engagement structure that will enable PCNs to identify and respond to the views of the communities they serve.

We will seek additional support to deal with the complexity of the ask. Without robust approaches to engagement that are co-ordinated across PCNs and linked to the system it will likely lead to duplication of effort as well as possible gaps in engagement.

b. Building inclusive primary care networks in partnership with people and communities

In line with the Mid and South Essex Health and Care Partnership Engagement Framework it is important that there are opportunities for engagement and involvement at all levels in the system to support and inform decision making. We also want to make sure we use insights (population health management approaches, lived experiences etc.) to inform decision making.

PCNs have the potential to benefit patients by offering improved access and extending the range of services available to them, and by helping to integrate primary care with wider health and community services.

c. Where are we now?

COVID-19 has exposed how health inequalities can affect people not just over a lifetime but in a matter of weeks. The impact of COVID-19 will be long-felt.

PCNs and the broader integration of health and care services offer an opportunity to move from a medical model of care to a whole system that embraces a holistic, preventative and social approach to supporting people with all aspects of their health and wellbeing, with a focus on reducing health inequalities.

People in primary and community care are already seeing the benefits of 'social prescribing' - Link Workers and Care Co-ordination works by helping people find the community and voluntary sector groups and organisations that can support them, directly, to improve their health and wellbeing; and indirectly, by tackling the other factors in their lives that impair health, such as low activity, isolation, finances and housing problems.

We will support the development of mechanisms to meaningfully engage and build long-term trusted relationships between individuals and organisations with an interest in health and wellbeing in mid and south Essex outside and alongside the traditional health and care system.

d. Plans for the future - building a framework to deliver outcomes in different ways

Over the next 18 months, we are committed to supporting PCNs to engage with a wider range of stakeholders to co-design how best to maximise health and wellbeing at the local level.

As part of this work, it is important to recognise, appreciate and build on what already exists.

Asset based community development (ABCD) is a localised and bottom-up way of strengthening communities through recognising, identifying and harnessing existing 'assets' (i.e. skills, knowledge, capacity, resources, experience or enthusiasm) that individuals and communities have which can help strengthen and improve things locally.

// Instead of looking at what a community needs or lacks, the approach focuses on utilising the 'assets' that are already there.

// The approach facilitates the empowerment of individuals and communities by helping them to identify and share their strengths and then work together to create their own social innovations.

As a starting point, we are therefore looking to support the PCNs to review existing local work on ABCD that is already underway that either specifically or potentially relates to the target populations, identifying opportunities to build upon this to support delivery of programme aims – e.g.:

// local authority initiatives, including welfare networks developed to support people who are/were shielding;

// VCSE organisations, (particularly those with 'Experts by Experience')

// local Healthwatch,

// GP Practice PPGs and other patient groups

// Local health and care provider expert patient groups/programmes.

Through Primary Care Transformation funding, we will explore the establishment of a Community Engagement Grant programme to offer community organisations that are currently engaged in Community Asset Development the means to work with our population to gather insight and intelligence from local communities that could positively contribute to the delivery of the PCN engagement programme.

We recognise that this approach is new and completely different to existing ways of working.

In order to embed this approach, it is essential that leaders in our PCNs understand the benefits and are equipped with the necessary co-production skills and tools. We will therefore provide Asset Based Community Engagement Training, to support the establishment of effective partnership working with the selected population cohorts and relevant community organisations, delivered at Place-level.

Following on from this discovery phase, we envisage practices collectively analyse and evaluate the learnings and co-produce a shortlist of opportunities (2-3) to test and learn new ways of improving the health and wellbeing of their patient populations. These plans would be tested and refined alongside a detailed implementation plan, budget and resourcing required to deliver them.

The ambition is that an asset-based community development approach will re-focus on early interventions and prevention, working closely with community services and with the voluntary and community sector.

PCNs should put themselves in the driving seat of population health management by marrying up the data they receive within their systems, with insight and intelligence that communities themselves contribute, about unmet need, unrecognised challenges, and getting the responses right first time for people who may be using services poorly or not at all.

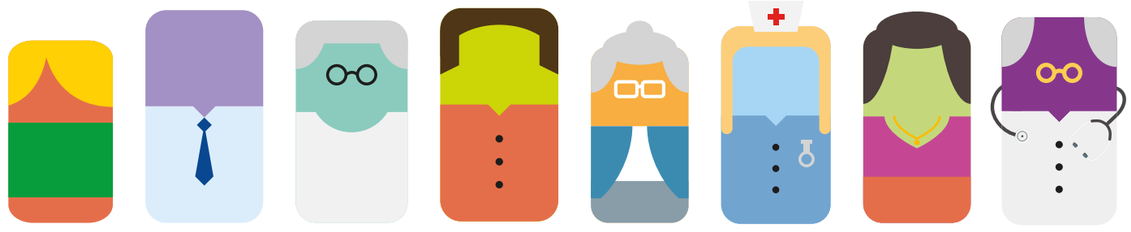
Through the on-going engagement with local voluntary and community sector, it is clear that to utilise local community assets fully, we need to:

// Support community assets to develop, grow and thrive

// Facilitate connections between community assets so that they can function as a network or group

// Facilitate connections of people to assets, so that people are informed and able to choose the activity/support they want to pursue

// Build trust and relationships, challenging existing ways of working and instigating culture change



9.2. Data

We will co-design with insights and intelligence, putting residents at the centre

// We will work with our residents and staff to shape services that are focused on better outcomes, long-term sustainability and continuous improvement, driven by a feedback culture.

// We will use data that is connected and evidence to ensure we understand fully the challenge and opportunity.

// We will ensure we have the right resources to enable us to get an accurate view from shared and collective knowledge, insight and data, which will inform our plans and actions.

General Practice in the UK hold one of the most complete patient records anywhere in the world. Traditional models of General Practice see this held by individual practices, and locally there has been very limited examples of this information being used at a scale to influence and drive change.

The success of PCNs to improve population health, shift to a model of prevention and reduce inequalities will require better use of data across organisational boundaries.

PCNs should be able to operate in an environment where aggregated primary care, community, mental health, acute and social care data enables them to make better operational decisions, utilising limited resources better, and drive improvements in population health.

Using data better will enable PCNs to better understand the needs of the population they serve. It will enable improvements in a number of areas including

// Improved understanding of the current needs of the population,

// Identifying those with deteriorating needs enabling a more proactive and preventative model of care, and

// Projecting forward to manage future risk and contribute to a reduction in health inequalities

As a Health & Care Partnership we will champion the legitimate collation and sharing of high-quality data for both direct patient care and secondary uses such as risk stratification and population health management. We will ensure PCNs have access to the competencies required to make best use of the opportunities this provides them with.

9.3. Digital

We will adopt digital and technology by default

// Services will seek to optimise the use of technology consistently e.g. digital channels will be adopted as the primary and preferred method for communication and patient interactions.

// Other channels will remain available but used only when most appropriate.

// Staff and residents are supported to adapt to new ways of working and champion innovation.

In 2018 it was noted that the adoption and spread of digital and other technologies would be a key enabler for the future model of care and was seen as contributing to

// Managing Demand

// Creating Capacity, and

// Operating at Scale

As included in the 2018 Strategy opportunities in these areas will be explored and harnessed in contributing to the aims of the strategy. The Mid and South Essex Health and Care Partnership Digital First Primary Care Team to be recruited during 2021/22 will support delivery of this commitment. Examples included at the time, and still relevant now, were

Managing demand

// **Self-care and community support.** These tools are well developed and have a range of applications, including apps and software that support behaviour change (for example people with diabetes) as well as providing online support for people with a wide range of conditions including anxiety and depression

// **Care navigation and triage.** These technologies support self-care, such as by navigating patients to appropriate sources of information and support, as well as by providing opportunities for rapid access to consultations, often via computers or smartphones

// **Prediction and risk stratification.** There are a number of established tools that can support practices to risk stratify patients on their list and identify those patients that have 'rising risk' and deliver anticipatory care. This enables comprehensive care plans to be put in place for these individuals, enabling them to stay well for longer

Creating capacity

// **Patient pathways and treatment.** These tools can support patients and professionals to provide improved on-going care and reduce the need for regular consultations, for example through Artificial Intelligence or remote patient monitoring where the patient's readings are constantly logged and reported automatically, with anomalies or concerning patterns flagged to the patient and their GP

// **Processes and productivity.** There is considerable scope to better harness technology to reduce bureaucracy in primary care, and across the system. Solutions that are already available include digital dictation that is integrated with clinical systems, and tools that enable automated data extraction from primary care platforms such as SystmOne.

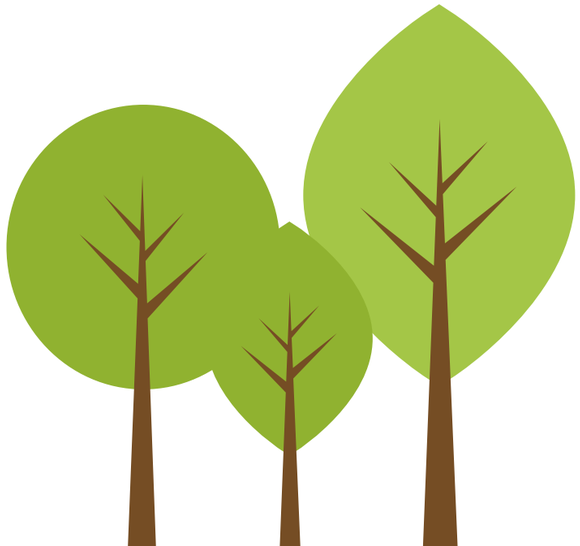
Operating at scale

// **Communication across settings.** Having access to patient level information across a range of care settings is vital, especially as patients are frequently in contact with multiple services. As well as a core shared care record, further digital solutions now enable summary records to be held on smartphones, and for automatic communication with patients (such as appointment reminders, medication alerts etc.)

Over the past three years there have been improvements made in this area, including implementation of remote monitoring tools and process automation contributing to positive impacts on both workflow and workload.

Digital continues to be seen as a fundamental enabler for the Target Operating Model for mid and south Essex, and the development of PCNs.

In parallel to the refresh of this strategy Mid and South Essex Health and Care Partnership have also progressed development of a Digital First Primary Care Strategy that supports both this refresh, and the delivery of the system's Digital Strategy, which should be read in conjunction with this.



9.4. Estate / PCN estate

In parallel to this strategy refresh the Health and Care Partnership is also reviewing its estates strategy, and the content and ambitions described here mirror emerging content of that document for primary and community care.

In order to enable collaborative working and deliver the Long-Term Plan, we need an estate that is fit for purpose. **All practices and providers need to be able to deliver services in premises that are accessible, attractive and of high quality, and in order to do this we are working with partners to deliver physical or virtual hubs that will facilitate the delivery of community and out of hospital services** to reduce activity at acute sites, support locality working, provide accommodation for the additional staff they plan to recruit and enabling services to be integrated and - where possible – co-located.

Hubs will have the following key features (estates principles):

// All space will be flexible to support the delivery of a range of services and providers

// There will be virtual consultation rooms available for the use of GPs but also accessible for all patients for virtual outpatient clinics

// All new builds will have an MDT room that is able to be divided for use by community providers, local authority services as well as multi-professional healthcare delivery

// All new builds will have at least one training / seminar room

// All facilities should be capable of operating seven days a week to maximise access and utilisation

// Increasing digital access to enable the estate to be used more flexibly and appropriately to improve access to services for patients and staff

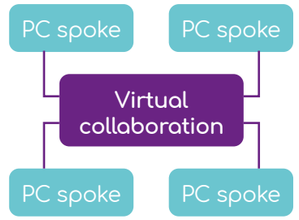
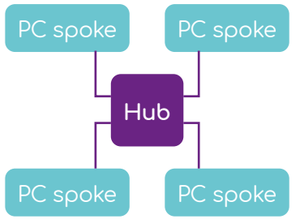
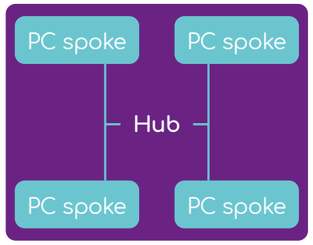
// Utilisation of buildings at 85% (applying Cavell assumptions)

// No more than 35% non-clinical space

// Accessible for third sector / voluntary organisations

// Review existing disposals and / or voids prior to committing to a new build

Building a physical hub potentially housing several practices and a wide range of other services is not practical in all areas, particularly in the more rural parts of the footprint. As a result, a broad model that is flexible has been developed, and is able to support the development of hubs at three different levels: separate practices and a virtual hub, separate practices and a physical hub, practices consolidate into a physical hub.

	Separate practices and a virtual hub	Separate practices and a virtual hub	Separate practices and a virtual hub
What it could look like			

Pros	// Minimal capital and revenue costs
	// Continue access to local services
	// Retention of individual practice identity
	// No disruption to patients
		// Increase in primary care capacity
		// Little disruption for patients
		// Retention of individual practice identity
		// Opportunities for collaborative working between practices and shared admin teams
		// Delivery of a wider range of services for a locality from purpose built premises	

Cons	// Practices do not enjoy benefits of physical co-location
	// IT infrastructure required
	// Current premises may be restrictive and could limit service provision
	// Location of services may not be suitable for growing communities
		// Added revenue costs of new hub and service delivery (7-10% of capital)
		// High capital costs
		// Head Lease holder/ Owner could not currently be NHS England or a CCG
		// Funding may be complicated for shared /bookable space
			// High capital and added revenue costs
			// Practices must relocate
			// Initial capital & time for delivery
			// Loss of individual practice identity
			// Possible lease implications
			// Disruptive for patients

Existing premise New build

NOTE: PC spoke - primary care spoke (refers to an existing practice)

In line with the NHS Long Term Plan to promote self-care, prevention and delivering more services at a local level, closer to people's homes, and the Partnerships key estates policy work streams, these hubs will facilitate the delivery of community and out of hospital services to reduce activity at acute sites.

9.5. Workforce

The workforce crisis was one of the main reasons behind the development of the 2018 Strategy as the system faced an underlying – and long-standing – factor of significantly fewer doctors and nurses per head than the national average.

The focus on recruitment and retention, as well as the diversified workforce through both locality models and subsequent PCN Additional Roles Reimbursement Schemes has seen the picture improve compared against projected numbers, but as identified in section 3 we continue to be understaffed when compared to national benchmarks.

There are currently around 3,500 staff working within primary care in mid and south Essex (December 2020 data). Of these 23% are GPs (including Registrars and Locums), 13% Nursing, 10% Direct Patient Care and 54% Admin staff. Under the ARRS, a further 477 FTE are planned to be employed by 2024. This being the local contribution to the national commitment of 26,000 additional FTE by 2023/24 in General Practice. Whilst the additional roles will strengthen the primary care workforce there are a number of challenges facing the current workforce.

The Mid and South Essex Health and Care Partnership has one of the most significantly challenged primary care workforces in the country with approximately a third of GPs forecast to retire in the next five years which is significantly higher than the national average of 22%. In addition, 43% of Nurses, 33% of Direct Patient Care staff and 48% of admin staff could retire over the next 10 years[2].

The overall clinical workforce has increased, as mentioned in the introductory section, but GP numbers are reducing, and the number of partners is low and decreasing. December 2020 data showed that only 69% of permanent GP's in mid and south Essex are Partners and these numbers are declining with a decrease of 6 Headcount (3 FTE) between June and September 2020. Not only is headcount decreasing but so is the number of hours partners are working.

A strategy based on networks of partner led practices needs to address the needs of the modern workforce and demonstrate flexibility beyond what is normally available. Partnership is seen by many new GPs as an onerous and thankless position, with little or no control of workload.

The expanded role for PCNs outlined above will hopefully create more opportunities for GPs and others to develop additional skills and enhance portfolio careers. A career structure within a partnership framework would be unique in England. "Super-partnerships" have been established in many areas of England, notably Birmingham, but in Essex this initiative has mainly been developed around Colchester and Tendring.

MSE will work with general practice to promote and improve the partnership model, and to develop a career development structure which strengthens the partnership offer.

[2] (MSE Integrated health and care workforce strategy, February 2020, gave estimates of 33% GP retirement in 5 years and 43% practice nurses in 10 years.)

The national "new to Partnership" Payment Scheme will continue to be promoted across the area and we are waiting for information from NHSE/I on uptake, but also we need to consider whether there are any other suggested programmes for people to access to ensure they emerge as confident Partners at the end of it.

Through the ARRS there is a real opportunity to shape the future and recruit, train, develop and integrate a workforce that will be flexible, adaptable and competent to deliver models of care that will result in improved health outcomes for the local population. Uptake of these roles are essential in underpinning delivery of this strategy, and a resilient and sustainable model of primary care.

The joint funded Mental Health workers – to be employed by the local mental health trust, part funded through the ARRS scheme, and fully aligned to PCN work – is one such example of a driver towards collaborative models of care, as is the approach being taken in some areas to the recruitment of First Contact Physiotherapists through the local acute provider, enabling stronger cross organization working than is achievable through other employment models.

Whilst the focus of workforce plans was on the additional staff, PCN's have been encouraged to think about the existing roles that they have and how these need to be adapted and developed to embrace the new way of working. This includes thinking about careers across the integrated care system to support the joint strategy and exploring opportunities to work differently e.g. rotational roles between primary care and other sectors such as acute and community services for roles such as physiotherapists and other allied health professionals, and the ambulance trust in relation to paramedics.

MSE will work with PCNs to meet reasonable, unfunded, additional costs of an expanded and essential clinical workforce.

The primary care strategy is aligned to the Integrated Health and Care Workforce Strategy - the overall aim of which is to enable the system to develop a more joined-up approach with health and care on workforce challenges especially in such key priority areas as recruitment and retention.

Working collaboratively on specific areas such as, training, education and development of the workforce creates invaluable learning and sharing of resources. The potential development of the Guardian service may provide opportunities for clinicians to train and solve system problems together.

9.5.1. The primary and community care training hub

Training Hubs are integral to Health Education England's core purpose of supporting the delivery of excellent healthcare and health improvement to patients and the public, through ensuring the primary care workforce of today and tomorrow are trained in the right numbers, have the necessary skills, NHS values and behaviours at the right time and in the right place as described.

Training Hubs contribute to development and retention of the workforce through delivery of locally commissioned initiatives which include:

a Support for new clinical staff through fellowships, preceptorships, peer and multi-professional "new professional" learning groups

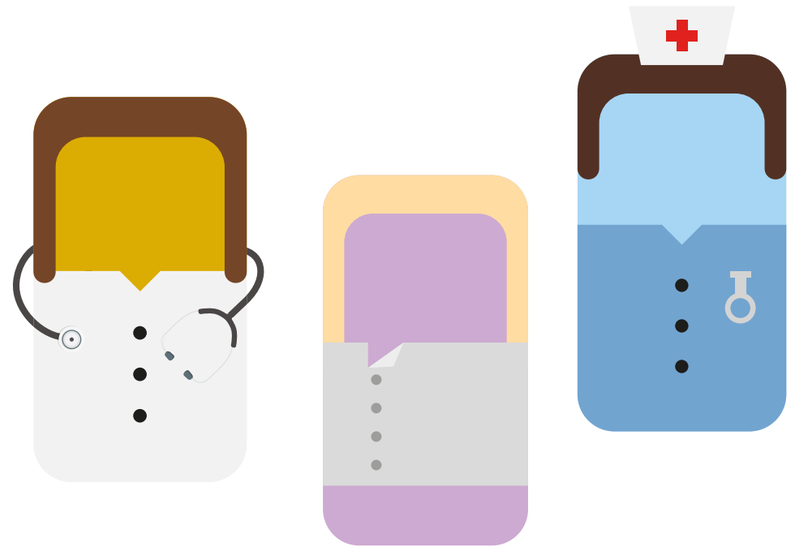
b Promotion and facilitation of key CPD programmes and multi-professional learning linked to clinical care intentions / service redesign initiatives at a systems level

c Promotion and facilitation of leadership programmes to develop staff and development of primary and community care educators

d Co-ordination of personal career support for all stages of Primary and Community Care

e Professionals' careers

f Support integrated education and training across existing current boundaries: including supporting rotational programmes across organisations.



Training Hubs are required to have six core functions

1. Further development and expansion of placement capacity to create innovative and high-quality clinical placements for all learners to meet the workforce needs of "the place" in line with the Long-Term Plan: thus, maximising the effective use of educational resources across the network
2. Support understanding of workforce planning, assisting in the co-ordination and realisation of the health and social care workforce across the ICS.
3. Support recruitment of the primary care workforce through:
   a. Developing, expanding and enhancing recruitment of multi-professional educators together with developing their capabilities to support the delivery of high-quality clinical learning placements and high-quality teaching and learning environments.
   b. Supporting the development and realisation of educational programmes to develop the primary/ community care workforce at scale to address identified population health needs, support service re-design and the delivery of integrated care (through, for example, rotational placements and integrated educational programmes of learning).
4. Enable, support and embed "new roles" within primary care
5. Support the retention of the primary care workforce across all key transitions including promoting primary care as an employment destination to students, through schools and higher education institutions
6. Enable both workforce planning intentions and placement co-ordination through the active management of clinical placement tariffs – moving towards "place-based tariffs".

Given the role Training Hubs have in supporting the existing and growing primary care workforce it is essential that they are aligned to the ambitions of PCNs, and we will support the continued development of a direct relationship between the Training Hub and PCN Clinical Directors. In time PCNs should be able to both direct the core work of, and commission additional support directly from, the Training Hub in order to improve the workforce offer of PCNs.

9.6. Investment

Investment into General Practice and wider Personal Medical Services is complex in terms of sources and use of funding. Throughout this strategy we will mirror the national intention that PCNs become the unit level at which investment is targeted. As part of the move to a system operating budget, and service line budgets, we will we look to set a target for investment as a proportion of overall spend, building on the current baseline with an intention to go beyond national ambition.

Investment is currently circa 10% of total local investment. This is intended to grow as a result of national GP Contract negotiations, and investment commitments made as part of the Long-Term Plan, in particular through the Network DES.

National direction will also see investment previously made by CCGs into service models 'funnelled' through the Network DES, for example the transfer of Extended Access funding into PCNs. This however is not new money.

The system, through this strategy and led by the ambition and capability of accelerator PCNs, are seeking to increase the proportion of investment made into General Practice. This should go beyond revenue investment, and could start to look at targeting capital investment into this area. One example could be through possible development of non-acute based diagnostic facilities, reducing acute footfall, and improving collaboration across sectors.
At the time of writing CCGs and systems had not been informed of allocations for 2021/22, and as such the investment below is considered the minimum investment to be made into General Practice based on known outcomes of the GP contract negotiations from previously published information and illustrates additional funding against the 2020/21 baseline. Through the national investment programme General Practice has access to an additional £26m of investment over the next three years. This additional investment was further committed within the NHSE Planning Guidance published on the 25th March 2021.

New investment through the National GP Contract (Network DES)				
Mid & South Essex Total (£'000's)	21/22	22/23	23/24	Total
Additional Role Reimbursement Scheme	7,084	6,272	8,652	22,008
Impact and Investment Fund	2,818	1,675	1,672	6,165
Average PCN (£'000's)	21/22	22/23	23/24	Total
Additional Role Reimbursement Scheme	253	224	309	786
Impact and Investment Fund	101	60	60	220

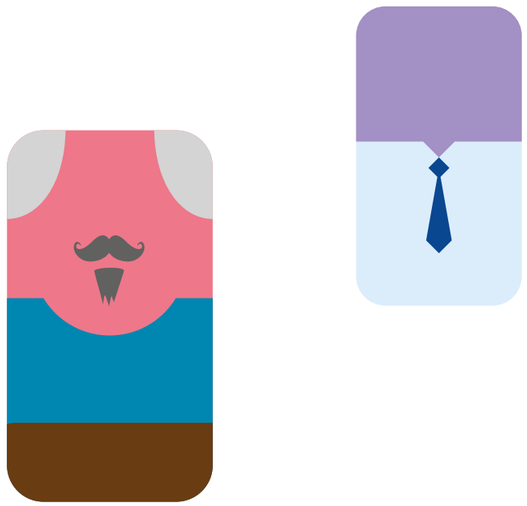
NOTES: Calculations as of BMA & NHSE 'Update to the GP contract agreement 2020/21 - 2023/24' 6 February 2020

FIGURES ABOVE:

// Do not include the ARRS underspend from 2020/21 being invested over the coming three year. If PCNs recover this under-recruitment this will see additional investment into General Practice of circa £5m.

// Do not include the contractual uplift agreed as part of the contract settlement.

It is the ambition for investment into General Practice to increase at a faster rate. This will be determined in part by the readiness of PCNs to expand their scope and deliver a greater range of services.



9.7. Implementation

In 2018 the system agreed an approach where each CCG would lead its local implementation, but co-ordinating across the system where that made sense. This acknowledged individual journeys to date, local pace, context and relationships.

Local implementation remains essential, but as we mature our ICS it is important that the end points become more aligned, in both time and expectation.

Here we seek to describe an approach based upon place-based leadership and accountability for delivery, within a collective system acknowledging the principles agreed within the Mid and South Essex Health and Care Partnership Memorandum of Understanding.

Transitioning to a model of collaboration built around Primary Care Network footprints will take time and will need to resolve some of the well-versed challenges that have limited progress over recent years. Effective GP involvement will need to recognise both the challenges presented by a nationally negotiated contract for Primary Medical Services and that CCGs (and the new ICS statutory body when it emerges), with delegated commissioning responsibilities for General Practice, cannot move away from the formal relationship with individual practices, and delivery of the functions delegated by NHS England and NHS Improvement.

To successfully deliver the ambitions of this strategy, and the local and national ambitions that this contributes to, we will need to successfully strike the balance between bottom-up change, and the achievement of system ambitions. It is the expectation that this is managed through Place in line with the principles already agreed as part of the Mid and South Essex Health and Care Partnership Memorandum of Understanding and ways of working .

It can be argued that there are two fundamental challenges to be addressed for successful implementation:

The first is the alignment of purpose and incentives. Through implementation of this strategy we will look to align purpose amongst stakeholders at a PCN. This will be co-ordinated at Place where assurance will be provided that they align to Place-based priorities whilst contributing to the collective purpose of the Health and Care Partnership. This will include as a minimum agreement of PCN level outcome measures that sit across all partners, identified and defined by the PCN, but endorsed by the Place based Alliances, and over the life of this strategy the movement to arrangements that incentivise collective delivery. This will be supported through the development of the system's service line budgets financial framework, and aligns with the principles of the Mid and South Essex Health and Care Partnership Memorandum of Understanding.

The second, and arguably more important element, will focus on leadership development and organisational/system culture. As is the case with the first point this will, in the main, be delivered through place level relationships upon which the success of PCNs are reliant.

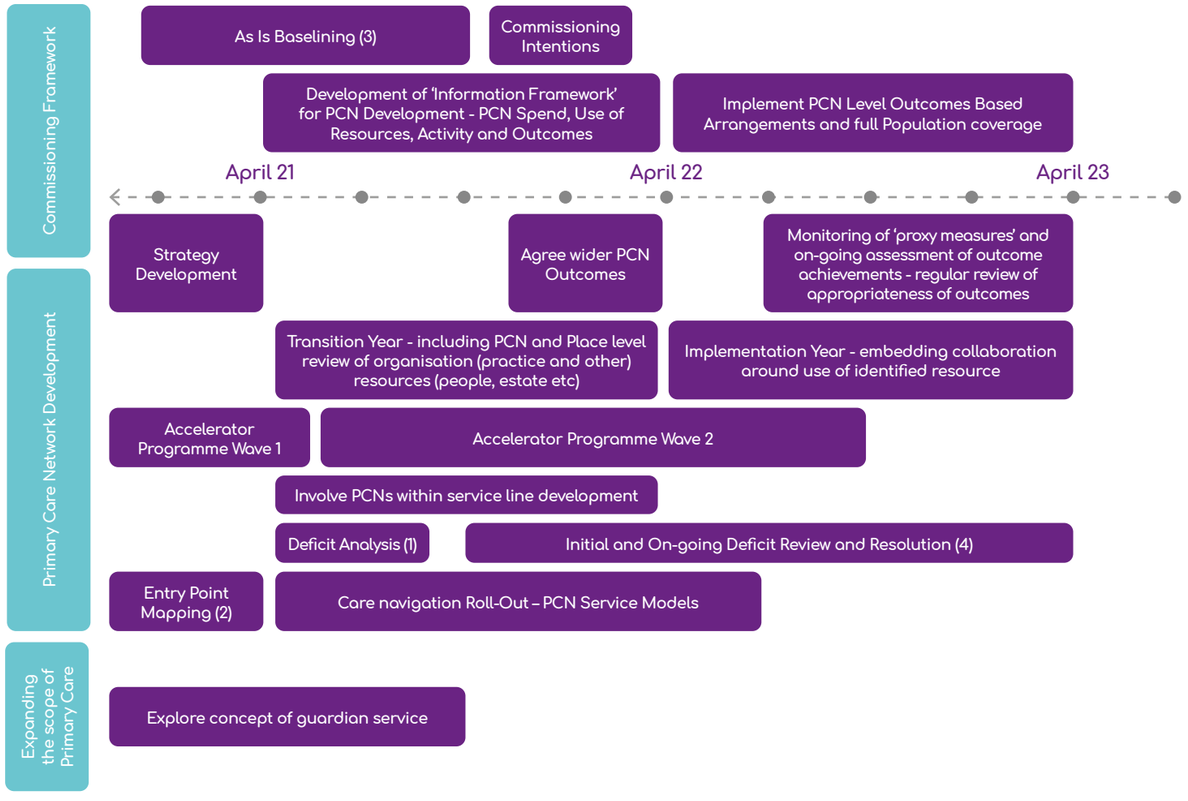
9.7.1. Accelerator Programme

Following a blanket offer of support to PCNs in 2019/20 in 2020/21 the system moved to an offer of targeted support to those PCNs willing and capable to develop faster, and open to sharing learning with others.

This accelerator approach, backed up by support to enable fast followers, will be the mechanism for PCN development at a system level. It is expected that through 'place' PCNs will be identified and supported to engage in this programme. As a system we will collectively support these PCNs to grow and become strategically important delivery vehicles in their area, using them to test new ways of working with partners before spreading and adopting across the wider footprint. An essential principle to test is how partners, such as local authorities and Acute Trusts, become members of PCNs.

Whilst it is accepted that development happens at a local level, the ambitions of the system as a whole need to ensure that collectively PCNs are all moving forward. The summary implementation timeline below identifies high-level milestones to be achieved within each Place and collectively.

The creation of place-based, or PCN specific, development plans will be required to move this forward through which it is expected that those areas where collaboration at a larger footprint is required will be identified. These should be developed at Place level, and fall in scope for the NHS Alliance Directors to agree with alliance partners .



9.8. Risks

We will adopt the Partnership approach to risk management as described in its 5 year strategy for the delivery of this strategy. The approach is designed to ensure that the risks and issues are identified, assessed, and mitigation plans developed in a risk management plan. All risks will have a responsible owner identified.

Each specific programme has its own risk log and items elevated to Partnership level are those significant risks that require partners to address together.

The overarching risk management policy is based on an iterative process of:

- // Identifying and prioritising the risks to the achievement of the programme aims and objectives;
- // Evaluating the likelihood of those risks being realised and the impact should they be realised;
- // Managing the risks efficiently, effectively and economically.

The key risks for delivery are as follows:

Risks	Mitigations
Partners do not agree the strategic direction as described in this document	Partners engaged in the development process of the strategy refresh and endorsement received at the Partnership Board
General Practice do not agree with the strategic direction as described in this document	The refresh does not alter the strategic direction as described in 2018, but enhances it in line with recent local and national policy. General Practice have been involved, including through the LMC and CCG Chairs, in the development of this document
Failure to attract and retain an appropriately skilled health and care workforce, and under recruitment of the ARRS	Focus on the challenge through the Workforce Training Hub, and making the explicit links to the wider workforce strategy of the Health and Care Partnership
PCNs do not have the appropriate capacity and competencies to develop	Through accelerator programme, and Alliance Directors, understand existing gap and as partners seek to address
Financial risks are not managed appropriately	All five CCGs have delegated authority for commissioning primary care services as of April 2021. Links made with the Service Line Budgets Financial Framework being developed under the system governance of System Executive and System Finance Leaders.

9.9. Governance

This section attempts to describe the governance approach to be adopted to oversee delivery of this strategy. It does not attempt to cover the governance arrangements for the ICS, or how Primary Care is represented within an integrated system. It is also likely to be reviewed as part of any transition requirements of new legislation.

The Mid and South Essex Health and Care Partnership have adopted a memorandum of understanding that clearly champions the concept of subsidiarity, and this has been reflected within the approach to implementation. However, the principles of working as a system require an understanding of the impact of decisions and actions made at each tier – system, place and PCN – and the importance of collective alignment where this makes sense. As such, as is the case with many current transformation programmes, the governance for oversight and delivery of the stated strategic ambitions will take two forms both of which feed into the Mid and South Essex Health and Care Partnership Governance arrangements. These arrangements are likely to be reviewed as part of any changes to landscape as a result of the White Paper.

9.9.1. Contractual Assurance

From April 2021 all five CCGs in mid and south Essex will have delegated responsibility for the commissioning of primary medical services. As part of the delegation agreement with NHS England each will also have a Primary Care Commissioning Committee, with an intention that these will meet as a Committee in Common. Delegation gives the CCGs the ability to make local decisions around primary care resource, and align local discussions and decisions on primary care commissioning and implementation of local strategy including transitioning to a new consistent contracting framework for local investment that supports the development and growth of PCNs.

Whilst the issues identified within this strategy refresh will not be addressed by delegation alone, the local decision making that delegation brings will give greater responsiveness, flexibility and freedom to act to address these issues.

9.9.2. Assurance at Place

The strongest message from this, and associated strategies, is one of improved collaboration amongst frontline staff. This cannot be undertaken at a system level - its success is down to local relationships and understanding and appreciating local context.

As such responsibility for delivering PCNs that achieve the triple integration aim, and contribute to improvements in local population health outcomes, must sit at place. This is currently assumed to be through the four place-based alliances and within their emerging arrangements. This is reflected in the expectations of the NHS Alliance Directors within the CCGs Joint Executive Team. Specific arrangements at place will be clarified during the first part of 2021/22.

Delivery of place-based plans will be overseen by the System Oversight and Assurance Group.

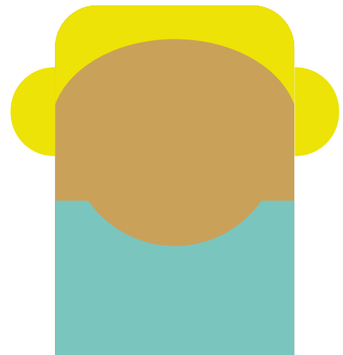
9.9.3. Collective Assurance

Since 2018 the Primary Care Programme Board has met to bring together the five CCGs to ensure that there is appropriate alignment in the transformation of General Practice, and to provide a shared forum for the discussion and agreement of the utilisation of specific primary care 'system' funding. Its current scope for collective oversight includes PCN Development, Primary Care Digital and Primary Care Workforce.

There is still a requirement for this collective oversight to exist, particularly amongst commissioners of Primary Medical Services, to ensure there is best value being achieved in the utilisation of shared resource, and that economies of scale can be extracted where possible.

To date this has been a health commissioner dominated forum, but as we move to more mature collaborative ways of working it is envisaged that the scope of this group may change.

We will review the Terms of Reference during 2021/22 to ensure they reflect the emerging accountability structure of the system, and ensure they are fit for purpose for the developing system and the relationships with place-based Alliances.

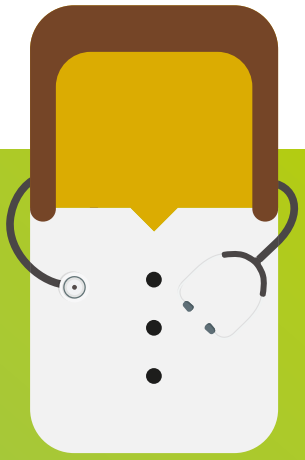


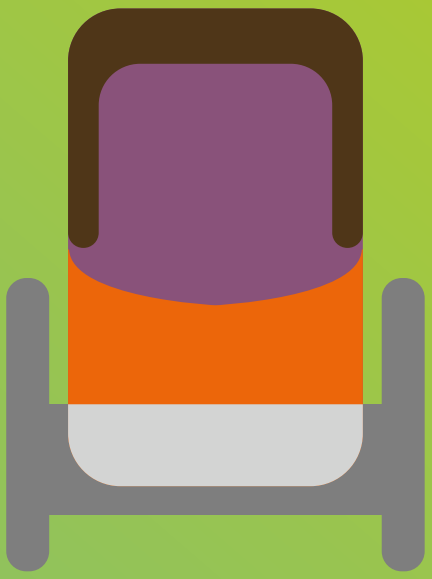
Mid and South Essex Health and Care Partnership

Our Priorities	System Programmes
Healthy Start	Maternity Children & Young People Health inequalities
Healthy Minds	Children and Adult Mental Health Mental Health
Healthy Places	Integrated care Place development Anchor institutions
Healthy Communities	Primary & community care Prevention Population Health
Healthy Living	Care closer to home Ageing well Cardiovascular disease Diabetes
Healthy Care	Covid Care Cancer Service improvements

Country, Borough and District Councils | Country, Borough and District Councils | Country, Borough and District Councils | Country, Borough and District Councils | Country, Borough and District Councils | Country, Borough and District Councils | Country, Borough and District Councils

Mid and South Essex
Health and Care
Partnership





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